U.S.W. LOCAL 10-00086 MERCK EMPLOYEES HEALTH AND WELFARE PLAN

SUMMARY PLAN DESCRIPTION

January 2016
(with revisions through 1.2025)

FOR HELP OR INFORMATION

When you need information, please check this booklet first. If you need further help, call the people listed in the following summary:

	CONTACT INFORMATION FOR BENEFIT MANAGERS	BENEFIT
Eligibility, Enrollment, COBRA and General Plan Information	**RAE Consulting (RAE)** **www.rgabriel.com/ClientResources/usw** Email: **USWHealth@rae-consulting.net** Phone: 215-773-0900 **Benefits Administration Team:** Viola Driscoll Karen Irwin - Manager	If you do not find the information you need in this SPD, you may also contact the Fund Office.
Medical Coverage	**Horizon BCBS of New Jersey** **www.horizonblue.com/usw1086** Customer Service: 1-888-444-8014 To obtain Horizon Reimbursement forms or plan information refer to RAE Consulting website at: **www.rgabriel.com/ClientResources/usw**	For information that may not be provided in your Horizon materials, please contact Horizon BCBS via phone or the website listed at left.
Prescription Drugs	**Express Scripts, Inc. ("ESI")** **www.express-scripts.com** Customer Service: 1-800-711-0917 To obtain ESI Mail Order and Prescription Reimbursement forms or plan information refer to RAE Consulting website at: **www.rgabriel.com/ClientResources/usw**	**Retail** (30-Day Supply) **Generic**: $10 per Rx **Brand**: $15 per Rx **Merck Manufactured**: $ 0 per Rx **Mail-Order** (90-Day Supply) **Generic**: $20 per Rx **Brand**: $30 per Rx **Merck Manufactured**: $ 0 per Rx **Smart 90 Voluntary CVS Program** (90-Day Supply) (Maintenance Drugs Only) **Generic**: $20 per Rx **Brand**: $30 per Rx **Merck Manufactured**: $ 0 per Rx

(pg 2 rev. 1.1.2020, 1.1.2024, 4.2024, 1/2025)

	CONTACT INFORMATION FOR BENEFIT MANAGERS	BENEFIT
Dental Benefits	**United Concordia (UCCI, Inc.)** **www.ucci.com** Customer Service: 1-800-332-0366 To obtain UCCI Reimbursement forms or plan information refer to RAE Consulting website at: **www.rgabriel.com/ClientResources/usw**	Benefits **Elite** (UCCI schedule of allowable charges) up to a Calendar Year maximum of $2,000 after annual deductible of $25 per covered individual; Orthodontia: lifetime maximum of $1,500 per covered individual. Also, medically and dentally necessary pediatric dental Services are covered.
Vision Benefits	**Vision Benefits of America (VBA)** **www.vbaplans.com** Customer Service: 1-800-432-4966 To obtain VBA Reimbursement forms or plan information refer to RAE Consulting website at: **www.rgabriel.com/ClientResources/usw**	Exams provided every 24 months for adults (19 and over), every 12 months for children (up to age 18). Lenses and Frames provided once each 24 months (adults or children); Contact lens benefit also available.

For your convenience, please find attached a brief Summary Benefit description provided by each of the Benefit Managers. NOTE: In order to understand your benefits fully, you should read the full benefits brochure provided by each Benefit Manager as well as the terms of this Summary Plan Description ("SPD").

(pg 3 revised 5.18.2018, 1.1.2024)

BOARD OF TRUSTEES

APPOINTED BY THE UNION	APPOINTED BY THE EMPLOYER
Kevin McCafferty – Co-Chair U.S.W. Local 10-00086 106 Winding Way Swedesboro, NJ 08085	Kristy Gonowon – Co-Chair Merck & Co., Inc. 126 E. Lincoln Avenue RY60-258B Rahway, NJ 07065
Daniel Peterson U.S.W. Local 10-00086 233 Stone Haven Drive Red Hill, PA 18076	Stephanie Perfetti Merck & Co., Inc. Mail Stop K1-1106 2000 Galloping Hill Road Kenilworth, NJ 07033
Gary Holland U.S.W. Local 10-00086 7009 Chew Street Philadelphia, PA 19119	Jennifer Davis Merck & Co., Inc. HR Leader-Employee & Labor Relations 770 Sumneytown Pike Mailstop: WP 53B-400 West Point, PA 19486

THIRD-PARTY-ADMINISTRATOR
(BENEFITS ADMINISTRATOR)
Horsham Office
RAE Consulting ***(formerly richard Gabriel associates)***
601 Dresher Road, Suite 201
Horsham, PA 19044
215-773-0900
USWHealth@rae-consulting.net

LEGAL CO-COUNSEL

Willig, Williams & Davidson
1845 Walnut Street, 24th Floor
Philadelphia, PA 19103
215-656-3600

Day Pitney LLC
One Jefferson Road
Parsippany, NJ 07054-2891
973-966-8136

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U.S.W. LOCAL 10-00086 MERCK EMPLOYEES HEALTH AND WELFARE PLAN

SUMMARY PLAN DESCRIPTION

SECTION 1: INTRODUCTION

The Board of Trustees of the U.S.W. Local 10-00086 Merck Employees Health and Welfare Plan (called the "Fund") is pleased to present you with this Summary Plan Description which, along with the individual benefit descriptions and provider directories from each of the Benefits Managers, summarizes the Benefits provided to you as a Fund Participant, as well as to your Dependents. The Fund was established and is maintained through contributions made to the Fund by and Merck Sharp & Dohme Corp., a wholly owned subsidiary of Merck & Co., Inc. a corporation organized under the laws of the State of New Jersey ("Company" or "Employer") as required by the collective bargaining agreement between U.S.W. Local 10-00086 and the Company and by Contributions made by Participants as required by the terms of the Plan or applicable law. The Fund is governed by a Board of Trustees. The Board consists of an equal number of Trustees from U.S.W. Local 10-00086 ("the Union"), and from the Company.

The Board of Trustees manages the Fund and makes decisions about what Benefits will be provided and how they are provided. It is important to note that the Board of Trustees' interpretation of the Fund's rules, regulations, and policies, including Eligibility rules, are final and binding. The Board of Trustees expects to continue this Fund indefinitely. However, the Board of Trustees reserves the right to amend, change, modify, suspend or terminate any Benefit at any time and the Union and the Employer retain the right to suspend or terminate the Fund in whole or in part at any time.

Please make sure to read this Summary Plan Description ("SPD") carefully and to keep it in a safe place for future reference. The information you need to understand your Benefits includes both this SPD and the information supplied by the Benefits Managers that provide your medical, dental, vision, prescription, and counseling Benefits.

Medical Benefits, which include, for example, hospitalization, physician office visits, telemedicine visits, outpatient surgery, diagnostic testing and emergency room treatment are described in the information provided to you through Horizon BCBS of New Jersey, 3 Penn Plaza East, Newark, NJ 07105. Prescription Benefits are described in information provided to you through Express Scripts, Inc. ("ESI"), 1 Express Way, St. Louis, MO 63121. The Fund self-insures your medical and prescription Benefits but has engaged Horizon BCBSNJ and ESI to administer these benefits. Your dental Benefits are provided on a self-insured basis through UCCI, Inc., 4401 Deer Path Road, Harrisburg, PA 17110 and your vision Benefits are provided on an insured basis through Vision Benefits of America, or "VBA", 300 Weyman Plaza, Suite 400, Pittsburgh, PA 15236-1588. These companies are referred collectively to in this SPD as "Benefit Managers."

The Benefit information and the underlying contracts between the Fund and the Benefit Managers are incorporated by reference into this SPD. If there is a conflict between the Benefit Manager's contract, Fund documents and this SPD, the Benefit Managers contracts, read in conjunction with other Fund documents, will prevail.

You will want to keep all of this information handy for ready reference, please contact the Fund Office directly if you have any questions regarding your Benefits. If the Trustees change any of the Benefit Managers of your benefits, they will provide you with the information you need about how to continue access to these Services.

The Plan described in this document is effective January 1, 2016. If a new provider is selected, the information you receive regarding the new provider will supersede the information contained in this booklet. As the Plan is amended from time to time, the Fund will send you information explaining the changes. The newer information will supersede the information provided in this SPD.

If you have any questions, please contact *RAE Consulting*, the "Benefits Administrator" that the Board of Trustees has retained to handle the regular day-to-day administration of the Plan. You can reach the RAE Consulting Benefits Administration Team at USWHealth@rae-consulting.net, at 601 Dresher Road, Suite 201, Horsham, PA 19044 or (215-773-0900).

GRANDFATHERED PLAN NOTICE

> This Fund's Trustees believe this Plan is a ``grandfathered health plan'' under the Patient Protection and Affordable Care Act (the Affordable Care Act). As permitted by the Affordable Care Act, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted. Being a grandfathered health plan means that your Plan may not include certain consumer protections of the Affordable Care Act that apply to other plans, for example, the requirement for the provision of preventive health services without any cost sharing. However, grandfathered health plans must comply with certain other consumer protections in the Affordable Care Act, for example, the elimination of lifetime limits on benefits.
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> Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to the Benefits Administration Team at RAE Consulting, USWHealth@rae-consulting.net or 215-773-0900. You may also contact the Employee Benefits Security Administration, U.S. Department of Labor at 1-866-444-3272 or www.dol.gov/ebsa/healthreform. This website has a table summarizing which protections do and do not apply to grandfathered health plans.

Consistent with the requirements of the Affordable Care Act, the Trustees shall not rescind coverage for Participants and/or their Dependents except in cases involving fraud or an intentional misrepresentation of material facts. In the event of suspected fraud or intentional misrepresentation, the Fund will provide at least 30 days advance notice of an intention to rescind the coverage, including retroactively, in order to give the affected individuals the opportunity the opportunity to appeal.

Note that the Trustees can cancel benefits, consistent with the terms of the Plan, if the cancellation or discontinuance of coverage has only a prospective effect; or the cancellation or discontinuance of coverage is effective retroactively to the extent it is attributable to a failure to timely pay required premiums or contributions towards the cost of coverage.

The great majority of our Participants and Dependents use only the benefits to which they are entitled. A few individuals, however, attempt to receive benefits to which they are not entitled. If any individual receives benefits to which he/she is not entitled, the Fund can terminate benefits to all Family Participants, offset the cost of these benefits against any other benefits payable to any Family Participants or, in the discretion of the Trustees, initiate legal action to recover the cost of the benefits. The Trustees regret having to take these actions, but they must safeguard the Fund for all deserving Participants and their Dependents.

Certain terms, like "Eligible," "Dependent" and "Participant," have a defined meaning when used in this SPD. Those terms will be capitalized throughout the document. See the "Definitions" section of this SPD for the definition of these terms.

SECTION 2: ELIGIBILITY

A. WHO IS ELIGIBLE FOR BENEFITS?

1. **Employees:** Eligible Employees include those individuals employed (including those returning from lay-off or Disability) in a bargaining unit represented by the Union and Eligible for Benefits under the collective bargaining agreement, provided that the Employer has made the required Contributions on behalf of the Employees and the Employees have made any required Contributions.

   Employees who are on a Disability, Workers Compensation or any type of Leave of absence are eligible for benefits but must continue to submit their Employee Contributions directly to the Fund through post-tax payments. Contact the Benefits Administrator to arrange for this payment process or if you have any questions. If the Employee Contributions are not submitted, the coverage will be terminated.

   Employees who are on a layoff are entitled to continue their benefits under COBRA. You and your Dependents, if applicable, will be sent a COBRA Notice allowing you or your dependents the right to elect to continue your current health benefits including medical, prescription, dental and vision.

   Employees who agree to a Separation Package are eligible for benefits and will be limited to the terms of the Separation Package.

2. **Dependents:** Your Dependents include your Spouse and your Children.

   a. **Your Spouse includes**:

i. **Ceremonially married same- and opposite-sex Spouses**, provided that your marriage was lawful in the jurisdiction in which you were married and you present the required documentation (that is, a valid marriage certificate); and

ii. **Common law spouses who meet the requirements established by the Trustees**. Contact the Fund Office to learn what information must be presented to establish common law spouse status). You can enroll your Common Law Spouse only if you submit all of the required documentation to the Fund Office and the Fund determines that you and your Spouse entered into a valid common law marriage. Note that under applicable Pennsylvania law, a common law marriage must have been entered into before January 2, 2005.

NOTE: If you assert and the Fund determines that you and your Spouse are parties to a valid common law marriage, you are legally married for all purposes, not just for Fund coverage. You will not be able to remove your Common Law Spouse from coverage unless you obtain a divorce decree from a court of competent jurisdiction. This may mean, for example, that your Common Law Spouse could claim a part of your pension. ***Therefore, you should only claim common law marriage status if you understand that you will be considered married for all purposes.***

b. **Children**: Coverage for an Eligible Child will be available until the end of the month the child turns 26. The Child is not required to live with the Employee, depend on the Employee for support, be unmarried, or maintain full time student status. Your Dependent Children may include the following individuals who are under age 26:

i. A natural or adopted child of a Participant;

ii. A child who has been placed with the Participant for adoption. The term "placed for adoption," means the assumption and retention of a legal obligation for total or partial support of such child in anticipation of adoption of such child. The child's placement with such person terminates upon the termination of such legal obligation. The Participant must provide the Fund with written updates about the progress of the adoption process at least once every six (6) months.

iii. A stepchild, that is, the Child of the Participant's current Spouse;

iv. A disabled Child, that is, a Child who has been determined to be disabled by the Social Security Administration; who is not able to earn a living because of the disability, whose disability began prior to the date on which the Child would have lost Benefit Coverage because of age (age 26); and who is financially dependent on the Participant for support and maintenance as evidenced by, *inter alia*, documentation showing that the Participant claims the disabled Child as a dependent for federal income tax purposes.

v. The term "Child" does not include grandchildren, unless the grandparent is the custodial parent as determined by a court of competent jurisdiction and the required documentation is submitted to the Fund as well as a Qualified Medical Child Support Order (QMCSO) that meets requirements explained below in this SPD.

vi. In order for your Dependents to be covered under the Fund, you and your Employer must pay the appropriate Contribution for them, as well as for yourself. You must also provide the required documentation to the Fund.

NOTE: Notwithstanding the foregoing, if your Spouse or Dependent is covered under a high-deductible health plan with a "health savings account" ("HSA"), this Spouse or Dependent may not be covered under this Plan. You should be aware that the Code provides that in order to be eligible to contribute to an HSA, an individual may NOT have coverage that is not a high-deductible health plan. The Plan does not meet the requirements to be a high-deductible health plan.

B. WHEN ARE YOU AND YOUR DEPENDENTS ELIGIBLE FOR BENEFITS?

a. EMPLOYEES: New Employees and Employees returning from layoff are Eligible for benefits on the date of their employment or reemployment.

i. Active Employees are entitled to receive Benefits in accordance with the terms of this Plan and of the collective bargaining agreement between your Employer and the Union.

ii. Employees who are on disability, Workers Compensation or any type of leave of absence must continue to submit their Employee Contributions directly to the Fund through post-tax payments. Contact the Benefits Administrator to arrange for this payment process or if you have any questions. NOTE: If the required Employee Contributions are not made, your coverage will be discontinued.

iii. Your coverage will continue until the end of the month following your date of termination or last day worked (layoff, retirement, resignation). For example, if your last day worked was April 5th, you will be covered through April 30th at midnight. If your last day worked was April 29th, you will be covered through April 30th at midnight. You and your Dependents, if applicable, will be sent a COBRA Notice allowing you or your dependents the right to elect to continue your current health benefits including medical, prescription, dental and vision.

b. DEPENDENTS: Dependents are Eligible for Benefits on the Employee's date of employment or reemployment. Your Dependents may receive medical, prescription drug, dental and vision benefits.

i. If, after your initial Eligibility, an individual becomes your Dependent, he or she is Eligible for Benefits Coverage on the date after your initial Eligibility when he or she first meets the Fund's definition of a Dependent, provided that you notify the Benefits Administrator of your new Dependent within 30 days following the event

(for example, the date of the marriage). Otherwise, coverage for a new Dependent will become effective as of the July 1 following the next Open Enrollment.

ii. As described above, your Dependents may include your Spouse and your Children from birth to age 26. Your newborn Child has coverage for 31 days immediately following his or her birth. Your newly adopted Child, or a Child placed with you for adoption, will have coverage effective the day he/she is placed in your custody. Proof of adoption must be sent promptly to the Benefits Administrator. A child born to a Dependent son or daughter will be covered only for the first 31 days including the date of birth.

> **NOTE: *Newborns*: Benefits are available for a newborn child of a Participant or Dependent for 31 days immediately following the birth. During that 31 day period, the Participant must enroll the Dependent newborn by contacting the Benefits Administrator and completing the necessary enrollment forms. Children of Dependents may not be enrolled for coverage under the Fund.**

iii. You should call RAE Consulting or refer to the Eligibility Rules above if you have any questions regarding you or your Dependents' Eligibility to participate.

c. OPEN ENROLLMENT: In addition to any Special Enrollment opportunities (described below) that you have to enroll yourself and your Dependents, you will have the opportunity between June 1st and June 30th each year to enroll yourself and your Dependents for whom, for example, you may have waived coverage when it was first made available. You will receive information from the Benefit Administrator in advance of the Open Enrollment period explaining what choices may be made at Open Enrollment.

d. CHANGES IN YOUR ADDRESS OR FAMILY STATUS: It is important that you notify the Benefits Administrator promptly of any change in your address or your Family status, including marriage, divorce, birth or legal adoption of a child, death of a spouse or child. Enrollment and change forms should be given directly to the Benefits Administrator. These changes may entitle you or your Dependent to exercise the Special Enrollment Rights described below, provided you timely notify the Fund through the Benefits Administrator.

e. SPECIAL ENROLLMENT RIGHTS: Federal law requires that you and your Dependents may be able to enroll in the Plan at a time other than the open enrollment period. If you, your Spouse or a Dependent is Eligible to enroll but declined coverage because such individual(s) had other medical coverage which is subsequently lost due to certain reasons (e.g., legal separation (in states where legal separation is recognized), divorce, death, termination of employment, reduction in hours, or exhaustion of COBRA period), you may be able to elect coverage from the Fund for the individual(s) who lost such coverage. In addition, if you have a new Dependent as a result of marriage, birth, adoption, or placement for adoption, you may also be able to enroll yourself, Spouse,

and your newly acquired Dependents, provided that you request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption.

C. TERMINATION OF COVERAGE (OTHER THAN COBRA COVERAGE)

a. Your coverage will automatically terminate upon the earliest of the dates listed below. Under certain circumstances, however, you can purchase continuation coverage, as explained below:

i. The last day of the month in which your employment terminates for any reason including layoff with recall rights and permanent layoff;

ii. The date of your death;

iii. The last day of the month in which you cease to be covered by a collective bargaining agreement that provides for your Fund participation;

iv. The date the Fund is terminated;

v. In the event of a leave of absence (for example, maternity, leave permitted under the Family Medical Leave Act ("FMLA"), long-term disability leave, workers' compensation), layoff with recall rights, the last day of the month of an absence in which you do not continue paying the equivalent of your employee contributions to the Benefits Administrator. **(To maintain your coverage while on leave, you must contact the Benefits Administrator. You will then be required to pay the equivalent amount of your employee contributions by sending the monthly amount, post-tax, directly to the Benefits Administrator.)**

vi. In the event of Employees who agree to a Separation Package, the benefits to which he or she is eligible will be limited to the terms of the separation package and will also cease the last day of the month in which you do not continue paying the equivalent of your employee contributions by sending the monthly amount, post-tax, to the Benefits Administrator.

b. Coverage for your Spouse and/or your Dependents shall automatically cease upon the earliest of the dates listed below. Under certain circumstances, however, your Spouse and/or your Dependents can purchase COBRA continuation coverage as explained below.

i. The last day of the month in which your employment terminates for any reason, including layoff, (layoff with recall rights or permanent layoff) or your death;

ii. The last day of the month in which the Employee ceases to be covered by a collective bargaining agreement that provides for Fund participation;

iii. The date the Fund is terminated;

iv. In the event of the Employee's leave of absence (e.g., maternity, FMLA leave, long-term disability, workers' compensation, the last day of the month of a leave of absence in which the Employee does not continue paying the equivalent of their payroll deductions to the Benefits Administrator. **(To maintain your coverage while on leave, you must contact the Benefits Administrator. You will then be required to pay the equivalent amount of your employee contributions by sending the monthly amount, post-tax, directly to the Benefits Administrator.)**

v. The last day of the month in which an individual no longer qualifies as a Dependent under the terms of the Plan (for example, your child reaches age 26, the date you and your Spouse divorce).

MEDICARE

Under current law, you become eligible for Medicare after you have received Social Security Disability Income (SSDI) benefits for two years. However, you must apply for Medicare in order to be covered. Having Medicare as the primary payer is advantageous to you as well as to the Fund. Please contact the Benefits Administrator once you become eligible for Medicare.

The Fund requires you and your 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 have coverage on account of your active employment, Medicare becomes the primary payer for individuals who qualify for Medicare and the Fund is the secondary payer. In this case, the Fund 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 the Fund does not require that you or your Dependents sign up for Medicare Part D.

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

The Fund assumes that your doctor accepts Medicare payments. When a doctor opts out of Medicare, you will continue to receive Plan Benefits as if the doctor accepts Medicare payments. If your doctor has opted out of Medicare, you will not receive reimbursement from the Fund for charges that would have been covered by Medicare.

Employees who agree to a Separation Package who are or become Medicare eligible due to age or disability during their benefit continuation period, are also required to enroll in Medicare Parts A

and B. Participation in Medicare Part D prescription drug coverage is voluntary and the Fund does not require that you or your Dependents sign up for Medicare Part D.

Medicare Part B Reimbursement Provision

Participants including members who agree to a separation package may be approved for quarterly reimbursement of the base monthly Medicare B premium as of the date their Medicare Part B benefits are effective. All reimbursements will be based on Medicare's Monthly Medicare Part B premium established annually. Participants must complete the appropriate form and provide proof of Medicare B enrollment to the Benefits Administrator for review. Members on a Separation Package are eligible for this reimbursement. Dependents are not eligible for this reimbursement.

SECTION 3: IMPORTANT FEDERAL LAWS

a. CHILDREN'S HEALTH INSURANCE PROGRAM REAUTHORIZATION ACT OF 2009 (CHIPRA). If you or your children are eligible for Medicaid or CHIP and you are Eligible for health coverage from your employer, your State may have a premium assistance program that can help pay for coverage. These States use funds from their Medicaid or CHIP programs to help people who are eligible for these programs, but also have access to health insurance through their employer. If you or your children are not eligible for Medicaid or CHIP, you will not be eligible for these premium assistance programs.

If you or your Dependents are already enrolled in Medicaid or CHIP and you live in a State listed below, you can contact your State Medicaid or CHIP office to find out if premium assistance is available.

If you or your Dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your Dependents might be eligible for either of these programs, you can contact your State Medicaid or CHIP office or dial 1-877-KIDS NOW or www.insurekidsnow.gov to find out how to apply. If you qualify, you can ask the State if it has a program that might help you pay the premiums for an employer-sponsored plan.

For more information in New Jersey, please contact the New Jersey Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ Medicaid Phone: 609-631-2392 CHIP Website: http://www.njfamilycare.org/index.html; CHIP Phone: 1-800-701-0710.

For more information in Pennsylvania, please contact the Pennsylvania Medicaid Website: http://www.dpw.state.pa.us/hipp; Phone: 1-800-692-7462.

Once it is determined that you or your Dependents are Eligible for premium assistance under Medicaid or CHIP, as well as Eligible under your employer plan, your employer must permit you to enroll in your employer plan if you are not already enrolled. This is called a "special enrollment" opportunity, and you must request coverage within 60 days of being determined Eligible for premium assistance. If you have questions about enrolling in your employer plan, you can contact the Department of Labor electronically at www.askebsa.dol.gov or by calling toll-free 1-866-444-EBSA (3272).

b. COVERAGE DURING MILITARY LEAVE UNIFORM SERVICES EMPLOYMENT AND REEMPLOYMENT RIGHTS ACT OF 1994 (USERRA):

Your right to continue participation in the group health plan benefit programs during leaves of absence for active United States military duty is protected by the Uniformed Services Employment and Reemployment Rights Act of 1994 ("USERRA"). Under USERRA, while on approved military leave, you may waive coverage or you may continue your current coverage under the Plan for a period of up to 24 months or, if earlier, the day after the date on which you are required to apply for or return to a position of employment in accordance with USERRA.

If you elect continuation coverage under USERRA and your approved military service exceeds 31 days, you must pay the entire premium for your Medical Program coverage, plus an additional amount of up to 2% of the total premium cost to cover administrative expenses.

Upon reemployment after military service, USERRA requires that coverage will be reinstated upon reemployment without having to satisfy any waiting period.

For purposes of USERRA, the "Uniformed Services" include the U.S. Armed Forces, the U.S. Army National Guard and U.S. Air National Guard when engaged in active duty for training, inactive duty training or full-time National Guard duty, the commissioned corps of the Public Health Service, and any other category of persons designated by the President of the U.S. in time of war or national emergency. "Service in the Uniformed Services" means the performance of duty on a voluntary or involuntary basis in a Uniformed Service under competent authority and includes active duty, active duty for training, initial active duty for training, inactive duty training, full-time National Guard duty, and a period for which a person is absent from a position of employment for the purpose of an examination to determine the fitness of the person to perform any such duty.

c. NEWBORNS' AND MOTHERS' HEALTH PROTECTION ACT OF 1996

Under this Plan, and as is required under federal and state law, when you or your Dependent enter the hospital to give birth, the Fund will provide Benefits for a hospital stay of at least 48 hours following birth if the birth is a normal vaginal delivery and for a hospital stay of at least 96 hours following birth if the birth is by caesarian section. You will still be responsible for any deductibles or copayments required under the Plan.

The Fund may provide Benefits for a shorter stay if your attending provider, in consultation with you, decides to discharge you earlier than 48 (or 96) hours after you give birth. You may, of course, elect to leave the hospital earlier than 48 or 96 hours after birth.

The Fund (and the Benefit Managers): (i) cannot deny you or your child Eligibility to enroll or to continue Fund coverage to avoid paying for the hospital stays described above; (ii) cannot give you or your attending provider any financial or other incentives to encourage you to accept a shorter stay in the hospital than the stays described above; (iii) cannot limit the amount it pays your attending provider because the attending provider determines that you should be in the hospital for 48 or 96 hour periods described above; and (iv) cannot pay

lesser benefits for the 48 or 96 hour hospital stay for the period after birth than it pays for any hospital stay you have prior to the birth.

d. MENTAL HEALTH PARITY ACT OF 1996

The Mental Health Parity Act of 1996 ("MHPA") generally requires that annual or lifetime dollar limits on mental health benefits be no lower than any such dollar limits for medical and surgical benefits offered by a group health plan or health insurance issuer offering coverage in connection with a group health plan. MHPA also provides that employers and funds retain discretion regarding the extent and scope of mental health benefits offered to employees and their dependents (including cost sharing, limits on numbers of visits or days of coverage, and requirements related to medical necessity).

e. MENTAL HEALTH/SUBSTANCE USE DISORDER PARITY

The Mental Health Parity and Addiction Equity Act of 2008 requires benefits for mental health conditions and substance use disorder conditions to be treated in the same manner and provided at the same level as Services for the treatment of any other sickness or injury. This means that the coinsurance and copayment requirements for mental health and substance use disorder conditions musts be no more restrictive than the predominant coinsurance and copayment requirements for substantially all medical/surgical benefits. This means:

i. Specialist copayments (if applicable) will no longer apply to office visits associated with mental health/substance use disorder Services. Instead, the physician office visit copayment will apply to such office visits.

ii. Prior exclusions for mental health conditions, neurobiological disorders (autism spectrum disorders) and substance use disorders that were specific to these conditions, but were not applicable to other sickness or medical conditions, do not apply.

iii. Prior authorization requirements or pre-Service notifications for mental health conditions, neurobiological disorders (autism spectrum disorders) and substance use disorders that were specific to these conditions, but were not applicable to comparable sickness or medical benefits, do not apply.

f. WOMEN'S HEALTH AND CANCER RIGHTS ACT OF 1998

If you have had or are going to have a mastectomy, you may be entitled to certain benefits under the Women's Health and Cancer Rights Act of 1998 ("WHCRA.") For individuals receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending physician and the patient, for:

- All stages of reconstruction of the breast on which the mastectomy was performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance;
- Prostheses; and
- Treatment of physical complications of the mastectomy, including lymphedemas.

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under the Plan. For details on the deductibles and coinsurance amounts applicable to these Benefits, please read the individual benefits summaries, booklets, certificates of coverage and Benefit Manager network information which you received as separate documents and which are part of this Plan/SPD.

If you would like more information on WHCRA benefits, please contact the Benefits Administrator.

g. QUALIFIED MEDICAL CHILD SUPPORT ORDERS: The Fund will provide this coverage in accordance with the provisions of any Qualified Medical Child Support Order ("QMCSO"). A QMCSO is a court or administrative order which creates or recognizes a child's right to receive coverage as a Dependent of a Participant from the Fund. The order is made under state domestic relations law or the medical child support law enacted under the Social Security Act. The order is generally obtained by a custodial parent in connection with a divorce or separation. In order for the Plan to recognize a QMCSO, the order must specifically identify the name of this Fund and must contain the following information:

- the name and last-known mailing address (if any) of the Participant and each child covered by the order;
- a reasonable description of the type of benefit coverage to be provided by the Plan, or the manner on which such coverage is to be determined; and
- the time period to which such order applies.

The order, however, cannot require the Fund to provide any type or form of benefit coverage, or any option for benefit coverage, not otherwise available under the Plan for Dependents of the Participant, or to provide increased benefits of any type.

Within 20 business days of the Fund's receipt of an order, which must be submitted through the Benefits Administrator, the Fund will notify the Participant, each child covered by the order and the child's (or children's) parent or legal guardian of such order and of the Fund's procedure for determining the qualified status of such orders. Within 30 business days after such notice, the Board will determine whether such order is a QMCSO and will notify the Participant, each child covered by the order and the child's (or children's) parent or legal guardian of such determination. The Fund may take up to 60 additional business days if the interested parties make comments with respect to the qualification of the order or if unusual circumstances are presented. Each child (or children) covered under the order may designate a representative to receive notices on his, her or their behalf.

If the Fund determines that an order is not a QMCSO, this decision may be appealed under the Fund's claims review procedure as described in this summary. If the Fund determines that the order is a QMCSO, the child (or children) will be enrolled in the benefits described in the order. All orders, and interested parties with respect to these orders, are bound by the rules and regulations of the Fund.

h. Continuation Coverage, or "COBRA"

If you lose coverage for health benefits under this Plan, you may be eligible to continue your health benefits coverage by purchasing "COBRA" continuation coverage. This coverage is described in detail below. You may also have other health coverage alternatives that may be available to you through the Health Insurance Marketplace at www.HealthCare.gov or call 1-800-318-2596. You may be able to get coverage through the Health Insurance Marketplace that costs less than COBRA continuation coverage.

Your health benefits coverage from the Fund may be terminated because you have experienced a "qualifying event." This term is described below. "Qualified Beneficiaries" have the legal right to continue group health care coverage, generally known as "COBRA Continuation Coverage," for a period of time even after a qualifying event. Under the law, a qualified beneficiary is any employee, his or her spouse or dependent who was covered by the Plan when a qualifying event occurs, and who is therefore entitled to elect COBRA Continuation Coverage. A child who becomes a dependent child by birth, adoption or placement for adoption with the covered employee during a period of COBRA Continuation Coverage is also a qualified beneficiary. A person who becomes the new spouse of an employee during a period of COBRA Continuation Coverage is not a qualified beneficiary

Each individual covered by the Plan will have the right to make his or her own decision about continuation coverage. For purposes of the section on COBRA Continuation, health coverage means medical, dental, vision and prescription drug coverage. The Plan offers the following COBRA benefit packages: (1) All benefits – medical, prescription, dental and vision, (2) medical, prescription and dental, (3) medical and prescription, or (4) dental only.

QUALIFYING EVENTS:

Qualified beneficiaries are entitled to COBRA Continuation Coverage when qualifying events (which are specified in the law and described below) occur, and as a result of the qualifying event, coverage of that qualified beneficiary ends. A qualifying event triggers the opportunity to elect COBRA when the covered individual LOSES health care coverage under this Plan. If a covered individual has a qualifying event but does not lose their health care coverage under this Plan, (e.g. employee continues working even though entitled to Medicare) then COBRA is not yet offered:

<u>Events that Apply to Employee</u>

- you no longer work for the Employer; or
- your working hours are reduced so that you no longer meet the eligibility requirements for coverage.

<u>Events that Apply to Spouses:</u>

- your Employee Spouse stopped working for an Employer that contributes to the Fund, or your Employee Spouse's hours were reduced causing loss of coverage, or your benefits were terminated after your Spouse's grievance arbitration was resolved and

your Employee Spouse was not reinstated provided that not more than 18 months has passed since his or her termination and he or she has not been reinstated, or

- your Employee Spouse dies, or becomes covered by Medicare, or
- you are divorced from your Spouse.

Events that Apply to Dependent Children

(Dependents include Dependent Children. NOTE: The definition of Dependent includes any newborn child or child adopted or placed with you for adoption if you have notified the Fund within thirty (30) days of the birth, adoption or placement for adoption.)

- your parent ceases to be employed by an Employer that participates in the Fund
- your parent's hours are reduced causing loss of coverage, or your benefits were terminated after your parent's grievance arbitration was resolved and your parent was not reinstated,
- your parent is divorced from the parent who is employed by an Employer that participates in the Fund, or
- you cease to be a "Dependent" under the terms of the group health plan.

TYPE OF COVERAGE

Generally, you can elect to receive the same type of coverage you had immediately prior to the qualifying event. However, you also may change coverage CATEGORY – for example, from Family Coverage to Single Coverage, by contacting the Benefit Administrator. In addition, your benefits will change if the benefits change. The Plan offers the following COBRA benefit packages: (1) All benefits – medical, prescription, dental and vision, (2) medical, prescription and dental, (3) medical and prescription, or (4) dental only.

Maximum Coverage Period

You may elect to continue coverage up to a maximum period as follows:

- Up to 18 months from the date coverage is lost in the event of the Employee's termination of employment or a reduction in working hours provided you were not reinstated during that time, unless (2) applies; or

- Up to 29 months if the employee is found by the Social Security Administration to have been disabled within sixty (60) days of the date he or she terminated employment, but only if the disabled person notifies the Benefits Administrator of the determination within 60 days after he or she receives it and before the end of the 18 month coverage period in (1); or

- Up to 36 months in all other cases. If you have elected continuation coverage following a

termination of employment, reduction in hours, or resolution of grievance arbitration, and a second qualifying event occurs, your total period of continuation coverage may last up to 36 months from the date coverage would have been lost on account of the employee's termination of employment or reduction in hours.

NOTE: COBRA Continuation Coverage begins on the date you otherwise would lose your health coverage.

COST OF COBRA CONTINUATION COVERAGE:

If you elect COBRA Continuation Coverage, you will be entitled to the same health coverage that you had when the event occurred that caused your health coverage under the Plan to end, but you must pay for it. If there is a change in the health coverage provided by the Plan to similarly situated active employees and their families, which same change will be made in your COBRA Continuation Coverage. The charge for the coverage is equal to the Fund's cost of providing group coverage plus two percent. The two percent charge covers a portion of the Fund's cost to provide you this coverage. If there is an increase or decrease in the Fund's cost, your future premiums will be adjusted accordingly.

NOTIFICATION REQUIREMENTS:

<u>You Must Notify the Fund:</u>

If you are divorced or become covered under Medicare, or one of your Children ceases to qualify as a Dependent under the Plan, or you experience a second qualifying event (as described later in this section) you must notify the Benefits Administrator in writing as soon as possible, but no later than 60 days from the later of: (1) the date of the qualifying event; or (2) the date you would lose coverage due to the qualifying event.

<u>The Fund Will Notify You</u>

The Benefits Administrator will notify you within fourteen (14) days of the date you advise us of one of the above events or of the date your Employer advises us of your termination of employment for any reason as well as death or entitlement to Medicare or of your reduction in hours.

ELECTION OF CONTINUATION COVERAGE:

You will have at least sixty (60) days in which to elect continuation coverage. This election period will end on the later of (1) 60 days from the date you would otherwise lose coverage (except for making a COBRA election) or (2) 60 days from the date the Benefit Administrator mails you a notice of your rights to continuation coverage and provides you with an election form.

<u>NOTE:</u> If you incur covered expenses during the election period before you have made an election, your claims will not be processed until the Benefits Administrator receives your election forms and payment of your first premium.

IMPORTANT NOTE: IF YOU AND/OR ANY OF YOUR DEPENDENTS DO NOT CHOOSE COBRA COVERAGE WITHIN 60 DAYS AFTER THE QUALIFYING EVENT (OR, IF LATER, WITHIN 60 DAYS AFTER RECEIVING THAT NOTICE), YOU AND/OR THEY WILL NOT HAVE ANY GROUP HEALTH COVERAGE FROM THIS PLAN AFTER COVERAGE ENDS.

Grace Periods

Once you elect COBRA, the initial payment for the COBRA Continuation Coverage is due to the Benefits Administrator 45 days after COBRA Continuation Coverage is elected. At that time, payment must be made for the full period **back** to the initial period of eligibility. If this payment is not made when due, COBRA Continuation Coverage will not take effect. Under this Plan, after the initial COBRA payment, monthly payments are due on the 25th day of the month for coverage in the next month but you will have a 30 day grace period to pay the monthly premiums. If payments are not made within the time indicated in this paragraph, COBRA Continuation Coverage will be canceled as of the due date. Payment is considered made when it is postmarked.

Special Enrollment Rights

If you elect COBRA, you have the same special and open enrollment rights as an active Participant. The special enrollment rights under federal law also allows you to request special enrollment under another group health plan for which you are otherwise eligible (such as a plan sponsored by your Spouse's employer) within 30 days after your group health coverage ends because of the qualifying events listed in this section. The special enrollment right is also available to you if you continue COBRA for the maximum time available to you.

Notice of Unavailability of COBRA Coverage

If the Fund is notified of a qualifying event but the Benefits Administrator determines that an individual is not entitled to the requested COBRA coverage, the individual will be sent an explanation indicating why COBRA coverage is not available. This notice of the unavailability of COBRA coverage will be sent according to the same timeframe as a COBRA election notice.

Extended COBRA Continuation Coverage When a Second Qualifying Event Occurs During an 18-Month COBRA Continuation Period

If, during an 18-month period of COBRA Continuation Coverage resulting from loss of coverage because of your termination of employment or reduction in hours, you die, become divorced, become entitled to Medicare, or if a Child ceases to be a Dependent Child under the Plan, the maximum COBRA Continuation period for the affected Spouse and/or Child is extended to 36 months from the date of your termination of employment or reduction in hours (or the date you first became entitled to Medicare, if that is earlier, as described below).

Notifying the Plan: To extend COBRA when a second qualifying event occurs, you must notify the Benefits Administrator in writing within 60 days of a second qualifying event.

Failure to notify the Plan in a timely fashion may jeopardize an individual's rights to extended COBRA coverage.

This extended period of COBRA Continuation Coverage is not available to anyone who became your Spouse after the termination of employment or reduction in hours. However, this extended period of COBRA Continuation Coverage is available to any Child(ren) born to, adopted by or placed for adoption with you during the 18-month period of COBRA Continuation Coverage.

In no case is an employee whose employment terminated or who had a reduction in hours entitled to COBRA Continuation Coverage for more than a total of 18 months (unless the employee is entitled to an additional period of up to 11 months of COBRA Continuation Coverage on account of disability as described in the following section). As a result, if an employee experiences a reduction in hours followed by termination of employment, the termination of employment is not treated as a second qualifying event and COBRA may not be extended beyond 18 months from the initial qualifying event.

Extended COBRA Continuation Coverage in Certain Cases of Disability during an 18-Month COBRA Continuation Period

If, at any time during or before the first 60 days of an 18-month period of COBRA Continuation Coverage, the Social Security Administration makes a formal determination that you or a covered Spouse or Dependent Child become totally and permanently disabled so as to be entitled to Social Security Disability Income benefits, the disabled person and any covered Family Participants who so choose, may be entitled to keep the COBRA Continuation Coverage for up to 29 months (instead of 18 months) or until the disabled person becomes entitled to Medicare (whichever is sooner).

This extension is available only if: (a) the Social Security Administration determines that the individual's disability began no later than 60 days after the termination of employment or reduction in hours; and (b) you or another Family Participant must notify the Plan by sending a **written** notification to the Fund Office of the Social Security Administration determination within 60 days after that determination was received by you or another covered Family Participant (failure to timely notify the Plan may jeopardize an individual's rights to extended COBRA coverage); and that notice is received by the Fund Office before the end of the 18-month COBRA Continuation period. The cost of COBRA Continuation Coverage during the additional 11-month period of COBRA Continuation Coverage 18-month period of COBRA Continuation Coverage is extended because of disability, the Plan may add an additional 50% applicable to the COBRA Family unit (but only if the disabled person is covered) during the 11-month additional COBRA period. The Fund Office must also be notified within 30 days of the determination by the Social Security Administration that you are no longer disabled.

TERMINATION OF COBRA COVERAGE:
Your continuation coverage will end when one of the following occurs:

- the last day of the 18, 29 or 36 month period described above.
- you fail to pay the premium for your continuation coverage when it is due. However,

there is a thirty (30) day grace period before we will actually cut off coverage for failing to pay your premium.

- the date after you elect COBRA on which you first become covered under another group health plan.
- the date after you elect COBRA on which you first become covered by Medicare.

Conversion rights may be available under the insured portions of this Plan. You will be notified by the applicable insurer when your coverage ends.

COORDINATION WITH SUBSIDIZED COVERAGE

If there is a qualifying event but you are Eligible for subsidized coverage offered by the Employer, your COBRA continuation coverage may run concurrently with some portion of the subsidized coverage, pursuant to the terms of the collective bargaining agreement. If so, you will need to timely elect COBRA coverage at the time you are first offered subsidized coverage and thereafter timely remit the applicable premium on a monthly basis. If you are eligible for subsidized coverage that does not run concurrently with COBRA coverage, you will need to timely elect COBRA coverage when your subsidized coverage terminates.

SECTION 4: CONTRIBUTIONS

Your Employer makes Contributions to the Fund on your behalf to pay for Benefits. The Employer Contributions are determined in accordance with the terms of a collective bargaining agreement between your Employer and the Union.

In addition to your Employer's contributions to the Plan, if you elect coverage from the Fund, you are required to contribute a specified dollar amount based on whether your coverage is single, two persons, or three persons or more and whether or not you elect medical and/or dental coverage. These Contributions can be made through payroll deduction on a pre-tax basis. Contact your Benefits Administrator for current weekly deduction amounts. IMPORTANT NOTE: If you are on an unpaid leave for any reason, you are responsible to contact the Benefits Administrator to make arrangements for payment of your employee contributions, post-tax, directly to the Benefits Administrator.

Employees who agree to a Separation Package are also required to contribute a specified dollar amount based on whether your coverage is single, two persons, or three persons or more and whether or not you elect medical and/or dental coverage. These Contributions can be made post-tax directly to the Benefits Administrator.

SECTION 5: BENEFITS DESCRIPTIONS

Accompanying this SPD are booklets from the Benefits Managers describing the medical, dental and vision coverage provided through the Fund. Except for vision coverage, these benefits are provided on a self-insured basis. The Trustees have engaged Benefit Managers to administer these benefits for the Fund. You should refer to the booklets from these Benefit Managers for detailed information regarding these Benefits. Also, each year you will receive a “Summary of Benefit Coverage,” an overview of your benefits as required by the Affordable Care Act.

SECTION 6: CLAIMS PROCEDURES

Filing Claims. Most providers will submit claims for your treatment directly to the Benefits Manager. If you are responsible for submitting a claim, you may do so as described below

Please note: the Trustees have delegated to these Benefit Managers the authority to act as a "named fiduciary" of the Fund to review and determine your initial claim for Benefits and, in the event your initial claim is denied, your appeal of claims denials. You should refer to these Benefit Manager booklets for more information. Outlined below are the general rules regarding how a Benefit Manager should treat your initial claim submission and your appeal.

For Horizon Blue Cross/Blue Shield of NJ, the address for filing appeals is:
Horizon BCBS of NJ
P.O. Box 1219
Newark, NJ 07101

For UCCI, the address for filing appeals is:
UCCI, Appeals Dept.
P.O. Box 69420
Harrisburg, PA 17106.

Any additional information, call the customer service number on the back of your card.

For ESI, the address for filing appeals is:
Administrative – 1st Level Appeals

Mail to:	EXPRESS SCRIPTS
Address:	P.O. Box 66587
City, State, Zip:	St. Louis, MO 63166-6587
Attn:	Administrative Appeals Department
Tel. No:	1-800-946-3979

Clinical – 1st Level Appeals

Mail to:	EXPRESS SCRIPTS
Address:	P.O. Box 66588
City, State, Zip:	St. Louis, MO 63166-6588
Attn:	Clinical Appeals Department
Tel. No:	1-800-753-2851

For VBA, the address for filing appeals is:
Vision Benefits of America
Attn: Appeal/Grievance Coordinator
300 Weyman Road, Suite 400
Pittsburgh, PA 15236

Claims Submission Procedure to the Plan

Claims will generally be submitted for you by the Benefit Manager, regardless of whether it is for a Provider in the Benefit Manager's network. All claims for payment of Benefits from the Plan must be submitted within one year from the date the service was rendered, or the onset of disability, or they will not be processed.

SECTION 7: OTHER CLAIM INFORMATION

Q. I have a complex health condition and need my wife or personal representative to help me work through the claims. Can the Plan accommodate this?

A. Yes. You may designate an "authorized representative" to act on your behalf with respect to processing claims or appealing the denial of a claim. Please contact the applicable Claim Manager or the Benefits Administrator for the appropriate form designating your authorized representative. After you have properly designated an "authorized representative," the Benefit Manager or Benefits Administrator will communicate directly with your authorized representative unless you tell the Provider, Benefit Manager or Fund Office on your authorization form that you would like the Provider, Benefit Manager or Fund to continue to communicate directly with you. (If you have an "urgent care claim," the health professional with knowledge of your medical condition may act as your authorized representative without an executed authorization form from you.)

Q. How are claims categorized?

A. There are four types of claims:

- Post-Service Claim: If you have already received the Service, the claim is a "Post-Service" claim. Post-Service claims will likely be the majority of claims that you or your Providers or Benefit Managers submit.
- Concurrent Claims: Once you begin a course of treatment, your health professional may determine that you need additional Services. A claim for extended visits or care is called "concurrent claims."
- Pre-Service Claim: Certain Services and procedures require pre-authorization or precertification. These claims are called "pre-service" claims.
- Urgent care claim. The different types of claims, and the time limits for processing these claims, are described below.

As explained above, these claims should first be submitted to the appropriate Benefit Manager.

Q. What is an "urgent care" claim and how long does the Benefit Manager have to respond? Are there special rules that apply?

A. Urgent Care Claims: An urgent care claim is a claim for treatment that the treating physician believes must be provided immediately or the Patient's health or life could be jeopardized or the Patient will suffer severe pain that cannot otherwise be managed. Your claim must be certified as an "urgent care" claim by a physician.

If your claim includes all of the information the Claims Manager needs to process your claim, you will receive a response *as soon as possible* but no later than 72 hours after your request for review is received. If your claim does not include all of the information needed, you will be contacted within 24 hours and told what information you need to submit to support your claim. You will have up to 48 hours to submit the requested information. You will receive a response, including the reason for the decision as soon as possible but no later than 48 hours after you submit the required information or the expiration of the period you were given to provide additional information. The Benefit Manager may initially provide response orally, including by telephone, if the situation so warrants.

Q. What is a "concurrent care" claim and how long does a Benefit Manager have to respond? Are there special rules that apply?

A. Concurrent Care Claim: A concurrent care claim arises when a Benefit Manager has approved an ongoing course of treatment to be provided over a period of time or a number of treatments. For example, a concurrent care claim is one for additional visits to the physical therapist or for additional Hospital days for an already Hospitalized Patient. If the Benefit Manager determines that the course of treatment, the number of treatments or the amount of Service is going to be reduced or terminated, it must notify you sufficiently in advance of the reduction or termination to allow you to appeal and obtain a determination on review before the Benefits are reduced or terminated. If your concurrent care claim is for "urgent care" and you notify the Benefit Manager, at least 24 hours before the expiration of the period or number of treatments, the Benefit Manager will notify you within 24 hours of the receipt of your claim. If the request is made less than 24 hours prior to the end of the course of treatment, the Benefit Manager will notify you of its decision within 72 hours of receipt of the claim. If the concurrent care claim is not an urgent care claim, the Benefit Manager will treat it as a pre-Service claim or post-Service claim and will process it according to the applicable deadlines described below.

Q. What is a "pre-service" claim and how long does the Benefit Manager have to respond? Are there special rules that apply?

A. A pre-Service claim must be submitted when the Claim Manager requires advance approval or certification prior to receiving Services. In many instances, pre-Service claims may be submitted directly by the Provider. The Benefit Manager will provide a response not later than fifteen (15) days after it receives your request, unless it cannot respond because you (or your Provider) have not submitted all of the information it needs to process the claim or for other reasons beyond its control. If the delay is caused by circumstances beyond its control, the Benefit Manager shall notify you in advance of the expiration of the first 15 day period that an additional fifteen (15) days are required. If you (or your Provider) have not submitted the information needed to process your claim, the Benefit Manager will inform you of the specific information needed to process your claim. At that point, consideration of your claim will be suspended. You will have forty five (45) days to submit this information. After you submit the required information, your claim will be processed during the balance of time remaining before consideration of your claim was suspended.

Q. What is a "post-Service" claim and how long does the Benefit Manager have to respond? Are there special rules that apply?

A. Post-Service Care Claim: A post-Service claim is a claim for Benefits for Services that you have already received. In many instances, post-Service claims may be submitted directly by the Provider to the Benefit Manager. The Benefit Manager will provide a response not later than thirty (30) days after it receives your request, unless it cannot because you (or your Provider) have not submitted all of the information it needs to process the claim or for other reasons beyond its control. If the delay is caused by circumstances beyond the control of the Benefit Manager you will be notified in advance of the expiration of the first thirty (30) day period that an additional fifteen (15) days are required. If you or your Provider has not submitted the information needed to process your claim, the Benefit Manager will inform you of the specific information needed to process your claim. At that point, consideration of your claim will be suspended. You will have forty five (45) days to submit this information. After you submit the required information, consideration of your claim will resume and it will be processed within the balance of time remaining before consideration of your claim was suspended

Q. Where do I submit my claim for processing?

A. If you use a Network Provider, the claim will be submitted by the Provider directly to the Benefit Manager. In most instances, non-Network Providers will also submit the claim directly to the appropriate Benefit Manager. If you use a non-Network Provider, you or your Provider may need to submit your claim directly to the Benefit Manager.

Q. What information will the Benefits Manager provide to me if my claim is denied?

A. If your claim is denied, you will receive a written notice that will include the following information. In the case of an urgent claim, the information may initially be provided orally but will be followed with written confirmation no later than three days after the original decision is rendered. The information will include:

i. The specific reasons for the denial (for example, you were not Eligible for Benefits at the time you applied for Benefits);

ii. The specific Plan provisions under which your claim was denied;

iii. If an internal rule, guideline or protocol was relied upon to make the decision, you will be provided with the rule, guideline or protocol itself or an explanation that the rule, guideline or protocol was relied on and that a copy will be available to you at no charge upon your request;

iv. If the decision turned on Medical Necessity or whether a treatment was Experimental, you will be provided with either an explanation of the scientific or clinical judgment for the decision, applying this to your situation, or a statement that it will be provided to you free of charge upon request;

v. A description and explanation of the information you must submit in order to perfect your claim;

vi. A description of the procedures you must follow to appeal the denial of your claim to the Benefit Manager.

Q. What can I do if I disagree with the Benefit Manager's decision on a claim?

A. Appeal of the Denial of Your Claim. If you are dissatisfied with the denial of your claim, or of a portion of your claim, you may appeal to the Benefit Manager for further review. You must submit your written request for review no later than 180 days after the denial or partial denial of your claim. Your request for review must include the reasons for your request for review. If you fail to appeal your claim, you waive your right to dispute the Provider or Benefit Manager's determination on this claim. Please see the Benefit Manager's booklet or materials for instructions on how to submit the appeal of a claim denial.

Note: Appeal of the denial of an urgent care claim may initially be submitted by telephone.

Q. Will my coverage under the Plan continue while my appeal is pending?

A. Your coverage from the Fund will continue pending the outcome of an appeal, provided that you otherwise remain Eligible for coverage (for example, you continue to be an Eligible Employee). However, if your appeal is regarding the Fund's Trustees' decision to rescind coverage, your coverage will not continue coverage during the pendency of that appeal.

Q. What are my rights on appeal?

A. Your rights when you request a review of the denial of a claim:

i. Your claim will be considered by the Benefit Manager by individuals different from those who handled the initial claim. These individuals will not defer to the original decision of the Benefit Manager staff who originally denied your claim.

ii. In support of your request for review, you are permitted to submit written comments, documents, records and other information relevant to your request for review. The Benefit Manager will review this information in making a determination about your request for review.

iii. At your request and free of charge, you will be provided reasonable access to and copies of all documents, records and other information relevant to the claim for Benefits;

iv. If consideration of your request for review requires that the Benefit Manager make a medical judgment (for example, if the Benefit Manager must consider whether the prescription drug was Medically Necessary or Experimental), it shall consult with an appropriate health care professional. If the Benefit Manager consults medical experts with respect to your request for review, it will provide for the identification of these experts. The medical expert consulted by the Benefit Manager on appeal shall be different from any medical professional consulted with respect to the original claim for Benefits.

Q. If the Benefit Manager on Appeal denies my claim, what information will be provided to me?

A. If your appeal of the claim is denied, the Benefit Manager will provide you with the following information:

i. The specific reasons for the determination;
ii. The Plan provisions which were relied on in making the determination;
iii. A statement that you are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records and other information relevant to your claim for Benefits;
iv. If an internal rule, guideline or protocol was relied upon to make the decision, the Benefit Manager will provide either the rule, guideline or protocol itself or an explanation that the rule, guideline or protocol was relied on and that a copy will be available to you at no charge upon your request;
v. If the decision turned on Medical Necessity or whether a treatment was Experimental, the Benefit Manager will provide either an explanation of the scientific or clinical judgment for the decision, applying this to your situation, or will provide the explanation to you free of charge upon request;

   You and your plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor Office;

vi. You have the right to bring an action against the Fund under Section 502(a) of the Employee Retirement Income Security Act of 1974, as amended, after you have exhausted all levels of appeal required under this claim procedure.

Q. When Will I Receive a Decision on Appeal?

A. It depends on the type of claim:

i. Urgent Care Claims: The Benefit Manager will provide a response no later than seventy two (72) hours after it receives your appeal of the denial of a claim.

ii. Pre-Service Claims: The Benefit Manager will provide a response no later than thirty (30) days after it receives your appeal of the denial of a claim.

iii. Post-Service Claims: The provider or Benefit Manager must respond no more than thirty (30) days after it receives your request for appeal.

Q. What happens if a Benefit Manager fails to make a decision within the time deadlines for my type of claim?

A. If the Benefit Manager fails to act within the time lines set forth above or fails to provide you with the information described above, your request for review is deemed denied. This means that you will be considered to have exhausted the Fund and Benefit Manager's appeals procedures and may proceed to take action against the Fund in federal district court, should you so choose.

Q. May I also ask the Trustees to review the Benefit Manager's denial of my claim?

A. Yes. For the denial of any claim not addressable by one of the above Benefit Manager, you may ask the Trustees for additional review. If you are not satisfied with the response of a Benefit Manager after you have exhausted the claims and appeals procedures outlined by the applicable Benefit Manager, you may submit your dispute to the Trustees for their consideration. However, the Trustees retain the discretion to consider any appeal or, alternatively, to rely on the determination of the Benefit Manager.

NOTE: Although you may appeal the final decision of the Benefit Manager to the Trustees, such a step is entirely voluntary and will not preclude you from taking action against the Fund pursuant to your rights under ERISA, and will not extend any deadlines for filing action against the Fund and/or the Benefit Manager as set forth in this SPD or in the booklets or materials of the Benefit Manager.

SECTION 8: TERMINATION AND AMENDMENT

The Trustees intended to provide only the Benefits described in this summary. It does not provide any form of deferred compensation, nor does it create any vested rights.

The Trustees expect to continue this Fund indefinitely. However, the Trustees reserve the right to right to amend, change, modify, or terminate the Benefits provided hereunder, in whole or in part at any time, or to amend, change, implement, modify, suspend or terminate any Benefit or Contribution requirement by Participants for Benefits under the Plan at any time. In addition, Merck and the Union reserve the right to terminate the Fund at any time through a written resolution unanimously adopted by both the Company and the Union and giving written notice of the termination to the Trustees. Furthermore, this Trust may also automatically terminate if the Company (1) is legally dissolved; (2) makes a general assignment for the Benefit of its creditors; (3) files for liquidation under the Bankruptcy Code; (4) merges or consolidates with any other entity and it is not the surviving entity, or if it sells or transfers substantially all of its assets, or goes out of business, unless the Company's successor in interest agrees to assume the liabilities under the related Plan as to the Participants and Dependents. The termination shall be effective on the date the notice is mailed.

SECTION 9: ASSIGNMENT OF BENEFITS

You cannot assign, sell or pledge your benefits from the Fund to another person, or use them as security for a loan. We will not pay benefits to anyone other than you or your Dependents.

Several exceptions, however, may apply. For some benefits, such as medical Benefits, it is customary for your Provider to accept an assignment of Benefit. In that case, payments will be made on your behalf directly to that Provider. Also, a court order (such as a Qualified Medical Child Support Order (QMCSO), which is described in this Summary) may provide that Benefits to be paid directly to someone other than a Participant or Dependent. The Fund must honor those court orders. Finally, the Fund may make deductions from Benefits to recover previous overpayments or to coordinate benefits with other plans.

SECTION 10: COORDINATION OF BENEFITS

The Fund coordinates the medical benefits available under the Plan with comparable benefits that a Participant or his or her Dependents may have under other insurance. In no event will payment from the Fund exceed one hundred percent (100%) of the amount payable under the Plan. If the Fund's Benefits are secondary, the maximum benefit payable will be the maximum amount payable by the primary carrier or the Participant's liability, whichever is less.

A. In General. The Fund coordinates the Benefits available under the Plan with comparable benefits that you or your Dependents may have under Other Insurance. This includes private insurance as well as Medicare, Medicaid or other governmental benefits. The Fund will pay Benefits in accordance with the Medicare Secondary Payor statute and other applicable laws. In addition, this Section describes how the Fund will coordinate out of pocket costs with Other Insurance. If your Spouse or Dependent is covered under a high-deductible health plan with a “health savings account” (“HSA”), this Spouse or Dependent may not be covered under another health plan like the Fund and, therefore, the Fund cannot coordinate with such plan.

B. Key Terms: The key terms in this Section are “Primary Plan” and “Secondary” or “Other” Insurance. When this Fund is the “Primary Plan,” the Fund will pay on your claims first and then any remaining balance can be paid by the “Secondary” or “Other” Insurance. NOTE: In no event will payment from the Fund, when combined with benefits available under Other Insurance, exceed 100% of the amount payable under the Plan, regardless of whether this Fund is Primary or Secondary.

C. Medicare and Other Insurance Available Under a Government Program. In all cases involving the Coordination of Benefits, Medicare and Other Insurance available under any government program will be the Primary Plan or Primary insurer to the greatest extent permitted by law.

D. Primary Plan Determination Rules. In determining whether Other Insurance is the Primary Plan, the Fund will apply the following rules:

   i. The Other Insurance will be the Primary Plan when it is the Primary Plan under the terms of that plan or if that plan does not include provisions for the coordination or non-duplication of benefits.

ii. The plan that covers an individual as an employee will be the Primary Plan; the plan that covers an individual as a dependent may be Secondary (depending on the Coordination of Benefits rules).

iii. If your Dependent Child is covered under the plans of two parents, the Primary Plan will be the coverage of the person whose birthday occurs first in a calendar year; except that, if the other plan does not have this rule, its alternate rule will govern; and in the case of a Dependent child of divorced or separated parents, the rules in the next subsection will apply.

iv. Unless there is a valid Qualified Medical Child Support court decree stating otherwise, plans covering a Dependent child shall determine the order of benefits as follows:

a. For a Dependent child whose parents are married or are living together, whether or not they have ever been married:

i. The plan of the parent whose birthday falls earlier in the calendar year is the Primary Plan; or

ii. If both parents have the same birthday, the plan that has covered the parent longest is the Primary Plan.

b. For a Dependent child whose parents are divorced or separated or are not living together, whether or not they have ever been married:

i. If a court decree states that one of the parents is responsible for the Dependent Child's health care expenses or health care coverage and the plan of that parent has actual knowledge of those terms, that plan is the Primary Plan. If the parent with responsibility has no health care coverage for the Dependent Child's health care expenses, but that parent's spouse does, that parent's spouse's plan is the Primary Plan;

ii. If a court decree states that both parents are responsible for the Dependent Child's health care expenses or health care coverage, the provisions of Subparagraph (a) of this paragraph shall determine the order of benefits;

iii. If a court decree states that the parents have joint custody without specifying that one parent has responsibility for the health care expenses or health care coverage of the Dependent Child, the provisions of Subparagraph (a) of this paragraph shall determine the order of benefits; or

iv. If there is no court decree allocating responsibility for the Child's health care expenses or health care coverage, the order of benefits for the child are as follows:

a. The plan covering the custodial parent;
b. The plan covering the custodial parent's spouse;

c. The plan covering the non-custodial parent; and then
d. The plan covering the non-custodial parent's spouse.

b. Adult Dependent Child: In the case of an adult Dependent Child who is not the subject of any court order regarding the provision of health insurance coverage, and considering not only the plan of a non-Participant parent but also the plan of the Dependent's spouse, the plan that has covered the Dependent Child for the longest period shall be the Primary Coverage.

c. Coordination of "Out of Pocket" costs: The Fund limits out of pocket costs to the statutory maximum. Effective January 2015, this amount is equal to the deductible permissible under the applicable provisions of the Internal Revenue Code for "high deductible health plans." The Fund will coordinate the "out of pocket" maximum expenditures with Other Coverage. The Fund will remit to the individual a refund of the amount that exceeds the out-of-pocket maximum only if you are actually left with an unpaid balance after the benefits are coordinated with available Other Coverage.

E. Other COB Rules.

i. Automobile Insurance. In all cases, this Fund is Secondary to any automobile insurance. In addition, this Fund will not pay any Benefits until the automobile insurance has paid its full policy limit. If you are required by applicable state law to carry at least a minimum level of insurance but failed to do so, the Fund will pay Benefits as if it is paying Secondary to such coverage.

ii. Supplemental Insurance Policies. If you or a Dependent purchase supplemental insurance (for example, for motorcycle accidents), this Fund shall be Primary as compared to the supplemental insurance. "Supplemental medical coverage" is coverage that can be purchased under a motorcycle or automobile policy but only provides medical insurance coverage and only to the person who is driver and his passengers. This coverage is secondary to any medical coverage provided by the Fund. "Supplemental medical coverage" must be distinguished from "Uninsured bodily injury coverage," which is broader liability coverage that covers medical claims as well as pain and suffering claims. "Uninsured bodily injury coverage" will be treated as Primary coverage and the Fund's coverage as Secondary Coverage.

iii. Special Rule for Former Employee. If you were previously covered under this Fund as an Employee and remain Eligible for Benefits from this Fund but become eligible for Other Insurance through a new employer, the other Insurance will be Primary.

iv. Coordination with Medicare. Provided that all payments are made in accordance with applicable Medicare Secondary Payer rules, in any case in which the Fund is properly Secondary to Medicare, the Fund will pay Benefits for you or your Dependent only as Secondary payer of Benefits, without regard to whether you or Dependent submit the claim to Medicare for payment as the Primary payer.

a. In any case in which the Fund is Secondary to Other Insurance (other than Medicare, to the extent the Plan is required to pay as Primary) pursuant to the Plan's coordination of benefits rules, the Fund will pay Benefits for you or Dependent only as the Secondary payer of Benefits.

b. Coordination of Determinations of Medical Necessity. In the case where this Fund is Secondary to Other Insurance, and the Other Insurance has denied a claim on the ground that the Service is not Medically Necessary as defined under that Other Insurance, you or your Dependent must first exhaust the administrative remedies available under that Other Insurance before submitting the claim to this Fund to pay as the Secondary Payor. If you or your Dependent exhausts the administrative remedies of the Other Insurance, the Fund will evaluate the claim by applying this Fund's Medical Necessity criteria.

c. Under no circumstances will the Plan pay any benefits as primary plan when a Participant or a Dependent has elected to make the Plan the primary plan by paying a reduced premium to his motor vehicle insurance carrier. Where an injury is caused by an accident for which the individual is required by state law to carry automobile insurance, the coverage under this Plan is secondary and the automobile insurance is responsible for paying the charges for that injury first.

NOTICE OF PRIVACY PRACTICES

We are providing this Notice in order to inform you about the way that your health information may be used by the Fund. A federal law, the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), provides your health information with important protection.

The Fund is required by federal law to maintain the privacy of your protected health information ("PHI"). The Fund is also required by federal law to provide you with this description of the privacy policies and practices adopted by the Fund. The Fund must follow these policies and practices, but as permitted by law, the Plan reserves the right to amend or modify these privacy policies and practices.

Changes in our policies and practices may be required by changes in federal and state laws and regulations. Regardless of the reason for the change, we will provide you with notice of any material changes within sixty (60) days of the date the change is adopted. The effective date of this notice is September 23, 2013.

Under HIPAA, how can the Fund use my protected health information ("PHI")? The Fund can use your PHI to facilitate your treatment, to make or obtain payment for your treatment and for health plan operations, including administration, oversight, and other legal purposes.

How may the Fund use my protected health information ("PHI") with respect to payment for my treatment? The Fund may use your PHI for the broad range of actions needed to make sure that the Fund can make payment for the Services you and your Family receive. The Fund may use your PHI for making payment to providers for Services or treatment you received, for making arrangements for payment through one of the networks of providers through which the Fund provides benefits to you, as well as for coordinating payment to providers though other health plans under the Fund's coordination of benefits rule. For example, the Fund provides Participants with

access to a network of providers outside this immediate geographic area. The Fund may provide your PHI to the network and directly to the provider in order to ensure that the provider receives the appropriate payment for the Services that have been provided to you.

How does HIPAA permit the Fund to use my protected health information ("PHI") with respect to "health care operations?" The Fund may use your PHI for a broad range of actions required to assess the quality of the Fund's plan of benefits as well as for its administration and operations. These activities include, but are not limited to, ensuring that Participants or their beneficiaries are Eligible for benefits prior to making payment; taking corrective action to recoup overpayments and assessing health plan performance; reviewing the Fund's plan of benefits and determining whether a reduction in costs is possible; continuing case management and coordination of care; commissioning and reviewing actuarial studies relating to the cost of benefits and management studies relating to the operation and administration of the plan; resolving internal grievances; and undertaking medical review, legal, and auditing functions. For example, the Fund may use PHI to determine the most cost-effective manner of providing vision benefits to its Participants and beneficiaries.

May the Fund use my protected health information ("PHI") for purposes besides payment and health care operations? Yes. HIPAA permits the Fund to use your PHI for a number of other purposes, including informing you of treatment alternatives or other health –related benefits that may be of interest to you.

Because my spouse takes care of the Family paperwork, my spouse often calls to find out the status of my health claims and to get other information about me or my benefits. Can the Fund release information relating to payment of my claims to my spouse? Unless you tell the Fund otherwise, the Fund will provide claims payment information to your spouse without requiring an authorization from you. If you do NOT wish the Fund to provide your spouse with this information, you must tell the Fund in writing that you do NOT wish the Fund to release claims payment information to your spouse.

NOTE: If you wish the Fund to release other information to your spouse, please file an authorization form with the Fund office. You can obtain release forms by calling the Fund office or visiting the Benefit Administrator's website at [www.rgabriel.com. Click on Client Resources. Click on USW].

May I call the Fund to get information about my children's health claims? The Fund will provide a minor child's parent, guardian (or person standing in loco parentis with respect to the child) with payment information about the child's claim. The Fund will carefully consider your written request for information other than claims payment information and will respond as permitted by these privacy policies and applicable state law. NOTE: If your child is not a minor, the Fund generally cannot provide you with the child's protected health information, even if the child is still covered under this Fund as your Dependent.

Does HIPAA permit the Fund to disclose my protected health information ("PHI") to my employer or insurer? Under HIPAA, the Fund generally cannot disclose your PHI to your employer without your written authorization. It is important to note, however, that HIPAA does permit the Fund to disclose your PHI without your authorization to workers' compensation insurers, state administrators, or others involved in the workers' compensation systems to the extent the disclosure is required by state or other law.

May the Fund release my protected health information ("PHI") to the Fund's plan sponsor? HIPAA does permit the Fund to disclose information to the "plan sponsor" for administrative functions. Here, the "plan sponsor" is the Fund's Board of Trustees. The Fund may provide summary health information to the plan sponsor so that the plan sponsor may solicit premium bids or modify, amend, or terminate the plan.

May the Fund release my protected health information ("PHI") to law enforcement or other governmental entities? Your PHI may be disclosed to law enforcement agencies, without your authorization or permission, to support government audits and inspections, to facilitate law-enforcement investigations, and to comply with government-mandated reporting. Note, however, that the Fund may not disclose your PHI if you are the subject of an investigation that does not arise out of or is directly related to your receipt of health care or public benefits. In addition, the Fund may disclose your PHI in the course of a judicial or administrative proceeding if the Fund receives a court order, subpoena, discovery request or other lawful process. Before releasing this information, the Fund will make reasonable efforts either to notify you or to obtain an order protecting your PHI.

Would the Fund release my protected health information ("PHI") if my health or safety or public health or safety would be jeopardized if it did not? If the Fund has a good faith belief that your health or safety or public health or safety would be jeopardized if it did not disclose the information, the Fund will do so, after consideration of appropriate legal and ethical standards.

Must the Fund have an authorization to release my protected health information ("PHI")? Yes. For example, the following uses and disclosures of your PHI will be made only with your written authorization:

- Uses and disclosures for marketing purposes;
- Uses and disclosures that constitute the sale of PHI; and
- Most uses and disclosures of psychotherapy notes (if the Fund maintains any psychotherapy notes).

Any other disclosure or use of your PHI for any other purpose not described in this notice requires your written authorization. This means that if you want your friend, relative, or union representative to check on the status of a claim you submitted or to advise when or if payment will be made, you must sign an authorization form and submit it to the Fund Office. If you change your mind after authorizing a use or disclosure of your PHI, you may submit a written revocation of the authorization. However, your decision to revoke the authorization will not affect or undo any use or disclosure of information that occurred before you provided written notice to the Fund of your decision to revoke the authorization.

May the Fund use or disclose my genetic information for underwriting purposes? No. The Fund is prohibited from using or disclosing genetic information for underwriting purposes.

Do I have any rights to information under the federal privacy standards? Your rights to information under HIPAA include:

- the right to request restrictions on the use and disclosure of your PHI. The Fund will carefully consider, although is not required to honor, your request for restrictions;

 the right to restrict confidential communications concerning your medical conditions or treatment if you believe that disclosure of this information could endanger you (this means, for example, that you can make a written request that the Fund send information about your medical treatment to a post office box or an address different from your home address in order to ensure that your PHI remains confidential). The Fund will attempt to honor reasonable requests;
 the right to opt out of receiving fundraising communications prepared the Fund;
 the right to inspect and copy your PHI. The Fund may charge a reasonable fee for copying, assembling and postage;
 the right to an electronic copy of electronic medical records. The Fund will make every effort to provide access to PHI in the form or format you request, if it is readily producible in such form or format;
 the right to get notice of a breach of any of your unsecured PHI;
 the right to amend or submit corrections to your PHI. If you believe that the information in your records is inaccurate or incomplete, you may submit a written request to correct these records. The Fund may deny your request if, for example, you do not include the reason you wish to correct your records or if the records were not created by the Fund;

 the right to receive an accounting of how and to whom your PHI has been disclosed if it was disclosed for reasons other than payment or health care operations. Your written request for information must be submitted to the Fund and should state the period of time for which you are requesting an accounting;
 the right to file a complaint, that your privacy rights have been violated, with the Fund and the Secretary of U.S. Department of Health & Human Services. NOTE: you will not be penalized or otherwise retaliated against for filing a complaint;
 the right to receive a printed copy of this notice. You can find this notice and authorization forms for release of PHI on the Fund's website at [www.usw-1086.org]. The link to the authorization form is available by clicking on the following link: [www.horizon-blue.com/usw1086].

Complaints? Comments? Requests? The Fund has designated Karen Irwin, RAE Consulting as the Privacy Officer. If you wish to request information which you have a right to receive, want to file a Complaint with the Fund or if you have any comments or questions regarding this notice, please contact Karen Irwin at 215-773-0900. Please note that the Fund can assess reasonable charges for copying and assembling documents you request as well as for postage.

SECTION 12: SUBROGATION

If you or a Dependent who is covered under this Fund become ill or injured as a result of a third party's actions, the Plan is given the broadest rights to recover any medical expenses paid on your behalf, including, but not limited to, reimbursement, subrogation, constructive trust and any other federal or state causes of action that may provide legal and/or equitable relief to the Plan, subject to any equitable principles or defenses that you raise and are cognizable under applicable federal law, except that the Trustees do not intend to be bound by any “common fund” or “make whole” defenses. Where this section refers to "you," it means both the Participant and the Dependent, regardless of whether the Participant is a party to any action against the third party. The Fund shall be entitled to be paid from the first dollars of recovery.

Generally, the Plan treats the third party as primarily liable for your medical expenses. However, the Plan will pay Benefits to you on the understanding that payment of these Benefits is expressly

and automatically conditioned on the Plan being reimbursed for these Benefits if there is any recovery from that third party (including any recovery from your automobile or Other Insurance carrier, for example, from an uninsured motorist rider on your automobile policy).

You and your attorney agree and are required, as a condition of the Fund providing any Benefits for you under this Plan, to hold money you receive in constructive trust for the Fund, regardless of whether you execute a subrogation agreement. You and your attorney may not disburse any recovery until you have resolved the Fund's lien. This means that you must treat the dollars you receive from the third party as if you are holding them to repay the Fund. Your attorney must place these funds in a restricted account and make payment to the Fund to ensure that the Fund is reasonably and equitably reimbursed for the monies it had paid on your behalf. If your Dependent is injured or becomes ill as a result of a third party's actions and this Fund pays benefits on the Dependent's behalf, both you, as the Participant, and the Dependent, are responsible for protecting the Fund's rights and interests, even if you are not a party to the action.

At the Plan's discretion, the Plan may choose to be subrogated to your rights against the third party, or to proceed with an action for reimbursement. If the Plan chooses to be subrogated, that means that it will take over your rights against the third party. If the Plan chooses to proceed with an action for reimbursement, it will look to the third party for repayment of expenses it paid on your behalf. The Plan also can proceed with an action against you if you receive money from the third party and do not take reasonable steps to reimburse the Plan. The Fund's subrogation rights extend to any excess coverage that the Participant or Dependents may have purchased on his own.

In addition to the above, the Plan may sue you, your attorney, or any other recipient of money from a third-party for imposition of a constructive trust or other legal and/or equitable remedy if you do not take reasonable steps to reimburse the Plan. Any reimbursement amounts which the Plan receives from a third party shall not be reduced by any attorney fees greater than 20%, unless the Plan has consented to a higher attorney fee in writing.

NOTE: You must not do anything that could interfere with the Plan's right to reimbursement from the third party. The Plan may ask you to assign to it your rights against that third party, or your recovery from that third party, to the extent of Benefits paid by the Plan. You must also contact the Plan before you settle the case without the prior written consent of the Plan. The Plan may request that you authorize the Plan to sue on your behalf. In addition, as noted above, you and your attorney agree and are required, as a condition of the Fund providing any Benefits for you under this Plan, to hold the money you receive in constructive trust for the Fund in order to ensure the Fund's reasonable reimbursement, regardless of whether you sign a subrogation agreement.

The Plan can and will deny Benefits to any Participant or Dependent who acts against the Plan's right to reimbursement from the third party. The Plan also can sue you, your attorney or any other person to recover the reimbursement owed to it if you or such person receives money from the third party and take no reasonable action to reimburse the Plan. Finally, the Plan can offset the amount that should have been reimbursed to it against other Benefits. The Plan's right to reimbursement is an ongoing one. If you have future medical expenses which were the result of the third party's actions, the Plan's right to reimbursement continues.

SECTION 13: GENERAL PLAN INFORMATION

There is certain general information which you may need to know about your Plan, as required by the Employee Retirement Income Security Act of 1974 (ERISA).

PLAN NAME: U.S.W. Local 10-00086 Merck Employees Health and Welfare Plan

PLAN SPONSOR: The Union Trustees and Employer Trustees constitute the Board of Trustees, which is the Plan Sponsor.

PARTICIPATING EMPLOYER AND UNION:

Merck Sharp & Dohme Corp., a wholly owned subsidiary of Merck & Co., Inc.
2000 Galloping Hill Road
Kenilworth, NJ 07033

U.S.W. Local 10-00086
P.O. Box 4
West Point, PA 19486
215-652-5000

PLAN SPONSOR'S EMPLOYER IDENTIFICATION NUMBER: 22-3548930

PLAN NUMBER: 501

TYPE OF PLAN: Tax-exempt VEBA as defined in IRC Section 501(c)(9) and regulations thereunder.

PLAN YEAR: July 1 through June 30

PLAN RECORDS: All Plan records are maintained at the Benefit Administrator's Horsham office at RAE Consulting, 601 Dresher Road, Suite 201, Horsham, PA 19044 and are available to you for inspection upon request. Any information regarding your benefits, and/or your rights under the Plan can be obtained, subject to the limitations set forth in ERISA Section 204 by contacting the Benefits Administrator, in writing.

EFFECTIVE DATE: July 1, 1995 (original effective date)

AGENT FOR SERVICE OF LEGAL PROCESS:

Board of Trustees
U.S.W. Local 10-00086 Merck Employees Health and Welfare Plan
c/o RAE Consulting
601 Dresher Road, Suite 201
Horsham, PA 19044

In addition to the person designated as agent of service of legal process, service of legal process may be made upon any Trustee.

TYPE OF PLAN ADMINISTRATION:

The Plan Administrator is the Board of Trustees (the “Trustees” or the "Board"). The Board consists of an equal number of Trustees appointed by the Union and the Employer. The Board controls the management, operation and administration of the Plan. The Board has functional responsibility for administering the terms and provisions of the Plan.

In the discharge of its duties, the Board is aided and advised by legal counsel, actuarial, accounting, investment advisory services, administrative services, and other services required in the administration of the Plan and the Fund.

The Board has retained RAE Consulting as “Benefits Administrator”, to operate and administer the regular day-to-day operations. The Board has also retained the Benefit Managers to assist with giving Participants access to a Network of Providers as well as to adjudicate claims. In the event that you disagree in whole or in part with a decision of the Benefits Administrator and the Benefit Manager, you have the right to appeal to the Board in accordance with the Claims Procedures described in this Summary.

TYPE OF FUNDING: Insured and Self-Insured

TRUST QUALIFICATIONS:

The U.S.W. Local 10-00086 Merck Employees Health and Welfare Fund is qualified and determined to be exempt for tax purposes by the U.S. Internal Revenue Service under IRC Section 501(c)(9) and regulations thereunder.

PLAN ASSETS:

Assets of the Plan are held in a trust administered by PNC Bank.

SOURCES OF CONTRIBUTION TO PLAN:

The Employer and the Participants are required to contribute to the Plan.

COLLECTIVE BARGAINING AGREEMENT:

This Plan is maintained in accordance with a collective bargaining agreement between the Employer and the Union. A copy of the applicable collective bargaining agreement may be obtained by you upon written request to the Benefits Administrator and is available for examination by you in the Union Office.

SECTION 14: RIGHTS AND PROTECTION UNDER ERISA

As a Fund Participant you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all plan Participants shall be entitled to:

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 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 Pension and Welfare Benefit 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 make a reasonable charge 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 Plan Coverage

Continue health care coverage for yourself, spouse or Dependents if there is a loss of coverage under the plan as a result of a qualifying event. You or your 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 preexisting 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 continuation coverage, when your COBRA continuation coverage ceases, if you request it before losing coverage, or if you request it up to 24 months after losing coverage. Without evidence of creditable coverage, you may be subject to a preexisting 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 (pension, welfare) benefit or exercising your rights under ERISA.

Enforce Your Rights

If your claim for a (pension, 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.

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 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 domestic relations order or a medical child support order, you may file suit in Federal court. If it should happen that 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 your 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 and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 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.

(1) For a group health plan, as defined in section 733(a)(1) of the Act, that provides maternity or newborn infant coverage, a statement describing any requirements under federal or state law applicable to the plan, and any health insurance coverage offered under the plan, relating to hospital length of stay in connection with childbirth for the mother or newborn child. If federal law applies in some areas in which the plan operates and state law applies in other areas, the statement should describe the different areas and the federal or state law requirements applicable in each.

(2) In the case of a group health plan subject to section 711 of the Act, the summary plan description will be deemed to have complied with paragraph (u)(1) of this section relating to the required description of federal law requirements if it includes the following statement in the summary plan description:

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).

DEFINITIONS

A. **Definitions**. The following words and phrases shall have the following meanings when used in this Summary Plan Description ("SPD"), unless their context clearly indicates otherwise.

Appeal. A request for your health plan to review a decision in accordance with the Claim Appeal Procedures set forth in this SPD or pursuant to the rules of the appropriate Benefit Manager.

Benefit. An amount payable for a Service, treatment or care provided for under the terms of the Fund's Plan of Benefits.

Benefits Administrator. That person or firm engaged by the Trustees to be responsible for the implementation of the Plan determined by the Trustees as well as for the administration of the Fund in accordance with the Fund's Plan documents and the direction of the Trustees. The "Benefits Administrator" is not the "Plan Administrator," as that term is defined in ERISA Section 1002(16)(B)(iii). This individual or firm may be referred to as the "Administrator" or the "Benefits Administrator."

Benefit Manager. The medical, dental, vision, prescription or other benefits claims adjudicator or network vendor with which the Fund has contracted to provide Participants and Dependents with access to Providers and/or to adjudicate claims incurred by Participants and Dependents for Benefits.

Child(ren). includes the individuals described at Section 3, ("Eligibility).

Co-insurance. Your share of the costs of a covered health care Service, calculated as a percent (e.g. 10%) of the allowed amount for the Service. You pay coinsurance *plus any deductible you owe.* For example, if the allowed amount for a hospital stay is $1500 and you have met your deductible ($500 for single coverage), your coinsurance payment of 10% would be $100 (10% of the $1000 remaining after your $500 deductible).

Collective Bargaining Agreement. An agreement between the Employer and the Union, which agreement governs the terms and conditions of employment of Participants of the bargaining

unit represented by the Union, and requires the Employer to make contributions to the Plan on behalf of individuals in a bargaining unit represented by the Union.

Common Law Spouse. An individual who is a Participant's spouse pursuant to common law and not pursuant to ceremonial marriage in accordance with the laws of the state in which the Participant and spouse reside; provided that both the Participant and the common law spouse have executed properly an affidavit of common law marriage required by the Plan and provided all required documentation. **NOTE**: *The Plan will not recognize any common law marriage entered into in Pennsylvania after January 1, 2005.*

Contribution. A payment made or required to be made by the Employer to the Plan pursuant to the terms of the Collective Bargaining Agreement as provided under the Plan's policies and procedures. Contributions that are payable but not yet paid are considered "plan assets" of the Fund

Co-payment. A fixed amount (for example, $10) you pay for a covered health care Service, usually when you receive the Service. The amount can vary by the type of covered health care Service.

Deductible. The amount you owe for health care Services covered under the Plan before the Plan begins to pay. For example, under this Plan, the medical deductible is $150 per individual and $500 per Family. The Plan will not pay anything for certain Services, for example, hospitalization, until you have met your deductible. The deductible does not apply to all Services. For example, the deductible is not applied to Network provider office visits for primary care, telemedicine visits or specialist physicians. There is also an annual dental deductible of $25 per person.

Dependent. A "Dependent" includes your lawfully married Spouse and Children who are Eligible for Benefits under the terms of the Plan These terms are described more fully in Section III (Eligibility).

Disabled Child. that is, a Child who has been determined to be disabled by the Social Security Administration; who is not able to earn a living because of the disability, whose disability began prior to the date on which the Child would have lost Benefit Coverage because of age (age 26); and who is financially Dependent on the Participant for support and maintenance as evidenced by, inter alia, documentation showing that the Participant claims the Disabled Child as a Dependent for federal income tax purposes.

Durable Medical Equipment. Equipment and supplies ordered by a health care provider for everyday or extended use and that are not generally useful in the absence of disease or illness. Coverage for DME may include: oxygen equipment, wheelchairs, crutches, or blood testing strips for diabetics.

Eligible (Eligibility). A Participant or his Dependent is "Eligible" to receive benefits from the Fund if in a bargaining unit represented by the Union and Eligible for Benefits under the collective bargaining agreement, provided that the Employer has made the required Contributions

on behalf of the Employees and the Employees have made any required Contributions and the Participant has complied with the rules and regulations of the Fund (for example, providing required birth or marriage certificates).

Employee.

1. A common law employee of the Employer who is performing bargaining unit work as a Participant of the bargaining unit with respect to which unit the Employer is required to make a Contribution to the Fund pursuant to a Collective Bargaining Agreement with the Union.

2. A common law employee who is engaged by or who is an Employee of the Union or any Local Union which Union or Local Union is required to make Contributions to the Fund pursuant to participation or other appropriate written agreement.

3. A common law employee who had been employed pursuant to one of the Subparagraphs set forth next-above and who is now making self-payments under rules established by the Trustees and who meets the requirements set forth in the Fund's Plan Documents.

Employer. Merck Sharp & Dohme Corp., a wholly owned subsidiary of Merck & Co., Inc.

Excluded Services. Services that the Plan does not pay for or cover.

Experimental/Investigational. An experimental or investigational treatment is one which is not generally accepted in the medical community. These may include, but are not limited to treatments which are undergoing certain early stage trials (note that the Plan will pay for claims arising from Services related to clinical trials to the extent required by the Patient Protection and Affordable Care Act); treatments for which there are no relevant articles in peer reviewed medical journals (journals in which articles are reviewed by other experts in the relevant field); a treatment which does not have the support of the majority of medical practitioners in the relevant field; a treatment which is being used in another way than has been approved by the FDA; and a treatment which is being used in a different body area than the use generally accepted in peer reviewed medical journals.

Family (Family Participants). An Employee Participant and all of his Dependents.

Fund. The U.S.W. Local 10-00086 Merck Employees Health & Welfare Plan, which is a welfare benefits plan governed by the Employee Retirement Income Security Act of 1974, as amended ("ERISA") and other applicable federal and state law and regulation.

Medically Necessary (or Medical Necessity). Health care Services or supplies needed to prevent, diagnose, or treat an illness, injury, condition, disease, or its symptoms and that are provided in accordance with medical and surgical practices and standards prevailing in the community where and when the Service is provided and are not experimental or investigational or custodial in nature. This term may be further defined under the policies of the Benefit Managers with which the Fund has contracted, and such definition is binding on the Fund, the Participants and their Dependents.

Other Insurance. "Other Insurance" includes any of the following types of coverage:

(a) Any group insurance coverage, including any plan covering individuals as employees of an employer or as Participants of any other group that provides hospital or medical care benefits or services on an insured, self-insured or a prepayment basis;

(i) "Other insurance" does **not** include the coverage of a Spouse or Dependent under a "health savings account" as that term is defined under Code Section 223 and regulations thereunder. If (a) all of the plans covering the Spouse are high-deductible health plans or the Spouse elects a high-deductible health plan offered by the Spouse's employer and (b) the Spouse intends to contribute to a "health savings account" as that term is defined in the applicable federal law and regulations, this Plan cannot coordinate benefits with or provide any reimbursement for the primary high-deductible health plan's deductible.

(b) Any coverage under a labor-management trustee plan or other welfare plan, employer plan, employer organization plan, or other arrangement for benefits for individuals or a group, whether insured, partially insured, self-insured, non-insured, or otherwise;

(c) Any coverage under any governmental program, including, but not limited to, worker's compensation, occupational disease, or similar programs; provided, however, that such coverage shall not be deemed Other Insurance for purposes of this plan if applicable law mandates that the plan provide primary coverage;

(d) Any Other Insurance, private or otherwise, carried by the Participant or an Dependent of a Participant, including, but not limited to, motor vehicle coverage (including fault, no-fault, financial responsibility, catastrophic, liability, collision or other coverage).

Participant. An Employee who may be Eligible for Benefits for him or herself and his or her Dependents under the terms of the Plan.

Patient. A Participant or Dependent receiving medical care.

Plan. The Plan of Benefits provided by the Fund, as described in this SPD and in the information provided to you by the medical, dental, vision, prescription Benefit Manager.

Prescription Drug Coverage. The portion of the cost of prescription drugs and medications for which the Fund pays.

Provider. An individual or entity that provides medical, dental, vision or prescription Benefits to Fund Participants and their Dependents.

Separation Package. A benefits continuation package agreed to between the Employer and a member in which a member will be eligible for benefits and benefits will be limited to the Separation Package agreement.

Service(s). Any medical care, treatment, Hospitalization, or item provided to a Participant or Dependent.

Spouse. Your lawfully married spouse, as determined under the laws of state in which your marriage was celebrated or in which you reside.

Trust. The entire trust estate of USW Local 10-00086 Merck Employees Health & Welfare Fund as it may, from time to time, be constituted, including, but not limited to, cash, cash equivalents, investments, income from investments, contracts of insurance, Contributions and any and all other assets received by and/or held by the Trustees for the uses and purposes of the Fund.

Trustees (or Board of Trustees). Those persons appointed by the Union or the Company, in accordance with the Fund's Agreement and Declaration of Trust, to serve as Trustees.

Union. The Union is U.S.W. 10-00086.

B. **Construction.**

1. The masculine gender, where appearing in the Plan, shall be deemed to include the feminine gender, unless the context clearly indicates otherwise.

2. The singular shall be deemed to include the plural, and the plural the singular, as the context may require.