2012

The Medical Plan

Your Summary Plan Description

Effective January 1, 2012
Released: October 21, 2011

This Summary Plan Description (SPD) describes:

- The Medical Plan for Union Employees, a component program of the MSD Medical, Dental and Long Term Disability Plan for Union Employees, as it applies to employees of Merck Sharp & Dohme Corp. who are members of collective bargaining units excluding the United Steelworkers Union Local 10-00086 collective bargaining unit;
- The Medical Plan for Nonunion Employees, a component program of the MSD Medical, Dental and Long Term Disability Plan for Nonunion Employees, as it applies to nonunion U.S.-based* employees of Merck Sharp & Dohme Corp. and its wholly owned subsidiaries (excluding employees of Telerx Marketing, Inc., employees of Inspire Pharmaceuticals Inc., employees of Comsort, Inc., employees based outside the U.S. on assignment outside their home country but in the U.S. and U.S.-based* employees on assignment outside the U.S.);
- The medical benefits provided under the Schering Corporation Employees' Benefit Trust Plan applicable to union and nonunion U.S.-based* employees of Schering Corporation and its wholly owned subsidiaries (excluding employees based outside the U.S. on assignment outside their home country but in the U.S. and U.S.-based* employees on assignment outside the U.S.).

The Medical Plan for Union Employees, the Medical Plan for Non-Union Employees and the medical benefits provided under the Schering Corporation Employees' Benefit Trust Plan are collectively referred to herein as the Medical Plan.

The Medical Plan for Union Employees also provides medical benefits to former employees of Merck Sharp & Dohme Corp. who on their retirement date were members of a collective bargaining unit (including the United Steelworkers Union Local 10-00086 collective bargaining unit) and who satisfy the Plan's requirements for retiree medical benefits. Benefits for these groups are described in a separate summary plan description(s).

The Medical Plan for Nonunion Employees also provides medical benefits to:

- Former nonunion U.S.-based* employees of Merck Sharp & Dohme and its wholly owned subsidiaries (excluding employees of Telerx Marketing, Inc., employees of Inspire Pharmaceuticals Inc., and employees of Comsort, Inc.) who satisfy the Plan's requirements for retiree medical benefits,
- U.S.-based* employees of Merck Sharp & Dohme and its wholly owned subsidiaries on assignment outside the U.S.; and
- Non-U.S.-based* employees of Merck Sharp & Dohme and its wholly owned subsidiaries on assignment outside their home country, including in the U.S.

Benefits for the groups described in the bullets above are described in separate summary plan descriptions. To receive a copy of the summary plan descriptions that describe the benefits provided to these groups, contact the Merck Benefits Service Center at **800-66-MERCK**.

The Schering Corporation Employees' Benefit Trust Plan also provides medical benefits to:

- Former union and nonunion U.S.-based* employees of Schering Corporation and its wholly owned subsidiaries who satisfy the plan's requirements for retiree medical benefits;
- U.S.-based* employees of Schering Corporation and its wholly owned subsidiaries on assignment outside the U.S.; and
- Non-U.S.-based* employees of Schering Corporation and its wholly owned subsidiaries on assignment outside their home country, including in the U.S.

Benefits for the groups described in the bullets above are described in separate summary plan descriptions. To receive a copy of the summary plan descriptions that describe the benefits provided to these groups, contact the Merck Benefits Service Center at **800-66-MERCK**.

A list of the collective bargaining units whose members (and former members) are eligible to participate in the Medical Plan for Union Employees (a component program of the MSD Medical, Dental and Long Term Disability Plan for Union Employees) and who are eligible to participate in the Schering Corporation Employees' Benefit Trust Plan as it applies to medical benefits is included in the official plan documents and is available upon request.

* U.S.-based excludes Puerto Rico.

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Your Medical Benefits

The Medical Plan offers you several options for medical coverage. This section provides a brief overview of all the Medical Plan options and resources that are available to you as an Eligible Employee.

Frequently Used Terms

Key words that are frequently used in the SPD are capitalized and defined in the Glossary.

Your Medical Plan Options

Eligible Employees may enroll themselves and their Eligible Dependents for coverage under the Medical Plan. Eligibility to elect a particular option may depend on your geographic location. Each medical plan option offers the same basic plan components (including prescription drug and behavioral health care benefits). However, the way benefits are delivered, the costs for coverage and services, and the provider networks vary by medical option. For details about your coverage, see the applicable section of this SPD and contact the Claims Administrator.

The Medical Plan offers the following coverage options:

- **Merck Preferred Provider Option — Horizon BCBS.** Administered by Horizon BCBS, uses the national BlueCard® PPO network and offers you the freedom to visit any licensed health care provider you choose, including In-Network or Out-Of-Network providers.
- **Merck Preferred Provider Option — Aetna Choice POS II**. Administered by Aetna, uses Aetna's national Choice POS II network and offers you the freedom to visit any licensed health care provider you choose, including In-Network or Out-Of-Network providers.
- **Merck 80/20 Option.** The Merck 80/20 option is generally a traditional fee-for-service option that is administered by Horizon BCBS and allows you the freedom to receive care from any licensed physician or specialist. The Merck 80/20 option uses the national BlueCard Traditional network.
- **Hawaii HMO Option.** Eligible Employees who reside in Hawaii may elect the Health Plan Hawaii Plus option. This is the only Medical Plan option available to employees who reside in Hawaii. This option is not available to Eligible Employees who reside outside of Hawaii.
- **Kaiser Permanente HMO Option**. This option is closed, only Eligible Employees who already participate in this option can continue their coverage.
- **No Coverage Option.** Eligible Employees may waive coverage under the Medical Plan by electing this option.

Prescription Drug Coverage

When you enroll in a Medical Plan option (except No Coverage option), you are automatically covered under the Managed Prescription Drug Program, which is administered by Medco Health Solutions, Inc. (Medco).

Mental Health and Substance Abuse Coverage

When you enroll in a Medical Plan (except the No Coverage option), benefits are provided for mental health care and substance abuse. The specifics of the coverage vary depending on the option in which you are enrolled. If you are enrolled in:

- Merck PPO — Horizon BCBS option or the Merck 80/20 option, your mental health and substance abuse benefits are provided through the Behavioral Health Care Program (administered through ValueOptions).
- Merck PPO — Aetna Choice POS II option, your mental health and substance abuse benefits are provided through Aetna.
- HMO Plans — Your mental health and substance abuse benefits are provided through your HMO.

Details about your coverage are provided in the applicable sections of this book. (See "ValueOptions Behavioral Health," page 77 or "Aetna Behavioral Health," page 86.)

KEY POINT — THE PPO NETWORKS

Horizon BCBS

The Horizon BCBS national provider networks are referred to as BlueCard PPO and BlueCard Traditional. The Merck PPO — Horizon BCBS option uses the BlueCard PPO network while the Merck 80/20 option uses 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 — Horizon BCBS option. In general, if you are enrolled in this option, you will receive the highest level of benefits when you 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. In general, if you are enrolled in this option, you will receive the same level of benefits regardless of the network status of the provider you utilize. However, when you receive treatment from a participating BlueCard Traditional provider, you will benefit from the BlueCard negotiated discounts.

You have three ways to locate a Horizon BCBS provider:

- Go to **www.horizonblue.com/merck,**
- Call Horizon BCBS at **877-663-7258**, and speak with a representative,
- Call Horizon BCBS at **877-663-7258**, and request to have a hard copy directory mailed to you.

Special note for Behavioral Health Care Benefits: If you participate in the Merck PPO-Horizon BCBS option, only providers in the ValueOptions Network are considered In-Network providers for behavioral health care. Providers in the BlueCard network are considered Out-Of-Network for behavioral health care; however, if you receive care from a BlueCard provider, you may be eligible to pay for services based on the Horizon BCBS negotiated fees.

Aetna Choice POS II

Aetna Choice POS II is a national provider network and is the only network in which providers will be considered In-Network under the Merck PPO — Aetna Choice POS II option. In general, if you are enrolled in this option, you will receive the highest level of benefits when you receive treatment from an In-Network provider. You have three ways to locate an Aetna provider:

- Go to AetnaNavigator™ at **www.aetna.com/docfind,**
- Call Aetna at **800-541-6711**, and speak with a representative,
- Call Aetna **at 800-541-6711**, and request to have a hard copy directory mailed to you.

Benefits Contacts and Resources

Several vendors administer Merck's medical benefits. This chart will help you decide who to contact when you have a question, need to update your benefits or precertify certain services.

When You Want to...	Contact	How
▪ Compare Plans ▪ Obtain Plan literature and forms ▪ View the *Merck Summary Plan Descriptions* ▪ If you're an Eligible Employee: – Enroll in your benefits when first hired or during annual enrollment – Report a Life Event change or HIPAA special enrollment event – Update dependent information – Access information and updates about all of Merck's benefits	Merck Benefits Service Center's Web site	**http://netbenefits.fidelity.com**
▪ Ask a benefits-related question	Merck Benefits Service Center's Phone Line	**800-66-MERCK (800-666-3725)** TDD: **888-343-0860**
▪ Contact a Medical Plan Provider with questions, for claims information or to precertify	Horizon BCBS (PPO or Merck 80/20) Aetna Kaiser Permanente Hawaii Health Plus HMO	**877-663-7258** **www.horizonblue.com/merck** **800-541-6711** **www.aetna.com** **800-464-4000** **www.KaiserPermanente.org** **808-948-6372** **www.hmsa.com**
▪ Precertify behavioral health	ValueOptions® Aetna	**877-44-MERCK or** **800-541-6711www.aetna.com**
▪ Mail order prescription drugs ▪ Locate a participating pharmacy	Medco Health Solutions, Inc.	**800-RX-MERCK (800-796-3725)** **www.medco.com**
▪ Obtain prior authorization for prescription drugs	Medco Health Solutions, Inc.	**800-753-2851**

KEY POINT — ENROLLING IN MEDICAL BENEFITS

Enrollment in the Medical Plan is through Fidelity Investments — the service provider for administration of Merck's Health & Insurance benefits. Eligible Employees can enroll in medical benefits online or by phone. Please see "How to Enroll" in the "About Your Medical Benefits" for detailed enrollment instructions.

Merck Benefits Service Center

To help you with enrollment, general benefits information and questions, the Merck Benefits Service Center is available to you through Fidelity NetBenefits® or by phone. The Merck Benefits Service

Center is administered by Fidelity Investments, the service provider for administration of Merck's Health & Insurance benefits.

Fidelity NetBenefits at http://netbenefits.fidelity.com

Fidelity NetBenefits is your source for benefit transactions and information virtually 24 hours a day, 7 days a week. Directions for logging in to NetBenefits are provided on the Web site.

Fidelity Customer Service Associates by Phone at 800-66-MERCK (800-666-3725)

Fidelity Customer Service Associates are available to help you with your benefit questions Monday through Friday (excluding New York Stock Exchange holidays), between 8:30 a.m. and 8:30 p.m., Eastern time. For overseas calls: dial your country's toll-free AT&T Direct® access number then enter **800-666-3725**. In the U.S., call **800-331-1140** to obtain AT&T Direct access numbers.

KEY POINT — ESTABLISHING A PIN

When accessing the Merck Benefits Service Center, online through NetBenefits or by phone through a Customer Service Associate, you will need a Personal Identification Number (PIN). Your PIN provides another level of security to ensure that only you can access your benefits information. For your protection, keep your PIN confidential.

You can establish your PIN directly through NetBenefits at **http://netbenefits.fidelity.com** or by calling the Merck Benefits Service Center at **800-66-MERCK (800-666-3725)** and following the instructions.

Note: Your PIN cannot be your date of birth or your Social Security number. It also cannot contain multiple repetitive digits or be in ascending or descending order.

Horizon BCBS Resources

If you have questions about your Merck PPO — Horizon BCBS or Merck 80/20 coverage, need help finding a physician, want to check the status of a claim or request ID cards, contact Horizon BCBS at **877-663-7258**.

www.horizonblue.com/merck

Horizon BCBS's Web site is a secure self-service member Web site, available 24 hours a day, seven days a week. You can access benefits and health information by visiting **www.horizonblue.com/merck**.

KEY POINT — THE BLUE DISTINCTION CENTER FOR TRANSPLANTATION

If your physician has recently discussed with you the need for transplantation and you are covered under a Medical option administered by Horizon BCBS, 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.

Aetna Choice POS II Resources

If you have questions about your Merck PPO — Aetna Choice POS II coverage, need help finding a physician, want to check the status of a claim or request ID cards, contact Aetna at **800-541-6711**.

www.aetna.com
Aetna's Web site is a secure self-service member Web site, available 24 hours a day, seven days a week. You can access benefits and health information, by visiting **www.aetna.com**.

KEY POINT — NATIONAL MEDICAL EXCELLENCE & INSTITUTES OF EXCELLENCE (IOE)

This program is available to Covered Employees and Covered Dependents enrolled in the Merck PPO-Aetna Choice II option to help arrange for access to effective care for particularly difficult conditions requiring transplants or complex cardiac, neurosurgical or other procedures. The program utilizes a national network of experienced providers and facilities selected based on their volume of cases and outcomes. The National Medical Excellence Unit provides specialized case management through the use of nurse case managers, each with procedure and/or disease specific training.

The Aetna Institutes of Excellence (IOE) transplant network is available to provide Covered Employees and Covered Dependents with high quality and efficienct transplant care. It is made up of a select group of hospitals and transplant centers that meet quality standards for the number of transplants performed and their outcomes.

ValueOptions Resources

ValueOptions is the Care Manager for the Behavioral Health Program that applies to all Covered Employees and their Covered Dependents other than those enrolled in the Merck PPO — Aetna Choice POS II. If you are a Covered Employee enrolled in any of the Horizon BCBS options, call **877-44-MERCK** if you have questions about mental health or substance abuse issues or to precertify mental health care services.

Medco Resources

Access Medco's Web site at **www.medco.com** if you have a question about your prescription drug benefits, want to look up information about a prescription drug, find a participating retail pharmacy or order a refill through The Medco Pharmacy™ Mail Order Service. You can also contact Medco Member Services at **800-RX-MERCK (800-796-3725)**.

About This Summary Plan Description

This SPD merely summarize the benefits and benefit coverage levels provided under the Medical Plan. Decisions regarding appropriate treatment (e.g., level and duration of care) are always left to the discretion of the patient and attending physician. This SPD reflects the provisions of the Medical Plan in effect as of January 1, 2012.

This SPD replaces the Medical SPD effective January 1, 2011 entitled "The Medical Plan — Your Summary Plan Description" and all summaries of material modifications applicable to it dated before January 1, 2012.

About Medical Benefits

This section provides Eligible Employees with important information about medical coverage under the Medical Plan — including eligibility, enrollment, contributions and when you can make changes to your benefits.

Medical Eligibility

If you are an Eligible Employee, you and your Eligible Dependents (you can find the definition of Eligible Dependents in the Glossary on Page 122) are eligible for coverage in the Medical Plan as of your date of hire (or rehire).

You are *not eligible* for coverage under the Medical Plan if you are an Excluded Person.

KEY POINT — ALL COVERED INDIVIDUALS MUST ENROLL IN THE SAME OPTION

You and your Covered Dependents must be enrolled in the same Medical Plan option, even if you reside in different locations.

Eligible Dependents

As an Eligible Employee, you can enroll your Eligible Dependents for coverage under the Medical Plan. For coverage to apply to your Eligible Dependents, they must be enrolled as Covered Dependents under the Medical Plan.

Adding Eligible Dependents to Your Coverage

Between annual enrollment periods, you are permitted to add an Eligible Dependent or delete a Covered Dependent only if you have a Life Event that allows you to make a Permitted Plan Change or you experience a HIPAA special enrollment event. See "When Life Changes" and "Special Enrollment Under HIPAA for Eligible Employees."

Same-Sex Domestic Partnerships

Merck extends coverage under the Medical Plan to Eligible Employees' Same-Sex Domestic Partners and Same-Sex Domestic Partners' Eligible Dependent children. (See "Eligible Dependents" in this chapter for a definition of Eligible Dependent children.) To elect Same-Sex Domestic Partner benefits through Merck, you and your partner must meet the Company's definition of a Same-Sex Domestic Partnership.

Tax Consequences

Under current federal income tax laws, the value of providing medical and dental benefits to a Same-Sex Domestic Partner and his/her Eligible Dependent children is considered taxable to you — unless they are considered your dependents for purposes of federal income taxes. As discussed in more detail below, this means you will pay federal, state and local income taxes, as well as employment taxes, on the full value of the coverage provided to your Same-Sex Domestic Partner and his/her dependents. This type of taxable

income is known as imputed income, and Merck will report it on your W-2 form at the end of each year.

It's important for you to understand the tax implications of covering a Same-Sex Domestic Partner and/or his/her Eligible Dependent children. You may wish to consult a tax advisor to determine the full tax and financial effect of electing this coverage. For more information, see "Paying for Medical Benefits." You can obtain more information about Same-Sex Domestic Partner benefits by calling the Merck Benefits Service Center at **800-66-MERCK**.

KEY POINT — OPPOSITE-SEX DOMESTIC PARTNERS

If you are a Legacy Schering-Plough Employee with an Opposite-Sex Domestic Partner, you were eligible to cover him/her (and his/her Eligible Dependent children) through December 31, 2011. Refer to your 2012 enrollment materials or call the Merck Benefits Service Center at **800-66-MERCK** for more details. Your Opposite-Sex Domestic Partner (and his/her Eligible Dependent children) may be eligible to continue their coverage for a period of up to 36 months under COBRA-like coverage, as explained in the "Continuation of Health Care Coverage for Opposite-Sex Domestic Partners of Legacy Schering-Plough Employees," see page 105.

Right to Audit Dependents Eligibility

By electing coverage for your dependents (either by affirmative election or through the default process), you are confirming that they meet the Plan's dependent eligibility requirements and agree to notify the Merck Benefits Service Center within 30 days of an event that causes any of these dependents to no longer meet the definition of an Eligible Dependent.

The Company, in its sole discretion, maintains the right to audit any and all dependent information on file, and may require that you promptly provide sufficient documentation verifying your Covered Dependents' continued eligibility.

If you do not promptly provide documentation sufficient to verify your Covered Dependents' continued eligibility or if the Company determines that any of the information you provide (or provided) regarding your Covered Dependents is untrue, incomplete or misleading, or if you fail to promptly notify the Merck Benefits Service Center of an individual's loss of eligibility, the Company may take such action as it deems appropriate under the circumstances. Those actions may include, but are not limited to requiring you to repay the Plan for any benefits/premiums paid with respect to your ineligible dependent and subjecting you to disciplinary action, up to and including termination of employment (subject to any applicable collective bargaining agreement). If you provide fraudulent information or make intentional misrepresentations regarding your Covered Dependents, the Company may retroactively terminate benefits for your ineligible dependents.

Enrolling in Medical Benefits

Coverage Tiers

For the Medical Plan, Eligible Employees may choose from one of four levels of coverage:

- Employee Only;
- Employee + Spouse/Same-Sex Domestic Partner;
- Employee + Child(ren); or
- Employee + Spouse/Same-Sex Domestic Partner + Child(ren).

If both you and your Spouse/Same-Sex Domestic Partner work, or worked, for Merck, special provisions apply to the Coverage Tier you are eligible to elect. See "Merck Couples Enrollment Rules" for details.

Medical Plan Options

The Medical Plan options for which you are eligible appear on your NetBenefits Enrollment Worksheet on Fidelity NetBenefits at **http://netbenefits.fidelity.com**. You may also call the Merck Benefits Service Center at **800-66-MERCK** to find out which options are available to you. In general, you may choose from the following Medical Plan options:

- Merck PPO — Horizon BCBS option;
- Merck PPO — Aetna Choice POS II option;
- Merck 80/20 option;
- Kaiser Permanente HMO option (for current participants only);
- Hawaii Health Plus HMO option (for residents of Hawaii only); or
- No coverage.

KEY POINT — OPTIONS VARY BY LOCATION

The Medical Plan options you are eligible for depend on your geographic area, as determined by the home address you have on file with Fidelity Investments. You may have only one address on record for you and your Covered Dependents. Please keep in mind that you and all Covered Dependents must be enrolled under the same Medical Plan option.

To find out the Medical Plan options that are available to you and their costs, review your Enrollment Worksheet on Fidelity NetBenefits at **http://netbenefits.fidelity.com**. You may also call the Merck Benefits Service Center at **800-66-MERCK** to learn more about the Medical Plan options for which you may be eligible.

If You Waive Coverage

Eligible Employees may elect to waive coverage by selecting the No Coverage option. If you elect the No Coverage option because you have other coverage through your Spouse's/Same-Sex Domestic Partner's plan, be sure to check the rules of his/her plan in advance. Some employers will not allow an employee to cover a Spouse/Same-Sex Domestic Partner if the Spouse/Same-Sex Domestic Partner can obtain coverage through his/her own employer. Electing No Coverage means that you waive coverage in the Medical Plan, Managed Prescription Drug Program and Behavioral Health Care Program and that you will not be able to change this election and enroll until the next annual enrollment period or until you experience a Life Event or a HIPAA special enrollment event.

In addition, if you have the No Coverage option on the date you qualify for Long-Term Disability (LTD) Benefits, you will have No Coverage under the Medical Plan while you are receiving LTD Benefits until the following annual enrollment, unless you experience a Life Event that allows you to make a Permitted Plan Change or circumstances permitting enrollment under HIPAA. See "When Life Changes" and "Special Enrollment under HIPAA for Eligible Employees" for more information. Also, you and your Eligible Dependents will not be entitled to Medical Plan coverage under COBRA should you have a qualifying event during the year.

State Mandates

The Medical Plan is governed by federal law known as the Employee Retirement Income Security Act of 1974 (ERISA). Certain states may have provisions that require certain coverage or level of coverage be provided. Under ERISA, Merck is not required to follow state law for coverage options that are self-insured by the Company. As a result, the Plan is not required to — and in many cases does not — provide coverage mandated by state law. For more information, contact the Merck Benefits Service Center at **800-66-MERCK**.

Enrollment for Newly Hired or Rehired Regular Full-Time and Regular Part-Time Employees

As an Eligible Employee, you are automatically enrolled for Employee Only coverage as of your date of hire or rehire. Your automatic enrollment option will be determined by your home address:

- If you live inside the BlueCard PPO network, you will be automatically enrolled for Employee Only coverage under the Merck PPO — Horizon BCBS option.
- If you live outside the BlueCard PPO network, but within the Aetna Choice POS II network , you will be automatically enrolled for Employee Only coverage under the Merck PPO — Aetna Choice POS II option.
- If you live outside of either PPO option's network, you will be automatically enrolled for Employee Only coverage under the Merck 80/20 option.

Changing Your Medical Plan Option within 30 Days of Your Hire or Rehire Date

You may elect to change your Medical Plan option within the first 30 days of your hire/rehire date through NetBenefits at **http://netbenefits.fidelity.com** or by calling the Merck Benefits Service Center at **800-66-MERCK**. As long as you enroll for coverage within 30 days of your hire/rehire date, your coverage will be effective as of your hire/rehire date. See "How to Enroll" for more detailed instructions.

Enrolling Your Dependents within 30 Days of Your Hire or Rehire Date

You may enroll your Eligible Dependents for coverage (with an effective date of your hire/rehire date) under the same medical option you choose within the first 30 days of your hire/rehire date. As long as you enroll your Eligible Dependents for coverage within 30 days of your hire/rehire date, their coverage will be effective as of your hire/rehire date.

If You Do Not Enroll within 30 Days of Your Hire Date

If you do not elect to change your Medical Plan option or enroll your Eligible Dependents within 30 days of your date of hire/rehire, you will have Employee Only coverage under the applicable Merck PPO option (or the Merck 80/20 option if you live outside the PPO networks) for the remainder of the Plan Year. You will not be able to add your Eligible Dependents or change Medical Plan options until the next annual enrollment period, unless you experience a Life Event that allows you to make a mid-year Permitted Plan Change or circumstances permitting enrollment under HIPAA. See "When Life Changes" and "Special Enrollment Under HIPAA for Eligible Employees" for more information.

KEY POINT — LIFE EVENTS

You are permitted to make certain Plan changes during the year only if you have certain Life Events — for example:

- The birth or adoption of a child;
- You get married or divorced (or meet the eligibility requirements for or end a Same-Sex Domestic Partnership);
- Your covered child reaches the maximum coverage age;
- One of your dependents dies;
- Your Spouse's/Same-Sex Domestic Partner's employment status changes; or
- You relocate out of your network service area.

See "When Life Changes" for information about how your medical coverage may be affected by certain Life Events.

Enrollment for Transferred Employees

If you are a Transferred Employee, you will be:

- Automatically enrolled in the coverage option closest to your prior medical coverage, as determined by Merck; or
- Automatically enrolled in the Merck PPO option, based on your home address, or the Merck 80/20 option if you live outside the PPO networks.

The Eligible Dependents whom you covered under your prior medical coverage are automatically enrolled in the coverage option under which you are automatically enrolled if your medical coverage was administered through a Merck entity.

Changing Your Coverage within 30 Days of Your Transfer Date

You may elect to change your Medical Plan coverage option and add an Eligible Dependent or drop a Covered Dependent from your coverage within 30 days of your Transfer Date through NetBenefits at **http://netbenefits.fidelity.com** or by calling the Merck Benefits Service Center at **800-66-MERCK**. See "How to Enroll" for more detailed instructions.

If you do not change your option within the first 30 days of your Transfer Date, you will not be able to change your option until the next annual enrollment period, unless you experience a Life Event that allows you to make a mid-year Permitted Plan Change or a HIPAA special enrollment event. See "When Life Changes" and "Special Enrollment under HIPAA for Eligible Employees" for more information.

Enrollment for Merck Temporary Employees

If you are a Merck Temporary Employee, you are automatically enrolled in Employee Only coverage in one of the following options as of your date of hire or rehire. Your automatic enrollment option will be determined by where you live:

- If you live inside the BlueCard PPO network, you will be automatically enrolled for Employee only coverage under the Merck PPO — Horizon BCBS option.
- If you live outside the BlueCard PPO network, but within the Aetna Choice POS II network , you will be automatically enrolled for Employee Only coverage under the Merck PPO — Aetna Choice POS II option.
- If you live outside of either PPO option's network, you will be automatically enrolled for Employee Only coverage under the Merck 80/20 option.

As a Merck Temporary Employee, you cannot change Medical Plan options or waive coverage by electing the No Coverage option.

Enrolling Your Dependents within 30 Days of Your Hire Date

You may enroll your Eligible Dependents for coverage under the Merck PPO option within the first 30 days of your hire/rehire date. As long as you enroll your Eligible Dependents for coverage within 30 days of your hire/rehire date, their coverage will be effective as of your hire/rehire date. To enroll your Eligible Dependents, log on to NetBenefits or call the Merck Benefits Service Center at **800-66-MERCK**.

If you don't enroll your Eligible Dependents within 30 days of your hire/rehire date, you will not be able to add them to your coverage at a later time, unless you experience a Life Event that allows you to make a mid-year Permitted Plan Change or circumstances permitting enrollment under HIPAA. See "When Life Changes" and "Special Enrollment Under HIPAA for Eligible Employees" for more information.

How to Enroll

You enroll in the Medical Plan through the Merck Benefits Service Center, which is administered by Fidelity Investments—the service provider for administration of Merck's Health & Insurance benefits. You have the convenience of enrolling in your medical benefits either online or by phone, as described below.

Online through Fidelity NetBenefits at http://netbenefits.fidelity.com

Once you've established your PIN and logged into NetBenefits, follow these steps for enrolling in your medical benefits:

- From the NetBenefits Health & Insurance tab, select Get Started Now.
- Enter or validate information about your Eligible Dependents.
- Enroll in your benefits through your online Benefit Elections page.
  - When you're satisfied with your selections, click "Save Your Benefits." The elections from your online session will not be saved until you click "Save Your Benefits."
  - A confirmation screen will display the elections you submitted. Print this page for your records.

Call a Fidelity Customer Service Associate

Customer Service Associates can take your benefit elections by phone between 8:30 a.m. and 8:30 p.m., Eastern time, Monday through Friday (excluding New York Stock Exchange holidays). Once you enroll by phone, it's a good idea to confirm your benefit elections by reviewing your Enrollment Worksheet on NetBenefits. You can reach the Merck Benefits Service Center at the following numbers:

- In the U.S.: call **800-66-MERCK**.
- TDD service for the hearing impaired: call **888-343-0860**.
- For overseas calls: dial your country's toll-free AT&T Direct access number then enter **800-666-3725**. In the U.S., call **800-331-1140** to obtain AT&T Direct access numbers. From anywhere in the world, access numbers are available online at **www.att.com/traveler** or from your local operator.

When Coverage Begins

- **Eligible Employees.** Your participation in the Medical Plan begins on your date of hire or rehire. As long as you enroll your Eligible Dependents in coverage within the first 30 days of your date of hire or rehire, your Eligible Dependents' coverage also begins on your date of hire or rehire.
- **Transferred Employees.** Medical coverage for you and your Covered Dependents under the Medical Plan continues without interruption on your Transfer Date. If you change your coverage option within 30 days of your Transfer Date, your new coverage begins on your Transfer Date. If you add Eligible Dependents to your medical coverage within the first 30 days of your Transfer Date, your Eligible Dependents' coverage begins on your Transfer Date.
- **Merck Temporary Employees.** Your participation in the Medical Plan begins on your date of hire or rehire. As long as you enroll your Eligible Dependents in coverage within the first 30 days of your date of hire or rehire, your Eligible Dependents' coverage will also begin on your date of hire or rehire.

ID Cards

Unless you elected the No Coverage option, as soon as administratively feasible after you are enrolled for medical coverage, you will receive an ID card directly from the health care carrier. You will also receive a separate ID card for Merck's Managed Prescription Drug Program.

Paying for Medical Benefits

Full-Time and Part-Time Employees

If you are a Regular Full-Time Employee or Regular Part-Time Employee, you and Merck share the cost of your medical coverage, with Merck paying the majority of the cost. You pay your share of the cost through regular payroll deductions made on a Pre-Tax basis. Your cost is based on the Medical Plan option and Coverage Tier you choose (Employee Only; Employee + Spouse/Same-Sex Domestic Partner; Employee + Child(ren); Employee + Spouse/Same-Sex Domestic Partner + Child(ren)) and your status as a Part-Time or Full-Time Employee.

Your employee contributions start the first of the month following your date of hire/rehire, although your coverage begins as of your date of hire/rehire. This first period of your medical coverage is paid for entirely by the Company.

Current employee contributions for the different Medical Plan options are listed on your Enrollment Worksheet, which you can view on NetBenefits at **http://netbenefits.fidelity.com**. Employee contributions may change from year to year. Merck will inform you, typically during the annual enrollment period, if there are any employee contribution changes.

Transferred Employees

If you are a Transferred Employee, you contribute toward the cost of your medical coverage as of your Transfer Date. You pay your share of the cost through regular payroll deductions made on a Pre-Tax basis. Your cost is based on the Medical Plan option and Coverage Tier you choose (Employee Only; Employee + Spouse/Same-Sex Domestic Partner; Employee + Child(ren); Employee + Spouse/Same-Sex Domestic Partner + Child(ren)). For the month in which your Transfer Date occurs, any difference in your employee contribution between your former medical plan and your new Medical Plan option will be adjusted in your paycheck as soon as administratively feasible.

Merck Temporary Employees

If you are a Merck Temporary Employee, coverage in the Medical Plan is provided at no cost to you and your Covered Dependents.

Merck Long-Term Disability (LTD) Employees

If you are a LTD Employee, coverage in the Medical Plan will be available as follows:

- For Legacy Merck employees disabled and receiving LTD Benefits before January 1, 2011, coverage in the Medical Plan is provided at no cost to you and your Covered Dependents.
- For Legacy Schering-Plough employees disabled and receiving LTD Benefits before January 1, 2005, coverage in the Medical Plan is provided at no cost to you and your Covered Dependents.
- For Legacy OBS employees disabled and receiving LTD Benefits before January 1, 2009, coverage in the Medical Plan is provided at no cost to you and your Covered Dependents.
- For all other LTD Employees, coverage in the Medical Plan is offered at the same rate as similarly situated active employees.

KEY POINT — A WORD ABOUT LTD MEDICAL PLAN OPTIONS AND MEDICARE

All of the Medical Plan options available to you require you and your Covered Dependents who are eligible for Medicare to enroll in Medicare — Parts A and B — when you are first eligible. Once you are eligible for Medicare due to disability and you are no longer considered to be in active employment, Medicare becomes the primary payer for you and your Covered Dependents who qualify for Medicare and the Merck Medical Plan is the secondary payer. In this case, the Medical Plan will coordinate benefits with Medicare. For more information, see "Coordinating Benefits with Medicare."

While participation in Medicare Parts A and B is required, participation in Medicare Part D prescription drug coverage is voluntary and Merck does *not* require that you or your Covered Dependents sign up for Medicare Part D.

Discounts for Completing the Personal Health Assesment, "LIVE IT"

If you complete the Personal Health Assesment ("LIVE IT") before November 11, 2011 you can receive a $10 per month discount from your 2012 contribution to medical coverage. If you also cover your Spouse or Same-Sex Domestic Partner you can receive an additional $10 per month discount if they also complete the Personal Health Assesment before November 11, 2011.

Visit the WebMD powered Web site: **http://www.liveit.merck.com**, to take the 15-minute questionnaire. Follow the instructions to register when you visit the first time. You need to complete your PHA before the November 11, 2011 deadline to receive the discount on your 2012 monthly contribution for medical coverage, obtain your Personal Health Summary, and to earn your other LIVE IT rewards.

Your privacy is important: No personal health information related to your participation in LIVE IT will be shared with Merck. Merck will only receive aggregated, anonymous health data needed to evaluate the success of LIVE IT and to design programs that meet employee's health and wellness needs. WebMD will use the information you provided in your Personal Health Assessment as well as in other LIVE IT programs and tools if needed, for example, to determine whether you qualify for WebMD health coaching and should be contacted to discuss participation. You are not required to participate. Information about your participation will be shared by WebMD with other organizations that support Merck health plans. For more information, please review the Merck Health Plans Notice of Privacy Practices available online at **http://www.merck.com/privacy** or contact the Merck Privacy Office at **merck_privacy_office@merck.com**

Pre-Tax Contributions

Your contributions toward the cost of medical coverage are deducted from your paycheck on a Pre-Pax basis. This means your contributions come out of your pay before federal income and Social Security taxes are deducted. Pre-Tax contributions save you money by reducing your gross salary, which lowers your taxable income and, therefore, the amount of income tax you must pay. In most states (except, for example, New Jersey), you also pay no state taxes on your contributions.

Please note that paying for your medical coverage on a Pre-Tax basis could slightly reduce your future Social Security benefits since the earnings used to calculate your Social Security benefits at retirement will not include these payments. However, your savings on current taxes under the Medical Plan will normally be greater than any eventual reduction in Social Security benefits.

Financial Considerations for Same-Sex Domestic Partner Coverage

You and Merck share the cost of covering a Same-Sex Domestic Partner and/or his/her Eligible Dependent children—the same as you would for coverage of a Spouse and your own Eligible Dependent children. However, there are additional financial and tax implications to consider. For example, if you elect medical coverage for your Same-Sex Domestic Partner and/or his/her Eligible

Dependent children, in most cases you'll pay more in taxes than you would if you were covering a Spouse and your own Eligible Dependent children.

About Imputed Income
Under the Internal Revenue Code, the tax treatment of employer and employee contributions toward the cost of medical coverage varies based on who is covered. Employer costs for coverage of:

- Employees and their Eligible Dependents (as defined under the federal tax code) are not considered taxable income to the employee.
- Same-Sex Domestic Partners and their Eligible Dependent children are considered taxable income to the employee — unless the individuals are the employee's dependents for federal income tax purposes. If you believe your Same-Sex Domestic Partner is your dependent for federal tax purposes, please contact the Merck Benefits Service Center at **800-66-MERCK**.

As a result, the full cost of medical coverage (employee and employer contributions) for your Same-Sex Domestic Partner and his/her Eligible Dependent children is, in most cases, added to your income and subject to federal, state and local taxes — as well as applicable employment and payroll taxes. These additions are known as imputed income and represent the value of the coverage provided through your contributions and the Company's contributions. They are determined based on Merck's COBRA coverage rates minus the 2% administrative fee (see "COBRA").

Your contributions for coverage for your Same-Sex Domestic Partner and/or his/her Eligible Dependent children will appear on your Enrollment Worksheet and your pay stub as Pre-Tax. However, the full value of these benefits — including the amounts you paid on a Pre-Tax basis, plus those contributions provided by the Company — will be taxed and shown as imputed income on your paycheck and your year-end W-2 statement.

Imputed income is not included in your Base Pay for purposes of calculating your benefits or contributions under pay-related benefits (such as, but not limited to, medical Out-of-Pocket Maximum, life insurance, 401(k)/Savings Plan contributions, Retirement Plan benefits, etc.).

Special Enrollment Under HIPAA for Eligible Employees

Under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), you have special enrollment rights under certain circumstances. If you decline enrollment in the Medical Plan because you had alternative health coverage, you may be eligible to enroll in the Medical Plan without waiting until the next annual enrollment period for yourself and your Eligible Dependents if:

- You initially declined coverage for yourself and your Eligible Dependents because you had alternative health coverage and that alternative health coverage has been terminated because:
  - The coverage was continuation coverage under the Consolidated Omnibus Budget Reconciliation Act (COBRA) and that coverage has been exhausted. (The special enrollment option is not available if COBRA coverage terminates because of failure to pay employee contributions or for cause.)
  - You lost eligibility for coverage you had elsewhere (including as a result of legal separation, divorce, death, termination of employment, reduction in hours or for reasons other than failure to pay employee contributions or for cause) or employer contributions toward the cost of coverage terminated.
- You have gained an Eligible Dependent (Spouse or child) through marriage, birth, adoption or placement for adoption.

However, you must request enrollment within 30 days after the occurrence of any of the events described above. The effective date of coverage as a result of the special enrollment right will be the

date of the event itself, but changes to your contribution amount will take effect the first of the month following or coincident with the date of notification.

In addition, you may be able to enroll yourself and your Eligible Dependents in this Plan if your or your Eligible Dependents,' coverage under a Medicaid plan or a State Children's Health Insurance Program (CHIP) plan terminates due to loss of eligibility for such coverage or if you or your Eligible Dependents become eligible for premium assistance under a Medicaid plan or a CHIP plan. However, you must request enrollment within 60 days after the date your or your Eligible Dependents' Medicaid or CHIP coverage terminates or the date you or your Eligible Dependents are determined to be eligible for such assistance.

Please note that while existing federal law does not extend HIPAA rights to your Same-Sex Domestic Partner and their children who are Eligible Dependents, Merck does permit Same-Sex Domestic Partners and their children who are Eligible Dependents to enroll under the HIPAA special enrollment provision. See "Your Rights Under HIPAA" for more information.

To request special enrollment through HIPAA, you must contact the Merck Benefits Service Center at **800-66-MERCK** within the required timeframes outlined above. Note that the rules regarding Life Event changes may be more generous than those under HIPAA. See "Making Changes to Your Coverage."

Merck Couples Enrollment Rules

If both you and your Spouse/Same-Sex Domestic Partner (or your former Spouse/Same-Sex Domestic Partner or his/her Spouse/Same-Sex Domestic Partner) work, or worked, for the Company, there are certain rules about the coordination of dependent medical coverage.

KEY POINT — SAME-SEX DOMESTIC PARTNERS

In general, for purposes of the rules related to Merck couples under the Medical Plan, your Same-Sex Domestic Partner is treated as your Spouse — and as stepparent to your Eligible Dependent children. And, your Same-Sex Domestic Partner's Eligible Dependent children are treated as your stepchildren.

No Duplicate Merck Coverage

If you, your Spouse/Same-Sex Domestic Partner (or your former Spouse/Same-Sex Domestic Partner or his/her Spouse/Same-Sex Domestic Partner) and/or your dependent children are eligible for medical coverage under the Medical Plan, you may not select duplicate coverage under the Medical Plan. In other words, no one may be covered under the Medical Plan as both a participant and a dependent. Furthermore, no two people may cover the same Eligible Dependent children under the Medical Plan.

You, your Spouse/Same-Sex Domestic Partner, your former Spouse/Same-Sex Domestic Partner, or his/her Spouse/Same-Sex Domestic Partner may choose to cover different dependents under different plans by selecting different Coverage Tiers. For example, if your Spouse is a Merck employee and an Eligible Employee, you may choose Employee Only coverage to cover yourself under the Medical Plan and Employee + Child(ren) or Employee + Spouse/Same-Sex Domestic Partner + Child(ren) to cover all Eligible Dependents under the Merck Dental Plan.

Merck Couples Enrollment Rules in General

Generally, if you and your Spouse/Same-Sex Domestic Partner both participate in the Medical Plan, you must decide who will cover your Spouse/Same-Sex Domestic Partner and/or your Eligible Dependents for purposes of the Medical Plan. You and your Spouse/Same-Sex Domestic Partner each

may enroll in Employee Only coverage or one Spouse/Same-Sex Domestic Partner may enroll as the Eligible Dependent of the other. However, special rules apply if your Spouse/Same-Sex Domestic Partner is a Non-Eligible Union Employee, LTD Employee or Retiree (see below).

KEY POINT — ENROLLMENT ELECTIONS FOR MERCK COUPLES

If you elect the No Coverage option because you plan to be covered as an Eligible Dependent under your Spouse's/Same-Sex Domestic Partner's coverage, it is your responsibility to ensure that your Spouse/Same-Sex Domestic Partner elects the correct Coverage Tier. You will not be able to make enrollment changes until the next annual enrollment period, unless you experience a Life Event or HIPAA special enrollment event that allows you to make a Permitted Plan Change, even if you elected No Coverage in error.

Covering Your Eligible Dependents

If you wish to cover your Spouse/Same-Sex Domestic Partner and any Eligible Dependent children, you must choose Employee + Spouse/Same-Sex Domestic Partner + Child(ren). Remember, the Employee + Child(ren) Coverage Tier allows your Spouse/Same-Sex Domestic Partner to cover an Eligible Dependent child without providing coverage for you. In no event can you and your Spouse/Same-Sex Domestic Partner each cover the same Eligible Dependent children.

You and your Spouse/Same-Sex Domestic Partner may choose to cover different Eligible Dependent children under different benefit plans by selecting different Coverage Tiers. For example, you can choose Employee Only to cover yourself under the Medical Plan and Employee + Spouse/Same-Sex Domestic Partner + Child(ren) to cover all Eligible Dependents under the Merck Dental Plan.

If Your Spouse/Same-Sex Domestic Partner Is a Non-Eligible Union Employee

If you are an Eligible Employee who is married to (or in a Same-Sex Domestic Partnership with) a Merck employee who is a Non-Eligible Union Employee, your Spouse/Same-Sex Domestic Partner does not qualify as an Eligible Dependent and may not be covered under your coverage. Likewise, you are not an Eligible Dependent under your Spouse's/Same-Sex Domestic Partner's union coverage.

This provision also applies if the Non-Eligible Union Employee who is your Spouse or Same-Sex Domestic Partner is not actively at work, for example is on a leave of absence (including long-term disability leave) or layoff from Merck.

For your children:

- If you elect dependent coverage, your Eligible Dependent children may be covered under the option you select for yourself under the Medical Plan, but your Spouse/Same-Sex Domestic Partner must consent to this choice by calling a Fidelity Customer Service Associate at **800-66-MERCK** between 8:30 a.m. and 8:30 p.m., Eastern time, Monday through Friday (excluding New York Stock Exchange holidays).
- If you choose Employee Only coverage, your Spouse/Same-Sex Domestic Partner must actively enroll the children under his/her union medical plan.

Please note the provisions listed above also apply if your current Spouse/Same-Sex Domestic Partner and ex-Spouse/ex-Same-Sex Domestic Partner both work for the Company. For example, if your current Spouse is a Eligible Union Employee and your former Spouse is a Non-Eligible Union Employee, they cannot both cover your Eligible Dependent children.

If Your Spouse/Same-Sex Domestic Partner Is a LTD Employee

If you are an Eligible Employee married to, or in a Same-Sex Domestic Partnership with, a LTD Employee, you and your Eligible Dependents are eligible for coverage under your Spouse's/Same-Sex Domestic Partner's coverage option as an Eligible Dependent.

If you are an Eligible Employee and married to, or in a Same-Sex Domestic Partnership with, an employee who is eligible for LTD Benefits but who is a Non-Eligible Union Employee, your Spouse/Same-Sex Domestic Partner does not qualify as an Eligible Dependent under your coverage. Likewise, you are not an Eligible Dependent under his/her Union coverage. To determine eligibility for your Eligible Dependent children, see "If Your Spouse/Same-Sex Domestic Partner Is a Non-Eligible Union Employee."

If Your Spouse/Same-Sex Domestic Partner Is a Retiree

If you are an Eligible Employee married to a person considered to be a retiree of the Company, you and your Eligible Dependents may be eligible for coverage under the retiree's coverage as a dependent. For more information, see "Merck SPD for Legacy Merck Retirees" or "Merck SPD for Legacy Schering-Plough Retirees."

Making Changes to Your Coverage

Annual Enrollment

Each year during annual enrollment, you may elect to make changes to your Medical Plan coverage or keep your current medical elections, subject to its continued availability. Generally, the benefit elections you make will remain in effect for the entire Plan Year (January 1-December 31) unless you or your Eligible Dependents experience a Life Event that allows you to make a Permitted Plan Change or circumstances permitting enrollment under HIPAA. See "When Life Changes" and "Special Enrollment Under HIPAA for Eligible Employees" for more information.

Changes made during the annual enrollment period are effective January 1 of the following year. If you do not make a change during annual enrollment, your Medical Plan coverage for the new Plan Year will automatically default to your current Medical Plan option (subject to its continued availability) and Coverage Tier.

Each year, you will be notified of the annual enrollment procedures, coverage costs and timeframes for enrolling in or changing your elections for the upcoming Plan Year. Since Merck may make changes to the Medical Plan at any time, it is important to review your annual enrollment materials carefully when you receive them. You may access annual enrollment materials, obtain contact information, review Plan design changes and confirm most benefits through NetBenefits at **http://netbenefits.fidelity.com**.

Between annual enrollment periods, you and your Eligible Dependents may change or enroll in (if you had waived coverage) medical coverage only if you or your Eligible Dependents experience a Life Event that allows you to make a Permitted Plan Change and the Plan Administrator permits you to make a change in coverage or circumstances permitting enrollment under HIPAA. See "When Life Changes" and "Special Enrollment Under HIPAA for Eligible Employees" for more information.

Please note: If you are a Merck Temporary Employee, or a LTD Employee who was a Merck Temporary Employee at the time you began receiving LTD Benefits, you are not permitted to make changes to your Medical Plan coverage during the annual enrollment period. However, you may add an Eligible Dependent or drop a Covered Dependent from your Medical Plan coverage or change your Coverage Tier if you experience a Life Event that allows you to make a Permitted Plan Change or circumstances permitting enrollment under HIPAA. See "When Life Changes" and "Special Enrollment Under HIPAA for Eligible Employees" for more information. You may not change your Medical Plan option for any reason.

When Life Changes

Life Events & Permitted Plan Changes

During the Plan Year, you may be eligible to make certain changes to your Medical Plan coverage if you experience a Life Event that allows you to make Permitted Plan Changes. Any requested change to your coverage must be consistent with the Life Event.

In general, Life Events may include:

- A change in your legal marital status, including marriage, divorce or legal separation/annulment (in states where legal separation is recognized);
- Meeting all of the criteria for a Same-Sex Domestic Partnership as defined by Merck, or ending a Same-Sex Domestic Partnership;
- Gaining a new Eligible Dependent through birth, adoption or placement for adoption;
- Your Eligible Dependents losing eligibility as a result of reaching the maximum coverage age;

- The death of your Eligible Dependent child or Spouse/Same-Sex Domestic Partner;
- A change to the employment status of you, your Spouse/Same-Sex Domestic Partner or Eligible Dependent child, including the beginning or end of an unpaid leave of absence, an FMLA leave or a change in work status (such as a switch from salaried to hourly pay or full-time to part-time hours);
- You, your Spouse/Same-Sex Domestic Partner or Eligible Dependent child terminating or commencing employment; or
- A change in the place of residence which includes a ZIP code change for you, your Spouse/Same-Sex Domestic Partner or Eligible Dependent child.

Permitted Plan Changes may also include changes to certain benefits resulting from other events such as:

- If another employer's medical plan allows for a change in your Eligible Dependents' coverage (either during that plan's open enrollment period or due to a mid-year election change permitted under that employer's plan), you may be able to make a corresponding election change under the Medical Plan.
- If the Medical Plan receives a Qualified Medical Child Support Order (QMCSO**)** requiring the Plan to provide health coverage to your child or foster child. In this instance, the Plan will automatically change your benefit elections to provide coverage for the child. In the case of a child whom you are required to cover pursuant to a QMCSO, coverage will begin on the date specified in the order, or if none is specified, the date of the order. You may decrease your coverage for that child, if the court order requires the child's other parent to provide coverage and your Spouse's or former Spouse's plan actually provides that coverage.
- If your Eligible Dependent becomes entitled to, or loses entitlement to, coverage under a government institution, Medicare, Medicaid or state children's health program, you may make corresponding changes to your benefit elections under the Medical Plan. This event may also qualify as a HIPAA special enrollment event. See "Special Enrollment Under HIPAA for Eligible Employees" for more information.

KEY POINT — IF A PROVIDER CHANGES NETWORKS, IT IS NOT CONSIDERED A LIFE EVENT

If you are an Eligible Employee and your health care provider or facility decides to drop out of — or start participating in — a participating network of providers, this change in access is not considered a Life Event that would allow you to change your medical election mid-year. If you wish to change your Medical Plan option, you must wait until the annual enrollment period.

How to Make a Permitted Plan Change

If you have a Life Event that allows you to make a Permitted Plan Change, you must request your change within the first 30 days of the event through NetBenefits at **http://netbenefits.fidelity.com** or by calling the Merck Benefits Service Center **at 800-66-MERCK**. Any requested change to your coverage must be consistent with the Life Event. If you do not make your request within 30 days — except for adding a new child through birth or adoption (see below) — you will have to wait until the next annual enrollment period to change your medical coverage, subject to any annual enrollment limitations.

When Permitted Plan Changes Go Into Effect

If you experience a Life Event that permits you to change your Medical Plan coverage during the Plan Year, the effective date for the change will be the date of the event itself, provided you notify Fidelity Investments within the first 30 days of the event, except if you are adding a new child through birth or adoption (see below). Any changes to your contribution amount will take effect the first of the month following or coincident with the date of notification. If you fail to notify Fidelity Investments

within the first 30 days, you will not be permitted to make a change until the next annual enrollment period, subject to any annual enrollment limitations.

Special Timeframes for Adding a New Child through Adoption or Birth
If you request coverage for a new child through birth, adoption or placement for adoption, the following special coverage and contribution effective dates apply:

- ***Within 30 days.*** If you request coverage for your new child within 30 days of the date of the birth or adoption, the coverage effective date will be the date of the event — with contributions effective the first of the month following the date of notification.
- ***After 30 days but within 90 days.*** If you request coverage for your new child after 30 — but within 90 days — of the date of the birth or adoption, the coverage effective date will be the date of the event — with contributions effective as of the first day of the month following the event and taxed accordingly.
- ***After 90 days.*** If you request coverage for your new child after 90 days of the date of the birth or adoption, the coverage effective date — and the contribution effective date — will be the first of the month following the date of notification.

To add a new child to your medical coverage, you must notify the Merck Benefits Service Center online through NetBenefits at **http://netbenefits.fidelity.com** or by calling **800-66-MERCK**.

KEY POINT — HOW TO ENROLL A NEW CHILD

To enroll your new child under your Medical Plan coverage option, you must contact the Merck Benefits Service Center online through NetBenefits at **http://netbenefits.fidelity.com** or by calling **800-66-MERCK**. You cannot enroll your child by calling your health care carrier directly. Even if your Coverage Tier will not change, you must enroll your child through the Merck Benefits Service Center in order for your child to receive medical coverage.

If You Take a Leave of Absence

- **Approved Paid Leave of Absence.** If you take an approved paid leave of absence, the Company will continue to deduct your portion of the cost of medical coverage through payroll deductions. Deductions will be on a Pre-Tax basis.
- **Approved Unpaid Leave of Absence.** If you take an approved unpaid leave of absence, you will be billed for coverage during your leave. Amounts paid during the leave will be paid for with after-tax dollars. For employees who return to work at the expiration of a leave, any accumulated unpaid amounts will be deducted from your initial paychecks on a pre-tax basis. However, if you fail to pay premiums to continue coverage in the time and manner specified by the Company, your coverage will end and you will not be able to re-enroll for coverage unless and until you return to active employment.

Information on the cost of coverage will be provided at the time of your leave.

If You Are a Eligible Union Employee Who Goes on Layoff

If you are placed on layoff, there are two different ways to continue coverage:

- **Continue Your Current Medical Coverage.** You may continue the Medical coverage you had on the date your layoff begins for the duration of your layoff. If you decide to continue your benefits coverage under this option, you will receive a monthly billing invoice for 100% of the cost to continue your coverage, as well as a 2% administrative fee. Payment for continued coverage is due on the first of the month to maintain coverage for that month. If you want to elect this option, you must call the Merck Benefits Service Center at **800-66-MERCK** within 30 days from the date of your benefits continuation letter to make your election. If you do not call within the 30 days, you will not be able to continue coverage under this option. If you fail to pay premiums to continue

coverage in the time and manner specified by Merck, your coverage will end and you will not be able to re-enroll for coverage unless and until you return to active employment.

- **Continue Your Medical Coverage under COBRA.** As an alternative, you may elect to continue your medical coverage for a period of 18 months under COBRA. If you want to elect this option, you must call the Merck Benefits Service Center at **800-66-MERCK** and make your elections within 60 days from the date your layoff begins or the date of your COBRA notification, whichever is later. If you do not call the Merck Benefits Service Center and make your election by this date, you will not be eligible to continue your medical coverage under the COBRA option. For more information about your COBRA rights, see the "COBRA" section of the "Administrative Information" chapter.

If at the time you go on layoff you are eligible for continuation of medical benefits while on layoff under the terms of the separation program described in the collective bargaining agreement applicable to you, the terms of the collective bargaining agreement — and not the terms described in this section above — apply to continuation of your medical benefits while on layoff.

If You Receive LTD Benefits

If you are or become a LTD Employee, your medical coverage in effect on the date you become eligible for LTD Benefits may continue while you are receiving LTD Benefits. (See "Merck Long-Term Disability (LTD) Employees" on page 13 for additional information.) While you are a LTD Employee, you may only make changes to your medical coverage — elect a new Medical Plan option, add an Eligible Dependent or drop a Covered Dependent — during the annual enrollment period, unless you experience a Life Event that allows you to make a Permitted Plan Change or circumstances permitting enrollment under HIPAA. See "When Life Changes" and "Special Enrollment Under HIPAA for Eligible Employees" for more information.

Any period of medical coverage provided to you and/or your Covered Dependents while you are receiving LTD Benefits is included in the period for which you and/or your Covered Dependents may be eligible for continuation coverage under COBRA. See the "COBRA" section in the "Administrative Information" chapter.

If You Had Elected No Coverage

If you had elected No Coverage at the time you qualified for LTD Benefits, you will not receive medical coverage, unless you enroll for coverage during the next annual enrollment or experience a Life Event that allows you to make a Permitted Plan Change or circumstances permitting enrollment under HIPAA. See "When Life Changes" and "Special Enrollment Under HIPAA for Eligible Employees" for more information.

Please note: If you are a LTD Employee who was a Merck Temporary Employee at the time you began receiving LTD Benefits, you are not permitted to make changes to your Medical Plan coverage during the annual enrollment period. However, you may add an Eligible Dependent or drop a Covered Dependent from your Medical Plan Coverage or change your Coverage Tier if you experience a Life Event that allows you to make a Permitted Plan Change or circumstances permitting enrollment under HIPAA. See "When Life Changes" and "Special Enrollment Under HIPAA for Eligible Employees" for more information.

If You Are Eligible for Medical Coverage as a Retiree

If you become a Legacy Merck or Legacy Schering-Plough Retiree while receiving LTD Benefits, you may be eligible for coverage under the applicable retiree medical plan and billed accordingly; however, when Medicare becomes your primary coverage; the retiree medical plan becomes your secondary coverage.

If you become a Legacy Merck Retiree or Legacy Schering-Plough Retiree while receiving LTD Benefits, your medical coverage as a LTD Employee will end and your coverage as a Legacy Merck Retiree or Legacy Schering-Plough Retiree will begin on the date you become a Legacy Merck Retiree or Legacy Schering-Plough Retiree. If you become a Legacy Merck Retiree or Legacy Schering-Plough Retiree before you begin receiving LTD Benefits, you will be eligible for coverage as a Legacy Merck Retiree or Legacy Schering-Plough Retiree, not as a LTD Employee. In either case, you will be billed as a Legacy Merck Retiree or Legacy Schering-Plough Retiree in accordance with the billing procedures established under the applicable retiree medical plan, effective the first of the month following or coincident with the date of your retirement.

A Word About LTD Medical Plan Options and Medicare
All of the Medical Plan options available to you require you and your Covered Dependents who are eligible for Medicare to enroll in Medicare — Parts A and B — when you are first eligible. Medicare is the primary payer for LTD Employees who are no longer considered to be in active employment and their Covered Dependents who qualify for Medicare. The Medical Plan is the secondary payer and will coordinate benefits with Medicare. For more information, see "Coordinating Benefits with Medicare."

Please note that while participation in Medicare Parts A and B is required, participation in Medicare Part D prescription drug coverage is voluntary and Merck does *not* require that you or your Covered Dependents sign up for Medicare Part D.

When Medical Coverage Ends

Your coverage in the Medical Plan ends on the earliest of:

- The end of the month in which your employment terminates, unless you qualify as a Retiree;
- The end of the month in which your employment terminates, unless you are eligible for LTD Benefits;
- The end of the month in which you are no longer eligible to participate;
- The day immediately prior to the day your No Coverage option goes into effect;
- If you are a LTD Employee, the date you fail to pay the required employee contributions for coverage;
- The date, the required contributions for coverage are not paid; or
- The date the Medical Plan is terminated by the Company.

Your Covered Dependents' Coverage ends on the earliest of:

- The date your coverage ends for any reason. Coverage may continue under the terms applicable to survivor coverage (see "Coverage for Surviving Dependents in the Event of Your Death");
- The end of the month in which your Covered Dependent no longer qualifies as an Eligible Dependent under the Medical Plan — such as the date the child turns 26 (see "Eligible Dependents" in the "About Medical Benefits" chapter);
- The date the required employee contributions for coverage are not paid; or
- The date the Medical Plan is terminated by the Company.

If a Covered Dependent Loses Eligibility Status

You must notify Merck when a Covered Dependent is no longer eligible for coverage by changing your dependent's status online at **http://netbenefits.fidelity.com** or by contacting the Merck Benefits Service Center at **800-66-MERCK**. If you do not notify Merck when a Covered Dependent becomes ineligible for coverage, you may be required to reimburse the Medical Plan for any or all costs incurred by the Plan to

cover your ineligible dependent. You may also be subject to disciplinary action, up to and including termination. Additionally, if you fail to notify Merck within 60 days of the event, your dependent may lose eligibility to continue coverage under COBRA (or if applicable, continuation coverage available to Same-Sex Domestic Partners and their Eligible Dependent children).

Please note that coverage for that dependent will end in accordance with the Plan's provisions regardless if you have notified the Company. For example, if you cover your Spouse as a dependent under the Medical Plan and become divorced, your Spouse's medical coverage will end as of the date of the divorce regardless of when you notify the Merck Benefits Service Center by phone or through NetBenefits.

Continuing Your Coverage Through COBRA

If you or your Covered Dependents lose medical coverage under the Medical Plan, you may be eligible to continue your coverage through COBRA. For more information, see "COBRA."

Note that if you drop a dependent during annual enrollment by reducing your coverage tier, the dropped dependent is not eligible to continue coverage through COBRA.

Although existing federal law does not extend rights to COBRA coverage to your Same-Sex Domestic Partner and his/her covered dependent children, Merck offers continuation of medical coverage in certain cases. For continuation of coverage options available to Same-Sex Domestic Partners and their Eligible Dependent children, see "Continuation of Health Care Coverage for Same-Sex Domestic Partners" in the "Administrative Information" chapter.

Coverage for Surviving Dependents in the Event of Your Death

If you die while employed by the Company, your surviving Eligible Dependents who are Covered Dependents on the date of your death are eligible to continue coverage under the Medical Plan as described in this section. Your Eligible Dependents who are not Covered Dependents on your date of death are not eligible for coverage as a surviving dependent under the Medical Plan after your death.

Your surviving Covered Dependents are eligible to continue coverage under the Medical Plan as it applies to active employees at no cost to them for as long as they continue to meet the requirements of an Eligible Dependent up to a maximum of 2 years, provided they elect to continue coverage in accordance with COBRA. Coverage provided to your surviving Covered Dependents runs concurrently with the continuation period available under COBRA. (For more information, see "COBRA.")

At the expiration of the up to 2 year period:

- **If you are not eligible to be a Retiree or do not have at least 25 years of service as of your death,** your surviving Covered Dependents are eligible to continue coverage in accordance with the rules applicable to COBRA for up to the remainder of the COBRA period provided they pay the full COBRA premium. For more information, see "COBRA."

- **If you are eligible to be a Retiree as of your death,** your surviving Covered Dependents are eligible for retiree medical coverage. Coverage under retiree medical may continue for so long as they qualify as Eligible Dependents. Their required contributions for this coverage are based on a variety of factors determined by the Company from time to time and may include the decedent's legacy company and his/her age and service as of date of death and the surviving Covered Dependent's eligibility for Medicare.

If you have at least 25 years of service but are not eligible to be a Retiree as of your death, your surviving Covered Dependents are eligible for coverage under the Medical Plan applicable to LTD Employees. Coverage under the Medical Plan may continue for so long as they qualify as Eligible Dependents. Their required contributions for this coverage are determined by the Company and are based on the contributions required for similarly situated LTD Employees.

KEY POINT — A WORD ABOUT MEDICAL PLAN OPTIONS AND MEDICARE

All of the Medical Plan options available to your surviving Covered Dependents who are eligible for Medicare require them to enroll in Medicare — Parts A and B — when they are first eligible. Medicare is the primary payer for those who qualify for Medicare. The Medical Plan is the secondary payer and will coordinate benefits with Medicare. For more information, see "Coordinating Benefits with Medicare."

While participation in Medicare Parts A and B is required, participation in Medicare Part D prescription drug coverage is voluntary and Merck does *not* require that your surviving Covered Dependents sign up for Medicare Part D.

You are eligible to be a Retiree as of your date of death for purposes of determining eligibility for medical benefits for your surviving Covered Dependents, if you meet the age and service requirements applicable to a non-disability retirement on your date of death as set forth in the definition of "Retiree" (see the Glossary for the definition of "Retiree").

If your surviving Spouse is an Eligible Employee or Retiree of the Company, special rules apply. For more information, your Spouse should call the Merck Benefits Service Center at **800-66-MERCK** and speak to a Customer Service Associate, Monday through Friday (excluding New York Stock Exchange holidays), between 8:30 a.m. and 8:30 p.m., Eastern time.

Your surviving Spouse or Same-Sex Domestic Partner continues to qualify as your dependent even if he/she remarries or forms another Same-Sex Domestic Partnership. No new dependents may be added to your surviving Spouse's or Same-Sex Domestic Partner's coverage. For example, should your surviving Spouse remarry, he/she would not be permitted to add a new Spouse or child as a dependent under the Medical Plan.

Coverage for your surviving Covered Dependents continues under the option in which they were enrolled at the time of your death until the next annual enrollment, unless they experience a Life Event that would allow them to make a Permitted Plan Change. During the next annual enrollment, your surviving Covered Dependents may elect any available option or remain in the same coverage. All surviving Covered Dependents must be enrolled in the same option.

KEY POINT — REPORTING A DEATH

In the event of the death of an Eligible Employee or Covered Dependents, please call Fidelity Survivor Services at **877-208-0807** from 8:30 a.m. to 5:00 p.m., Eastern time, Monday through Friday.

Merck PPO Options

The Merck PPO is comprised of two options which are administered by Horizon BCBS or Aetna and give you the flexibility to see any licensed health care provider of your choice. Each Medical Plan option offers the same basic plan components (including prescription drug and behavioral health care benefits). However, the way benefits are delivered, the costs for coverage and services, and the provider networks vary by medical option. The PPO options are not available to Eligible Employees who reside in Hawaii.

KEY POINT — ELIGIBILITY

You are eligible to enroll in the Merck PPO options if you are an Eligible Employee and your home address on file with Fidelity Investments is within the BlueCard PPO or Aetna Choice POS II network areas. *Eligible Employees who are residents of Hawaii are not eligible for the Merck PPO options.*

About the Merck PPO Options

Merck offers two preferred provider organization (PPO) options. The Merck PPO — Horizon BCBS, administered by Horizon BCBS, uses the national BlueCard® PPO network. The Merck PPO — Aetna Choice POS II, administered by Aetna, uses Aetna's national Choice POS II network. Regardless of the administrator, the Merck PPO options cover you for a range of services, including preventive care, hospitalizations and Emergency care.

When you visit a health care provider who participates in the 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 and Aetna Choice POS II are the Claims Administrators and fiduciaries for the Merck PPO options.

Key Features

In general, under the Merck PPO options:

- 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 negotiated fees 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 Reasonable & Customary (R&C) Limits.
- You must precertify certain services, including inpatient hospitalization, certain surgeries and certain maternity care.

Prescription Drug Benefits

When you enroll in a Medical Plan option (except for the No Coverage option), you automatically receive coverage under Merck's Managed Prescription Drug Program. See the "Managed Prescription Drug Program" section starting on page 62 for details.

Behavioral Health Benefits

When you enroll in a Medical Plan, you automatically receive coverage for mental health and substance abuse coverage which is generally the same no matter which option you choose, but the benefits will be administered differently:

- If you choose the Merck PPO — Horizon BCBS option or the Merck 80/20 option, you receive mental health and substance abuse benefits through Merck's Behavioral Health Care Program, administered by ValueOptions. Also note that if you participate in the Merck PPO—Horizon BCBS option, only providers in the ValueOptions Network are considered In-Network providers for behavioral health care. Providers in the BlueCard network are considered Out-Of-Network for behavioral health care; however, if you receive care from a BlueCard provider, you may be eligible to pay for services based on the Horizon BCBS negotiated fees. See "ValueOptions Behavioral Health" section starting on page 77 for details.
- If you enroll for the Merck PPO — Aetna Choice POS II option, you receive Aetna mental health and substance abuse coverage. See the "Aetna Behavioral Health" section starting on page 86 for details.

Merck PPO Coverage

Each time you receive care for covered expenses you have a choice of obtaining care In-Network, using one of the PPO network 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 Medical Plan pays a percentage of your covered expenses. If you receive care Out-of-Network, the 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 options when you use an In-Network provider. For a list of In-Network providers or to find out if your provider is In-Network, contact the Claims Administrator (see "Benefits Contacts and Resources" on page 3). Every time you visit a health care provider who participates in the 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 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 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 PPO network.

Merck PPO Options At A Glance

The charts on the following pages summarize the coverage levels for services under both options under the Merck PPO (Horizon BCBS and Aetna Choice POS II). ***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 the Claims Administrator determines are not Medically Necessary. In addition, not all services that are Medically Necessary are covered. See "What's Covered Under the Medical Options" for a complete list of covered services and any applicable additional limitations under the Merck PPO options. In addition, more detailed information regarding the benefits that will be provided under the Medical Plan is available from Horizon BCBS and Aetna.

	In-Network Coverage	Out-of-Network Coverage[1]
COSTS		
Annual Deductible[2] *Individual* *Family*	 $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] *Individual* *Family* *See "Schedule A" at the back of this booklet for complete information about your annual Out-of-Pocket Maximum*	 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[4]		
Well-Child Care *(up to age 6)*	100%, no Copay and no Deductible	70% of R&C Limit, no Deductible
Routine Annual Physical Exams *One exam per calendar year (over age 6)*	100%, no Copay and no Deductible	70% of R&C Limit, no Deductible
Routine Immunizations	100%, no Copay and no Deductible	70% of R&C Limit, no Deductible
Routine Immunization-Related Office Visits	100%, no Copay and no Deductible	70% of R&C Limit, no Deductible
Routine Preventive OB/GYN Exams *One exam per calendar year*	100%, no Copay and no Deductible	70% of R&C Limit, no Deductible
Routine Eye Exams *One exam every 24 months* *Eyewear discounts may be available[5]*	100%, no Copay and 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 or lifetime maximums may apply to certain services such as infertility-related services.

4 All In-Network preventive services required to be covered by the Medical Plan pursuant to the Patient Protection and Affordable Health Care Act of 2010 will be covered by the Medical Plan with no cost-sharing requirement. For additional information about these preventive services and about specific age and gender guidelines, contact Horizon BCBS or Aetna.

5 For information about eyewear discounts, contact Horizon BCBS or Aetna.

	In-Network Coverage	Out-of-Network Coverage[6]
Routine Hearing Exams *One exam every 24 months*	100%, no Copay and no Deductible	70% of R&C Limit, no Deductible
Routine Preventive Lab/X-Ray[7, 8] *Services related to routine annual physical exams limited to one per calendar year (over age 6)*	100%, no Copay and no Deductible	70% of R&C Limit, no Deductible
PREVENTIVE MEDICAL CARE — ROUTINE SCREENINGS, LABS AND X-RAY[8]		
Certain Preventive Services that Are Not Part of a Routine Annual Physical/Office Visit[3]	100%, no Copay and no Deductible	70% of R&C Limit, no Deductible
Routine Mammography Screenings *Ages 35–39, one baseline; ages 40 and above, one screening per year*	100%, no Copay and no Deductible *If additional screenings are prescribed by your physician as Medically Necessary, 90% after Deductible*	70% of R&C Limit, no Deductible *If additional screenings are prescribed by your physician as Medically Necessary, 70% after Deductible*
Routine Preventive Pap Test *One per calendar year*	100%, no Copay and no Deductible	70% of R&C Limit, no Deductible
Routine Colonoscopy	100%, no Copay and no Deductible *If additional screenings are prescribed by your physician as Medically Necessary, 90% after Deductible*	70% of R&C Limit, no Deductible *If additional screenings are prescribed by your physician as Medically Necessary, 70% after Deductible*
OUTPATIENT MEDICAL CARE		
Office Visits	$15 physician Copay $25 specialist Copay	70% of R&C Limit, after Deductible
Outpatient Surgery *Performed in a doctor's office*	$15 physician Copay $25 specialist Copay	70% of R&C Limit, after Deductible
Outpatient Surgery *Performed in a hospital or ambulatory surgical center*	90%, after Deductible *Includes physician's charges*	70% of R&C Limit, after Deductible *Includes physician's charges*
Allergy Testing	$15 physician Copay $25 specialist Copay	70% of R&C Limit, after Deductible
Allergy Treatment *Injections, serum*	$15 physician Copay $25 specialist Copay *Copay only applies when office visit is billed*	70% of R&C Limit, after Deductible
Infertility Diagnosis and Treatment[9] *Artificial insemination, advanced reproductive treatment (ART)*	90%, after Deductible	70% of R&C Limit, after Deductible
	Note that a combined lifetime maximum of $25,000 applies for medical benefits	

[6] 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.

[7] Coverage for routine preventive lab/x-ray is determined by the carrier. Contact Horizon BCBS or Aetna for more information.

[8] All In-Network preventive services required to be covered by the Medical Plan pursuant to the Patient Protection and Affordable Health Care Act of 2010 will be covered by the Medical Plan with no cost-sharing requirement. For additional information about these preventive services and about specific age and gender guidelines, contact Horizon BCBS or Aetna.

[9] Medical benefits for infertility are not available in excess of the lifetime maximums. These limits apply across the Merck Medical options. If you change options under the Merck Medical Plan, you do not restart these limits (see "Key Point — Special Transition Infertility Rules as of January 1, 2011" on page 51 for additional information). 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[10]
Chiropractic Care Up to 25 visits per calendar year per person Maintenance therapy not covered	$25 specialist Copay	70% of R&C Limit, after Deductible
Acupuncture *For pain, illness or injury when performed by an M.D., D.O. or state-licensed physician or practitioner and is Medically Necessary*	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
OUTPATIENT MEDICAL CARE		
Short-Term Rehabilitation[11] *Physical therapy, occupational therapy, speech therapy*	90%, after Deductible	70% of R&C Limit, after Deductible
Oral Surgery *Certain procedures if performed in a hospital or ambulatory surgical facility due to medical necessity* [12]	90%, after Deductible	70% of R&C Limit, after Deductible
Outpatient Hospice Care *Contact the network for coverage details*	90%, after Deductible	70% of R&C Limit, after Deductible
OUTPATIENT MEDICAL CARE — LABS AND X-RAY		
Diagnostic Labs and X-Rays *Performed in a physician's office*	100%, after office visit Copay	70% of R&C Limit, after Deductible
Diagnostic Labs and X-Rays *Performed in an outpatient hospital or other outpatient facility (including lab processing)*	90%, after Deductible	70% of R&C Limit, after Deductible
INPATIENT MEDICAL CARE		
Inpatient Hospital Services *Includes inpatient surgery expenses, semi-private room and board, physician expenses, routine nursery care, prescription drugs, all other inpatient care*	90%, after Deductible Precertification required[13]	70% of R&C Limit, after Deductible Precertification required[13]
Maternity Services *Delivery charges in a hospital or approved, licensed birthing center*	90%, after Deductible Precertification required[13]	70% of R&C Limit, after Deductible Precertification required[13]

[10] 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.

[11] 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 or Aetna 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.

[12] 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.

[13] You must precertify all inpatient medical hospitalizations, including surgeries and certain maternity care. If you fail to precertify and care is deemed not Medically Necessary, you will have no coverage for the non-Medically Necessary care. Contact Horizon BCBS or Aetna to precertify.

	In-Network Coverage	Out-of-Network Coverage[14]
Inpatient Hospice Care	90%, after Deductible Precertification required[15]	70% of R&C Limit, after Deductible Precertification required[15]
OTHER SERVICES		
Emergency Services *Ambulance* *Emergency Room* *Urgent Care*	 90%, after Deductible 90%, after Deductible[16] 100%, after $15 physician Copay	 90% of R&C Limit, after Deductible 90% of R&C Limit, after Deductible[16] 70% of R&C Limit, after Deductible
Durable Medical Equipment[17] *Wheelchairs, walkers, etc.*	90%, after Deductible	70% of R&C Limit, after Deductible
Foot Orthotics[18]	90%, after Deductible	70% of R&C limit, after Deductible
Prosthetics and Appliances *Artificial limbs, etc.*	90%, after Deductible	70% of R&C Limit, after Deductible
Skilled Nursing Facility *Up to 120 days per calendar year*	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[19] *Diaphragms, IUDs, implants, injections*	90%, after Deductible	70% of R&C Limit, after Deductible
PRESCRIPTION DRUG BENEFITS[20]		
Inpatient	90%, after Deductible Merck-Brand Drugs covered at 100%	70% of R&C Limit, after Deductible Merck-Brand Drugs covered at 100%
Outpatient	Provided under the Merck Managed Prescription Drug Program (prescriptions filled through Retail Pharmacies or Medco Pharmacy™)	

[14] 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.

[15] You must precertify all inpatient medical hospitalizations, including surgeries and certain maternity care. If you fail to precertify and care is deemed not Medically Necessary, you will have no coverage for the non-Medically Necessary care. Contact Horizon BCBS or Aetna to precertify.

[16] Depending on your option, Horizon BCBS or Aetna determines whether use of an emergency room meets the prudent layperson standard of Emergency. If you or a Covered Dependents are admitted, you must call Horizon BCBS or Aetna within 48 hours (even if you are discharged by then) to receive In-Network benefits, if applicable.

[17] 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**.

[18] 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. 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.

[19] Non-Merck Brand oral contraception is covered under the Merck Managed Prescription Drug Program (Medco Pharmacy™ only).

[20] Medical benefits for infertility are not available in excess of the lifetime maximums. These limits apply across the Merck Medical options. If you change options under the Merck Medical Plan, you do not restart these limits (see "Key Point — Special Transition Infertility Rules as of January 1, 2011" on page 51 for additional information). 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[21]
MENTAL HEALTH AND SUBSTANCE ABUSE BENEFITS		
Coverage for Eligible Employees	Mental health and substance abuse benefits for employees who elect the Merck PPO — Horizon BCBS are provided through Merck's Behavioral Health Care Program administered by ValueOptions. Mental health and substance abuse benefits for employees who elect the Merck PPO — Aetna Choice POS II are provided through Aetna.	
Inpatient Mental Health and Substance Abuse Care[22, 23]	90%, after Medical Plan Deductible[24] Precertification Required[23,26]	70% of R&C Limit,[25] after Medical Plan Deductible[23, 26] Precertification Required[24, 26]
Outpatient Facility Mental Health and Substance Abuse Care	90%, after Medical Plan Deductible[24]	70% of R&C Limit,[25] after Medical Plan Deductible[24, 26]
Outpatient Mental Health and Substance Abuse Care *Performed in a behavioral health care provider's office*	100% after a $15 Copay	70% of R&C Limit,[25] after Medical Plan Deductible[4]

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.

[21] 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.

[22] Inpatient services apply to Medically Necessary hospital and treatment facility stays and Medically Necessary Emergency treatment.

[23] You must precertify. See "Precertification."

[24] The same Deductible that applies to the Merck Medical Plan option in which you are enrolled applies to mental health and/or substance abuse treatment under the Behavioral Health Care Program. Your share of covered expenses counts toward the annual Out-of-Pocket Maximum under your Medical Plan option.

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

[26] The following inpatient 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.

Precertification

If you or your Covered Dependents 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 options.

KEY POINT — PRECERTIFICATION OVERVIEW

	Eligible Employees and Their Covered Dependents enrolled in Merck PPO — Horizon BCBS	Eligible Employees and Their Covered Dependents enrolled in Merck PPO — Aetna Choice POS II
Inpatient Medical	Horizon BCBS **877-663-7258**	Aetna **800-541-6711**
Behavioral Health	ValueOptions **877-44-MERCK**	Aetna **800-424-4047**

How to Precertify Inpatient Medical Services (*not* Behavioral Health)

To precertify an inpatient admission, or to determine if a particular service requires precertification, contact the Claims Administrator (see chart on previous page). 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. 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.

Lengthened Maternity Hospital Stays

If you expect your or your Covered Dependents' 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 the Claims Administrator.

How to Precertify Behavioral Health Care Services

Inpatient behavioral health care services require precertification:

- **Employees and their Covered Dependents who are enrolled in Merck PPO — Horizon BCBS.** You must contact ValueOptions, the Merck 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 — Horizon BCBS option.
- **Employees and their Covered Dependents who are enrolled in Merck PPO — Aetna Choice POS II.** You must contact Aetna at **800-541-6711** 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 — Aetna Choice POS II option.

In Case of an Emergency

If you or a Covered Dependent 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. The Claims Administrator 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.

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

For Medical Reasons

If you or your Covered Dependents are admitted to the hospital for medical reasons, you must call the Claims Administrator (Horizon BCBS at **877-663-7258** or Aetna at **800-541-6711**) 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 options.

For Mental Health Reasons

- **Employees and their Covered Dependents who are enrolled in Merck PPO — Horizon BCBS.** You must contact ValueOptions, the Merck 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 — Horizon BCBS option.
- **Employees and their Covered Dependents who are enrolled in Merck PPO — Aetna Choice POS II.** You must contact Aetna at **800-541-6711** 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 — Aetna Choice POS II option.

How to File a Claim

In-Network Care

If you or your Covered Dependents 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 ID card and pay the applicable Copay. Your network provider then bills the 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 Medical Plan is secondary, you must first file claims with the primary plan and then submit your claims to the Medical Plan 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.

Out-of-Network Care

When you or your Covered Dependents 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 Medical Plan. Here's how:

- Complete the "Employee" section of the Medical Claim Form, available on:
  - NetBenefits at **http://netbenefits.fidelity.com**; or
  - **http://hr.merck.com**.

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;
  - Dates of services;
  - Condition being treated;
  - Relationship to employee;
  - Type of services 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 your option's Claims Administrator:

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

  OR

  Aetna
  P.O Box 981106
  El Paso, TX 79998-1106

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 27 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 or your Covered Dependents believe you/they are entitled to a benefit, or to a greater amount of benefits, under the Medical Plan than the amount received or are receiving, either in whole or in part, you and your Covered Dependents have the right to file an appeal with the applicable Claims Administrator. For more information, see the "Claims and Appeals" chapter.

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. This option is not available to Eligible Employees who reside in Hawaii.

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. When you enroll in the Merck 80/20 option, you also receive behavioral health care coverage through ValueOptions (VO). For more information, see the Managed Prescription Drug Program and Behavioral Health Care chapters of this book.

Merck 80/20 Coverage

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 Medical Plan generally pays 80% Coinsurance for your In-Network covered expenses. If you receive care Out-of-Network, the Medical Plan pays 80% Coinsurance up to the R&C Limit. Once you reach the annual Out-of-Pocket Maximum, the 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. For a list of In-Network providers or to find out if your provider is In-Network, contact the Claims Administrator (see "Benefits Contacts and Resources" on page 3). 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.

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. More detailed information regarding the benefits that will be provided under the Medical Plan is available from Horizon BCBS.

Merck 80/20 Option At A Glance

	Coverage
COSTS	
Annual Deductible[27] *Individual* *Family*	 $400 $800
Coinsurance *Plan pays* *You pay*	 80% of R&C Limit 20% of R&C Limit plus any amounts in excess of R&C Limit[28]
Annual Out-of-Pocket Maximum[28] *Individual* *Family* 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[29]
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[30]	
Well-Child Care *(up to age 6)*	100% of R&C Limit, no Deductible
Routine Annual Physical Exams *One exam per calendar year* *(over age 6)*	100% of R&C Limit, no Deductible
Routine Immunizations	100% of R&C Limit, no Deductible
Routine Immunization-Related Office Visits	100% of R&C Limit, no Deductible
Routine Preventive OB/GYN Exams *One exam per calendar year*	100% of R&C Limit, no Deductible
Routine Eye Exams *One exam every 24 months* *Eyewear discounts available through Complete Advantage™®*[31]	100% of R&C Limit, no Deductible
Routine Hearing Exams *One exam every 24 months*	100% of R&C Limit, no Deductible
PREVENTIVE MEDICAL CARE — ROUTINE SCREENINGS, LABS AND X-RAY	
Routine Preventive Lab/X-Rays *Services related to routine annual physical exams for individuals over age 6; limited to one per calendar year*	100% of R&C Limit, no Deductible

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

[28] 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.

[29] Certain treatment limits may apply to certain services such as infertility-related services.

[30] All preventive services required to be covered by the Medical Plan pursuant to the Patient Protection and Affordable Health Care Act of 2010 will be covered by the Medical Plan with no cost-sharing requirement. For additional information about these preventive services and about specific age and gender guidelines, contact Horizon BCBS at **877-663-7258** or visit **www.horizonblue.com/merck**.

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

	Coverage
PREVENTIVE MEDICAL CARE — ROUTINE SCREENINGS, LABS AND X-RAY	
Certain Preventive Services That Are Not Part of a Routine Annual Physical/Office Visit[32]	100% of R&C Limit, no Deductible
Routine Mammography Screenings *Ages 35–39, one baseline; ages 40 and above, one screening per year; additional screenings if prescribed by your physician as Medically Necessary*	Routine: 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 *One per calendar year*	100% of R&C Limit, no Deductible
Routine Colonoscopy	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*
OUTPATIENT MEDICAL CARE	
Office Visits	80% of R&C Limit, after Deductible
Outpatient Surgery *Performed in a doctor's office*	80% of R&C Limit, after Deductible
Outpatient Surgery *Performed in a hospital or ambulatory surgical center*	80% of R&C Limit, after Deductible
Allergy Testing	80% of R&C Limit, after Deductible
Allergy Treatment *Injections, serum*	80% of R&C Limit, after Deductible
Infertility Diagnosis and Treatment[33] *Artificial insemination, advanced reproductive treatment (ART)*	80% of R&C Limit, after Deductible, up to a $25,000 lifetime maximum for medical benefits
Chiropractic Care *Up to 25 visits per calendar year per person* *Maintenance therapy not covered*	80% of R&C Limit, after Deductible
Acupuncture *Medically Necessary for pain, illness or injury, performed by an M.D., D.O. or state-licensed physician or practitioner and is Medically Necessary*	80% of R&C Limit, after Deductible
Second Surgical Opinion	80% of R&C Limit, after Deductible
Short-Term Rehabilitation[34] *Physical therapy, occupational therapy, speech therapy*	80% of R&C Limit, after Deductible

[32] 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/** for information about specific age and gender guidelines for covered preventive services.

[33] Medical benefits for infertility are not available in excess of the lifetime maximums. These limits apply across the Merck Medical options. If you change options under the Merck Medical Plan, you do not restart these limits (see Key Point — Special Infertility Rules as of January 1, 2011 on page 51 for additional information). 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.

[34] 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	
Oral Surgery[35] *Certain procedures if performed in a hospital or ambulatory surgical facility due to medical necessity*	80% of R&C Limit, after Deductible
Outpatient Hospice Care *Includes bereavement counseling for one year*	80% of R&C Limit, after Deductible
OUTPATIENT MEDICAL CARE — LABS AND X-RAY	
Diagnostic Labs and X-Rays *Performed in a physician's office*	80% of R&C Limit, after Deductible
Diagnostic Labs and X-Rays *Performed in an outpatient hospital or other outpatient facility (including lab processing)*	80% of R&C Limit, after Deductible
INPATIENT MEDICAL CARE	
Inpatient Hospital Services *Includes inpatient surgery expenses, semi-private room and board, physician expenses, routine nursery care, prescription drugs, all other patient care*	80% of R&C Limit, after Deductible Precertification required[36]
Maternity Services *Delivery charges in a hospital or approved, licensed birthing center*	80% of R&C Limit, after Deductible Precertification required[36]
Inpatient Hospice Care	80% of R&C Limit, after Deductible Precertification required[36]
OTHER SERVICES	
Emergency Services *Ambulance* *Emergency Room* *Urgent Care*	 80% of R&C Limit, after Deductible 80% of R&C Limit, after Deductible[37] 80% of R&C Limit, after Deductible
Durable Medical Equipment[38] *(Wheelchairs, walkers, etc.)*	80% of R&C Limit, after Deductible
Foot Orthotics[39]	80%, after Deductible

35 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.

36 You must precertify all inpatient medical hospitalizations by calling Horizon BCBS at **877-663-7258**, including surgeries and certain maternity care. If you fail to precertify and care is deemed not Medically Necessary, you will have no coverage for the non-Medically Necessary care.

37 Horizon BCBS determines whether use of an emergency room meets the prudent layperson standard of Emergency. If you or a Covered Dependent 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.

38 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**.

39 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. Orthotics and 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	
Prosthetics and Appliances Artificial limbs, etc.	80% of R&C Limit, after Deductible
Skilled Nursing Facility *Up to 120 days per calendar year*	80% of R&C Limit, after Deductible
Home Health Care	80% of R&C Limit, after Deductible
Custodial Care	Not covered
Contraceptive Devices[40] *(Diaphragms, IUDs, implants, injections)*	80% of R&C Limit, after Deductible
PRESCRIPTION DRUG BENEFITS[41]	
Inpatient	80% of R&C Limit, after Deductible Merck Brand Drugs covered at 100%
Outpatient — Prescriptions filled through retail pharmacies or Medco Pharmacy™	Provided under the Merck Managed Prescription Drug Program. See page 62 for coverage details.
MENTAL HEALTH AND SUBSTANCE ABUSE BENEFITS — Provided by ValueOptions	
Coverage for Eligible Employees	Mental health and substance abuse benefits for employees are provided through Merck's Behavioral Health Care Program administered by ValueOptions.
Inpatient Mental Health and Substance Abuse Care[42, 43]	80% of R&C after Medical Plan Deductible[44, 45, 46] Precertification Required[42, 45]
Outpatient Mental Health and Substance Abuse Care	80% of R&C after Medical Plan Deductible[44, 45]

[40] Non-Merck Brand oral contraception is covered under the Merck Managed Prescription Drug Program (Medco Pharmacy™ only).

[41] Medical benefits for infertility are not available in excess of the lifetime maximums. These limits apply across the Merck Medical options. If you change options under the Merck Medical Plan, you do not restart these limits (see "Key Point — Special Transition Infertility Rules as of January 1, 2011" on page 51 for additional information). 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.

[42] Inpatient services apply to Medically Necessary hospital and treatment facility stays and Medically Necessary Emergency treatment.

[43] You must precertify. See "Precertification."

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

[45] The same Deductible that applies to the Merck Medical Plan option in which you are enrolled applies to behavioral health care coverage for mental health and/or substance abuse treatment. Your share of covered expenses counts toward the annual Out-of-Pocket Maximum under your Medical Plan option.

[46] The following inpatient 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.

Precertification

KEY POINT — PRECERTIFICATION OVERVIEW

	Eligible Employees and Their Covered Dependents
Inpatient Medical	Horizon BCBS **877-663-7258**
Behavioral Health	ValueOptions **877-44-MERCK**

How to Precertify Inpatient Medical Services (*not* Behavioral Health)

If you or your Covered Dependents 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.

KEY POINT — ABOUT HORIZON BCBS

Horizon BCBS is the utilization and case management provider for the Merck 80/20 option. 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-emegency 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 ten 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. 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 Dependents' 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;
- Hemerrhoidectomy (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

Certain services, such as inpatient stays, require precertification by your provider. Precertification is a process that helps you and your physician determine whether the services being recommended are covered expenses under the plan. It also allows ValueOptions to help your provider coordinate your transition from an inpatient setting to an outpatient setting (called discharge planning), and to register you for specialized programs or case management when appropriate.

You do not need to precertify services provided by a network provider. Network providers will be responsible for obtaining necessary precertification for you. Since precertification is the provider's responsibility, there is no additional out-of-pocket cost to you as a result of a network provider's failure to precertify services.

When you go to an Out-Of-Network provider, it is your responsibility to obtain precertification from ValueOptions. There is no penalty if you fail to precertify. However, if your care is not Medically Necessary it will not be covered under the plan.

Call ValueOptions to Precertify Behavioral Health Care Services

Behavioral health precertification for employees and their Covered Dependents is handled by ValueOptions, the Claims Administrator for behavioral health care services. 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.

In Case of an Emergency

If you or a Covered Dependent 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.

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.

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

For Medical Reasons

If you or a Covered Dependent 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 Dependents need non-Emergency medical hospitalization or surgery, you may need to call Horizon BCBS for advance approval.

For Behavioral Health

For Employees and their Covered Dependents, you must contact ValueOptions, the Merck 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.

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 Medical Plan. If you have duplicate coverage, including Medicare, and the 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."

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**; or
  - **http://hr.merck.com**.

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;
  - Dates of services;
  - Condition being treated;
  - Relationship to employee;
  - Type of services 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 27 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 or your Covered Dependents believe you/they are entitled to a benefit, or to a greater amount of benefits, under the Medical Plan than the amount received or are receiving, either in whole or in part, you and your Covered Dependents have the right to file an appeal with the applicable Claims Administrator. For more information, see the "Claims and Appeals" chapter.

What's Covered Under the Medical Options

This section provides an alphabetical list of Medically Necessary covered services and supplies for the Merck PPO options and the Merck 80/20 option. Horizon BCBS and Aetna administer the Merck PPO options and Horizon BCBS administers the Merck 80/20 option. Each Medical Plan option offers the same basic plan components (including prescription drug and behavioral health care benefits). However, the way benefits are delivered, the costs for coverage and services, and the provider networks vary by medical option and Claims Administrator.

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

For additional information regarding what is covered or to verify coverage of a medical service or device, contact your Claims Administrator (Horizon BCBS or Aetna).

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 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) provided the service is performed in a hospital (inpatient or outpatient) or an ambulatory surgical facility. However, the TMJ appliance is not covered under the Medical Plan.

Care Coordination Services provided within the **Diabetes Care Coordination Program,** administered by Partners In Care ("PIC"), are covered under the Plan.

KEY POINT — DIABETES CARE COORDINATION PROGRAM FOR RESIDENTS OF NJ

The Diabetes Care Coordination program is available to Covered Employees and Covered Dependents who are diagnosed, or who have certain risk factors, for Diabetes Mellitus. The program is administered with the physician owned company Partners In Care, Corp. or "PIC." PIC will coordinate care, together with your primary treating physician, to follow the guidelines of the Patient-Centered Medical Home. Patient-Centered Medical Home is a model for care established by several national physician associations, such as The American College of Physicians, which seeks to strengthen the physician — patient relationship.

If you or your Covered Dependent participate in this program, the Plan will provide coverage for care coordination services not otherwise covered under the Plan but determined by PIC to be Medically Necessary for Diabetics. These services must be provided under the Diabetes Care Coordination Program to be covered.

Services included as part of this program are patient/caregiver calls, care team meetings or problem solving consultations with physicians. This program will work in conjunction with ActiveHealth Management, the organization that provides a patient safety and disease management program to Eligible Employees and Covered Dependents.

Together PIC and ActiveHealth Management will provide information and reminders to your physicians to allow them to provide extra time and attention sometimes needed to bring care into compliance with national guidelines for the treatment of Diabetes. The care coordination services included in this program will have no patient payment component. This is an additional benefit provided at no additional cost to you.

The following individuals are not eligible to participate in the Diabetes Care Coordination Program:

- Covered Employees whose home address on file with Fidelity is not in New Jersey and their Covered Dependents; and
- Covered individuals who have not been diagnosed with, or whom PIC has determined do not have the appropriate level of risk factors for Diabetes Mellitus.

Care coordination services provided outside of the Diabetes Care Coordination Program administered by PIC are not covered under the Plan.

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

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%. Note that drugs that are subject to the Specialty Pharmacy Program managed by Accredo Health Group, Inc., a subsidiary of Medco, are generally not covered under the Medical Plan option in which you are enrolled. (See page 67 for more information.)

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 Medical Options" for additional exclusions). Orthotic shoes are covered, subject to medical necessity, for children under age 12. For Eligible Employees and Covered Dependents age 12 or older, up to one pair of orthotic shoes is covered per calendar year.

Home Health Care. As a general rule, the 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 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. And for Aetna Choice POS II care must be certified by the provider In-Network or the member Out Of Network.

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 the Claims Administrator 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 the Claims Administrator.

Hospice Care expenses are covered if you, or a Covered Dependent, 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 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 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. 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:

- Unlimited inpatient care in a hospice unit of a health care facility or in a free-standing hospice (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;
- Respite care in the home is covered up to 10 days per calendar year;
- 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 Dependents 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 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 the Claims Administrator.

Infertility Treatment. Diagnosis and treatment of infertility due to an underlying medical condition, including surgery and drug therapy. The Medical Plans cover Medically Necessary diagnosis and treatment of infertility, including, but not limited to, the following:

- Artificial insemination;
- Diagnosis and diagnostic tests;
- Embryo transfer;
- Gamete intrafallopian transfer (GIFT);
- In vitro fertilization;
- Intracytoplasmic sperm injection;

- Medications;
- Surgery; and
- Zygote intrafallopian transfer (ZIFT).

Infertility is defined as abnormal function so that a person is not able to impregnate another person, conceive after one year if the female partner is under age 35, conceive after six months if the female partner is 35 or older, or carry a pregnancy to live birth. Medical benefits for infertility are limited to $25,000 per person per lifetime. Prescription drug benefits received through the Managed Prescription Drug Program for infertility are separate from the medical benefits limits and are limited to $10,000 per person per lifetime. The prescription drug benefit maximum excludes Merck-Brand Drugs for the treatment of infertility obtained through your pharmacist, or Medco Pharmacy™ mail order service, which are covered at 100%.

KEY POINT — INFERTILITY RULES AS OF JANUARY 1, 2011

Effective January 1, 2011, infertility benefits are limited to a $25,000 medical lifetime maximum; $10,000 prescription lifetime maximum (excludes Merck-Brand infertility drugs).

- If you are a Legacy Merck Employee who has reached the lifetime limit on your infertility benefits under a legacy Merck-sponsored non-HMO Medical Plan option by December 31, 2010, you will not be eligible for future infertility benefits under any Merck-sponsored Medical Plan option as of January 1, 2011. You will be able to utilize the Managed Prescription Drug Program up to the prescription drug lifetime maximum of $10,000 for non-Merck-Brand infertility drugs.
- If you are a Legacy Merck Employee who has not reached the lifetime limit on your infertility benefits under a legacy Merck-sponsored non-HMO Medical Plan option as of December 31, 2010, you will be eligible for future infertility benefits up to the medical lifetime maximum of $25,000 under a Merck Medical Plan option as of January 1, 2011, and you will be eligible for future infertility benefits under the Managed Prescription Drug Program up to lifetime maximum of $10,000 for non-Merck Brand infertility drugs. Any infertility benefits that you have received before December 31, 2010 will not count toward the infertility lifetime benefits maximum under the Medical Plan and Prescription Drug Program that go into effect Janauary 1, 2011.
- If you are a Legacy Schering-Plough Employee who has reached the lifetime limit on your infertility benefits under a legacy Schering-Plough sponsored Medical Plan option as of December 31, 2010, you will not be eligible for future infertility benefits under any Merck-sponsored Medical Plan option as of January 1, 2011. You will be able to utilize the Managed Prescription Drug Program up to the lifetime maximum of $10,000 for non-Merck brand infertility drugs (if you have not already reached the $10,000 lifetime limit).
- If you are a Legacy Schering-Plough Employee who has not reached the lifetime limit on your infertility benefits limit under a Legacy Schering-Plough sponsored Medical Plan option as of December 31, 2010, you will be eligible for future infertility benefits up to the lifetime maximum of $25,000 under a Merck Medical option as of January 1, 2011. Any infertility benefits that you have received before December 31, 2010 will count towards the infertility lifetime benefits maximums under the Medical Plan that goes into effect January 1, 2011.If you are a Legacy Schering-Plough Employee who has not reached the lifetime limit for infertility benefits under your prescription drug coverage as of December 31, 2010, you will be eligible for future infertility benefits under the Managed Prescription Drug Program up to the lifetime maximum of $10,000 for non-Merck brand infertility drugs. Any infertility benefits that you have received before December 31, 2010 will count towards the infertility lifetime benefits maximums under the Prescription Drug Program that go into effect January 1, 2011.

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 the Claims Administrator 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. 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;
- Cholesterol testing;
- Routine fecal occult blood testing;
- Routine sigmoidoscopy and colonoscopy;
- Routine mammograms (see "Women's Health");
- Routine OB/GYN and PAP (see "Women's Health");
- Routine prostate specific antigen (PSA) test and digital rectal exam; and
- Routine Osteoporosis Screening (Bone Mass Density Testing).

All preventive services required to be covered by the Medical Plan pursuant to the Patient Protection and Affordable Health Care Act of 2010 will be covered by the Medical Plan with no cost-sharing requirement. For additional information about these preventive services, contact the Claims Administrator for your Medical Plan option.

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. Exclusions may apply; see information about Speech Therapy, Occupational Therapy and Physical Therapy in the list of "What's Not Covered Under the Medical Plan."

Surgery, including inpatient and outpatient hospital and surgical treatment for an illness or injury. The Medical Plan also covers:

- Bariatric surgery subject to the Claims Administrator's 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 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 Discount Program call **877-518-8748** or visit **www.horizonblue.com/merck**. For more information about Aetna's Discount Program call **800-793-8616** or visits **www.aetna.com**.

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

Wigs or hairpieces when prescribed by a physician for hair loss due to injury, chemotherapy or otherwise provided under the clinical policies of the Claims Administrators, up to one wig or hairpiece every two years.

Women's Health services covered under the 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
- Prostheses and treatment of physical complications of all stages of the mastectomy, including lymphedema.

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

For more information contact the Claims Administrator (see "Benefits Contacts and Resources" on page 3).

What's Not Covered Under the Medical Options

This section provides a list of services and supplies that are not covered by the Medical Plan options. Services that are not deemed Medically Necessary 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. Each Medical Plan option offers the same basic plan components (including prescription drug and behavioral health care benefits). However, the way benefits are delivered, the costs for coverage and services, and the provider networks vary by medical option and Claims Administrator.

For additional information regarding what is not covered or to verify coverage of a medical service or device, contact your Claims Administrator (Horizon BCBS or Aetna).

Medical expenses *not covered* under the 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 Dependents') automobile insurance policy's personal injury policy, whether or not elected by you or your Eligible Dependents.

Claims Submitted More Than 27 Months After Charges Were Incurred, unless it is shown that it was not reasonably possible to furnish the claims within the time limit.

Care Coordination Services provided outside of the Diabetes Care Coordination Program, administered by Partners In Care ("PIC"), are not covered under the Plan. See "Diabetes Care Coordination" in the "Introduction" for more details about this program.

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.

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

Experimental or Investigational drugs, devices, treatments or procedures, are not covered unless ***all*** of the following conditions are met:

- You have been diagnosed with cancer or a condition likely to cause death within one year or less;
- Standard therapies have not been effective or are inappropriate;
- The Claims Administrator determines, based on at least two documents of medical and scientific evidence, that you would likely benefit from the treatment;
- There is an ongoing clinical trial. You are enrolled in a clinical trial that meets these criteria:
  - The drug, device, treatment or procedure to be investigated has been granted investigational new drug (IND) or Group c/treatment IND status;
  - The clinical trial has passed independent scientific scrutiny and has been approved by an Institutional Review Board that will oversee the investigation;
  - The clinical trial is sponsored by the National Cancer Institute (NCI) or similar national organization (such as the Food & Drug Administration or the Department of Defense) and conforms to the NCI standards;
  - The clinical trial is not a single institution or investigator study unless the clinical trial is performed at an NCI-designated cancer center; and
  - You are treated in accordance with protocol.

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 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;
- Routine OB/GYN exams in excess of one exam every 12 months;
- Routine 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 Claims Administrators' vision discount 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.

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

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

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 Medical Options").

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

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.

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 Dependents 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.**

Service, treatment or supplies **Not Generally Accepted In Medical Practice** for the prevention, diagnosis or treatment of an illness or injury.

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

Occupational Therapy as a result of a learning disability. This exclusion does not apply to charges for occupational therapy needed as a result of disease or injury.

Physical Therapy as a result of a learning disability. This exclusion does not apply to charges for physical therapy needed as a result of disease or injury.

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.

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.

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

Health Plan Plus Hawaii

This section contains information about the Hawaii Health Plus HMO option.

If you are an Eligible Employee residing in Hawaii, you are eligible for the Hawaii Health Plus HMO or you may choose the No Coverage option. If you choose the No Coverage option, you will be required to complete a waiver of coverage form in compliance with Hawaii state law. You are not eligible to participate in the Merck PPO or the Merck 80/20 options.

For More Information

All benefits, limitations and exclusions for the Hawaii Health Plus HMO are listed in the Hawaii Health Plus HMO member brochures and contract. The member brochure is considered part of this summary plan description. The HMO will supply you with the written materials concerning:

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

The Hawaii Health Plus HMO generally requires the designation of a primary care provider. You have the right to designate any primary care provider who participates in Hawaii Health Plus HMO network and who is available to accept you or your family members. For children, you may designate a pediatrician as the primary care provider. For information on how to select a primary care provider, and for a list of the participating primary care providers, contact Health Plan Hawaii Plus – HI at 808-948-6372 or visit www.hmsa.com.

You do not need prior authorization from the Hawaii Health Plus HMO or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a health care professional in the Hawaii Health Plus HMO network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, contact Health Plan Hawaii Plus – HI at 808-948-6372 or visit www.hmsa.com.

For more information about an HMO, including covered services, call Health Plan Hawaii Plus – HI at **808-948-6372** or visit **www.hmsa.com**.

How to File a Claim

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

Appealing a Claim

If you believe you are entitled to a benefit, or to a greater amount of benefits under the HMO option than the amount you have received or are receiving, either in whole or in part, you have the right to file a claim with the applicable Claims Administrator. For more information, see "Claims and Appeals."

Kaiser Permanente HMO

This section contains information about the Kaiser Permanente HMO option.

This option is closed. Only Eligible Employees who participated in this option on December 31, 2010 and who have not thereafter elected a different option available to them are eligible to continue coverage under this option. If you are an Eligible Employee covered by the Kaiser Permanente HMO through the Merck Medical Plan, you are eligible to continue the Kaiser Permanente HMO option, or select another option offered to you. If you choose an option other than the Kaiser Permanente HMO, you will not be allowed to select the Kaiser Permanente HMO option in the future.

For More Information

All benefits, limitations and exclusions for the Kaiser Permanente HMO are listed in the Kaiser Permanente HMO member brochures and group agreement. The member brochure is considered part of this summary plan description. The HMO will supply you with the written materials concerning:

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

The Kaiser Permanente HMO generally requires the designation of a primary care provider. You have the right to designate any primary care provider who participates in Kaiser Permanente HMO network and who is available to accept you or your family members. For children, you may designate a pediatrician as the primary care provider. For information on how to select a primary care provider, and for a list of the participating primary care providers, contact Kaiser Permanente Membership Services at **800-464-4000** or visit **www.kp.org**.

You do not need prior authorization from the Kaiser Permanente HMO or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a health care professional in the Kaiser Permanente HMO network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, contact Kaiser Permanente Membership Services at **800-464-4000** or visit **www.kp.org**.

How to File a Claim

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

Appealing a Claim

If you believe you are entitled to a benefit, or to a greater amount of benefits under the HMO option than the amount you have received or are receiving, either in whole or in part, you have the right to file a claim with the applicable Claims Administrator. For more information, see "Claims and Appeals."

Managed Prescription Drug Program

While you are covered under any option under the Medical Plan, except the No Coverage option, you are covered automatically in the Merck Managed Prescription Drug Program. There is no separate charge for this program. It is included as part of the cost of the option you select under the Medical Plan. The Merck Managed Prescription Drug Program is administered by Medco Health Solutions, Inc. (Medco), the Plan's Pharmacy Benefit Manager and the Program's Claims Administrator and fiduciary. Shortly after you enroll in the Medical Plan, you will receive a separate Medco ID card.

KEY POINT — MERCK-BRAND DRUGS

When you have your prescription filled with a Merck-Brand Drug, there is no Copay for that prescription. The Company pays the full cost for any Merck-Brand Drugs for you and your Covered Dependents.

About the Managed Prescription Drug Program

The Managed Prescription Drug Program provides you with coverage for certain Medically Necessary outpatient drugs that are prescribed by a licensed prescriber. Drugs provided inpatient are not covered under the Managed Prescription Drug Program but may be covered under the Medical Plan option in which you are enrolled. Drugs provided outpatient that are administered in an ambulatory facility or doctor's office or provided by a doctor for use at home are not covered under the Managed Prescription Drug Program (but may be covered under the Medical Plan option in which you are enrolled) except as follows:

- They are subject to the Specialty Pharmacy Program managed by Accredo Health Group, Inc., a subsidiary of Medco*; or
- They are picked up at a retail pharmacy and delivered to the provider for administration**; or
- They are mail-ordered and delivered to the provider's office—ordered by you or on your behalf—for administration in the provider's office**.

Drugs that are subject to the Specialty Pharmacy Program are generally not covered under the Medical Plan option in which you are enrolled. Your cost for prescription drugs depends on the type of medication (Merck-Brand, generic or non-Merck brand), if you use a participating pharmacy and if you choose retail or mail-order.

There are three ways to purchase outpatient prescription drugs:

- At a Medco participating pharmacy;
- Through the *Medco Pharmacy*™ mail order service (within the U.S. only); and
- At a non-participating pharmacy.

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* See the section on Medco's Specialty Pharmacy Program for coverage details.

** Please note that these drugs will still be subject to the applicable prescription benefit Copay under the Managed Prescription Drug Program and may also be subject to a fee for administration by the provider. The administration fee is not covered under the Managed Prescription Drug Program but under certain circumstances may be covered under the medical plan option in which the patient is enrolled.

KEY POINT — MEMBER PAY THE DIFFERENCE

The amount you pay for certain non-Merck brand-name prescription drugs, when a generic equivalent is available, is subject to the provisions of the Member Pay the Difference program.

Medco, Merck's Pharmacy Benefit Manager, is the Claims Administrator and fiduciary for this Program. If you purchase a non-Merck brand-name drug when a generic equivalent is available, you will pay the generic Copay — plus the difference in cost between the brand and the generic drug — up to a capped amount. See "Managed Prescription Drug Program At A Glance" chart for the applicable Copays and refer to this Summary Plan Description for additional information regarding the Program.

There may be rare instances where a member has an adverse reaction, allergy or sensitivity to the generic equivalent and as a result needs to be prescribed the brand medication. In such case the member may submit a claim to the clinical review department of Medco. The clinical review department will determine the medical necessity of staying with the brand medication. If Medco denies the claim for use of the brand medication, the participant may appeal this denial in accordance with the Medical Plan's claim procedures described below.

Managed Prescription Drug Program At A Glance

The following chart summarizes prescription drug costs for 2012. Please note that all the 2012 medical options (except the No Coverage option) offer the same prescription drug coverage through Medco, Merck's pharmacy benefit manager.

	ledco Participating Retail harmacies[47]	***The Medco Pharmacy™***[48] **(Mail Order)**
COPAYS[2]		
	For Up to a 30-Day Supply	**For Up to a 90-Day Supply**
Merck-Brand Drugs	$0	$0
Generic Drugs	$10	$20
Non-Merck Brand Drugs with a generic equivalent [49]	$10 Copay plus the cost difference between the retail price for the non-Merck brand-name drug and its generic equivalent, up to $50 (per prescription).	$20 Copay plus the cost difference between the retail price for the non-Merck brand-name drug and its generic equivalent, up to $100 (per prescription).
Non-Merck Brand Drugs without a generic equivalent	$ 25 Copay	$50 Copay
Generic Diabetes Medications and Supplies	$0	$0
Non-Merck Brand Diabetes Drugs	$10	$20
FEATURES		
When to Use	For short-term, immediate medication needs.	For long-term, maintenance prescriptions
Claim Forms	Not applicable when you use your ID card at a participating pharmacy. You must file a claim if you do not present your ID card or if you use a non-participating pharmacy.	Not applicable

[47] Prescriptions filled at non-participating pharmacies will be reimbursed based on the network-negotiated price of the medication, minus the applicable Copayment. Employees are responsible for any drug costs in excess of network negotiated fees. *In addition, Member Pay the Difference provisions (without the cap) apply for non-Merck brand drugs that are filled when a generic is available.*

[48] Certain medications are only available through Medco Pharmacy™ (mail order), such as oral contraceptives and prescriptions for Male Erectile Dysfunction if they are not a Merck-Brand drug.

[49] Member Pay the Difference provisions apply whether you or your physician chooses the Non-Merck Brand drug.

KEY POINT — BRAND NAME AND GENERIC BRAND DRUGS

Brand-name (prescription drug). A drug protected by a patent issued to the original innovator or marketer. The patent prohibits the manufacture of the drug by other companies as long as the patent remains in effect.

Generic Brand (prescription drug). A drug that is equal in therapeutic power to the brand-name original because they contain identical active ingredients at the same doses.

KEY POINT — REDUCED COSTS FOR DIABETES MEDICATIONS AND SUPPLIES

In order to encourage diabetics to follow their treatment plan, beginning Jan. 1, 2012, all generic diabetes medications and supplies, as well as Merck brand drugs, will be provided at no cost to you. In addition, the cost for non-Merck brand diabetic drugs and supplies will be reduced to the generic copay rate ($10 at retail pharmacies for a 30-day supply; $20 at mail order for a 90-day supply).

How to Get Your Prescription Filled

Participating Pharmacies

Most of the retail pharmacies in the United States participate in the Medco network. These pharmacies agree to accept lower negotiated fees. You can call Medco at **800-RX-MERCK (800-796-3725)** to find a network pharmacy near you or to find out if your current pharmacy is in the network.

When you need a prescription filled, simply present your Medco ID Card at a participating pharmacy and pay the applicable Copay. (The Medco ID card is separate from your Medical Plan option ID card.) You may purchase up to a 30-day supply of covered medication for each Copay. The participating pharmacy will handle the claim for you.

Non-Participating Pharmacies

If you choose to have a prescription filled at a pharmacy that does not participate in Medco's network (a non-participating pharmacy), you must pay 100% of the pharmacy's regular charge at the time you receive your medication. You then file a claim for reimbursement. If you use a non-participating pharmacy, you may receive more than a 30-day supply of medication , but Medco will only reimburse you for a 30-day supply.

You will be reimbursed based on the network negotiated price of your covered medication offered by participating pharmacies, minus your Copay. If the drug cost is higher than the network negotiated fee, you are responsible for the difference. Your reimbursement check will be mailed approximately two weeks after the date your claim is received.

How to File a Claim for Non-Participating Pharmacy Benefits

Complete a *Direct Claim Reimbursement Form* and submit it together with a receipt for the medication to:

Medco Health Solutions, Inc.
P.O. Box 14711
Lexington, KY 40512

Claim Forms are available on Medco's Web site at **www.medco.com** or by calling Medco Member Services at **800-RX-MERCK**. You must file a claim within one year of when the prescription for which you are filing a claim was written by the physician, unless you can show that it was not reasonably possible to submit the claim within the time limit. If your claim for benefits is denied, in whole or in part, you or your authorized representative may appeal the denial. For more information on appealing a denied claim, see "Claims and Appeals" in the "Administrative Information chapter."

Mail Order Pharmacy Service

If you require maintenance medications or have an ongoing condition, you may purchase prescription drugs through the *Medco Pharmacy™*, which can help you save both time and money. In addition, certain medications are covered only through the *Medco Pharmacy™*. (See "Covered Medications and Supplies.")

You may order up to a 90-day supply of your medication for one Copay. The *Medco Pharmacy™* is not available outside the United States.

To order a prescription by mail:

- Obtain a prescription for ongoing medication — for up to a 90-day supply, plus refills.
- Complete the Patient Information section of the *Medco Pharmacy™ Order Form*, available through NetBenefits at **http://netbenefits.fidelity.com** and on Medco's Web site at **www.medco.com**. This information alerts the mail order pharmacy to any potential drug interactions. Your Patient Profile and prescription history are strictly confidential.
- Mail your original prescriptions or refill slips together with the completed *Medco Pharmacy™ Order Form* and payment for the Copays to:

  Medco Health Solutions, Inc.
  P.O. Box 650022
  Dallas, TX 75265-0022

If you mail more than one prescription in the same envelope, be sure to include one Copay for each. Medco will promptly process your order and send your medications to your door within approximately 14 days through U.S. Mail or United Parcel Service (UPS), along with instructions for refills.

How to Order Refills

- **To order by phone,** call **800-4REFILL (800-473-3455)** to use the automated system. Be sure to have your member ID number (shown on your ID card) and refill slip with the prescription information ready.
- **To order from Medco's Web site,** log on to **www.medco.com** and have your member ID and a prescription number available. (If you are a first-time visitor to the site, please take a moment to register.)

KEY POINT — LARGER PRESCRIPTION SUPPLIES FOR SPECIAL CIRCUMSTANCES

Medco, in its discretion, may authorize prescriptions in excess of the 30-day or 90-day supply under certain special circumstances, such as extended travel outside the U.S., provided you have a physician's written prescription.

For more information or to request an extended supply, contact Medco at **800-RX-MERCK**. Please note that multiple Copays may apply.

Medco will process your order and send your medications to your home via U.S. Mail or UPS, along with instructions for refills.

KEY POINT — MEDCO'S REVIEW PROCESS

Medco continually monitors new prescription drugs and reviews new clinical studies. Therefore, this list of covered drugs, non-covered drugs and coverage management programs and processes are subject to change. As new drugs become available, they will be considered for coverage under the Managed Prescription Drug Program as they are introduced. Merck will review recommendations by Medco to determine possible coverage as well as any coverage limitations or restrictions.

Medco Prescription Drug Management Programs

Prior Authorization Program

Certain medications require prior authorization before your prescription will be covered under the Plan.

KEY POINT — LIST OF DRUGS REQUIRING PRIOR AUTHORIZATION IS SUBJECT TO CHANGE

The list of medications that require prior authorization is subject to change. To confirm if a drug is covered, subject to dispensing limits, age limits or other coverage review processes, call Medco Member Services at **800-RX MERCK**.

Here's a list of medications that currently require prior authorization. You, your doctor or your pharmacist must call Medco at **800-753-2851** to authorize these medications:

- Compounded Progesterone products;
- Dietary supplements and dietary aids;
- Growth hormones;
- Anorexiants and anti-obesity medication;
- Retin-A® at age 35 and over;
- Alzheimer medications (e.g., Cognex®);
- Multiple Sclerosis medications (e.g., Betaseron®, Avonex® and Copaxone®);
- Fertility drugs;
- Anabolic steroids and Androgens;
- Xolair®;
- Erythroid stimulants (e.g., Epogen®, Procrit® and Aranesp®);
- Pain Medications (e.g., Actiq® and Fentora®);
- Myeloid Stimulants (e.g., Neupogen®, Leukine®, Neulasta®);
- Antinarcoleptic Agents (e.g., Provigil®);
- CNS Stimulants/Amphetamines for use after 18 years of age and prior to 5 years of age (e.g., Ritalin®, Focalin®, Adderall®);
- Rheumatoid Arthritis Agents (e.g., Enbrel®, Humira®, Simponi®);
- Dermatological Topicals (e.g. Elidel®, Protopic®);
- Retatio®; and
- Adcirca®.

Managed Rx Program

Certain medications are prone to misuse. The Managed Rx Program may contact your physician and/or pharmacist to ensure that a prescribed drug is being used in a clinically appropriate way. And, Medco may offer recommendations and place limits on current and future prescriptions of these medications.

The following classes of medications will be subject to the Managed Rx Program. Please note: the list of classes of medications that require prior authorization is subject to change. To confirm if a drug is covered, subject to dispensing limits, age limits or other coverage review processes, call Medco Member Services at **800-RX-MERCK**. To obtain prior authorization, call **800-753-2851.**

- Sleep aids and hypnotic medications (e.g., Ambien®, Sonata®);
- Pain relief medications (e.g., Toradol®, Stadol NS®, Actiq™, Fentora™);
- Male erectile dysfunction medications (e.g., Viagra®, Muse®, Edex®, Caverject®). Prescriptions must be filled through the *Medco Pharmacy™*; and
- Plaque Psoriasis (e.g., Enbrel™/Humira™).

Dose Optimization Program

The Dose Optimization Program can help reduce the number of pills you take each day. This program is geared toward participants who take prescription drug "maintenance medications" daily. It is designed to help patients and providers optimize prescription drug dosing schedules and maximize patient convenience. Participation in the Dose Optimization Program is completely voluntary; if you are eligible to participate in this program, you will be notified directly by Medco.

Medco's Specialty Pharmacy Managed by Accredo Health Group, Inc.

Accredo Health Group, Inc. Staff is dedicated to providing comprehensive support for members who use specialty medications and their prescribing physicians. The Specialty Pharmacy staff consists of patient care representatives, pharmacists and nurses, all of whom are specifically trained to provide services and support to patients on specialty medications to:

- Promote the safe and effective use of specialty drugs;
- Provide patients with therapeutic-centric training, education and clinical support, across both specialty and traditional medications;
- Provide physicians with evidence-based practice guidelines and actionable patient information;
- Ensure coverage is consistent with Plan provisions; and
- Encourage patient adherence and persistence.

The clinical services offered through Accredo are designed to support the physician's therapy regimen and any coordination being conducted by health plan case managers. The majority of medications administered or obtained through a physician's office must be pre-ordered by your physician from Accredo. All specialty medications should be initiated by calling Accredo at **800-922-8279**.

Specialty drugs include, but are not limited to, medications used to treat the following conditions:

- Growth hormones and related disorders (e.g. Genotropin, Humatrope, Increlex, Zorbitive, etc);
- Hemophilia and related bleeding disorders (e.g. Advate, Alphanate, Benefix, Hemophil, Humate-P, etc.);
- Hepatitis C medications (e.g. Infergen, Intron A, Peg-Intron, Pegasys, etc.);
- Immune Deficiency medication-Actimmune;
- Multiple Sclerosis medications (e.g., Avonex, Betaseron, Copaxone, etc.);

- Oral Oncology Agents (e.g., Gleevec, Temodar, Xeloda, etc.);
- Pulmonary Disorders (e.g., Pulmozyme, Tobi, etc.); and
- Rheumatoid Arthritis Agents (e.g. Enbrel, Humira, etc.).

Prescriptions are filled for up to a 30-day supply, and are express delivered to the location of choice (home, physician's office, vacation destination, etc.). The Specialty Drug Program also provides claims assistance and access to pharmacists for information. To fill a prescription for a specialty drug, or if you have questions regarding the Specialty Program, please contact Accredo at **800-922-8279**. Drugs that are subject to the Specialty Pharmacy Program are not generally covered under the Medical Plan option in which you are enrolled.

Specialty Drug

Specialty medications are drugs that are used to treat complex conditions, such as cancer, growth hormone deficiancy, hemophilia, hepatitis C, immune deficiency, multiple sclerosis, and rheumatoid arthritis. Medco's dedicated specialty pharmacy, Accredo Health Group, Inc., is composed of therapy-specific teams that provide an enhanced level of personalized service to patients with special therapy needs. Whether they're administered by a healthcare professional, self-injected, or taken by mouth, specialty medications require an enhanced level of service. By ordering your specialty medications through Accredo, you can receive:

- Toll-Free Access to specialty-trained pharmacists and nurses 24 hours a day, 7 days a week;
- Expedited, scheduled delivery of your medications at no additional charge;
- Necessary supplies, such as needles and syringes, provided with your medications;
- Safety checks to help prevent potential drug interactions;
- Refill reminders;
- Health and safety monitoring; and
- Up to a 90-day supply of your specialty medication for just one co-payment.

KEY POINT — SPECIALTY MEDICATIONS ONLY AVAILABLE THROUGH MAIL ORDER

Certain specialty medications are only available through mail order (you may receive your first fill at retail) through Accredo Health Group, Inc., Medco's specialty pharmacy. If you are taking a specialty medication, contact Accredo at **800-922-8279** for details.

For more information about Accredo, or to order your specialty medications, please call Member Services toll-free at **800-RX-MERCK**(800-796-3725).

Personalized Medicine Program

Your prescription drug coverage includes the Personalized Medicine Program, a program that incorporates genetic testing to optimize prescription drug therapies for certain conditions. The conditions, drugs and testing covered by the program will change from time to time as new genetic tests become available and are included in the program. Currently, the Personalized Medicine Program is available to participants meeting a specified clinical profile who are prescribed Tamoxifen, Warfarin, Plavix, Gleevec®, Tasigna®, Sprycel®, Ziagen®, Epzicom®, Trizivir® , and Selzentry®. The most up to date information on the conditions and drugs covered by the program can be accessed by calling a Medco customer service representative at **800-RX-MERCK**.

If you are a qualified participant, additional services are available to you through the Personalized Medicine Program at no additional cost. The Personalized Medicine Program includes:

- Access to certain specified genetic tests administered and analyzed by one of several designated

clinical laboratories; and

- A clinical program that includes consultation with your prescriber of your test result by a representative of Medco specifically trained in genetic testing. Medco will also offer ongoing outreach and education to physicians and patients when appropriate.

When you qualify, Medco will contact you and/or your physician to enroll you in the program. With approval from your physician, the clinical laboratory will facilitate the processing of a genetic test and share the results of the test with your physician and Medco. The results of the genetic test are for informational purposes only; any dosing or medication changes remain in the sole discretion of your physician. Your participation is voluntary and if you decide to participate, Medco will facilitate your coverage under the Personalized Medicine Program. The result of any genetic tests will not be shared with the Company.

Covered Medications and Supplies

The following prescription drugs are covered under the Managed Prescription Drug Program:

- Prescribed Federal Legend drugs (other than those identified as not covered);[50]
- State restricted drugs;
- Prescribed injectable drugs (other than those identified as not covered);
- Compounded medications of which at least one ingredient is a prescribed drug (other than those identified as not covered);
- Insulin;
- Needles and syringes;
- Oral, Transdermal and Intravaginal contraceptives (prescriptions must be filled through the Medco Pharmacy™ unless the contraceptive is a Merck-Brand drug);
- All injectable vaccines, subject to FDA label requirements for use;
- Retin-A® covered up to age 35;
- Ostomy supplies;
- Over-the-counter diabetes supplies (except insulin pumps);
- Federal Legend vitamins, (i.e., vitamins that require a prescription);
- Fluoride vitamins for children through age 16;
- Inhaler Assisted Devices;
- Tussi-Organidin® DM NR with medical necessity;
- Certain over-the-counter medications that are considered preventive and are required to be covered at 100% pursuant to the Patient Protection and Affordable Care act of 2010;
- Anti-smoking aids requiring a prescription, including over-the-counter anti-smoking aids when written on a prescription by your prescriber are covered at 100%;
- Vaccines; and
- Medication for which prior authorization is required and obtained.

For specific drug coverage and to determine the applicable Copay associated with a prescription drug, visit Medco online at **www.medco.com** or call Medco Member Services at **800-RX-MERCK**.

[50] There is limited coverage for prescriptions filled outside of the U.S. Retirees and Eligible Employees and their Covered Dependents who are living or traveling outside the U.S. and who fill a prescription outside the U.S. should contact Medco for information pertaining to applicable coverage and claims submission.

Medications and Supplies That Are Not Covered

The following prescription drugs are *not* covered under the Managed Prescription Drug Program:

- Drugs whose sole purpose is to stimulate hair growth;
- Diaphragms, contraceptive jellies, creams, foams, devices or implants or injections unless specifically mentioned in the Covered Section above;
- Preven®;
- Plan B®;
- Mifeprex®;
- Limbrel®;
- Cosamine® DS;
- Immunizing agents, biological blood or blood plasma;
- Non-federal legend drugs;
- Therapeutic devices or appliances;
- Zestril® or Zestoretic® (Merck's identical products, PRINIVIL® and PRINZIDE®, are covered);
- Drugs labeled "Caution — limited by Federal Law to investigational use," or experimental drugs, even though a charge is made to the individual;
- Medication for which the cost is recoverable under any Workers' Compensation or Occupational Disease Law or any state or government agency, or medication furnished by any other drug or medical service for which no charge is made to the participant;
- Medications for which prior authorization is required and not obtained;
- Medication that is taken by or administered to an individual, in whole or in part, while a patient in a licensed hospital, rest home, sanitarium, extended care facility, skilled nursing facility, convalescent hospital, nursing home or similar institution that operates on its premises or allows to be operated on its premises, or a facility for dispensing pharmaceuticals;
- Medication that is taken or administered in an ambulatory surgical facility or in a doctor's office or is provided by a doctor for use at home;
- Any prescription refilled in excess of the number of refills specified by the physician, or any prescription or refill dispensed after one year from the physician's original order;
- Any prescription filled before the patient's prior-filled 30-day or 90-day supply of medication is scheduled to be exhausted unless special circumstances exist and are authorized by Medco;
- Over-the-counter medications that are not considered preventive and are not required to be covered at 100% pursuant to the Patient Protection and Affordable Care act of 2010;
- Anti-smoking aids that that are not dispensed at a pharmacy from a written prescription by your prescriber;
- Dental fluoride products;
- Fluoride vitamins for children age 17 and over; and
- All injectable vaccines administered outside of FDA label requirements for use.

Please note that outpatient drugs and supplies that are not covered under the Managed Prescription Drug program are generally not covered under the Medical Plan option in which you are enrolled.

Coordination of Benefits

The Merck Managed Prescription Drug Program does not coordinate benefits with any other coverage that you or your covered Eligible Dependents might have, including Medicare Part D.

Claims and Appeals

If you, your beneficiary or your authorized representative feels that Medco has made an error concerning your benefits, you, your beneficiary or your authorized representative has the right to request reconsideration under the Plan in accordance with the following procedure.

Upon receipt of a claim denial, you may request information regarding any diagnosis codes and treatment codes applicable to your claim and their corresponding meaning. Upon such a request, the diagnosis and treatment codes and their meaning will be provided as soon as possible, but will not be considered a request for review of an adverse benefit determination or a request for external review.

KEY POINT — IF YOU ARE ELIGIBLE FOR MEDICARE PART D

Medicare Part D is a voluntary prescription drug program that went into effect January 1, 2006. Medicare Part D is available to participants who are enrolled in Medicare Parts A and B.

More information about Medicare Part D is available through *Merck's ABC's of Medicare Part D* brochure, available on NetBenefits at **http://netbenefits.fidelity.com**.

Initial Claim

Medco is responsible for evaluating all prescription drug claims. Medco will review your claim in accordance with its standard claims procedures, as required by ERISA. Medco has the right to secure independent medical advice and to require other evidence as it deems necessary in order to decide the status of your claim.

There are four categories of claims: urgent health claims, pre-service health claims, post-service health claims and concurrent health claims. Each category has different claims procedures. For many of these procedures, your health care provider may work directly with Medco.

- **"Urgent" health claims.** These are claims where if not processed quickly (within 72 hours) the life or health of the patient is jeopardized. The Claims Administrator will notify you or your doctor of the Plan's decision no later than 72 hours after your claim is received, unless you fail to provide sufficient information to determine whether, or to what extent, benefits are covered or payable under the Plan.
- **"Pre-service" health claims.** These are claims that must be decided before a patient will be allowed access to health care (for example, pre-authorization requests or referrals). The Claims Administrator will notify you or your doctor of the decision no later than 15 days after your claim is received. This 15-day period may be extended by another 15 days in certain circumstances.
- **"Post-service" health claims.** These are claims involving the payment or reimbursement of costs for care that has already been provided. For non-urgent, post-service health claims, the Claims Administrator has up to 30 days to evaluate and respond to claims for benefits. The 30-day period begins on the date the claim is first filed. This 30-day period may be extended by 15 days, in certain circumstances.

If Your Claim Is Denied

If Medco does not fully agree with your claim, you will receive an "adverse benefit determination," which is a denial, reduction, or termination of, or a failure to provide or make payment in whole or in part (a "denial") for a benefit, including any such denial if based on a determination of a participant's

or beneficiary's eligibility to participate in a plan. An adverse benefit determination also means a claim denial based on a utilization review or a determination that a treatment is experimental, or investigational or not Medically Necessary or appropriate or a retroactive termination of coverage due to fraud or intentional misconduct (a "rescission"). This includes concurrent care determinations.

You will receive notice of a denial, which will include:

- Information sufficient to identify the claim involved, including the date of service, identification of the health care provider,and the claim amount (if applicable) and a statement indicating that the diagnosis codes, treatment codes and their corresponding meaning are available upon request;
- The specific reasons for the denial, including the applicable denial code and its meaning;
- If applicable, a description of the standard used by the Plan to deny the claim;
- A reference to the specific Plan provisions on which the denial is based;
- A description of any additional material or information needed to reconsider the claim and an explanation of why such material or information is necessary;
- A description of the Plan's internal and external review procedures, including the time limits applicable to such procedures; and contact information for any applicable office of health insurance consumer assistance or ombudsman that will assist you with such procedures;
- A statement of your right to bring a civil action under Section 502(a) of ERISA following a denial on review;
- Any internal rules, guidelines, protocols, or other similar criteria that were used for the basis of the denial, either the specific rule, guideline, protocol or criterion, or a statement that a copy of such information will be made available free of charge to you upon request;
- For a denial based on medical necessity or an experimental treatment or other similar exclusion or limit, an explanation of the scientific or clinical judgment used in the decision, applying the terms of the Plan to your medical circumstances, or a statement that such explanation will be provided free of charge upon request; and
- For a denial involving urgent care, a description of the expedited review process applicable to such claims. Also, in the case of denial concerning a claim involving urgent care, the information set out in this section may be provided orally within the time frames provided in the section above entitled "Urgent health claims." If an oral notice is provided, a written notification that meets all the requirements of this section will be furnished within three days of the oral notice.

Appealing a Claim Other Than a Member-Submitted Paper Claim

In the event you receive an adverse determination following a request for coverage of a prescription benefit claim, you have the right to appeal the adverse benefit determination in writing within 180 days of receipt of notice of the initial coverage decision. To initiate an appeal for coverage, you or your authorized representative (such as your physician), must provide, in writing, your name, member ID, phone number, the prescription drug for which benefit coverage has been denied and any additional information that may be relevant to your appeal. This information should be mailed to:

Medco Health Solutions, Inc.
8111 Royal Ridge Parkway
Irving, TX 75063
ATTN: Coverage Reviews

A decision regarding your appeal will be sent to you within 15 days of receipt of your written request. The decision will set forth:

- Information sufficient to identify the claim involved, including the date of service, identification of

the health care provider,and the claim amount (if applicable) and a statement indicating that the diagnosis codes, treatment codes and their corresponding meaning are available upon request;

- The specific reasons for the denial, including the applicable denial code and its meaning;
- If applicable, a description of the standard used by the Plan to deny the claim;
- A reference to the specific Plan provisions on which the denial is based;
- A description of any additional material or information needed to reconsider the claim and an explanation of why such material or information is necessary;
- A description of the Plan's internal and external review procedures, including the time limits applicable to such procedures and contact information for any applicable office of health insurance consumer assistance or ombudsman that will assist you with such procedures;
- A statement of your right to bring a civil action under Section 502(a) of ERISA following a denial on review;
- Any internal rules, guidelines, protocols, or other similar criteria that were used for the basis of the denial, either the specific rule, guideline, protocol or criterion, or a statement that a copy of such information will be made available free of charge to you upon request; and
- For a denial based on medical necessity or an experimental treatment or other similar exclusion or limit, an explanation of the scientific or clinical judgment used in the decision, applying the terms of the Plan to your medical circumstances, or a statement that such explanation will be provided free of charge upon request.
- For a denial involving urgent care, a description of the expedited review process applicable to such claims. Also, in the case of denial concerning a claim involving urgent care, the information set out in this section may be provided orally within the time frames provided in the section above entitled "Urgent health claims." If an oral notice is provided, a written notification that meets all the requirements of this section will be furnished within three days of the oral notice.

You have the right to receive, upon request and at no charge, the information used to review your appeal. You also have the right to receive any additional evidence used to evaluate your claim or any additional rationale applied to your claim. If the Plan receives any additional evidence regarding your claim or applies a new rationale, you will be provided with the additional evidence and the rational and given an opportunity to respond before the final claim determination is issued.

If you are not satisfied with the coverage decision made on appeal, you may request in writing, within 90 days of the receipt of notice of the decision, a second-level appeal. To initiate a second level appeal, you or your authorized representative (such as your physician), must provide in writing, your name, member ID, phone number, the prescription drug for which benefit coverage has been denied and any additional information that may be relevant to your appeal.

This information should be mailed to:

Medco Health Solutions, Inc.
8111 Royal Ridge Parkway
Irving, TX 75063
ATTN: Coverage Reviews

A decision regarding your request will be sent to you in writing within 15 days of receipt of your written request for appeal. The decision will comply with the requirements listed above for the first level of appeal determination. You have the right to receive, upon request and at no charge, the information used to review your second level appeal. You also have the right to receive any additional evidence used to evaluate your claim or any additional rationale applied to your claim. If the Plan

receives any additional evidence regarding your claim or applies a new rationale, you will be provided with the additional evidence and the rational and given an opportunity to respond before the final claim determination is issued. The decision made on your second level appeal is final and binding.

If you are not satisfied with the decision of the second level appeal, you also have the right to bring a civil action under section 502(a) of the Employee Retirement Income Security Act of 1974 (ERISA).

In the case of a claim for coverage involving urgent care, you will be notified of the benefit determination within 72 hours of receipt of the claim. An urgent care claim is any claim for treatment with respect to which the application of the time periods for making non-urgent care determinations could seriously jeopardize the life or health of the claimant or the ability of the claimant to regain maximum function, or in the opinion of a physician with knowledge of the claimant's medical condition, would subject the claimant to severe pain that cannot be adequately managed. If the claim does not contain sufficient information to determine whether, or to what extent, benefits are covered, you will be notified, within 24 hours after receipt of your claim, of the information necessary to complete the claim. You will then have 48 hours to provide the information and will be notified of the decision within 48 hours of receipt of the information.

You have the right to request an urgent appeal of an adverse determination if you request coverage of a claim that is urgent. Urgent appeal requests may be oral or written. You or your physician may call Medco Member Services at **800-RX-MERCK**. Or send a written request to:

Medco Health Solutions, Inc.
8111 Royal Ridge Parkway
Irving, TX 75063
ATTN: Coverage Reviews

In the case of an urgent appeal for coverage involving urgent care, you will be notified of the benefit determination within 72 hours of receipt of the claim. This coverage decision is final and binding. You have the right to receive, upon request and at no charge, the information used to review your appeal. You also have the right to receive and respond to any new evidence or rational applied to your claim. You also have the right to bring a civil action under section 502(a) of ERISA if your final appeal is denied.

Appealing a Member-Submitted Paper Claim

Your Plan provides for reimbursement of prescriptions when you pay 100% of the prescription price at the time of purchase. This claim will be processed based on your Plan benefit. You will receive an explanation of benefits within 30 days of receipt of your claim. If you are not satisfied with the decision regarding your benefit coverage, you have the right to appeal this decision in writing within 180 days of receipt of notice of the initial decision. To initiate an appeal for coverage, you or your authorized representative (such as your physician), must provide in writing, your name, member ID, phone number, the prescription drug for which benefit coverage has been reduced or denied and any additional information that may be relevant to your appeal.

This information should be mailed to:

Medco Health Solutions, Inc.
8111 Royal Ridge Parkway
Irving, TX 75063
ATTN: Coverage Reviews

A decision regarding your appeal will be sent to you within 30 days of receipt of your written request. The notice will include:

- Information sufficient to identify the claim involved, including the date of service, identification of the health care provider,and the claim amount (if applicable) and a statement indicating that the diagnosis codes, treatment codes and their corresponding meaning are available upon request;
- The specific reasons for the denial, including the applicable denial code and its meaning;
- If applicable, a description of the standard used by the Plan to deny the claim;
- A reference to the specific Plan provisions on which the denial is based;
- A description of any additional material or information needed to reconsider the claim and an explanation of why such material or information is necessary;
- A description of the Plan's internal and external review procedures, including the time limits applicable to such procedures and contact information for any applicable office of health insurance consumer assistance or ombudsman that will assist you with such procedures;
- A statement of your right to bring a civil action under Section 502(a) of ERISA following a denial on review;
- Any internal rules, guidelines, protocols, or other similar criteria that were used for the basis of the denial, either the specific rule, guideline, protocol or criterion, or a statement that a copy of such information will be made available free of charge to you upon request; and
- For a denial based on medical necessity or an experimental treatment or other similar exclusion or limit, an explanation of the scientific or clinical judgment used in the decision, applying the terms of the Plan to your medical circumstances, or a statement that such explanation will be provided free of charge upon request.
- For a denial involving urgent care, a description of the expedited review process applicable to such claims. Also, in the case of denial concerning a claim involving urgent care, the information set out in this section may be provided orally within the time frames provided in the section above entitled "Urgent health claims." If an oral notice is provided, a written notification that meets all the requirements of this section will be furnished within three days of the oral notice.

You have the right to receive, upon request and at no charge, the information used to review your appeal. You also have the right to receive any additional evidence used to evaluate your claim or any additional rationale applied to your claim. If the Plan receives any additional evidence regarding your claim or applies a new rationale, you will be provided with the additional evidence and the rational and given an opportunity to respond before the final claim determination is issued.

If you are not satisfied with the coverage decision made on appeal, you may request in writing, within 90 days of the receipt of notice of the decision, a second level appeal. To initiate a second level appeal, you or your authorized representative (such as your physician), must provide in writing, your name, member ID, phone number, the prescription drug for which benefit coverage has been reduced or denied and any additional information that may be relevant to your appeal. This information should be mailed to:

Medco Health Solutions, Inc.
8111 Royal Ridge Parkway
Irving, TX 75063
ATTN: Coverage Reviews

A decision regarding your request will be sent to you in writing within 30 days of receipt of your written request for appeal. The decision will comply with the requirements listed above for the first level of appeal determination. The decision made on your second level appeal is final and binding.

If you are not satisfied with the decision of the second level appeal, you also have the right to bring a civil action under section 502(a) of the Employee Retirement Income Security Act of 1974 (ERISA).

External Review
Medco may deny a claim because it determines that the care is not appropriate or a service or treatment is Experimental or Investigational in nature. In either of these situations, you may request an external review if you or your provider disagrees with Medco's decision. An external review is a review by an independent physician, selected by an External Review Organization, who has expertise in the problem or question involved.

To request an external review, the following requirements must be met:
- You have received notice of the denial of a claim by the Medco; and
- Your claim was denied because Medco determined that the care was not necessary, appropriate or effective or was Experimental or Investigational or your claim was denied due to a rescission of coverage; and
- You have exhausted the applicable internal appeal processes or the process is deemed exhausted due to the failure of the plan to adjudicate your claim in accordance with the procedures set forth herein where such failure is not de-minimis.

The claim denial letter you receive from Medco will describe the process to follow if you wish to pursue an external review, including a copy of the Request for External Review Form.

You must submit the Request for External Review Form to Medco within 120 calendar days of the date you received the final claim denial letter. You also must include a copy of the final claim denial letter and all other pertinent information that supports your request.

Medco will contact the External Review Organization that will conduct the review of your claim. The External Review Organization will select an independent physician with appropriate expertise to perform the review. In making a decision, the external reviewer may consider any appropriate credible information that you send along with the Request for External Review Form, and will follow Medco's contractual documents and plan criteria governing the benefits. You will be notified of the decision of the External Review Organization usually within 45 calendar days of Medco's receipt of your request form and all necessary information. A quicker review is possible if your physician certifies (by telephone or on a separate Request for External Review Form) that a delay in receiving the service would endanger your health. Expedited reviews are decided within 72 hours after Medco receives the request.

Medco, the Company and the Health Plan will abide by the decision of the External Review Organization, except where Medco can show conflict of interest, bias or fraud.

You are responsible for the cost of compiling and sending the information that you wish to be reviewed by the External Review Organization to Medco. Medco is responsible for the cost of sending this information to the External Review Organization and for the cost of the external review.

For more information about Medco's External Review process, call Medco Member Services at **800-RX-MERCK**.

ValueOptions Behavioral Health

Eligibility for Behavioral Health Care benefits depends on the Medical Plan option you choose. The administrator of these behavioral health care benefits — and the network providers available — will differ depending on which option you enroll in.

Behavioral Health Care Benefits	
Merck PPO—Horizon BCBS or 80/20 medical options	**Merck PPO—Aetna Choice POS II medical option**
ValueOptions will administer behavioral health care benefits. For In-Network providers and additional information, visit **http://www.achievesolutions.net/merck** or call **877-44-MERCK (877-446-3725)**. You can contact ValueOptions by phone 365 days a year, 24 hours a day.	Aetna will administer behavioral health care benefits. For In-Network providers and additional information, visit **http://www.aetna.com/docfind** or call **800-541-6711 (group number: 479265)**. Representatives are available from 8:00 a.m. to 6:00 p.m., Eastern time.

How ValueOptions Behavioral Health Works

ValueOptions offers a national network of more than 50,000 practitioners and 3,500 nationwide facilities in 70,000 locations. When you select In-Network providers, your claims are filed by the provider and your cost is generally lower. Each time you need care, you can choose to see a provider who does not participate in the ValueOptions network.

If you choose an Out-of-Network provider, you usually pay more for treatment than if your care is referred through ValueOptions. ValueOptions Care Managers are available at **877-44-MERCK** to discuss your care options 24/7 and can help you select a provider based on your needs. You may also choose to see an Employee Assistance Program counselor in your area at no cost to you. If you use an out of network provider, you may also be responsible for submitting your own claims. Before seeing a provider, contact ValueOptions at **877-44-MERCK** to see if he or she participates in the ValueOptions network. Even if you use a provider who doesn't participate in the ValueOptions network, he or she may participate in the BlueCard network; in this case, you may be eligible for costs based on the Horizon BCBS negotiated fee. If your provider does not participate in the ValueOptions network, call **800-424-4047** to see if he or she participates in the Horizon BCBS network.

Please note that all treatments for behavioral health and substance abuse must be Medically Necessary to be covered under the Plan. The Medical Plan will not pay benefits (In-Network or Out-of-Network) if the applicable Claims Administrator determines that treatment is not Medically Necessary. If you obtain care Out-of-Network, Reasonable and Customary Limits (R&C Limits) apply.

Also note that if you participate in the Merck PPO-Horizon BCBS option, only providers in the ValueOptions Network are considered In-Network providers for behavioral health care. Providers in the BlueCard network are considered Out-Of-Network for behavioral health care; however, if you receive care from a BlueCard provider, you may be eligible to pay for services based on the Horizon BCBS negotiated fees.

Please refer to the applicable "At A Glance" chart for information regarding Deductibles, Copays and Coinsurance applicable to behavioral health care benefits under the Merck PPO or the Merck 80/20 option in which you are enrolled.

KEY POINT — ACCESS TO CARE

The ValueOptions Care Managers are available 24 hours a day, 7 days a week to assist you. For more information call **877-44-MERCK** or visit **www.achievesolutions.net/merck**.

In Case of an Emergency

If you or a Covered Dependent has a behavioral health Emergency, you should call 911 or immediately go to the nearest emergency room. When you are able, if you are enrolled in the Merck PPO — Horizon BCBS or Merck 80/20 options, you or your representative should contact ValueOptions.

KEY POINT — INPATIENT PRECERTIFICATION

Certain services, such as inpatient stays, require precertification by your provider. Precertification is a process that helps you and your physician determine whether the services being recommended are covered expenses under the Plan. It also allows Aetna to help your provider coordinate your transition from an inpatient setting to an outpatient setting (called discharge planning), and to register you for specialized programs or case management when appropriate.

You do not need to precertify services provided by a network provider. Network providers will be responsible for obtaining necessary precertification for you. Since precertification is the provider's responsibility, there is no additional out-of-pocket cost to you as a result of a network provider's failure to precertify services.

When you go to an Out-Of-Network provider, it is your responsibility to obtain precertification from Horizon BCBS. There is no penalty if you fail to precertify. However, if your care is not Medically Necessity it will not be covered under the Plan.

Covered Services

The ValueOptions Behavioral Health Care Program covers Medically Necessary services and supplies needed for mental health and substance abuse care. Services and supplies that are not deemed Medically Necessary, as determined by ValueOptions, are not covered expenses. In addition, certain services and supplies that may be deemed Medically Necessary may not be covered expenses. Determinations of Medically Necessary services and supplies are made by ValueOptions as Plan Administrator, and ValueOptions, in its sole discretion, will make such determinations (which are final and binding). See "Services Not Covered" on the next page or contact ValueOptions for more details.

- **Mental Health and Substance Abuse Outpatient Services** that are provided in an outpatient provider's office or center, where a patient can seek brief periods of treatment for diagnosable mental health or substance abuse conditions but where the patient is not confined to a hospital bed or receiving inpatient services; and
- **Mental Health and Substance Abuse Inpatient Care** for diagnosable mental health or substance abuse conditions that consist of more intensive types of treatment, including acute inpatient, residential treatment, partial hospitalization and intensive or structured outpatient are considered inpatient treatment modalities, that are more intensive than outpatient care, and therefore, fall under the inpatient benefit claims adjudication and Medical Necessity review process. Inpatient care must be precertified by ValueOptions as Medically Necessary.

Services Not Covered

This section provides a list of services and supplies that are not covered by the ValueOptions Behavioral Health Care Program. Services that are not deemed Medically Necessary, as determined by ValueOptions, 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 ValueOptions.

Some types of treatment are *not covered* by ValueOptions, including, but not limited to:

- Custodial care, educational rehabilitation or treatment of learning disabilities, regardless of the setting in which the services are provided;
- State hospital treatment, except when determined by ValueOptions to be Medically Necessary;
- Treatment for personal or professional growth, development, training or professional certification;
- Evaluations, consultations or therapy for educational or professional training or for investigational purposes relating to employment;
- Psychiatric or psychological examinations, testing or treatments that ValueOptions determines are not Medically Necessary, but may be required for purposes of obtaining or maintaining employment or medical coverage related to judicial or administrative proceedings;
- Academic education during residential treatment;
- Therapies that do not meet national standards for mental health professional practice, for example, Erhard/The Forum, primal therapy, bioenergetic therapy, crystal healing therapy;
- Experimental or investigational therapies;
- Court-ordered psychiatric or substance abuse treatment, unless ValueOptions determines that such services are Medically Necessary for the treatment of a condition included in The Diagnostic and Statistical Manual of Mental Disorders – Fourth Edition;
- Psychological testing, except when conducted for purposes of diagnosing a mental disorder or when rendered in connection with treatment of the mental disorder (all outpatient testing requires preauthorization by ValueOptions);
- Services to treat conditions that are identified by the Diagnostic and Statistical Manual of Mental Disorders – Fourth Edition as not being attributable to a mental disorder (i.e., V Codes);
- Treatment of congenital and/or organic disorders, including, but not limited to, organic brain disease, Alzheimer's disease, autism and mental retardation, except for acute behavioral manifestations attributable to a The Diagnostic and Statistical Manual of Mental Disorders – Fourth Edition mental disorder and which may be amenable to brief psychiatric interventions or pharmacotherapy;
- Marriage counseling, except when rendered in connection with a The Diagnostic and Statistical Manual of Mental Disorders – Fourth Edition mental disorder;
- Treatment of stress, except when rendered in connection with a The Diagnostic and Statistical Manual of Mental Disorders – Fourth Edition mental disorder;
- Treatment for smoking cessation, weight reduction, obesity, stammering or stuttering;
- Aversion therapy;
- Treatment for chronic pain, except when rendered in connection with treatment of a The Diagnostic and Statistical Manual of Mental Disorders – Fourth Edition mental disorder;
- Treatment or consultations provided via telephone;
- Services, treatment or supplies provided as a result of any Workers' Compensation law or similar legislation, or obtained through, or required by, any governmental agency or program, whether

federal, state or any subdivision thereof, or caused by the conduct or omission of a third party for which you or your dependent has a claim for damages or relief, unless you provide ValueOptions with a lien against the claim for damages or relief in a form and manner satisfactory to ValueOptions;

- Treatment or consultations provided by the patient's parents, siblings, children, current or former Spouse or live-in partner;
- Prometa;
- Vagus Nerve Stimulation;
- Biofeedback, except for the primary treatment of anxiety disorders;
- Applied Behavioral Analysis; and
- Transcranial Magnetic Stimulation.

How to File a Claim

In-Network Care

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

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 Medical Plan.

Inpatient
Claim forms are available on NetBenefits, **http://hr.merck.com** or by calling the Merck Benefits Service Center at **800-66-MERCK**. Horizon BCBS is the claims payer for inpatient Out-of-Network claims, which are submitted to Horizon BCBS for payment.

Outpatient
Claim forms are available on NetBenefits, **http://hr.merck.com** or by calling the Merck Benefits Service Center at **800-66-MERCK**. Complete the claim form and send it together with an itemized bill from your provider to:

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

Coordination of Benefits

If you have duplicate coverage and the Medical Plan is secondary, you must first file claims with the primary plan and then submit your claims to Horizon BCBS at the address above — even if you received care from an In-Network provider. Coordination of benefits rules apply. For more information when you have other coverage, see "Coordination of Benefits" in the "Administrative Information" chapter.

Claims and Appeals

If you, your beneficiary or your authorized representative receive an adverse benefit determination regarding your claim and you, your beneficiary or you authorized representative feels that the Claims Administrator has made an error concerning your benefits, you, your beneficiary or your authorized representative have the right to request reconsideration under the Plan in accordance with the following procedure.

For this purpose an "adverse benefit determination," will mean a denial, reduction, or termination of, or a failure to provide or make payment in whole or in part (a "denial") for a benefit, including where such denial is based on a determination of a participant's or beneficiary's eligibility to participate in a plan. An adverse benefit determination also means a claim denial based on a utilization review or a determination that a treatment is experimental or investigational or not Medically Necessary or appropriate or a retroactive termination of coverage due to fraud or intentional misconduct (a "rescission").

Upon receipt of an adverse benefit determination, you may request information regarding any diagnosis codes and treatment codes applicable to your claim and their corresponding meaning. Upon such a request, the diagnosis and treatment codes and their meaning will be provided as soon as possible, but will not be considered a request for review of an adverse benefit determination or a request for external review.

Initial Claim

The Behavioral Health Care Claims Administrator is responsible for evaluating all benefit claims. The Behavioral Health Care Claims Administrator will review your claim in accordance with its standard claims procedures, as required by ERISA. The Behavioral Health Care Claims Administrator has the right to secure independent medical advice and to require other evidence as it deems necessary in order to decide the status of your claim.

There are four categories of claims: urgent health claims, pre-service health claims, post-service health claims and concurrent health claims. Each category has different claims procedures. For many of these procedures, your health care provider may work directly with the Behavioral Health Care Claims Administrator.

- **"Urgent" health claims.** These are claims that if not processed quickly (within 72 hours) the life or health of the patient is jeopardized. The Behavioral Health Care Claims Administrator will notify you or your doctor of the Plan's decision no later than 72 hours after your claim is received, unless you fail to provide sufficient information to determine whether, or to what extent, benefits are covered or payable under the Plan.
- **"Pre-service" health claims.** These are claims that must be decided before a patient will be allowed access to health care (for example, pre-authorization requests or referrals). The Behavioral Health Care Claims Administrator will notify you or your doctor of the decision no later than 15 days after your claim is received. This 15-day period may be extended by another 15 days in certain circumstances.
- **"Post-service" health claims.** These are claims involving the payment or reimbursement of costs for care that has already been provided. For non-urgent, post-service health claims, The Behavioral Health Care Claims Administrator has up to 30 days to evaluate and respond to claims for benefits. The 30-day period begins on the date the claim is first filed. This 30-day period may be extended by 15 days, in certain circumstances.
- **"Concurrent" health claims.** These are claims for which the Behavioral Health Care Claims Administrator has previously approved a course of treatment over a period of time or for a specific number of treatments, and the Plan later reduces or terminates coverage for those treatments.

Concurrent care claims may fall under any of the above three categories, depending on when the appeal is made. However, the Plan must give you enough advance notice to appeal the claim before a concurrent care decision takes effect.

If Your Claim Is Denied

If the Behavioral Health Care Claims Administrator does not fully agree with your claim, you will receive an "adverse benefit determination," which is a denial, reduction or termination of a benefit. An adverse benefit determination also means a claim denial on the grounds that the treatment is experimental, investigational, or not Medically Necessary. This includes concurrent care determinations. You will receive notice of a denial, which will include:

- Information sufficient to identify the claim involved, including the date of service, identification of the health care provider,and the claim amount (if applicable) and a statement indicating that the diagnosis codes, treatment codes and their corresponding meaning are available upon request;
- The specific reasons for the denial, including the applicable denial code and its meaning;
- If applicable, a description of the standard used by the Plan to deny the claim;
- A reference to the specific Plan provisions on which the denial is based;
- A description of any additional material or information needed to reconsider the claim and an explanation of why such material or information is necessary;
- A description of the Plan's internal and external review procedures, including the time limits applicable to such procedures; and contact information for any applicable office of health insurance consumer assistance or ombudsman that will assist you with such procedures;
- A statement of your right to bring a civil action under Section 502(a) of ERISA following a denial on review;
- Any internal rules, guidelines, protocols, or other similar criteria that were used for the basis of the denial, either the specific rule, guideline, protocol or criterion, or a statement that a copy of such information will be made available free of charge to you upon request; and
- For a denial based on medical necessity, or an experimental treatment or other similar exclusion or limit, an explanation of the scientific or clinical judgment used in the decision, applying the terms of the Plan to your medical circumstances, or a statement that such explanation will be provided free of charge upon request.
- For a denial involving urgent care, a description of the expedited review process applicable to such claims. Also, in the case of denial concerning a claim involving urgent care, the information set out in this section may be provided orally within the time frames provided in the section above entitled "Urgent health claims." If an oral notice is provided, a written notification that meets all the requirements of this section will be furnished within three days of the oral notice.

Appealing a Claim

If your claim for benefits is denied, in whole or in part, you or your authorized representative may appeal the denial within 180 days of the receipt of the written or electronic notice of denial. If you choose to appeal your claim, your appeal should be in writing and should explain why you believe the claim should be paid. Please note that all requests for reconsideration shall be submitted in writing:

Behavioral Health Care Appeals (including behavioral health precertification)	
ValueOptions Behavioral Health Care Program for Employees *In-Network Benefits*	ValueOptions Attn: Appeals and Grievances P.O. Box 1347 Latham, NY 12110
ValueOptions Behavioral Health Care Program for Employees *Out-of-Network Benefits,* ***including:*** ▪ *Inpatient* ▪ *Residential treatment*	ValueOptions Attn: Appeals and Grievances P.O. Box 1347 Latham, NY 12110
ValueOptions Behavioral Health Care Program for Employees *Out-of-Network,* ***other than:*** ▪ *Inpatient* ▪ *Residential treatment*	Claims Administrator and fiduciary for the Medical Plan: Merck Dedicated Service Team Horizon BCBS P.O. Box 18 Newark, NJ 07101-0018

Upon your request, you will have access to, and the right to obtain copies of, all documents, records and information relevant to your claim free of charge. You also have the right to receive any additional evidence used to evaluate your claim or any additional rationale applied to your claim. If the Plan receives any additional evidence regarding your claim or applies a new rationale, you will be provided with the additional evidence and the rational and given an opportunity to respond before the final claim determination is issued.

You may submit with your appeal any written comments, documents, records and any other information relating to your claim, even if you didn't include that information with your original claim. Reviewers must take all the information into account, even if it was not submitted or considered in the initial decision. The review will not afford any deference to the initial claim determination.

A qualified individual who was not involved in the previous claim determination (and is not that person's subordinate) will decide your appeal. If your appeal involves a medical judgment — including whether a treatment, drug or other item is experimental, investigational or not Medically Necessary or appropriate — the review will be done in consultation with a health care professional who has appropriate training and experience in the relevant field of medicine involved in the medical judgment, who was not consulted in connection with the previous adverse claim determination and who is not that person's subordinate.

After receiving your appeal, the Behavioral Health Care Claims Administrator will provide notice of its decision within the following timeframes:

- *Urgent care appeals.* You or your authorized representative should call Horizon BCBS as soon as possible. You can request an expedited appeal process orally or in writing. In this case, all necessary information, including the Behavioral Health Care Claims Administrator's benefits determination on review, shall be relayed to you or your representative by telephone, fax or other similarly expeditious method. The Behavioral Health Care Claims Administrator will provide notice of the appeal decision as soon as possible, taking into account the seriousness of your condition, but no later than 72 hours after receipt of your appeal.

- *Pre-service appeals.* The Behavioral Health Care Claims Administrator will provide notice of the appeal within 30 days following receipt of your appeal.
- *Post-service appeals.* The Behavioral Health Care Claims Administrator will provide notice of the appeal decision within 60 days following receipt of your appeal.

You will receive written notification of the determination of your appeal. If the claim on appeal is denied in whole or in part, the notice will include:

- Information sufficient to identify the claim involved, including the date of service, identification of the health care provider,and the claim amount (if applicable) and a statement indicating that the diagnosis codes, treatment codes and their corresponding meaning are available upon request;
- The specific reasons for the denial, including the applicable denial code and its meaning;
- If applicable, a description of the standard used by the Plan to deny the claim;
- A reference to the specific Plan provisions on which the denial is based;
- A description of any additional material or information needed to reconsider the claim and an explanation of why such material or information is necessary;
- A description of the Plan's internal and external review procedures, including the time limits applicable to such procedures and contact information for any applicable office of health insurance consumer assistance or ombudsman that will assist you with such procedures;
- A statement of your right to bring a civil action under Section 502(a) of ERISA following a denial on review;
- Any internal rules, guidelines, protocols, or other similar criteria that were used for the basis of the denial, either the specific rule, guideline, protocol or criterion, or a statement that a copy of such information will be made available free of charge to you upon request; and
- For a denial based on medical necessity or an experimental treatment or other similar exclusion or limit, an explanation of the scientific or clinical judgment used in the decision, applying the terms of the Plan to your medical circumstances, or a statement that such explanation will be provided free of charge upon request.
- For a denial involving urgent care, a description of the expedited review process applicable to such claims. Also, in the case of denial concerning a claim involving urgent care, the information set out in this section may be provided orally within the time frames provided in the section above entitled "Urgent health claims." If an oral notice is provided, a written notification that meets all the requirements of this section will be furnished within three days of the oral notice.

KEY POINT — LIMITED ELIGIBILITY FOR THE VALUEOPTIONS BEHAVIORAL HEALTH CARE PROGRAM

The ValueOptions Behavioral Health Care Program does not apply to Eligible Employees who are enrolled in the Merck PPO – Aetna Choice POS II option or elected the No Coverage option. Eligible Employees enrolled in the Merck PPO – Aetna POS II option are eligible for behavioral health care benefits under Aetna's Mental Health and Substance Abuse Program.

External Review
ValueOptions may deny a claim because it determines that the care is not appropriate or a service or treatment is Experimental or Investigational in nature. In either of these situations, you may request an external review if you or your provider disagrees with ValueOptions' decision. An external review is a review by an independent physician, selected by an External Review Organization, who has expertise in the problem or question involved.

To request an external review, the following requirements must be met:
- You have received notice of the denial of a claim by the ValueOptions; and
- Your claim was denied because ValueOptions determined that the care was not necessary, appropriate or effective or was Experimental or Investigational or your claim was denied due to a rescission of coverage; and
- You have exhausted the applicable internal appeal processes or the process is deemed exhausted due to the failure of the plan to adjudicate your claim in accordance with the procedures set forth herein where such failure is not de-minimis.

The claim denial letter you receive from ValueOptions will describe the process to follow if you wish to pursue an external review, including a copy of the Request for External Review Form.

You must submit the Request for External Review Form to ValueOptions within 120 calendar days of the date you received the final claim denial letter. You also must include a copy of the final claim denial letter and all other pertinent information that supports your request.

ValueOptions will contact the External Review Organization that will conduct the review of your claim. The External Review Organization will select an independent physician with appropriate expertise to perform the review. In making a decision, the external reviewer may consider any appropriate credible information that you send along with the Request for External Review Form, and will follow ValueOptions' contractual documents and plan criteria governing the benefits. You will be notified of the decision of the External Review Organization usually within 45 calendar days of ValueOptions' receipt of your request form and all necessary information. A quicker review is possible if your physician certifies (by telephone or on a separate Request for External Review Form) that a delay in receiving the service would endanger your health. Expedited reviews are decided within 72 hours after ValueOptions receives the request.

ValueOptions, the Company and the Health Plan will abide by the decision of the External Review Organization, except where ValueOptions can show conflict of interest, bias or fraud.

You are responsible for the cost of compiling and sending the information that you wish to be reviewed by the External Review Organization to ValueOptions. ValueOptions is responsible for the cost of sending this information to the External Review Organization and for the cost of the external review.

For more information about ValueOptions' External Review process, call ValueOptions at **877-44-MERCK**.

Aetna Behavioral Health

Behavioral health benefits are available only under one of the Plan's medical coverage options. The administrator of these behavioral health care benefits — and the network providers available — will differ depending on which option you enroll in.

Behavioral Health Care Benefits	
Merck PPO—Aetna Choice POS II medical option	**Merck PPO—Horizon BCBS or 80/20 medical options**
Aetna will administer behavioral health care benefits. For In-Network providers and additional information, visit **http://www.aetna.com/docfind** or call **800-541-6711 (group number: 479265)**. Representatives are available from 8:00 a.m. to 6:00 p.m., Eastern time.	ValueOptions will administer behavioral health care benefits. For In-Network providers and additional information, visit **http://www.achievesolutions.net/merck** or call **877-44-MERCK (877-446-3725)**. You can contact ValueOptions by phone 365 days a year, 24 hours a day.

How Aetna Behavioral Health Works

In-Network Mental Health and Substance Abuse Benefits

Aetna Behavioral Health has one of the largest networks, consisting of over 85,000 providers. The network is comprised of over 14,000 psychiatrists as well as psychologists, social workers, clinical counselors, psychiatric nurses and marriage and family therapists. When you select In-Network providers, your claims are filed by the provider and your cost is generally lower. A complete listing of Aetna Behavioral Health providers is available by contacting Aetna at **800-541-6711** or by visiting **www.aetna.com/docfind**.

Out-of-Network Mental Health and Substance Abuse Benefits

You also have the option to access care with providers who are not in Aetna's network. However you usually pay more for treatment with Out-Of-Network providers.

Please refer to the applicable "At A Glance" chart for information regarding Deductibles, Copays and Coinsurance applicable to behavioral health care benefits under the Merck PPO option in which you are enrolled.

KEY POINT — PRECERTIFICATION

Certain services, such as inpatient stays, require precertification by your provider. Precertification is a process that helps you and your physician determine whether the services being recommended are covered expenses under the plan. It also allows Aetna to help your provider coordinate your transition from an inpatient setting to an outpatient setting (called discharge planning), and to register you for specialized programs or case management when appropriate.

You do not need to precertify services provided by a network provider. Network providers will be responsible for obtaining necessary precertification for you. Since precertification is the provider's responsibility, there is no additional out-of-pocket cost to you as a result of a network provider's failure to precertify services.

When you go to an Out-Of-Network provider, it is your responsibility to obtain precertification from Aetna. There is no penalty if you fail to precertify. However, if your care is not Medically Necessary it will not be covered under the plan.

Covered Services

Covered expenses include charges made for the treatment of mental health or substance abuse disorders by behavioral health providers.

Outpatient Treatment

Covered expenses include charges for treatment received while not confined as a full-time inpatient in a hospital, psychiatric hospital or residential treatment facility.

Mental Health and Substance Abuse Partial Hospitalization

The Plan covers partial hospitalization services (more than 4 hours, but less than 24 hours per day) provided in a facility or program for the intermediate short-term or medically-directed intensive treatment. The partial hospitalization will only be covered if you would need inpatient care if you were not admitted to this type of facility.

Mental Health and Substance Abuse Inpatient Care

Benefits are payable for charges incurred in a hospital, psychiatric hospital, residential treatment facility or behavioral health provider's office for the treatment of mental disorders as follows:

- Inpatient treatment, including charges for room and board at the semi-private room rate, and other services and supplies provided during your stay in a hospital, psychiatric hospital or residential treatment facility.
- Substance abuse inpatient treatment coverage includes treatment in a hospital for the medical complications of substance abuse. "Medical complications" include detoxification, electrolyte imbalances, malnutrition, cirrhosis of the liver, delirium tremens and hepatitis.

Services Not Covered

This section provides a list of services and supplies that are not covered by Aetna. Services that are not deemed Medically Necessary, as determined by Aetna, are not covered expenses. These include, but are not limited to, services that are deemed maintenance or custodial. In addition, certain services that may be deemed Medically Necessary may not be covered expenses. To verify coverage of a medical service or device, contact Aetna.

Some types of treatment are *not covered* by Aetna, including, but not limited to:

- Applied Behavioral Analysis, the LEAP, TEACCH, Denver and Rutgers programs;
- Treatment of impulse control disorders such as pathological gambling, kleptomania, pedophilia, caffeine or nicotine use;
- Treatment in wilderness programs or other similar programs;
- Any services or supplies related to education, training or retraining services or testing, including: special education, remedial education, job training and job hardening programs;
- Evaluation or treatment of learning disabilities, minimal brain dysfunction, developmental, learning and communication disorders, behavioral disorders, (including pervasive developmental disorders) training or cognitive rehabilitation, regardless of the underlying cause;
- Services, treatment, and educational testing and training related to behavioral (conduct) problems, learning disabilities and delays in developing skills;
- Any health examinations:
  - Required by a third party, including examinations and treatments required to obtain or maintain employment, or which an employer is required to provide under a labor agreement;

  - Required by any law of a government, securing insurance or school admissions, or professional or other licenses;
  - Required to travel, attend a school, camp, or sporting event or participate in a sport or other recreational activity; and
  - Any special medical reports not directly related to treatment except when provided as part of a covered service;
- Therapies for the treatment of delays in development, unless resulting from acute illness or injury, or congenital defects amenable to surgical repair (such as cleft lip/palate), are not covered. Examples of non-covered diagnoses include Pervasive Developmental Disorders (including Autism), Down Syndrome, and Cerebral Palsy, as they are considered both developmental and/or chronic in nature;
- Therapies and tests: Any of the following treatments or procedures:
  - Aromatherapy;
  - Bio-feedback and bioenergetic therapy;
  - Carbon dioxide therapy;
  - Chelation therapy (except for heavy metal poisoning);
  - Computer-aided tomography (CAT) scanning of the entire body;
  - Educational therapy;
  - Gastric irrigation;
  - Hair analysis;
  - Hyperbaric therapy, except for the treatment of decompression or to promote healing of wounds;
  - Hypnosis, and hypnotherapy, except when performed by a physician as a form of anesthesia in connection with covered surgery;
  - Lovaas therapy;
  - Massage therapy;
  - Megavitamin therapy;
  - Primal therapy;
  - Psychodrama;
  - Purging;
  - Recreational therapy;
  - Rolfing;
  - Sensory or auditory integration therapy;
  - Sleep therapy; and
  - Thermograms and thermography.

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 provider will file all claims for you. Simply show your medical ID care and pay the applicable Copay for outpatient care. For inpatient care, your network providers bills the plan directly for the Medical Plan share of the cost of your care. Subsequently, your network provider bills you for your remaining share of the cost of care (e.g. Coinsurance).

Out-of-Network Care

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

Inpatient & Outpatient Claims Forms
Claims forms are available on NetBenefits, **http://hr.merck.com** or by calling the Merck Benefits Service Center at **800-66-MERCK**. Aetna is the claims payer for inpatient and outpatient claims and claim forms are submitted to Aetna for payment using the address found on the claim form.

Coordination of Benefits

If you have duplicate coverage and the Medical Plan is secondary, you must first file claims with the primary plan and then submit your claims to Aetna using the address found on the claim form — even if you received care from an In-Network provider. Coordination of benefits rules apply. For more information when you have other coverage, see "Coordination of Benefits" in the Administrative Information chapter.

Claims and Appeals

If you, your beneficiary or your authorized representative feel that the Claims Administrator has made an error concerning your benefits, you, your beneficiary or your authorized representative have the right to request reconsideration under the Plan in accordance with the following procedure.

Upon receipt of a claim denial, you may request information regarding any diagnosis codes and treatment codes applicable to your claim and their corresponding meaning. Upon such a request, the diagnosis and treatment codes and their meaning will be provided as soon as possible, but will not be considered a request for review of an adverse benefit determination or a request for external review.

Initial Claim

Aetna is responsible for evaluating all benefit claims. Aetna will review your claim in accordance with its standard claims procedures, as required by ERISA. Aetna has the right to secure independent medical advice and to require other evidence as it deems necessary in order to decide the status of your claim.

There are four categories of claims: urgent health claims, pre-service health claims, post-service health claims and concurrent health claims. Each category has different claims procedures. For many of these procedures, your health care provider may work directly with Aetna.

- **"Urgent" health claims.** These are claims that if not processed quickly (within 72 hours) the life or health of the patient is jeopardized. Aetna will notify you or your doctor of the Plan's decision no later than 72 hours after your claim is received, unless you fail to provide sufficient information to determine whether, or to what extent, benefits are covered or payable under the Plan.
- **"Pre-service" health claims.** These are claims that must be decided before a patient will be allowed access to health care (for example, pre-authorization requests or referrals). Aetna will notify you or

your doctor of the decision no later than 15 days after your claim is received. This 15-day period may be extended by another 15 days in certain circumstances.

- **"Post-service" health claims.** These are claims involving the payment or reimbursement of costs for care that has already been provided. For non-urgent, post-service health claims, Aetna has up to 30 days to evaluate and respond to claims for benefits. The 30-day period begins on the date the claim is first filed. This 30-day period may be extended by 15 days, in certain circumstances.
- **"Concurrent" health claims.** These are claims for which Aetna has previously approved a course of treatment over a period of time or for a specific number of treatments, and the Plan later reduces or terminates coverage for those treatments. Concurrent care claims may fall under any of the above three categories, depending on when the appeal is made. However, the Plan must give you enough advance notice to appeal the claim before a concurrent care decision takes effect.

If Your Claim Is Denied

If Aetna does not fully agree with your claim, you will receive an "adverse benefit determination." For this purpose an "adverse benefit determination," will mean a denial, reduction, or termination of, or a failure to provide or make payment in whole or in part (a "denial") for a benefit, including where such denial is based on a determination of a participant's or beneficiary's eligibility to participate in a plan. An adverse benefit determination also means a claim denial based on a utilization review or a determination that a treatment is experimental, or investigational, or not Medically Necessary or appropriate or a retroactive termination of coverage due to fraud or intentional misconduct (a "rescission").

You will receive notice of a denial, which will include:

- Information sufficient to identify the claim involved, including the date of service, identification of the health care provider,and the claim amount (if applicable) and a statement indicating that the diagnosis codes, treatment codes and their corresponding meaning are available upon request;
- The specific reasons for the denial, including the applicable denial code and its meaning;
- If applicable, a description of the standard used by the Plan to deny the claim;
- A reference to the specific Plan provisions on which the denial is based;
- A description of any additional material or information needed to reconsider the claim and an explanation of why such material or information is necessary;
- A description of the Plan's internal and external review procedures, including the time limits applicable to such procedures; and contact information for any applicable office of health insurance consumer assistance or ombudsman that will assist you with such procedures;
- A statement of your right to bring a civil action under Section 502(a) of ERISA following a denial on review;
- Any internal rules, guidelines, protocols, or other similar criteria that were used for the basis of the denial, either the specific rule, guideline, protocol or criterion, or a statement that a copy of such information will be made available free of charge to you upon request; and
- For a denial based on medical necessity, or an experimental treatment or other similar exclusion or limit, an explanation of the scientific or clinical judgment used in the decision, applying the terms of the Plan to your medical circumstances, or a statement that such explanation will be provided free of charge upon request.
- For a denial involving urgent care, a description of the expedited review process applicable to such claims. Also, in the case of denial concerning a claim involving urgent care, the information set out in this section may be provided orally within the time frames provided in the section above entitled "Urgent health claims." If an oral notice is provided, a written notification that meets all the requirements of this section will be furnished within three days of the oral notice.

Appealing a Claim

If your claim for benefits is denied, in whole or in part, you or your authorized representative may appeal the denial within 180 days of the receipt of the written or electronic notice of denial. If you choose to appeal your claim, your appeal should be in writing and should explain why you believe the claim should be paid. Please note that all requests for reconsideration shall be submitted in writing:

Aetna Behavioral Health Care Appeals (including behavioral health precertification)	
Claims and Appeals	National CRT Unit P.O. Box 14463 Lexington, KY 40512

Upon your request, you will have access to, and the right to obtain copies of, all documents, records and information relevant to your claim free of charge. You also have the right to receive any additional evidence used to evaluate your claim or any additional rationale applied to your claim. If the Plan receives any additional evidence regarding your claim or applies a new rationale, you will be provided with the additional evidence and the rational and given an opportunity to respond before the final claim determination is issued.

You may submit with your appeal any written comments, documents, records and any other information relating to your claim, even if you didn't include that information with your original claim. Reviewers must take all the information into account, even if it was not submitted or considered in the initial decision. The review will not afford any deference to the initial claim determination.

A qualified individual who was not involved in the previous claim determination (and is not that person's subordinate) will decide your appeal. If your appeal involves a medical judgment — including whether a treatment, drug or other item is experimental, investigational or not Medically Necessary or appropriate — the review will be done in consultation with a health care professional who has appropriate training and experience in the relevant field of medicine involved in the medical judgment, who was not consulted in connection with the previous adverse claim determination and who is not that person's subordinate.

After receiving your appeal, the Aetna will provide notice of its decision within the following timeframes:

- *Urgent care appeals.* You or your authorized representative should call Aetna as soon as possible. You can request an expedited appeal process orally or in writing. In this case, all necessary information, including Aetna's benefits determination on review, shall be relayed to you or your representative by telephone, fax or other similarly expeditious method. Aetna will provide notice of the appeal decision as soon as possible, taking into account the seriousness of your condition, but no later than 72 hours after receipt of your appeal.
- *Pre-service appeals.* Aetna will provide notice of the appeal within 30 days following receipt of your appeal.
- *Post-service appeals.* Aetna will provide notice of the appeal decision within 60 days following receipt of your appeal.

You will receive written notification of the determination of your appeal. If the claim on appeal is denied in whole or in part, the notice will include:

- Information sufficient to identify the claim involved, including the date of service, identification of the health care provider,and the claim amount (if applicable) and a statement indicating that the diagnosis codes, treatment codes and their corresponding meaning are available upon request;

- The specific reasons for the denial, including the applicable denial code and its meaning;
- If applicable, a description of the standard used by the Plan to deny the claim;
- A reference to the specific Plan provisions on which the denial is based;
- A description of any additional material or information needed to reconsider the claim and an explanation of why such material or information is necessary;
- A description of the Plan's internal and external review procedures, including the time limits applicable to such procedures and contact information for any applicable office of health insurance consumer assistance or ombudsman that will assist you with such procedures;
- A statement of your right to bring a civil action under Section 502(a) of ERISA following a denial on review;
- Any internal rules, guidelines, protocols, or other similar criteria that were used for the basis of the denial, either the specific rule, guideline, protocol or criterion, or a statement that a copy of such information will be made available free of charge to you upon request; and
- For a denial based on medical necessity or an experimental treatment or other similar exclusion or limit, an explanation of the scientific or clinical judgment used in the decision, applying the terms of the Plan to your medical circumstances, or a statement that such explanation will be provided free of charge upon request.
- For a denial involving urgent care, a description of the expedited review process applicable to such claims. Also, in the case of denial concerning a claim involving urgent care, the information set out in this section may be provided orally within the time frames provided in the section above entitled "Urgent health claims." If an oral notice is provided, a written notification that meets all the requirements of this section will be furnished within three days of the oral notice.

KEY POINT — LIMITED ELIGIBILITY FOR THE AETNA MENTAL HEALTH AND SUBSTANCE ABUSE PROGRAM

The Aetna Mental Health and Substance Abuse Program does not apply to Eligible Employees who are enrolled in the Merck PPO — Horizon BCBS option, the Merck 80/20 option or those who elected the No Coverage option. Eligible Employees who are enrolled in the Merck PPO — Horizon BCBS option or the Merck 80/20 option are eligible for behavioral health care benefits under the Behavioral Health Care Program administered by ValueOptions.

External Review

Aetna may deny a claim because it determines that the care is not appropriate or a service or treatment is Experimental or Investigational in nature. In either of these situations, you may request an external review if you or your provider disagrees with Aetna's decision. An external review is a review by an independent physician, selected by an External Review Organization, who has expertise in the problem or question involved.

To request an external review, the following requirements must be met:

- You have received notice of the denial of a claim by the Aetna; and
- Your claim was denied because Aetna determined that the care was not necessary appropriate or effective or was Experimental or Investigational or your claim was denied due to a rescission of coverage; and
- You have exhausted the applicable internal appeal processes or the process is deemed exhausted due to the failure of the plan to adjudicate your claim in accordance with the procedures set forth herein where such failure is not de-minimis.

The claim denial letter you receive from Aetna will describe the process to follow if you wish to pursue an external review, including a copy of the Request for External Review Form.

You must submit the Request for External Review Form to Aetna within 120 calendar days of the date you received the final claim denial letter. You also must include a copy of the final claim denial letter and all other pertinent information that supports your request.

Aetna will contact the External Review Organization that will conduct the review of your claim. The External Review Organization will select an independent physician with appropriate expertise to perform the review. In making a decision, the external reviewer may consider any appropriate credible information that you send along with the Request for External Review Form, and will follow Aetna's contractual documents and plan criteria governing the benefits. You will be notified of the decision of the External Review Organization usually within 45 calendar days of Aetna's receipt of your request form and all necessary information. A quicker review is possible if your physician certifies (by telephone or on a separate Request for External Review Form) that a delay in receiving the service would endanger your health. Expedited reviews are decided within 72 hours after Aetna receives the request.

Aetna, the Company and the Health Plan will abide by the decision of the External Review Organization, except where Aetna can show conflict of interest, bias or fraud.

You are responsible for the cost of compiling and sending the information that you wish to be reviewed by the External Review Organization to Aetna. Aetna is responsible for the cost of sending this information to the External Review Organization and for the cost of the external review.

For more information about Aetna's External Review process, call Aetna at **800-541-6711**.

Administrative Information

This section contains information on the administration and funding for the Medical Plan, as well as your rights as a Medical Plan participant. While you may not need this information for day-to-day participation in the Medical Plan, you should read through this section. It is important for you to understand your rights, the procedures you need to follow and the appropriate contacts you may need in certain situations.

Coordination of Benefits

If you or your Eligible Dependents are covered by the Merck Medical Plan and by certain other types of coverage, the Merck Medical Plan will coordinate your benefits with other coverage. The Merck Medical Plan coordinates benefits with these types of coverage:

- Group insurance (e.g., group coverage sponsored by another employer, a college, an association, etc.) whether the coverage:
  - Pays benefits on an insured or uninsured basis, or
  - Provides benefits on a prepaid or managed care basis (e.g., PPO) or an indemnity basis;
- Coverage for students that is sponsored by, or provided through, a school or other educational institution, except for accident-type coverage for grammar and high school students;
- No fault auto insurance; and
- Medicare.

If you have a medical expense that is covered by two or more plans:

- One plan, the primary plan, will pay your claim first; and
- The other plan(s), the secondary plan(s), may then pay some of the difference between what the primary plan paid and the total covered expenses.

Keep in mind that in most cases, you and your Covered Dependents will not receive 100% reimbursement for expenses when you have two or more coverages.

If the primary plan covers a certain service or supply at the same level as the secondary plan, the secondary plan may not pay any additional benefits for that service or supply. As a result, it may not be to your advantage to be covered by two medical plans. For example, if your Spouse/Same-Sex Domestic Partner is covered under his/her employer's plan and as a Covered Dependent under the Merck Medical Plan, the Merck Medical Plan is secondary. If your Spouse/Same-Sex Domestic Partner submits expenses to the Merck Medical Plan, and the amount payable by the Merck Medical Plan is less than or equal to what your Spouse's/Same-Sex Domestic Partner's plan would have paid, the Merck Medical Plan will pay nothing.

KEY POINT — MAXIMUM BENEFIT PAID WHEN COORDINATING COVERAGE

The Merck Medical Plan never pays more than the amount which, when added to the amount paid by the primary coverage, equals the amount the Merck Medical Plan would have paid had it been the primary plan.

Coverage Under Your Spouse's/Same-Sex Domestic Partner's Plan

Eligible Employees may choose the No Coverage option. However, if you choose the No Coverage option because you intend to enroll in alternate coverage (such as a dependent through your Spouse's/Same-Sex Domestic Partner's employer), be sure to check the rules of the other plan in advance. Some employers will not allow an employee to cover a Spouse/Same-Sex Domestic Partner if the Spouse/Same-Sex Domestic Partner can obtain coverage through his/her own employer.

Coordinating Benefits in General

The Merck Medical Plan coordinates benefits with other coverage in accordance with the rules of the National Association of Insurance Companies. Following are some examples of those rules:

- The plan that covers you as an employee pays first, and the plan that covers you as a dependent or COBRA participant pays second.
- If dependent children are covered by both parents, the "birthday rule" applies, unless the parents are divorced or separated. Under the "birthday rule," the plan of the parent whose birthday falls earlier in the year pays first.
- If children of separated or divorced parents are covered by the plans of both parents, the plan of the parent with custody pays first. The plan of the Spouse of the parent with custody pays second. The plan of the parent without custody pays next.
- The plan that covers you as an active employee pays first, and the plan that covers you as a Retiree pays second.
- Automobile insurance coverage will always pay first, including for states that allow the selection of private medical coverage over automatic medical coverage (e.g., New Jersey).

A court may establish financial responsibility for all medical care of a Covered Dependent. In that case, the plan of the parent assigned financial responsibility will pay benefits first without regard to these rules.

Coordinating Benefits When Another Managed Care Plan Is Primary

If you elected the Merck PPO option (including if you are seeking benefits under the Behavioral Health Care Program): If the primary plan was paid on an In-Network basis (i.e., the member followed that plan's requirements for In-Network coverage under that plan), then the Merck Medical Plan will pay an amount which, when added to the amount paid by the primary plan, equals the amount the Merck Medical Plan would have paid had it been primary on an In-Network basis. If the primary plan paid on an Out-of-Network basis, the Merck Medical Plan would pay an amount which, when added to the amount paid by the primary plan, equals the amount the Merck Medical Plan would have paid had it been primary on an Out-of-Network basis.

If you elected the Merck 80/20 option (including if you are seeking benefits under the Behavioral Health Care Program): If the primary plan paid on an In-Network basis or Out-of-Network basis, the Merck Medical Plan will pay an amount which, when added to the amount paid by the primary plan, equals the amount the Merck Medical Plan would have paid had it been primary under the selected Merck 80/20 option (on an Out-of-Network basis).

Coordinating Benefits with No Fault Automobile Insurance

Even if the Merck Medical Plan is your primary or secondary plan, in states with no fault automobile insurance, the automobile insurance carrier is the primary insurance for injuries resulting from an automobile accident. In no fault states, all medical expenses related to an automobile accident must be submitted to the automobile insurance carrier first. The Merck Medical Plan will pay covered expenses not payable under the no fault automobile insurance according to the coordination of benefit rules discussed above. Then, you can submit claims under another plan, such as your Spouse's employer's plan, for any expenses not paid by the Merck Medical Plan. Depending on the coordination of benefit provisions of the other plan, you may or may not receive additional benefits. Note, however, that in states where personal injury coverage is available under an automobile insurance policy (e.g., New Jersey), the Merck Medical Plan will assume that you and your Covered Dependents elected such personal injury coverage. As a result, the Merck Medical Plan will not pay expenses payable under such coverage, whether or not such coverage was actually elected.

Coordinating Benefits with Medicare

Generally, you become eligible for Medicare coverage once you reach age 65. In certain circumstances you can become Medicare eligible earlier than age 65, such as if you become disabled. As long as you remain an active employee, the Merck Medical Plan pays benefits first — before Medicare. After you retire or are not an active employee and if you are eligible for medical coverage under the Merck Medical Plan, then Medicare becomes the primary plan and all bills should be submitted to Medicare first.

The same holds true for your other Covered Dependents if they have no other group insurance coverage. If your Spouse and/or Covered Dependents are eligible for Medicare, the Merck Medical Plan pays benefits before Medicare as long as you remain an active employee. After you retire or are not an active employee, Medicare becomes the primary plan for your Spouse and other Covered Dependents — even if you are not covered by Medicare. Different rules apply if your Spouse or other Covered Dependent has group insurance coverage.

If you or an Eligible Dependent become eligible for Medicare coverage under circumstances where Medicare is primary, the Merck Medical Plan will assume full Medicare Parts A and B coverage has been elected as soon as you or your Covered Dependents are eligible for Medicare coverage. Should you or your dependent elect anything other than full Medicare Parts A and B coverage, the Merck Medical Plan will reduce benefits to reflect whatever Medicare would have paid had you elected the full Medicare Parts A and B coverage.

For purposes of the Plan, it is assumed that your doctor accepts Medicare payments. When a doctor opts out of Medicare, the Plan continues to pay benefits as if the doctor accepts Medicare payments. If your doctor has opted out of Medicare, you will not receive reimbursement from the Plan for charges that would have been covered by Medicare.

You are eligible for Medicare if you:

- Are age 65 or over;
- Suffer from end-stage renal disease for 30 months or more; or
- Have been receiving Social Security Disability Insurance benefits for two or more years.

Medicare B Reimbursement for Legacy Merck Employees

Merck does not provide Medicare Part B reimbursements. Merck does not reimburse Part B premiums for Covered Dependents.

Recovery Provisions

The Claims Administrator can exchange benefit information with other employers, administrators and insurers to determine responsibility for benefits between the Merck Medical Plan and other coverage.

Overpayment of Benefits

The Claims Administrator has the right to recover any overpayment or make adjustments to the payment of future claims to meet the coordination of benefit provisions or otherwise.

Subrogation and Reimbursement

If you or your Covered Dependents are injured or otherwise harmed due to the conduct of another party, the Plan Administrator has the right to recover benefits paid by the Merck Medical Plan directly from that party or his/her insurance company or from any amount received from that party or his/her insurance company by you or your Covered Dependents. This right is referred to as the right of "subrogation and reimbursement." This right exists with respect to any amount received or receivable through a lawsuit or any other manner, whether or not characterized as related to medical expenses. The amount to which the Merck Medical Plan is entitled is not reduced by attorney fees or other amounts that may have been incurred in collection.

In this situation, acceptance of benefits from the Merck Medical Plan constitutes an agreement to reimburse the Merck Medical Plan for any benefits you (including your Covered Dependents) receive. You may be required to document your agreement by signing a subrogation and reimbursement agreement before benefits are provided. However, if you do not sign the agreement for any reason (including but not limited to because you were not given an agreement to sign, or you are unable or refused to sign), the Plan Administrator, in its sole discretion, may or may not advance benefits to you under the Merck Medical Plan. If the Plan Administrator has advanced benefits, it has the right to subrogation and reimbursement whether or not you have signed the agreement. The Plan Administrator, in its own discretion, also may commence an action against any party it feels caused an injury to you which caused the Merck Medical Plan to provide benefits to you or your Covered Dependents (although it has no obligation to do so, and will not provide you with legal representation if you decide to commence your own legal action).

You also must take any reasonably necessary action to protect the Merck Medical Plan's subrogation and reimbursement right. That means by accepting benefits from the Merck Medical Plan, you agree to notify the Plan Administrator if and when you institute a lawsuit, or other action, or enter into settlement negotiations with another party (including his/her insurance company) in connection with or related to the conduct of another party. You also must cooperate with the Plan Administrator's reasonable requests concerning the Plan's subrogation and reimbursement rights and must keep the Plan Administrator informed of any important developments in your action.

The Plan Administrator may delegate to the Claims Administrator all or any portion of its rights and/or obligations with respect to the Plan's right of subrogation and reimbursement.

By accepting benefits (whether the payment of such benefits is made to the Covered Employee or Covered Dependent or made on behalf of the Covered Employee or Covered Dependent to any provider) from the plan, the Covered Employee or Covered Dependent agrees that if he/she receives any payment as a result of an injury, illness or condition, he/she will serve as a constructive trustee over the funds that constitute such payment. Further, the plan will automatically have a lien to the

extent of benefits paid by the plan for the treatment of the illness, injury or condition for which the responsible party is liable. The lien shall be imposed upon any recovery whether by settlement, judgment, or otherwise, including from any insurance coverage, related to treatment for any illness, injury or condition for which the plan paid benefits. The lien may be enforced against any party who possesses funds or proceeds representing the amount of benefits paid by the Plan including, but not limited to, the Covered Employee, the Covered Dependent, a representative or agent; responsible party; responsible party's insurer, representative, or agent; and/or any other source possessing funds representing the amount of benefits paid by the Plan.

By accepting benefits (whether the payment of such benefits is made to the Covered Employee or Covered Dependent or made on behalf of the Covered Employee or Covered Dependent to any provider) from the Plan, the Covered Employee or Covered Dependent acknowledges that the Plan's recovery rights are a first priority claim against all responsible parties and are to be paid to the Plan before any other claim for the Covered Employee's or Covered Dependent's damages. The Plan shall be entitled to full reimbursement on a first-dollar basis from any responsible party's payments, even if such payment to the Plan will result in a recovery to the Covered Employee or Covered Dependent which is insufficient to make the Covered Employee or Covered Dependent whole or to compensate the Covered Employee or Covered Dependent in part or in whole for the damages sustained. The Plan is not required to participate in or pay court costs or attorney fees to any attorney hired by the Covered Employee or Covered Dependent to pursue the Covered Employee's or Covered Dependent's damage claim.

The terms of this entire subrogation and right of recovery provision shall apply and the Plan is entitled to full recovery regardless of whether any liability for payment is admitted by any responsible party and regardless of whether the settlement or judgment received by the Covered Employee or Covered Dependent identifies the medical benefits the Plan provided or purports to allocate any portion of such settlement or judgment to payment of expenses other than medical expenses. The Plan is entitled to recover from any and all settlements or judgments, even those designated as pain and suffering, non-economic damages, and/or general damages only.

COBRA

A federal law, the Consolidated Omnibus Budget Reconciliation Act (COBRA) requires that the Medical Plan offer Eligible Employees, Retirees and their Eligible Dependents the opportunity for a temporary extension of health coverage (called COBRA coverage) at group rates in certain instances where coverage under the Plan would otherwise end (qualifying events). The following information is intended to inform you of your rights and obligations under COBRA.

Please note that although existing federal law does not extend COBRA coverage rights to your Same-Sex Domestic Partner and his/her Covered Dependent children, Merck offers continuation of medical coverage in certain cases. For continuation of coverage options available to Same-Sex Domestic Partners, see "Continuation of Health Care Coverage for Same-Sex Domestic Partners" for more information.

You do not have to show that you are insurable to choose COBRA coverage. However, you will have to pay the entire premium for your COBRA coverage. There is a 30-day grace period for the payment of the regularly scheduled premium (other than the initial premium which must be paid by its due date). You should be aware that in some of the situations outlined in this SPD, Merck automatically extends coverage at no cost to you or your Covered Dependents for a period after coverage under the Merck Medical Plan would otherwise end (e.g., coverage provided to surviving Covered Dependents under certain circumstances). This coverage is included in the period for which you or your Covered Dependents may be eligible for continuation coverage under COBRA. For example, if your Covered Dependents are eligible for 36 months of continuation coverage under COBRA due to your death and

Merck provides 24 months of coverage to them under the Merck Medical Plan at no cost to them as surviving Covered Dependents, then they will have 12 months of continuation coverage under COBRA remaining for which they must pay premiums.

KEY POINT — YOUR COVERAGE OPTION UNDER COBRA

When you elect COBRA, you are only able to continue the Merck Medical Plan option in which you are enrolled, unless the option is no longer available to you (e.g., you moved). You can make a change during the next annual enrollment period, effective for the following year, or you may make a mid-year change if you experience a Life Event that allows you to make a change.

Who May Elect COBRA Coverage

If you are an Eligible Employee of the Company covered by the Medical Plan on the day before the qualifying event, you are a Qualified Beneficiary and have a right to choose COBRA coverage if you lose your Medical Plan coverage because of a reduction in your hours of employment or the termination of your employment (for reasons other than gross misconduct on your part). An employment termination or reduction in hours that results in the loss of Medical Plan coverage is a qualifying event under COBRA. Even if you do not lose your coverage completely, a reduction in hours is a qualifying event if it results in an increase in the cost of your Plan coverage. Special rules may apply if you are offered other medical coverage as an alternative to COBRA coverage. For more information, contact the Merck Benefits Service Center at **800-66-MERCK**.

If you are the Spouse of an Eligible Employee and are covered by the Merck Medical Plan as a Covered Dependent on the day before a qualifying event, you are a Qualified Beneficiary and have the right to choose COBRA coverage for yourself if you lose coverage under the Merck Medical Plan for any of the following reasons (qualifying events):

- The death of your Spouse;
- The termination of your Spouse's employment (for reasons other than gross misconduct) or reduction in your Spouse's hours of employment;
- Divorce or legal separation from your Spouse (in states where legal separation equals divorce); or
- Your Spouse becoming enrolled in Medicare.

If you are an Eligible Dependent child of an Eligible Employee and were covered by the Plan on the day before the qualifying event, you also are a Qualified Beneficiary and have the right to COBRA coverage if your coverage under the Merck Medical Plan is lost for any of the following five reasons (qualifying events):

- The death of the employee;
- The termination of the employee's employment (for reasons other than gross misconduct) or reduction in the employee's hours of employment;
- The divorce or legal separation (in states where legal separation equals divorce) of the employee;
- The employee becoming enrolled in Medicare; or
- The dependent ceasing to be eligible for coverage under the Plan.

If have a newborn or newly adopted child during your COBRA coverage period and you are an Eligible Employee who elected COBRA, the new child will have an independent right to elect COBRA coverage. To elect this coverage, the COBRA Administrator must be notified in writing within 31 days after the new child's birth or adoption, or the date the Covered Employee becomes legally obligated to provide support for the child in anticipation of adoption. If the COBRA Administrator is not notified within the 31-day period, then the new child will not be offered the option to elect COBRA coverage.

If you have taken a leave of absence under the Family and Medical Leave Act (FMLA) and you do not return to work at the end of your FMLA leave, you may elect COBRA coverage. In this situation, you will experience a qualifying event on the last day of your FMLA leave, which is the earliest of:

- When you unequivocally inform the Company that you are not returning at the end of the leave;
- The end of the leave, assuming you do not return; or
- When the FMLA entitlement ends.

For purposes of an FMLA leave, you will be eligible for COBRA coverage only if:

- You or your Eligible Dependents are covered by the Merck Medical Plan on the day before your FMLA leave begins;
- You do not return to employment at the end of the FMLA leave; and
- You or your Covered Dependents lose coverage under the Merck Medical Plan before the end of what would be the maximum COBRA continuation period.

If you are illegally denied medical care coverage**,** you may elect COBRA coverage after what would have been a qualifying event.

If you, your Spouse or other Eligible Dependents lose coverage in anticipation of a qualifying event described earlier, then that individual is a Qualified Beneficiary and may elect to receive COBRA coverage. This may occur, for example, if you eliminate a Spouse's coverage in anticipation of divorce or separation, or if the Company ends your coverage in the Merck Medical Plan in anticipation of your employment termination.

If you, your Spouse or other Eligible Dependents lose coverage in anticipation of a qualifying event described earlier, then that individual is a Qualified Beneficiary and may elect to receive COBRA coverage. This may occur, for example, if you eliminate a Spouse's coverage in anticipation of divorce, or if the Company ends your coverage in the Merck Medical Plan in anticipation of your employment termination.

KEY POINT — IN THE EVENT OF YOUR DEATH

If you die while you are a participant in the Merck Medical Plan, your Covered Dependents may be eligible to continue to receive medical coverage from Merck. This coverage runs concurrent with COBRA coverage. For information, see "Coverage for Surviving Dependents in the Event of Your Death."

Your Duties Under the Law

You or Covered Dependent have the responsibility of informing the Merck Benefits Service Center (the COBRA Administrator) of a divorce, legal separation or a child losing dependent status under the Merck Medical Plan. This notice *must* be provided within 60 days from the date of the divorce, legal separation or a child losing dependent status (or, if later, the date coverage would normally be lost because of the event). If you, or a Covered Dependent, fail to provide this notice to Merck during this 60-day notice period, any Covered Dependent who loses coverage will *not* be offered the option to elect COBRA coverage.

To notify Merck of a Covered Dependent losing coverage due to divorce, legal separation or a child losing dependent status, contact Fidelity Investments online through NetBenefits or by calling the Merck Benefits Service Center at **800-66-MERCK**.

For your Spouse and each child, the following information is required for COBRA:

- Full name;

- Mailing address;
- Date of birth;
- Relationship to you; and
- Social Security number.

Once you or your Covered Dependent has notified the Merck Benefits Service Center of the event resulting in the loss of coverage, COBRA information and an election form for continuation coverage will be mailed within 44 days by the COBRA Administrator. After you receive the information and election form, you and your Covered Dependents then have 60 days from the date coverage ends or the date this information package is mailed to you (whichever is later) to accept or decline continuation coverage.

If you or your Covered Dependents fail to notify the Merck Benefits Service Center of a divorce, legal separation or a child losing dependent status and any claims are mistakenly paid for expenses incurred after the date coverage would normally be lost due to the event, then you and your Covered Dependents will be required to reimburse the Plan for any claims mistakenly paid.

KEY POINT — IF YOU MOVE

To ensure that you receive the most up-to-date benefits information — and have access to appropriate coverage options, you must notify the Merck Benefits Service Center any time you have a change in address. Contact the Merck Benefits Service Center at **800-66-MERCK** to change your address.

Merck's Duties Under the Law

Merck will cause the COBRA Administrator to notify Qualified Beneficiaries of the right to elect continued coverage automatically (without any action required by you or a Covered Dependent) if any of the following events occur that result in a loss of coverage:

- Your death;
- Termination of employment (for reasons other than gross misconduct) or reduction in hours; or
- If you lose benefits because of entitlement to Medicare.

Electing COBRA Coverage

Time Period for Elections

Under the law, a Qualified Beneficiary must elect COBRA coverage within 60 days from the date he/she would lose coverage because of one of the events described earlier, or, if later, 60 days after the COBRA Administrator provides the Qualified Beneficiary with notice of the right to elect COBRA coverage. A third party, such as a health care provider, also may elect and pay for coverage on behalf of a Qualified Beneficiary. *If COBRA coverage is not elected within the time period described above, the Qualified Beneficiary will lose the right to elect COBRA coverage.*

A Qualified Beneficiary may change or revoke an election to receive COBRA coverage until the election period expires. If a Qualified Beneficiary waives COBRA coverage prior to the end of the election period, the Qualified Beneficiary will be permitted to revoke the waiver and elect coverage at any time before the election period ends. In that case, COBRA coverage shall begin with the date the waiver is revoked, which will be considered the COBRA election date.

Separate Elections

Each Qualified Beneficiary has an independent election right to elect COBRA coverage. For example, if there is a choice among types of coverage under the Plan, each Qualified Beneficiary who is eligible for COBRA coverage is entitled to make a separate election among the types of coverage. Thus, a Spouse

or dependent child is entitled to elect COBRA coverage even if you do not make that election. Similarly, a Spouse or dependent child may elect different coverage from the coverage you elect.

Types of Coverage You Will Receive and Changes to Coverage

If you choose COBRA coverage, Merck is required to give you coverage that is identical to the coverage provided under the Plan to similarly situated non-COBRA beneficiaries or Covered Dependents. If the coverage for similarly situated non-COBRA beneficiaries or Covered Dependents is modified, your coverage will be modified in the same manner. "Similarly situated non-COBRA beneficiaries" means the individuals receiving coverage under the Plan who are receiving coverage for a reason other than due to the rights under COBRA and who, based on all the facts and circumstances, are most similarly situated to the situation of the Qualified Beneficiary immediately before the qualifying event.

As a Qualified Beneficiary, you will have the same opportunity to change your benefit elections as similarly situated non-COBRA beneficiaries. This means that you will be eligible to participate in the Plan's annual open enrollment and you are subject to the Plan's rules regarding mid-year changes. You also have the same right as active Eligible Employees to enroll Eligible Dependents.

If Merck discontinues the Plan or benefit option you elected as COBRA coverage, you may be entitled to receive different coverage from Merck. In addition, if you move out of a network service area for your coverage option, Merck must offer you coverage available to other Merck employees in the new geographic area (or coverage available to employees of related companies, if there are no Merck employees in the area). If there is no other coverage available for that area, then Merck must offer you other existing coverage that may extend to that area.

Duration of COBRA Coverage

Employment Termination or Reduction in Hours

The law requires that you be afforded the opportunity to purchase COBRA coverage for 18 months following a qualifying event that is a termination of employment or reduction in hours. For purposes of this rule, a qualifying event includes an increase in the cost of coverage following your employment termination or reduction in hours.

If you experience an employment termination or reduction in hours following Medicare enrollment, however, your Covered Dependents who are Qualified Beneficiaries may elect COBRA for up to 36 months from the date of Medicare enrollment or 18 months from the employee's termination or reduction in hours, whichever is greater.

Other Qualifying Events

A period of up to 36 months of coverage applies to Covered Dependents who are Qualified Beneficiaries who experience qualifying events other than due to your termination of employment or reduction in hours. This longer period applies to a loss of coverage due to:

- Your death;
- Divorce or legal separation of you and your Spouse (in states where legal separation is recognized);
- If you lose benefits because of entitlement to Medicare (your Covered Dependents may elect COBRA coverage for up to 36 months from the date you became enrolled in Medicare); or
- Your Eligible Dependent becoming no longer eligible for coverage under the Merck Medical Plan.

Second Qualifying Events

A period of up to 36-months also applies if one of these qualifying events occurs during the initial 18-month COBRA period described above, or during a 29-month COBRA period applicable to disabilities, described on the next page. These events can result in an extension of an 18-month COBRA

period to 36 months from the date of employment termination or reduction in hours. You must notify the COBRA Administrator within 60 days of the second qualifying event in order to be eligible for the 36-month COBRA period.

Special Rules for Disability
The initial 18 months of COBRA coverage due to employment termination or reduction in hours may be extended to 29 months if you or a Covered Dependent is disabled (for Social Security disability purposes) at any time during the first 60 days of COBRA coverage, as determined by the Social Security Administration. This 11-month extension is available to all Covered Dependents who are Qualified Beneficiaries due to termination of employment or reduction in hours, even those who are not disabled. It also applies to children born to, or adopted by, you after the initial qualifying event, who are determined to be disabled within the first 60 days of being covered under COBRA.

To benefit from the 11-month disability extension, you or a Covered Dependent must provide the COBRA Administrator with a copy of the determination by the Social Security Administration that you or a Covered Dependent who is a Qualified Beneficiary was disabled during the 60-day period after your termination of employment or reduction in hours. You must provide this notice to the COBRA Administrator within 60 days of the later of the date (a) such determination is made, (b) the qualifying event date or (c) the loss of Plan coverage and before the end of the original 18-month COBRA coverage period.

If, during the COBRA coverage period, the Social Security Administration determines that you or a Covered Dependent are no longer disabled, the individual must inform Merck of this new determination within 30 days of the date it is made.

If you or a Covered Dependent are disabled and another qualifying event occurs within the 29-month COBRA period, then the COBRA coverage period is 36 months after the termination of employment or reduction in hours.

Early Termination of COBRA Coverage

The law provides that your COBRA coverage may be cut short prior to the expiration of the 18-month, 29-month or 36-month period for any of the following five reasons:

- Merck no longer provides group health coverage to any of its employees.
- The premium for COBRA coverage is not paid within 30 days of the due date; or the initial premium is not paid within 45 days after the initial election.
- The Qualified Beneficiary becomes covered — after the date COBRA is elected — under another group health plan (whether or not as an employee) that does not contain any applicable exclusion or limitation with respect to any pre-existing condition of the individual or that does not apply to (or is satisfied by) such person by reason of the Health Insurance Portability and Accountability Act of 1996. (COBRA coverage ends only for the person covered by the other group medical plan.)
- The Qualified Beneficiary becomes enrolled in Medicare after the date COBRA is elected. (COBRA coverage ends only for the person enrolled in Medicare.)
- Coverage has been extended for up to 29 months due to disability and there has been a final determination that the individual is no longer disabled. (Coverage for all Qualified Beneficiaries who received the extension due to disability may end as of the first day of the month that is more than 30 days after such final determination, provided that the termination date is after the end of the initial 18-month period of COBRA coverage.)

If your COBRA coverage ends before the maximum period of coverage expires, you will receive a notice regarding the termination of COBRA coverage.

COBRA coverage is provided subject to your eligibility for such coverage. Merck reserves the right to terminate your coverage retroactively in the event it is determined that you are ineligible for COBRA.

Paying for COBRA Coverage

You do not have to show that you are insurable to choose COBRA coverage. However, under the law, you may be required to pay the full amount of the cost of covering an active employee (and his/her Covered Dependents, if applicable), plus a 2% administrative fee (for a total of 102% of the cost of coverage). If your coverage is extended from 18 to 29 months for disability, you may be required to pay up to 150% of the cost of covering an active employee (and his/her Eligible Dependents, as applicable) beginning with the 19th month of COBRA coverage, provided that the disabled individual is one of the individuals that elected the disability extension. The cost of group health coverage periodically changes. If you elect COBRA coverage, the COBRA Administrator will notify you of any changes in the cost.

COBRA coverage will not take effect until you elect COBRA and make the required payment. You have an initial grace period of 45 days from the date of your election, to make the first premium payment. Thereafter, payments for COBRA coverage are due by the first day of each month to which the payments apply (payments must be postmarked on or before the end of the 30-day grace period). If you pay part but not all of the premium, and the amount you paid is not significantly less than the full amount due, then the COBRA Administrator may inform you of the amount of the underpayment and allow you a reasonable period of time to pay the outstanding amount due (such as 30 days). If you do not make payments on a timely basis as described above, COBRA coverage will terminate as of the last day of the month for which you made timely payment.

Your COBRA premiums may change in certain circumstances, for example, if the COBRA Administrator has been charging you less than the maximum permissible amount, if you add Eligible Dependents or drop Covered Dependents as permitted under the Plans, or in the case of a disability extension described above.

COBRA Administration/Notices

If you have any questions about COBRA coverage or the application of the law, please contact the COBRA Administrator at the address listed below. Also, if your marital status has changed, or you, your Covered Dependents have changed addresses, or a Covered Dependent child ceases to eligible for coverage under the terms of the Plan, you must notify the COBRA Administrator in writing immediately, as provided in this section, at the address listed below. Fidelity Investments is the COBRA Administrator. If you have questions about your COBRA rights, call the Merck Benefits Service Center at **800-66-MERCK**.

All notices and other communications regarding COBRA and the Merck Medical Plan should be directed to the following address:

Merck Benefits Service Center
P.O. Box 770001
Cincinnati, OH 45277-0020

Continuation of Health Care Coverage for Same-Sex Domestic Partners

Although existing federal law does not extend rights to COBRA coverage to your Same-Sex Domestic Partner and his/her covered dependent children, Merck offers continuation of medical coverage in certain cases. Your Same-Sex Domestic Partner and his/her covered dependent children will be eligible to elect and pay for continuation of coverage if their benefits are lost under certain circumstances. And, just like COBRA benefits, this continuation of coverage:

- Is available for a maximum of 18, 29 or 36 months; and

- Must be paid for on a monthly basis — with contributions based on the full cost of coverage, plus 2% for administrative costs.

Continuation of coverage benefits generally follow the same rules as COBRA. The Continuation of Medical Coverage Summary for Same-Sex Domestic Partners chart below summarizes the events that trigger continuation of coverage benefits for your Same-Sex Domestic Partner and/or his/her covered dependent children.

For purposes of these COBRA-like benefits, your Same-Sex Domestic Partner and his/her eligible dependent children who lose medical coverage as a result of certain events (listed in the Continuation of Medical Coverage Summary for Same-Sex Domestic Partners) will be treated as if they were Qualified Beneficiaries.

To be eligible for continuation of coverage, you must notify the Merck Benefits Service Center at **800-66-MERCK** within 60 days of certain events, as shown in the chart below and you must follow the enrollment instructions (and the enrollment timeframes) provided by the Merck Benefits Service Center. You and/or your Covered Dependents will not be eligible for continuation of coverage benefits if the Merck Benefits Service Center is not notified within the 60-day period or if you do not enroll for continuation coverage in accordance with the instructions and timeframe required by Fidelity Investments.

Continuation of Medical Coverage Summary for Same-Sex Domestic Partners

You must notify Fidelity Investments within 60 days of these events for your Same-Sex Domestic Partner and/or his/her Covered Dependent children to be eligible for continuation of coverage benefits:

Event	Same-Sex Domestic Partner	Employee's/Same-Sex Domestic Partner's Covered Dependent Children
	MAXIMUM CONTINUATION OF COVERAGE PERIOD	
Employee terminates employment for any reason (except gross misconduct)	18 months[51]	18 months[1]
Employee dies	36 months	36 months
Same-Sex Domestic Partnership ends	36 months	36 months
Disabled employee becomes entitled to Medicare (and dependents lose coverage)	36 months	36 months
Child is no longer an Eligible Dependent under Merck's Plans	Not applicable	36 months

Continuation of Health Care Coverage for Opposite-Sex Domestic Partners of Legacy Schering-Plough Employees

Your Opposite-Sex Domestic Partner and his/her eligible dependent children who are Covered Dependents of Legacy Schering-Plough Employees as of December 31, 2011 and who lose medical coverage as a result of losing eligibility to participate on January 1, 2012 will be treated as if they were Qualified Beneficiaries under the COBRA-like coverage described for Same-Sex Domestic Partners.

[51] May be extended to 29 months if your Covered Dependent is determined — by Social Security — to be disabled at any time within the first 60 days of continuation of coverage.

You or the individuals losing coverage have 60 days after this event to enroll in COBRA coverage, which is limited to a maximum period of 36 months.

Your Rights Under HIPAA

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) is a federal law that is designed to make it easier for you and your Covered Dependents to have continued group health coverage when changing jobs.

Special Enrollment Period

Under HIPAA, you have special enrollment rights under certain circumstances. For more information see the *Special Enrollment Under HIPAA for Eligible Employees* section in the chapter "About Medical Benefits" in this SPD.

HIPAA Certificate of Coverage

Pursuant to the Health Insurance Portability and Accountability Act of 1996 (HIPAA), you and your Covered Dependents that lose group health coverage must receive certification of your coverage under the Merck Medical Plan. You may need this certification in the event you later become covered by a new plan under a different employer, or under an individual policy.

You and your Covered Dependents will receive a coverage certification when your Medical Plan coverage terminates, again when COBRA coverage terminates (if you elected COBRA), and also upon your request (if the request is made within 24 months following either termination of coverage).

You should keep a copy of the coverage certifications you receive, as you may need to prove you had prior coverage when you join a new health plan. For example, if you obtain new employment and your new employer's plan has a pre-existing condition limitation (which delays coverage for conditions treated before you were eligible for the new plan), the employer may be required to reduce the duration of the limitation by one day for each day you had prior coverage (subject to certain requirements). If you are purchasing individual coverage, you may need to present the coverage certification to your insurer at that time as well.

HIPAA-Like Provisions for Same-Sex Domestic Partners*

Although existing federal law does not extend HIPAA rights to your Same-Sex Domestic Partner and his/her Covered Dependent children, Merck does apply similar provisions to Same-Sex Domestic Partners and their Covered Dependents. Your Same-Sex Domestic Partner and their Covered Dependents may be eligible for:

- The special enrollment period (described in *Special Enrollment Under HIPAA for Eligible Employees* in the chapter "About Medical Benefits" in this SPD); and
- A coverage certification verifying coverage under the Merck Medical Plan (described above).

Effective January 1, 2012, this section applies to opposite-sex domestic partners of Legacy Schering-Plough Employees only with respect to the provision of a coverage certification.

Your Rights Under NMHPA

The Newborns' and Mothers' Health Protection Act (NMHPA) provides that 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 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 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).

Your Rights Under WHCRA

The Women's Health and Cancer Rights Act (WHCRA) requires that all group health plans that provide medical and surgical benefits with respect to a mastectomy to provide coverage for:

- Reconstruction of the breast on which the mastectomy has been performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance; and
- Prostheses and treatment of physical complications of all stages of 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, Copays and Coinsurance provisions applicable to other such medical and surgical benefits provided under the applicable medical option. Please refer to the applicable "At A Glance" chart for information regarding Deductibles, Copays and Coinsurance under the Merck Medical Plan option in which you are enrolled. If you would like more information on the Women's Health and Cancer Rights Act benefits, call the Merck Benefits Service Center at **800-66-MERCK**.

Your Rights Under USERRA

The Medical Plan is subject to the "continuation coverage" requirements of the Uniformed Services Employment and Reemployment Rights Act of 1994 ("USERRA") and will be administered in accordance with USERRA and the military leave rules established by the Plan Administrator. As a result, you will be entitled to continue coverage under the Medical Plan during your military leave for at least a period of twenty-four (24) months. To continue coverage, you may be required to pay 102% of the applicable premiums. If you elect not to continue coverage during a military leave, you will be entitled to reinstatement of coverage upon your return to active employment. Coverage provided under USERRA will run concurrently with any coverage provided under COBRA. For more information regarding your rights during a military leave contact the Merck Benefits Service Center at **800-66-MERCK**.

Your Rights Under ERISA

As a participant in the Merck Medical Plan, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all Plan participants will be entitled to the following.

Receive Information about Your Plan and Benefits

- Examine, without charge, at the Plan Administrator's office and at other specified locations, such as worksites and union halls, all documents governing the Merck Medical Plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.

- Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated summary plan description. The administrator may charge a reasonable fee for the copies.
- Receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report.

Continue Group Health Care

Continue health care coverage for yourself, your Spouse or dependents if there is a loss of coverage under the Plan as a result of a qualifying event. You, your Spouse or dependents may have to pay for such coverage. Review this summary plan description and the documents governing the Plan on the rules governing your COBRA continuation coverage rights. Reduction or elimination of exclusionary periods of coverage for pre-existing conditions under your group health plan, if you have creditable coverage from another plan. You should be provided a certificate of creditable coverage, free of charge, from your group health plan or health insurance issuer when you lose coverage under the Plan, when you become entitled to elect COBRA or when your COBRA continuation coverage ceases if you request it up to 24 months after losing coverage. Without evidence of creditable coverage, you may be subject to pre-existing condition exclusion for 12 months (18 months for late enrollees) after your enrollment date in your coverage.

Prudent Actions by Plan Fiduciaries

In addition to creating rights for Plan participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate your Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of you and other Plan participants and beneficiaries. No one, including your employer, your union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA.

Enforcing Your Rights

If your claim for a welfare benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge and to appeal any denial, all within certain time schedules. For more information, see "Claims and Appeals."

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of Plan documents or the latest annual report from the Plan and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator.

If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or federal court. In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a medical child support order, you may file suit in federal court. If it should happen that the Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

Assistance with Your Questions

If you have any questions about the Merck Medical Plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, or if you need

assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance of the Employee Benefits Security Administration at:

Division of Technical Assistance/Employee Benefits Security Administration
U.S. Department of Labor
200 Constitution Avenue, N.W.
Washington, DC 20210

You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration at **866-444-3272** or accessing their website at **http://www.dol.gov/ebsa**.

Claims and Appeals

If you or your Covered Dependent or authorized representative feel that the Claims Administrator has made an error concerning your benefits, you, your Covered Dependent or authorized representative have the right to request reconsideration under the Plan in accordance with the following procedure. Please note that all requests for reconsideration will be submitted in writing to the Claims Administrator. See "Contact Information for Written Appeals" for address information.

Upon receipt of a claim denial, you may request information regarding any diagnosis codes and treatment codes applicable to your claim and their corresponding meaning. Upon such a request, the diagnosis and treatment codes and their meaning will be provided as soon as possible, but will not be considered a request for review of an adverse benefit determination or a request for external review.

Initial Claim

The Claims Administrator is responsible for evaluating all benefit claims. The Claims Administrator will review your claim in accordance with its standard claims procedures, as required by ERISA. The Claims Administrator has the right to secure independent medical advice and to require other evidence as it deems necessary in order to decide the status of your claim.

There are four categories of claims: urgent health claims, pre-service health claims, post-service health claims and concurrent health claims. Each category has different claims procedures. For many of these procedures, your health care provider may work directly with the Claims Administrator.

- **"Urgent" health claims.** These are claims that if not processed quickly (within 72 hours) the life or health of the patient is jeopardized. The Claims Administrator will notify you or your doctor of the Plan's decision no later than 72 hours after your claim is received, unless you fail to provide sufficient information to determine whether, or to what extent, benefits are covered or payable under the Plan.
- **"Pre-service" health claims.** These are claims that must be decided before a patient will be allowed access to health care (for example, pre-authorization requests or referrals). The Claims Administrator will notify you or your doctor of the decision no later than 15 days after your claim is received. This 15-day period may be extended by another 15 days in certain circumstances.
- **"Post-service" health claims.** These are claims involving the payment or reimbursement of costs for care that has already been provided. For non-urgent, post-service health claims, the Claims Administrator has up to 30 days to evaluate and respond to claims for benefits. The 30-day period begins on the date the claim is first filed. This 30-day period may be extended by 15 days, in certain circumstances.
- **"Concurrent" health claims.** These are claims for which the Claims Administrator has previously approved a course of treatment over a period of time or for a specific number of treatments, and

the Plan later reduces or terminates coverage for those treatments. Concurrent care claims may fall under any of the above three categories, depending on when the appeal is made. However, the Plan must give you enough advance notice to appeal the claim before a concurrent care decision takes effect.

If Your Claim is Denied

If the Claims Administrator does not fully agree with your claim, you will receive an "adverse benefit determination." For this purpose an "adverse benefit determination," will mean a denial, reduction, or termination of, or a failure to provide or make payment in whole or in part (a "denial") for a benefit, including where such denial is based on a determination of a participant's or beneficiary's eligibility to participate in a plan. An adverse benefit determination also means a claim denial based on a utilization review or a determination that a treatment is experimental, or investigational, or not Medically Necessary or appropriate or a retroactive termination of coverage due to fraud or intentional misconduct (a "rescission").

You will receive notice of a denial, which will include:

- Information sufficient to identify the claim involved, including the date of service, identification of the health care provider,and the claim amount (if applicable) and a statement indicating that the diagnosis codes, treatment codes and their corresponding meaning are available upon request;
- The specific reasons for the denial, including the applicable denial code and its meaning;
- If applicable, a description of the standard used by the Plan to deny the claim;
- A reference to the specific Plan provisions on which the denial is based;
- A description of any additional material or information needed to reconsider the claim and an explanation of why such material or information is necessary;
- A description of the Plan's internal and external review procedures, including the time limits applicable to such procedures; and contact information for any applicable office of health insurance consumer assistance or ombudsman that will assist you with such procedures;
- A statement of your right to bring a civil action under Section 502(a) of ERISA following a denial on review;
- Any internal rules, guidelines, protocols, or other similar criteria that were used for the basis of the denial, either the specific rule, guideline, protocol or criterion, or a statement that a copy of such information will be made available free of charge to you upon request; and
- For a denial based on medical necessity or an experimental treatment or other similar exclusion or limit, an explanation of the scientific or clinical judgment used in the decision, applying the terms of the Plan to your medical circumstances, or a statement that such explanation will be provided free of charge upon request.
- For a denial involving urgent care, a description of the expedited review process applicable to such claims. Also, in the case of denial concerning a claim involving urgent care, the information set out in this section may be provided orally within the time frames provided in the section above entitled "Urgent health claims." If an oral notice is provided, a written notification that meets all the requirements of this section will be furnished within three days of the oral notice.

Level One Appeal of a Claim

If your claim for benefits is denied, in whole or in part, you or your authorized representative may appeal the denial within 180 days of the receipt of the written or electronic notice of denial. If you choose to appeal your claim, your appeal should be in writing and should explain why you believe the claim should be paid. See "Contact Information for Written Appeals."

Upon your request, you will have access to, and the right to obtain copies of, all documents, records and information relevant to your claim free of charge. You also have the right to receive any additional evidence used to evaluate your claim or any additional rationale applied to your claim. If the Plan receives any additional evidence regarding your claim or applies a new rationale, you will be provided with the additional evidence and the rational and given an opportunity to respond before the final claim determination is issued.

You may submit with your appeal any written comments, documents, records and any other information relating to your claim, even if you didn't include that information with your original claim. See "Contact Information for Written Appeals." Reviewers must take all the information into account, even if it was not submitted or considered in the initial decision. The review will not afford any deference to the initial claim determination.

A qualified individual who was not involved in the previous claim determination (and is not that person's subordinate) will decide your appeal. If your appeal involves a medical judgment — including whether a treatment, drug or other item is experimental, investigational or not Medically Necessary or appropriate—the review will be done in consultation with a healthcare professional who has appropriate training and experience in the relevant field of medicine involved in the medical judgment, who was not consulted in connection with the previous adverse claim determination and who is not that person's subordinate.

After receiving your appeal, the Claims Administrator will provide notice of its decision within the following timeframes:

- *Urgent care appeals.* You or your authorized representative should contact the Claims Administrator as soon as possible. You can request an expedited appeal process orally or in writing. In this case, all necessary information, including the Claim Administrator's benefits determination on review, shall be relayed to you or your representative by telephone, fax or other similarly expeditious method. The Claims Administrator will provide notice of the appeal decision as soon as possible, taking into account the seriousness of your condition, but no later than 72 hours after receipt of your appeal.
- *Pre-service appeals.* The Claims Administrator will provide notice of the appeal within 15 days following receipt of your appeal.
- *Post-service appeals.* The Claims Administrator will provide notice of the appeal decision within 30 days following receipt of your appeal.

You will receive written or electronic notification of the determination of your appeal. If the claim on appeal is denied in whole or in part, the notice will include:

- Information sufficient to identify the claim involved, including the date of service, identification of the health care provider,and the claim amount (if applicable) and a statement indicating that the diagnosis codes, treatment codes and their corresponding meaning are available upon request;
- The specific reasons for the denial, including the applicable denial code and its meaning;
- If applicable, a description of the standard used by the Plan to deny the claim;
- A reference to the specific Plan provisions on which the denial is based;
- A description of any additional material or information needed to reconsider the claim and an explanation of why such material or information is necessary;
- A description of the Plan's internal and external review procedures, including the time limits applicable to such procedures and contact information for any applicable office of health insurance consumer assistance or ombudsman that will assist you with such procedures;

- A statement of your right to bring a civil action under Section 502(a) of ERISA following a denial on review;
- Any internal rules, guidelines, protocols, or other similar criteria that were used for the basis of the denial, either the specific rule, guideline, protocol or criterion, or a statement that a copy of such information will be made available free of charge to you upon request;
- For a denial based on medical necessity or an experimental treatment or other similar exclusion or limit, an explanation of the scientific or clinical judgment used in the decision, applying the terms of the Plan to your medical circumstances, or a statement that such explanation will be provided free of charge upon request; and
- For a denial involving urgent care, a description of the expedited review process applicable to such claims. Also, in the case of denial concerning a claim involving urgent care, the information set out in this section may be provided orally within the time frames provided in the section above entitled "Urgent health claims." If an oral notice is provided, a written notification that meets all the requirements of this section will be furnished within three days of the oral notice.

Level Two Appeal of a Claim

If the Claims Administrator upholds an adverse benefit determination at the first level of appeal, you or your authorized representative have the right to file a level two appeal. The appeal must be submitted within 60 calendar days following the receipt of notice of a level one appeal.

A level two appeal of an adverse benefit determination of an urgent care claim, a pre-service health Claim, or a post-service health claim shall be provided by Aetna personnel not involved in making an adverse benefit determination.

- *Urgent Care Level Two Appeals.* (May Include concurrent care claim reduction or termination.) Claims Administrator shall issue a decision within 36 hours of receipt of the request for a level two appeal.
- *Pre-Service Level Two Appeals.* (May Include concurrent care claim reduction or termination.) Claims Administrator shall issue a decision within 15 calendar days of receipt of the request for level two appeal.
- *Post-Service Level Two Appeals.* The Claims Administrator shall issue a decision within 30 calendar days of receipt of the request for a level two appeal.

The decision on the second level appeal will comply with the requirements listed above for the first level of appeal determination. If you do not agree with the final determination on review, you have the right to bring a civil action, if applicable.

Exhaustion of Process

You must exhaust the applicable level one and level two processes of the Appeal Procedure regarding an alleged breach of the policy terms by the Claims Administrator; or any matter within the scope of the Appeals Procedure before you commence any:

- Litigation;
- Arbitration; or
- Administrative proceeding.

Any suit or proceeding brought against the Medical Plan must be brought within two years of the date of the final determination on the claim.

External Review

The Claims Administrator may deny a claim because it determines that the care is not appropriate or a service or treatment is experimental or investigational in nature. In either of these situations, you may request an external review if you or your provider disagrees with the Claims Administrator's decision. An external review is a review by an independent physician, selected by an External Review Organization, who has expertise in the problem or question involved.

To request an external review, the following requirements must be met:

- You have received notice of the denial of a claim by the Claims Administrator; and
- Your claim was denied because the Claims Administrator determined that the care was not necessary, appropriate or effective or was Experimental or Investigational or your claim was denied due to a rescission of coverage; and
- You have exhausted the applicable internal appeal processes or the process is deemed exhausted due to the failure of the plan to adjudicate your claim in accordance with the procedures set forth herein where such failure is not de-minimis.

The claim denial letter you receive from Claims Administrator will describe the process to follow if you wish to pursue an external review, including a copy of the Request for External Review Form.

You must submit the Request for External Review Form to Claims Administrator within 120 calendar days of the date you received the final claim denial letter. You also must include a copy of the final claim denial letter and all other pertinent information that supports your request.

The Claims Administrator will contact the External Review Organization that will conduct the review of your claim. The External Review Organization will select an independent physician with appropriate expertise to perform the review. In making a decision, the external reviewer may consider any appropriate credible information that you send along with the Request for External Review Form, and will follow the Claims Administrator's contractual documents and plan criteria governing the benefits. You will be notified of the decision of the External Review Organization usually within 45 calendar days of the Claims Administrator's receipt of your request form and all necessary information. A quicker review is possible if your physician certifies (by telephone or on a separate Request for External Review Form) that a delay in receiving the service would endanger your health. Expedited reviews are decided within 72 hours after the Claims Administrator receives the request.

The Claims Administrator, the Company and the Health Plan will abide by the decision of the External Review Organization, except where the Claims Administrator can show conflict of interest, bias or fraud.

You are responsible for the cost of compiling and sending the information that you wish to be reviewed by the External Review Organization to the Claims Administrator. The Claims Administrator is responsible for the cost of sending this information to the External Review Organization and for the cost of the external review.

For more information about the Claims Administrator's External Review process, call the toll-free Customer Services telephone number shown on your ID card.

Claims and Appeals for the Managed Prescription Drug Program, ValueOptions Behavioral Health Program and the Aetna Behavioral Health Program

See the applicable sections under each of the chapters in this SPD for the Managed Prescription Drug Program, ValueOptions Behavioral Healthcare Program and the Aetna Behavioral Health Program.

Claims and Appeals for Eligibility to Participate in the Merck Medical Plan

If you, your beneficiary or your authorized representative feel that an error has been made concerning your eligibility to participate in the Plan (e.g., your eligibility to elect a particular coverage option, Coverage Tier, add a dependent, etc.), you, your beneficiary or your authorized representative may request reconsideration under the Plan. All requests for reconsideration shall be submitted in writing to the Plan Administrator at the following address:

Merck & Co., Inc.
Attn: Plan Administrator (GSA-HTR)
8050 Microsoft Way, Suite 300
Charlotte, NC 28273

The Plan Administrator will review your claim and respond to you with a determination. The decision of the Plan Administrator is final and binding.

If your claim for eligibility involves whether an incapacitated child is eligible to participate in the Plan as an Eligible Dependent, you need to follow the claims and appeals procedure for the Medical Plan option in which you are enrolled. Please note that all requests for reconsideration regarding participation by the incapacitated child must be submitted in writing to the Claims Administrator for the option in which you are enrolled. See "Contact Information for Written Appeals" for address information.

Contact Information for Written Appeals

The following chart lists the appeals address for each of the available Merck Medical Plan coverage options and/or benefit features of the Plan.

If a Claim Is Denied	Send Your Written Appeal to the Claims Administrator at this Address
Benefit Appeals	
▪ Merck PPO — Horizon BCBS option ▪ Merck 80/20 option	Claims Administrator and fiduciary for the Medical Plan: Merck Dedicated Service Team Horizon BCBS P.O. Box 18 Newark, NJ 07101-0018
▪ Merck PPO — Aetna Choice POS II option	Claims Administrator and fiduciary for the Medical Plan: Aetna National CRT Unit P.O. Box 14463 Lexington, KY 40512
▪ Hawaii HMO	**808-948-6372** **www.hmsa.com**
Eligibility Appeals	
For all Plan options	Plan Administrator for the Medical Plan: Merck & Co., Inc. Attn: Plan Administrator (GSA-HTR) 8050 Microsoft Way, Suite 300 Charlotte, NC 28273
Medical Precertification Appeals	
▪ Merck PPO — Horizon BCBS option ▪ Merck 80/20 option	Claims Administrator and fiduciary for the Medical Plan: Merck Dedicated Service Team Horizon BCBS P.O. Box 18 Newark, NJ 07101-0018
▪ Merck PPO — Aetna Choice POS II option	Claims Administrator and fiduciary for the Medical Plan: Aetna National CRT Unit P.O. Box 14463 Lexington, KY 40512
Behavioral Health Care Appeals (including behavioral health precertification)	
▪ Merck PPO — Horizon BCBS option ▪ Merck 80/20 option	ValueOptions Attn: Appeals and Grievances P.O. Box 1347 Latham, NY 12110
▪ Merck PPO — Aetna Choice POS II option	Aetna National CRT Unit P.O. Box 14463 Lexington, KY 40512
Managed Prescription Drug Appeals	
Managed Prescription Drug Program	Medco Health Solutions, Inc. Benefit Appeals Unit 8111 Royal Ridge Parkway Irving, TX 75063 Attn: Clinical Appeals

Plan Disclosure Information

Employer/Sponsor

Merck Sharp & Dohme Corp. sponsors the MSD Medical, Dental and Long Term Disability Program for Nonunion Employees and the MSD Medical, Dental and Long Term Disability Program for Union Employees. The employer identification number assigned to Merck Sharp & Dohme by the IRS is #22-1109110. Schering Corporation sponsors the Schering Corporation employees' Benefit Trust Plan. The employer identification number assigned to Schering Corporation by the IRS is #22-1261880.

The address and phone number for both Plan Sponsors is:

Merck & Co., Inc.
Attn: Plan Administrator (GSA-HTR)
8050 Microsoft Way, Suite 300
Charlotte, NC 28273

Telephone: **866-MERCK-HD (866-637-2543)**
For U.S. employees calling from outside of the United States, **+1-908-423-HELP (+1-908-423-4357)**

Plan Administrator/Claims Administrator

The Plan Administrator for the Medical Plan is the Plan Sponsor. Administration of the Medical Plan is the responsibility of the Plan Administrator. The Claims Administrators determine eligibility for benefits under the Medical Plan in accordance with the official Medical Plan documents. For the list of Claims Administrators, see the "Plan Funding and Administration" chart.

The Plan Administrator has the exclusive discretion to construe and interpret the terms of the Medical Plan as follows:

- To adopt such rules for the administration of the Plan as it considers desirable;
- To make factual determinations, interpret and construe the Plan, correct defects, supply omissions and reconcile inconsistencies to the extent necessary to effectuate the Plan, resolve all questions arising in the administration, interpretation and application of the Plan, and such action will be conclusive upon the Company, the Plan, participants, employees, their dependents and beneficiaries;
- To decide all questions of eligibility and participation;
- To prescribe procedures and election forms to be followed by participants to make elections to this Plan;
- To accept, modify or reject elections under the Plan;
- To authorize disbursements on behalf of the Plan;
- To prepare and distribute to participants information explaining the Plan and the benefits available hereunder in such a manner as the Plan Administrator deems appropriate;
- To settle any lawsuit against the Plan or Plan Administrator; and
- To request and receive from all participants such information as the Plan Administrator will from time-to-time determine to be necessary for the proper administration of the Plan.

The Plan Administrator has reserved the right to delegate all or any portion of its authority described above to a representative. The Plan Administrator has delegated all of its authority described above with respect to adjudicating claims and appeals for benefits (and handling any resulting lawsuits) under the Medical Plan to the Claims Administrators. That means that the Claims Administrator has the sole authority to determine such matters under the Plan and the Plan Administrator will not and cannot substitute its judgment for that of the Claims Administrators on such matters. It also means the

Claims Administrator has all of the discretion described above to the extent it relates to the Claims Administrator's duties under the Medical Plan, for example regarding eligibility for benefits, according to the broad discretion set forth above.

The amounts paid to the Claims Administrator by the Company and the Plan are designed to, and do, ensure that the Claims Administrator is not subject to influence by the Plan Sponsor or its subsidiaries, including but not limited to financial influence, as the Claims Administrator acts as a fiduciary for the Plan and the Plan participants. The Plan Sponsor designed this structure to ensure that any court reviewing determinations made by the Claims Administrator will defer to the Claims Administrator's decisions unless the court finds that the determination was both arbitrary and capricious, a highly deferential standard.

Contact the Plan Administrator if you have any questions about the Medical Plan other than routine questions or questions about the filing or status of claims under the Plan. For routine questions, call the Merck Benefits Service Center at **800-66-MERCK**. For questions about the filing status of claims, contact the Claims Administrator at the address listed in "Contact Information for Written Appeals."

Agent for Service of Legal Process

If, for any reason, you want to seek legal action against the Medical Plan, you can serve legal process on Merck by directing such service to Senior Director, HR Services at the following address:

Merck & Co., Inc.
Attn: Plan Administrator (GSA-HTR)
8050 Microsoft Way, Suite 300
Charlotte, NC 28273

Service of legal process may also be made upon the Plan Administrator or the Trustee.

Plan Funding and Administration

The Medical Plan is funded and administered through various sources. The Merck Medical Plan is financed by contributions from the Plan Sponsor (and/or certain affiliates of Merck) and participating Eligible Employees. Funds may be held in a trust (see "Trust"), and used to pay benefits, insurance premiums and certain Medical Plan expenses. Medical Plan expenses are paid from the Trust unless otherwise paid by the Plan Sponsor or its affiliates from the general assets. The Trustee is:

The Bank of New York Mellon Corporation
AIM 102-1200
One Wall Street
New York, NY 10286

Plan Funding and Administration Chart

Official Plan Name and Plan Type	Plan Number	Benefits Type	Claims Administrator	Type of Administration	Insured or Self-Insured
The Merck Medical Plan for Nonunion Employees, which is part of the MSD Medical, Dental and Long-Term Disability Plan for Nonunion Employees The Merck Medical Plan for Union Employees, which is part of the MSD Medical, Dental and Long-Term Disability Plan for Union Employees The Schering Corporation Employees' Benefit Trust Plan Plan type: *Employee welfare program providing group medical coverage*	502 540 508	▪ Merck PPO — Horizon BCBS option ▪ Merck 80/20 option ▪ Merck PPO — Aetna Choice POS II option	Horizon BCBS Aetna	Contract Administration	Self-insured by the Company[5][2]
		Medical Precertification ▪ Merck PPO — Horizon BCBS option ▪ Merck 80/20 option ▪ Merck PPO — Aetna Choice POS II option	Horizon BCBS Aetna	Contract Administration	N/A
		COBRA	Fidelity Investments	Contract Administration	N/A
		Outpatient Prescription Drug ▪ Managed Prescription Drug Program — Drug card ▪ Managed Prescription Drug Program — Online and Mail-order	Medco Health Prescription Solutions, LLC (a subsidiary of Medco Health Solutions, Inc.)	Contract Administration	Self-insured by the Company
		Behavioral Health Care Program for Employees enrolled in the Merck PPO — Horizon BCBS option or Merck 80/20 option	ValueOptions	Contract Administration	Self-insured by the Company
		Behavioral Health Care Program for Employees enrolled in the Merck PPO — Aetna Choice POS II option	Aetna	Contract Administration	Self-insured by the Company[1]

[52] These benefits are self-insured by the Plan Sponsor (and certain affiliates of the Plan Sponsor) and are governed by and subject to the Employee Retirement Income Security Act of 1974 (ERISA), as amended (see "Your Rights Under ERISA"). State insurance law does not apply to these benefits. As a result, state-mandated benefits do not apply to these benefits.

Trust

In general, the benefits provided to participants in the Medical Plan may be funded by contributions made by the Plan Sponsor (and/or certain affiliates of the Plan Sponsor) and/or the participants to one or more trusts. Merck & Co. Inc., parent of the Plan Sponsor is responsible for the funding policy of the trusts and for determining the amount of contributions. The trusts are intended to be tax-exempt under the Internal Revenue Code of 1986, as amended. Merck & Co., Inc. or its affiliates may fund additional benefits through the trusts at a later time. If a trust is terminated, the assets in the trust will be used to pay all existing liabilities. Any remaining assets may then be used to provide other benefits for employees in accordance with Internal Revenue Code guidelines.

No Right to Employment

Nothing in this SPD represents nor is considered an employment contract, and neither the existence of the Medical Plan nor any statements made by or on behalf of the Company shall be construed to create any promise or contractual right to employment or to the benefits of employment. The Company or you may terminate the employment relationship without notice at any time and for any reason.

Plan Amendment or Termination

The Plan Sponsor reserves the right to amend the Medical Plan in whole or in part or to completely discontinue the Medical Plan at any time. However, following a "change in control," as defined in the Merck & Co., Inc. Change in Control Separation Benefits Plan ("the Separation Benefits Plan"), certain limitations apply to the ability of Merck & Co., Inc, or its subsidiaries to amend or terminate the Medical Plan.

Amendments may be retroactive; however, no amendment or termination shall reduce the amount of any benefit otherwise payable under the Medical Plan for charges incurred prior to the effective date of such amendment or termination.

The Medical Plan is not and cannot be amended by any verbal representation.

If a benefit is terminated and surplus assets remain after all liabilities have been paid, such surplus shall revert to the Company to the extent permitted under applicable law, unless otherwise stated in the applicable Plan document.

For two years following a "change in control" (as defined in the Separation Benefits Plan) the material terms of the Medical Plan (including terms relating to eligibility, benefit calculation, benefit accrual, cost to participants, subsidies and rates of employee contributions) may not be modified in a manner that is materially adverse to Covered Employees and Covered Dependents in the Plan immediately before the "change in control." During that two-year period, the Company will pay the legal fees and expenses of any participant that prevails on his/her claim for relief in an action regarding an impermissible amendment (other than ordinary claims for benefits).

Plan Documents

This SPD is intended as merely a summary of the official plan documents and should be retained as part of your permanent records. It does not describe every plan or program provision in full detail and it does not alter the plan or program or any legal instrument related to the plan's or program's creation, operations, funding or benefit payment obligations. Every effort has been made to ensure that this SPD accurately reflects relevant plan or program provisions currently in effect. However, the plan or program documents, which may include insurance contracts and other written agreements with service providers (each of which are held on file with the Company) will govern in the event of any conflict between those documents and this SPD, any verbal representation, or with respect to any provision not discussed in this SPD.

Plan Year

The Plan Year for the Medical Plan ends on December 31 of each year. The financial records of the Medical Plan are kept on a calendar-year basis.

Rescission

The Plan Administrator may retroactively terminate your Plan coverage, or the coverage of your Covered Dependent, as applicable, if you or your Covered Dependents fraudulently or intentionally misrepresent any fact material to the Plan, including but not limited to enrollment information or benefit claims. The Plan Administrator may terminate your coverage and/or the coverage of your Covered Dependents if you provide false or misleading information material to the Plan.

Glossary

This section defines key words that are frequently used in the SPD. These terms are capitalized throughout the SPD.

Annual Deductible. See definition of deductible.

Base Pay. Your annual rate of compensation before any Pre-Tax deductions, excluding bonuses, overtime, shift differential, incentives, lump sum merit increases, non-recurring incentives, commissions and sales cash incentives, and other forms of special compensation or other extra pay as determined by the Company in its sole discretion. For employees of covered collective bargaining units, Base Pay includes cost of living adjustments (COLA).

Casual Employee. A person who may be called by the Company at any time for employment in the United States on a non-scheduled and non-recurring basis, and becomes an employee of the Company only after reporting to work for the period of time during which the person is working and who is not a Non-Eligible Union Employee and is not an Excluded Person.

Claims Administrator. Depends on the option under which you are covered, see the "Plan Funding and Administration" chart.

COBRA Administrator. Fidelity Investments is the COBRA Administrator.

Coinsurance. The percentage of covered expenses that you are required to pay after you have met your Deductible.

Company. Individually or collectively, Merck Sharp & Dohme Corp. and its wholly owned subsidiaries (excluding Telerx Marketing, Inc., Inspire Pharmaceuticals Inc., and Comsort, Inc.) and Schering Corporation and its wholly owned subsidiaries.

Copay. A flat-dollar amount that you pay for certain services when you use a participating network provider.

Coverage Tiers. Individually and collectively, the following levels of coverage:

- Employee only;
- Employee + Spouse/Same-Sex Domestic Partner;
- Employee + Child(ren); and
- Employee + Spouse/Same-Sex Domestic Partner + Child(ren).

Covered Dependents. Your Eligible Dependents whom you have enrolled for coverage under the Medical Plan in the time and manner specified by the Plan Sponsor. See "Eligible Dependents" in the About Medical Benefits.

Covered Employees. Eligible Employees who have enrolled for coverage under the Medical Plan in the time and manner specified by the Plan Sponsor.

Deductible.

Annual Deductible. The amount of money you pay each year before the Medical Plan begins to pay benefits for covered medical expenses for you and your Covered Dependents. There are two types of Annual Deductibles: individual and family. The Individual and Family Deductibles are based on the option you elect under the Medical Plan. See the "At A Glance" charts in each Medical Plan option chapter for specific details.

Under the Merck PPO option, there are different Deductibles for In-Network and Out-of-Network expenses. Your Out-of-Network expenses will be credited toward both your Out-of-Network and In-Network Deductible. Your In-Network expenses will be credited toward both your In-Network and Out-of-Network Deductible.

The Annual Deductible does not apply to certain preventive services covered under the Medical Plan, whether In-Network or Out-of-Network. Age and other restrictions apply.

Individual Deductible. The amount of money you and each Covered Dependent pay each year before the Medical Plan begins to pay benefits for covered medical expenses for that covered family member. Once a covered family member has met his/her Individual Deductible, the Medical Plan pays the Coinsurance percentage of the cost of most covered medical expenses, and you pay the rest.

Family Deductible. A ceiling on what a family contributes toward the Deductible. If a number of covered family members' expenses add up to the Family Deductible, then the Individual Deductibles are deemed "satisfied" for all covered family members for the year. Once you meet the Family Deductible, all other expenses for any covered family member will be paid by the Medical Plan based on the option you select. However, if one person in the family reaches the Individual Deductible, then the Medical Plan will start to pay the Coinsurance for that person's covered expenses.

KEY POINT — EXAMPLE OF HOW THE FAMILY DEDUCTIBLE IS MET

Let's say that your family of three chooses the Merck 80/20 option. Under that option, your Individual Deductible is $400 and your Family Deductible is $800. Assume that your covered expenses equal $300, your Spouse's/Same-Sex Domestic Partner's equal $300 and your child's equal $200 — totaling $800. No one has met the $400 Individual Deductible, but together you have met the $800 Family Deductible. Therefore, the Medical Plan will pay 80% of covered expenses for all covered family members.

Eligible Dependents.

- Your Spouse or Same-Sex Domestic Partner—*If your Spouse/Same-Sex Domestic partner is a Non-Eligible Union Employee, he/she does not qualify as a dependent.*
- Your children up to age 26. Children mean your:
  - Biological children;
  - Stepchildren, including your Spouse's/Same-Sex Domestic Partner's biological children, foster children, legally adopted children and children for whom your Spouse/Same-Sex Domestic Partner is legal guardian, in each case who are not also your biological children, foster children, legally adopted children and children for whom you are legal guardian;
  - Foster children;
  - Legally adopted children (eligibility begins on the date of placement for adoption or commencement of legal obligation to provide support in anticipation of adoption);
  - Children for whom you are legal guardian; and
  - Those for whom coverage is required by a Qualified Medical Child Support Order (QMCSO).

KEY POINT — SPOUSE AND CHILDREN OF COVERED CHILDREN ARE NOT ELIGIBLE FOR COVERAGE

While coverage is extended to your children up to age 26, this coverage does not extend to your child's Spouse or your child's children, unless they would otherwise meet the definition of Eligible Dependents.

If You Have a Child with a Disability
If your dependent child is physically or mentally disabled, coverage for the child may continue beyond age 26, provided the child's disability begins before the date the child reaches the age at which coverage would otherwise end. You will need to provide proof of your child's disability to the Claims Administrator at least 60 days before the date coverage is scheduled to end and annually thereafter. To continue coverage, the Claims Administrator also reserves the right to have a physician of its choice examine your child once a year. For more information on how to contact the Claims Administrator, see the "Administrative Information" chapter.

Qualified Medical Child Support Order
A Qualified Medical Child Support Order (QMCSO) may require you to provide coverage to your child. You may obtain a copy of Merck's procedures governing QMCSO determinations, free of charge, by calling the Support Center at **866-MERCK-HD (866-637-2543).** For U.S. employees calling from outside of the United States, dial **+1-908-423-HELP (+1-908-423-4357).**

Spouses/Same-Sex Domestic Partners Who Work for Merck
If you or your Spouse/Same-Sex Domestic Partner (or your former Spouse/Same-Sex Domestic Partner or his/her Spouse/Same-Sex Domestic Partner) work (or worked) for the Company, special provisions apply when enrolling Eligible Dependents for coverage. See "Merck Couples Enrollment Rules."

Eligible Employees. Regular Full-Time Employees, Regular Part-Time Employees, Merck Temporary Employees, Eligible Union Employees and LTD Employees.

Eligible Union Employees. All U.S.-based employees of the Company who are members of a collective bargaining unit, except those who are members of the United Steelworkers Local 10-00086 collective bargaining unit.

Emergency. 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.

Emergencies include, but are not limited to:

- Severe pain;
- Psychiatric disturbances; and/or
- Symptoms of Substance Abuse.

With respect to a pregnant woman who is having contractions, an Emergency exists where:

- There is inadequate time to effect a safe transfer to another Hospital before delivery; or
- The transfer may pose a threat to the health or safety of the woman or the unborn child.

Specific examples of Emergencies include but are not limited to heart attacks, strokes, convulsions, severe burns, obvious bone fractures, wounds requiring sutures, poisoning and loss of consciousness.

Excluded Employees. Casual Employees, U.S. Expatriates[53], and Intern/Graduate/ Cooperative Student Associates, any class of Excluded Person and Non- Eligible Union Employees.

Excluded Persons. A person who is an independent contractor, or agrees or has agreed that he/she is an independent contractor, or has any agreement or understanding with the Company, or any of its affiliates, that he/she is not an employee or an Eligible Employee, even if he/she previously had been an employee or Eligible Employee or is employed by a temporary or other employment agency, regardless of the amount of control, supervision or training provided by the Company or its affiliates, or he/she is a "leased employee" as defined under section 414 (n) of the Internal Revenue code of 1986, as amended. An Excluded Person is not eligible to participate in the Medical Plan even if a court, agency or other authority rules that he/she is a common-law employee of the Company or its affiliates.

External Review Organization. An independent review organization contracted with Claims Administrator to choose an independent physician review (or reviewers, if necessary or required by applicable law) to examine a case.

Experimental or Investigational
A drug, a device, a procedure, or treatment will be determined to be experimental or investigational if:

- There are insufficient outcomes data available from controlled clinical trials published in the peer-reviewed literature to substantiate its safety and effectiveness for the illness or injury involved; or
- Approval required by the FDA has not been granted for marketing; or
- A recognized national medical or dental society or regulatory agency has determined, in writing, that it is experimental or investigational, or for research purposes; or
- It is a type of drug, device or treatment that is the subject of a Phase I or Phase II clinical trial or the experimental or research arm of a Phase III clinical trial, using the definition of "phases" indicated in regulations and other official actions and publications of the FDA and Department of Health and Human Services; or
- The written protocol or protocols used by the treating facility, or the protocol or protocols of any other facility studying substantially the same drug, device, procedure, or treatment, or the written informed consent used by the treating facility or by another facility studying the same drug, device, procedure, or treatment states that it is experimental or investigational, or for research purposes.

In-Network. A provider, or the covered services and supplies provided by a provider, who has an agreement with the Claims Administrator for the applicable benefit to furnish covered services or supplies.

Intern/Graduate/Cooperative Student Associate. A student hired by the Company as a participant in the Company Intern/Graduate/Cooperative Student Associate Program. The student must be designated as a participant in that program at least annually by the Director of University Relations.

Legacy Merck Employee. An Eligible Employee who is employed by Merck Sharp & Dohme Corp. or one of its wholly owned subsidiaries (excluding Telerx Marketing, Inc., Inspire Pharmaceuticals Inc., and Comsort, Inc.).

[53] U.S. Expatriates are not eligible for the medical coverage under the Merck Medical Plan described in this SPD. However, they are eligible for medical coverage through Merck under a program insured by Cigna International.

Legacy Merck Retiree. An individual who was an Eligible Employee of Merck Sharp & Dohme or one of its wholly owned subsidiaries (excluding Telerx Marketing, Inc., Inspire Pharmaceuticals Inc., and Comsort, Inc.) and who when employment ends (or ended), meets the definition of a Retiree under the applicable Plan sponsored by the Company. A more complete definition is provided in the "Merck SPD for Legacy Merck Retirees."

Legacy OBS Employee. An Eligible Employee of Schering Corporation or one of its wholly owned subsidiaries who was employed on November 20, 2007 by Organon BioSciences (OBS) or an OBS affiliate.

Legacy Schering-Plough Employee. An Eligible Employee who is employed by Schering Corporation or one of its wholly owned subsidiaries.

Legacy Schering-Plough Retiree. An individual, who was an Eligible Employee of Schering Corporation or one of its wholly owned subsidiaries and who when employment ends (or ended), meets the definition of a Retiree under the applicable Plan sponsored by the Schering Corporation. A more complete definition is provided in the "Merck SPD for Legacy Schering-Plough Retirees."

Life Event. Certain events in your life that may allow you to change some of your benefit choices or coverage levels during the year (e.g., marriage, divorce, birth or adoption of a child, etc.). For more information about Life Events — and Permitted Plan Changes — see "When Life Changes" in the About Medical Benefits chapter or contact the Merck Benefits Service Center.

Lifetime Benefit Maximum. The maximum amount of benefits you and your Covered Dependents can receive under the Medical Plan. The Medical Plan options do not have Lifetime Benefit Maximums other than for infertility-related medical and pharmacy services.

LTD Benefits. Income replacement benefits provided under the MSD Medical, Dental and Long-term Disability Plan for Union Employees or the MSD Medical, Dental and Long-term Disability Plan for Nonunion Employees or the Merck & Co., Inc. Group Benefits Plan, as applicable.

LTD Employee. An employee who is receiving LTD Benefits who on the day he/she became eligible for LTD Benefits was considered by the Company to be a Regular Full-Time Employee, Regular Part-Time Employee, Eligible Union Employee, Merck Temporary Employee or a U.S. Expatriate.

Merck-Brand Drug. Those drugs identified by the Plan Sponsor to Medco as Merck prescriptions eligible for $0 Copay, subject to change from time to time at the Company's discretion.

Medical Plan/Merck Medical Plan. The medical, prescription drug and behavioral health care benefits provided under the MSD Medical, Dental and Long Term Disability Plan for Union Employees, the MSD Medical, Dental and Long Term Disability Plan for Nonunion Employees and the Schering Corporation Employees' Benefits Trust Plan as applicable.

Medically Necessary. A service or supply is Medically Necessary if it is:

- Reasonably required for the treatment or management of the medical condition;
- Commonly and customarily recognized by physicians as appropriate treatment or management of the medical condition; and
- Other than educational or experimental in nature.

A hospital confinement is Medically Necessary if:

- The medical condition requires confinement; and
- Safe and effective treatment cannot be provided on an outpatient basis.

The Claims Administrator has the final authority for determining medical necessity.

Merck Temporary Employee. An employee hired and paid by the Company (rather than an agency) for a specific position in the United States for a designated length of time which is normally not more than 24 consecutive months in duration, who is committed to leave the Company at the end of that time and is not a Non- Eligible Union Employee and is not an Excluded Employee.

Non-Eligible Union Employee. An employee of Merck Sharp & Dohme Corp. who is a member of the United Steelworkers Union Local 10-00086 (or its predecessor).

Non-Merck-Brand Drug. Those drugs identified by the Plan Sponsor to Medco as non-Merck prescriptions not eligible for $0 Copay, subject to change from time to time at the Plan Sponsor's discretion.

Out-of-Network. A provider, or the services and supplies provided by a provider, who does not have an agreement with the Claims Administrator for the applicable benefit to provide covered services or supplies.

Out-of-Pocket Maximum. The most that you and your Covered Dependents are required to pay for covered expenses in a year after your Deductibles have been met. This maximum is calculated using the table found in Schedule A of this SPD and using your Base Pay as of the November 1 immediately before the beginning of the given calendar year. The Out-of-Pocket Maximum protects you against paying extraordinary medical bills in a given year. Certain expenses are not credited toward your Out-of-Pocket Maximum including:

- Expenses that satisfy your Deductible (Individual or Family);
- Office visit Copays;
- Expenses for services and supplies not covered by the Medical Plan; and
- Charges in excess of Reasonable and Customary Limits.

Under the Merck PPO option, there are different Out-of-Pocket Maximums for In-Network and Out-of-Network expenses. Your Out-of-Network expenses will be credited toward both your Out-of-Network and In-Network Out-of-Pocket Maximums. Your In-Network expenses will be credited toward both your In-Network and Out-of-Network Out-of-Pocket Maximums.

If your covered expenses reach the Out-of-Pocket Maximum, the Medical Plan pays 100% of any additional covered expenses for the rest of the calendar year.

Opposite-Sex Domestic Partner. Note: Opposite-Sex Domestic Partners are no longer eligible to participate in the Merck Medical Plan after December 31, 2011. An Opposite-Sex Domestic Partner is a person of the opposite sex, age 18 or older, with whom you have been in a committed relationship for at least 12 consecutive months. A domestic partnership meets these qualifications if:

- You are both mentally competent to consent to contract;
- You are each other's sole domestic partner, and intend to remain so indefinitely;
- Neither of you is married to (or married, but legally separated from) anyone else;
- Neither of you has had another domestic partner within the prior 12 months;
- You are not related by blood to a degree of closeness that would prohibit legal marriage in the state in which you legally reside;
- You have lived in the same household for at least 12 months, and intend to do so indefinitely;
- You are engaged in a committed relationship of mutual caring and support and are jointly responsible for your common welfare and living expenses; and
- Your interdependence is demonstrated by at least two of the following: common ownership of real property (joint deed or mortgage agreement) or a common leasehold interest in property; common ownership of a motor vehicle; driver's licenses or passports listing a common address; same automobile insurance policy; joint bank accounts or credit accounts; a primary beneficiary designation for a will or life insurance; or a durable property and/or health care power of attorney assignment.

Permitted Plan Change. Changes in benefit choices or coverage levels during the year that are consistent with a Life Event and comply with applicable regulations under the Internal Revenue Code and the guidelines established by the Plan Administrator (subject to periodic change). For more information about Permitted Plan Changes — and related Life Events —see "When Life Changes" in the "About Medical Benefits" chapter or contact the Merck Benefits Service Center.

Plan. See definition of Medical Plan.

Plan Administrator. Merck Sharp & Dohme Corp. for the MSD Medical, Dental and Long Term Disability Program for Union Employees and the MSD Medical, Dental and Long Term Disability Program for Nonunion Employees; Schering Corporation for the Schering Corporation Employees' Benefit Trust Plan.

Plan Sponsor. Merck Sharp & Dohme Corp. for the MSD Medical, Dental and Long Term Disability Plan for Union Employees and the MSD Medical, Dental and Long Term Disability Plan for Nonunion Employees; Schering Corporation for the Schering Corporation Employees' Benefit Trust Plan.

Plan Year. The calendar year, January 1 through December 31, on which the records of the Plan are kept.

Pre-Tax. Contributions for benefits coverage that are deducted from an employee's pay before federal and certain state income and employment taxes are deducted.

Qualified Beneficiary. For the purposes of COBRA:

- An employee, former employee and associated Spouse and Eligible Dependents who are eligible for continuation coverage under COBRA because of their status on the day before a qualifying event; and
- An individual covered by a group health plan, or a dependent of such an individual, as of the day before a qualifying event takes place.

Qualified Medical Child Support Order (QMCSO). Any judgment, decree or order issued (including a settlement established under state law, which has the force and effect of law in that state) that creates, recognizes or assigns to a child the right to receive benefits for which you are eligible under the Medical Plan and that the Plan Administrator determines to be qualified under applicable law.

Reasonable and Customary (R&C) Limit. For the Merck PPO — Horizon BCBS and the Merck 80/20 options (including behavioral health care benefits under those options), **R&C Limits are determined by Horizon BCBS. For** the Merck PPO **—Aetna Choice POS II option**(including behavioral health care benefits under that option)**, R&C Limits are determined by Aetna. Generally, R&C Limits are based on nationwide claims data compiled by the Health Insurance Association of America (HIAA). On behalf of Horizon BCBS and Aetna and most other large insurance companies, HIAA collects prevailing provider fees from millions of medical claims processed by the member insurers. These actual fees for a given medical service or procedure, in a given geographic area, are organized highest-to-lowest.**

A percentile within this array is established by the sponsor of the plan (usually between the 70th and 90th percentile) and the actual charge at that percentile is determined to be the maximum reasonable and customary charge for that particular service in that particular area for that particular plan. The 90th percentile has been established as the maximum reasonable and customary level for the Medical Plan. HIAA frequently updates its database and, therefore, R&C Limits may change from time to time.

Any amounts you are reimbursed for covered expenses received Out-of-Network are based on the R&C Limit for the treatment or service you receive. The Medical Plan pays a percentage of covered expenses only up to the R&C Limits. (R&C Limits do not apply to In-Network expenses covered under the following: Merck PPO options, Merck 80/20 option or the Behavioral Health Program because participating providers have agreed to specified, reduced fees for their services.)

For example, assume the Plan pays 80% and the R&C Limit for a certain service was $100. If your health care provider charges you $120 for that service, the Medical Plan will only pay $80 (80% of the $100 R&C Limit).

If your expenses exceed the R&C Limit, you are responsible for paying the additional amount. Any charges above the R&C Limit will not count toward your Deductible or your Out-of-Pocket Maximum.

If your doctor has recommended a surgical or diagnostic procedure, you can call the Horizon BCBS Customer Service line at **877-663-7258** or Aetna Choice POS II Customer Service line at **800-541-6711** to see if the fee to be charged is more than the R&C Limit. If it is more, Horizon BCBS and Aetna will give you the R&C Limit so that you can discuss the reasonableness of the fee with your doctor in advance. If it is less, Horizon BCBS and Aetna will confirm that the fee to be charged is less than the R&C Limit, but will not disclose the R&C Limit. When you call Horizon BCBS or Aetna, you will need the name and description of the procedure, the "procedure code" and the fee, all of which your doctor can provide.

Regular Full-Time Employee. You are considered an employee if you are employed by the Company in the United States on a scheduled basis for a normal work week, are not classified as Part-Time, Merck Temporary or Casual, are not a Non- Eligible Union Employee and are not an Excluded Employee.

Regular Part-Time Employee. You are considered an employee if you are employed by the Company in the United States on a scheduled basis for less than the number of regularly scheduled hours for your site, are not a Non-Eligible Union Employee and are not an Excluded Employee.

Retiree. Collectively, Legacy Merck Retirees and Legacy Schering-Plough Retirees.

Same-Sex Domestic Partner/Same-Sex Domestic Partnership. Two people in a Spouse-like relationship who share an ongoing, exclusive, emotionally committed relationship (and intend to do so indefinitely) and meet all of the following criteria:

- Are the same sex;
- Are at least age 18 and mentally competent to enter into a legal contract;
- Are not related by blood or adoption to a degree closer than permitted by state law for marriage;
- Are not legally married to — or the domestic partner of — anyone else;
- Are jointly responsible for each other's welfare, financial and other obligations;
- Reside together in the same household — and have done so for at least 12 months; and
- Have registered the same-sex relationship — (if residing in a state/municipality that permits such registration or are legally married if permitted to do so under applicable law).

Spouse. The person recognized as your legal spouse under federal law.

Transfer Date. The date a Transferred Employee becomes a Regular Full-Time Employee or a Regular Part-Time Employee.

Transferred Employee. An employee of Merck (or its subsidiaries) who is transferred to a position as a Regular Full-Time Employee or a Regular Part-Time Employee and who is not an Excluded Person and who on the day before his or her transfer was not an Eligible Employee.

U.S. Expatriate. A U.S. citizen or individual with U.S. Permanent Resident status who is employed by a foreign subsidiary of the Company, as a foreign service employee, provided that the individual has not elected coverage under any retirement plan of the foreign subsidiary if the subsidiary is covered by an agreement entered into by Merck, under Section 3121(l) of the Internal Revenue Code (dealing with Social Security benefits) and who is not an Excluded Person.

Out-of-Pocket Maximum Amounts

The Out-of-Pocket Maximum Amount is the most that you and your Covered Dependents 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 a date determined by the Plan Sponsor, which is generally immediately before the beginning of the given calendar year. For a definition of "Out-of-Pocket Maximum," please refer to the Glossary.

Merck PPO options

Annual Out-of-Pocket Maximum[1]		In-Network		Out-of-Network[2]	
Varies based on your Base Pay:[3]		*Individual*	*Family*	*Individual*	*Family*
$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 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 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.

3 Base Pay equals Base Pay plus COLA.

Merck 80/20 Option

Annual Out-of-Pocket Maximum[1]		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.