U.S.W. Local 10-00086 Merck Employees H&W Plan

Summary of Benefits and Coverage: What this Plan Covers & What You Pay For Covered Services

Coverage Period: 07/01/2025-06/30/2026

Coverage for: All Coverage Types | **Plan Type:** PPO

The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately.

This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, contact your Benefits Administrator, RAE Consulting at USWHealth@rae-consulting.net. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at https://www.healthcare.gov/sbc-glossary/ or contact your Benefit Administrator at USWHealth@rae-consulting.net or 215-773-0900.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	For participating providers **$150** person / **$300** family. For non-participating providers **$300** person /**$600** family. Doesn't apply to office visits.	You must pay all the costs up to the **deductible** amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the **deductible** starts over (usually, but not always, January 1st). See the chart starting on page 2 for how much you pay for covered services after you meet the **deductible**.
Are there services covered before you meet your deductible?	Yes. Office Visits, Therapy Visits, with copayment, etc.	
Are there other deductibles for specific services?	No. There are no other specific **deductibles**.	You don't have to meet **deductibles** for specific services but see the chart starting on page 2 for other costs for services this plan covers.
What is the out-of-pocket limit for this plan?	Coinsurance after the deductible is met. For participating providers: Plan pays 90%/Member pays 10% up to **$500 person/$1,000 family**. For Non-participating providers: Plan pay 70%/Member pays 30% of allowance up to **$1,000 person/$2,000 family**.	The **out-of-pocket limit** is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.
What is not included in the out-of-pocket limit?	Office Copays, Premiums, balance-billed charges, and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the **out-of-pocket limit**.
Will you pay less if you use a network provider?	Yes.	
Do you need a referral to see a specialist?	No.	

All coinsurance costs shown in this chart are after your deductible has been met, if a deductible applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$10 co-pay/visit	30% co-insurance, after deductible	——————none——————
	Specialist visit	$10 co-pay/visit	30% co-insurance, after deductible	——————none——————
	Preventive care/screening/ immunization	$10 co-pay/visit	30% co-insurance, after deductible	——————none——————
	Horizon CareOnline Telemedicine visit Virtual Office visit	$0 co-pay/visit $10 co-pay/visit	30% co-insurance, after deductible	——————none——————
	Urgent Care visit	$10 co-pay/visit	30% co-insurance, after deductible	——————none——————
If you have a test	Diagnostic test (blood work)	No Charge	30% co-insurance, after deductible	——————none——————
	Imaging (Xrays, CT/PET scans, MRIs)	10% coinsurance, after deductible	30% co-insurance, after deductible	——————none——————
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at **https://www.express-scripts.com**	Generic drugs	$10 co-pay (retail) $20 co-pay mail order for 90 days)	30% co-insurance, after deductible	Covers up to a 30-day supply (retail prescription); 31-90 day supply (mail order prescription)
	Preferred brand drugs	$15 co-pay (retail) $30 co-pay mail order for 90 days)	30% co-insurance, after deductible	Covers up to a 30-day supply (retail prescription); 31-90 day supply (mail order prescription)
	Merck manufactured drugs	$0 co-pay (retail) $0 co-pay mail order for 90 days)	30% co-insurance, after deductible	Covers up to a 30-day supply (retail prescription); 31-90 day supply (mail order prescription)
	Specialty drugs	$15 co-pay (retail) $30 co-pay mail order for 90 days)	30% co-insurance, after deductible	Covers up to a 30-day supply (retail prescription); 31-90 day supply (mail order prescription)
	Smart-90 Voluntary **CVS** Program – Retail 90-day	Generic - $20 co-pay Brand - $30 co-pay Merck/SP - $0 co-pay	N/A	Maintenance Drugs Only – Covers 90-day supply at **CVS Retail Pharmacies only**.

* For more information about limitations and exceptions and copies of plan documents, email RAE Consulting at admin@rae-consulting.net.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	10% co-insurance, after deductible	30% co-insurance, after deductible	————————none————————
	Physician/surgeon fees	10% co-insurance, after deductible	30% co-insurance, after deductible	————————none————————
If you need immediate medical attention	Emergency room care	$25 co-pay	$25 co-pay	Waived if admitted.
	Emergency medical transportation	10% co-insurance, after deductible	30% co-insurance, after deductible	————————none————————
If you have a hospital stay	Facility fee (e.g., hospital room)	10% co-insurance, after deductible	30% co-insurance, after deductible	————————none————————
	Physician/surgeon fees	10% co-insurance, after deductible	30% co-insurance, after deductible	————————none————————
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$10 co-pay/office visit	30% co-insurance, after deductible	————————none————————
	Inpatient services	10% co-insurance, after deductible	30% co-insurance, after deductible	————————none————————
If you are pregnant	Office visits	$10 co-pay for initial visit then 10% co-insurance, after deductible	30% co-insurance, after deductible	————————none————————
	Childbirth/delivery professional services	10% co-insurance, after deductible	30% co-insurance, after deductible	————————none————————
	Childbirth/delivery facility services	10% co-insurance, after deductible	30% co-insurance, after deductible	————————none————————
If you need help recovering or have other special health needs	Home health care	10% co-insurance, after deductible	30% co-insurance, after deductible	————————none————————
	Rehabilitation services	10% co-insurance, after deductible	30% co-insurance, after deductible	————————none————————
	Habilitation services	10% co-insurance, after deductible	30% co-insurance, after deductible	————————none————————
	Skilled nursing care	10% co-insurance, after deductible	30% co-insurance, after deductible	————————none————————
	Durable medical equipment	10% co-insurance, after deductible	30% co-insurance, after deductible	————————none————————
	Hospice services	10% co-insurance, after deductible	30% co-insurance, after deductible	————————none————————

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Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If your child needs dental or eye care	Children's eye exam	No Charge	Refunded per Non-Par Reimbursement Schedule	Limited to one exam per 12 months
	Children's glasses	No Charge	Refunded per Non-Par Reimbursement Schedule	Limited to one pair of glasses per 12 months
	Children's dental check-up	No Charge	Refunded per Non-Par Reimbursement Schedule	Routine exams, x-rays, cleanings, fluoride treatments (two per calendar year)

Excluded Services & Other Covered Services:

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

- Dental care (Adult) (covered under Dental plan)
- Infertility treatment
- Weight Loss Programs
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Birth Control Methods (oral medication only)
- Routine foot care
- Private-duty nursing
- Acupuncture
- Hearing Aids

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

- Bariatric surgery (Medically Necessary Only)
- Cosmetic surgery
- Hair Prosthesis (Alopecia patients)
- Chiropractic care
- Orthotics
- Most coverage provided outside the United States. Emergency only. Pays same as In-Network.

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. Contact your Benefits Administrator at 215-773-0900. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at 1-877-267-2323 or www.cciio.cms.gov. Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318-2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact: [insert applicable contact information from instructions].

Does this plan provide Minimum Essential Coverage? Yes.
Minimum Essential Coverage generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of Minimum Essential Coverage, you may not be eligible for the premium tax credit.

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

Language Access Services:
[Spanish (Español): Para obtener asistencia en Español, llame al -
[Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa-
[Chinese (中文): 如果需要中文的帮助，请拨打这个号码 -
[Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' -

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

* For more information about limitations and exceptions and copies of plan documents, email RAE Consulting at admin@rae-consulting.net.

About these Coverage Examples:

This is not a cost estimator. Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby
(9 months of in-network pre-natal care and a hospital delivery)

- **The plan's overall deductible $150/$300**
- **Specialist *[cost sharing office visit]* $10**
- **Hospital (facility) *[cost sharing]* 10%**
- **Other *[cost sharing]* 10%**

This EXAMPLE event includes services like:
Specialist office visits (*prenatal care)*
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests (*ultrasounds and blood work)*
Specialist visit *(anesthesia)*

Total Example Cost	**$7,540**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$150
Copayments	$10
Coinsurance	$500
What isn't covered	
Limits or exclusions	$0
The total Peg would pay is	**$660**

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

- **The plan's overall deductible $150/$300**
- **Specialist *[cost sharing office visit]* $10**
- **Hospital (facility) *[cost sharing]* 10%**
- **Other *[cost sharing]* 10%**

This EXAMPLE event includes services like:
Primary care physician office visits (*including disease education)*
Diagnostic tests *(blood work)*
Prescription drugs
Durable medical equipment *(glucose meter)*

Total Example Cost	**$1,900**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$150
Copayments	$120
Coinsurance	$100
What isn't covered	
Limits or exclusions	$0
The total Joe would pay is	**$370**

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

- **The plan's overall deductible $150/$300**
- **Specialist *[cost sharing office visit]* $10**
- **Hospital (facility) *[cost sharing]* 10%**
- **Other *[cost sharing]* 10%**

This EXAMPLE event includes services like:
Emergency room care *(including medical supplies)*
Diagnostic test *(x-ray)*
Durable medical equipment *(crutches)*
Rehabilitation services *(physical therapy)*

Total Example Cost	**$2,100**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$150
Copayments	$115
Coinsurance	$75
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$340**

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