If you are privately insured and not satisfied with BELSOMRA® (suvorexant) C-IV, you may be eligible to receive your money back for 1 qualifying prescription of up to 30 tablets of BELSOMRA, up to a maximum of $400. Not all patients are eligible. Please see the following Terms and Conditions to confirm eligibility.

Please follow these 4 steps if you are eligible for a refund:

1. **Save your original pharmacy receipt(s)**. Your receipt(s) must show: BELSOMRA was purchased, the date(s) the prescription was purchased, and the price **you** paid for BELSOMRA (your out-of-pocket cost). At least 7 days must have elapsed between the date your claim is postmarked and the date on your receipt.
2. **Complete the attached Refund Request Form**. The form must include your information and original signature. No signature stamps will be accepted. Also attach a **copy of the front and back of your private insurance card**.
3. **Sign and clearly print your name and mailing address**.
4. **Mail your original pharmacy receipt(s), insurance card, and completed Refund Request Form to:** Refund Request • PO Box 29 • Horsham, PA 19044-0029.

   This Refund Request Form must be postmarked within 90 days of the date when the prescription was purchased, as indicated on your pharmacy receipt.

Not all patients are eligible. Please see Terms and Conditions below. If you are eligible, the refund check will be issued 6 to 8 weeks after we receive the Refund Request Form. To receive reimbursement, the prescription for BELSOMRA must have been purchased between April 30, 2020 and December 31, 2020. Refund Request Forms must be postmarked within 90 days of the date of purchase. Please call toll-free, 800-613-6866, with any questions about this offer.

Terms and Conditions for the BELSOMRA Pledge Program

- You must be 18 years of age or older.
- You must purchase your qualifying prescription of BELSOMRA between April 30, 2020 and December 31, 2020. Refund is valid only for 1 qualifying prescription of BELSOMRA (up to 30 tablets). Prescriptions for BELSOMRA purchased before April 30, 2020 or after December 31, 2020 will not qualify for a refund.
- You must have a co-payment, or if you are privately insured without coverage for the product, make a full cash payment for the prescription.
- **Patient must have private insurance. Not valid for uninsured patients or patients covered under Medicaid (including Medicaid patients enrolled in a qualified health plan purchased through a health insurance exchange [marketplace] established by a state government or the federal government), Medicare, a Medicare Part D, or Medicare Advantage plan (regardless of whether a specific prescription is covered), TRICARE, CHAMPUS, Puerto Rico Government Health Insurance Plan ("Healthcare Reform"), or any other state or federal medical or pharmaceutical benefit program or pharmaceutical assistance program (collectively, "Government Programs").**
- **Subject to changes in state law, this coupon may become invalid for residents of Massachusetts prior to its expiration date.**
- You must be a resident of the United States or the Commonwealth of Puerto Rico. Product must be purchased at participating eligible retail or mail-order pharmacies in the United States or the Commonwealth of Puerto Rico. Product must originate in the United States or the Commonwealth of Puerto Rico.
- No other purchase is necessary.
- The maximum amount of any refund will be equal to the out-of-pocket cost paid for one (1) qualifying prescription of BELSOMRA (up to 30 tablets), not to exceed $400.
- Refund is not valid for any other products, other out-of-pocket costs listed on your submitted pharmacy receipt, or your prescriber visit co-pay.
- Only the patient may request the refund. The patient's prescriber or health care professional may not request the refund on behalf of the patient and may not receive the refund.
- Patient is limited to one (1) refund request submission, provided the patient meets eligibility requirements and Terms and Conditions.
- **This Refund Request Form must be postmarked within 90 days of the date of purchase, as indicated on your pharmacy receipt. Refund Request Forms postmarked after 90 days of the date of purchase will not be honored.**

Terms and Conditions continues on next page.

Terms and Conditions for the BELSOMRA® (suvorexant) C-IV Pledge Program (*continued*)

- If the Terms and Conditions are met, the refund will be paid to the patient submitting the refund request.
- All information requested on the Refund Request Form must be provided, and the certification must be signed. Forms that are not filled out completely or are modified will not be eligible for a refund.
- You must submit the required documentation with this Refund Request Form. Refund request submission must include:
  - — This original Refund Request Form. This form must be filled out completely and may not be modified in any manner. This form must contain an original signature. No signature stamps will be accepted.
  - — The original pharmacy receipt indicating that the product you purchased was BELSOMRA, the date the prescription was purchased, and the price you paid out-of-pocket for BELSOMRA. At least 7 days must have elapsed between the date your claim is postmarked and the date on your receipt.
  - — A copy of the front and back of your private insurance card must be attached.
- This refund is not transferable. No substitutions are permitted.
- This Refund Request Form is void if reproduced and void where prohibited by law, taxed, or restricted.
- **It is illegal to sell, purchase, trade, or counterfeit this Refund Request Form**.
- Patient, pharmacist, and prescriber agree not to seek reimbursement for all or any part of the benefit received by the patient through this offer. Patient is responsible for reporting receipt of refund to any insurer, health plan, or other third party who pays for or reimburses any part of the prescription for which a refund has been received as may be required.
- If a coupon or savings card was used for the prescription submitted for refund, the pharmacy receipt must clearly reflect the actual cost paid by the patient after the coupon or savings card was applied.
- **This refund is not insurance or a substitute for insurance.**
- This Refund Request Form is the property of Merck and must be turned in on request.
- Merck reserves the right to rescind, revoke, or amend this offer at any time without notice.
- **Expiration date: December 31, 2020.**

Refund Request Form

PATIENT CERTIFICATION AND CONSENT: I understand that the information provided will be available to Merck Sharp & Dohme Corp. (Merck), a subsidiary of Merck & Co., Inc., and others working on behalf of Merck (including C3I SOLUTIONS, the administrator for the program), whose access is necessary for data processing, eligibility verification, and follow-up related to this refund program. By signing below, I agree that Merck and others working on behalf of Merck are authorized to verify this information and use it to verify my compliance with the Program's Terms and Conditions, to verify my compliance with the terms and conditions of other money-back or savings offers in which I may seek to participate in the future, to conduct fraud prevention processes, and to help Merck evaluate this refund program.

I understand that my prescriber, pharmacist, insurance company, or I may be contacted by others working on behalf of Merck for additional information to process the request. The information I provide on or in support of this refund request will not be used for marketing purposes unless I have provided this permission previously.

For more information about how Merck protects personal information about you, please read our Internet Privacy Policy and Privacy Commitment for US patients, consumers, and caregivers, both of which are available at: www.msd.com/privacy.

I certify that I have read and understood the Terms and Conditions of the BELSOMRA® (suvorexant) C-IV Pledge Program. I certify that I meet the eligibility requirements listed in the Terms and Conditions and that the information I am providing on this form is true and correct. I certify that I have private prescription insurance.

I understand that I am eligible to receive a refund for only the out-of-pocket cost that I actually paid up to a maximum of $400 and that the enclosed pharmacy receipt submitted accurately reflects my out-of-pocket cost. I certify that I personally paid the co-pay required by my prescription insurer for the product for which I am seeking reimbursement. I also certify that I have not sought and shall not seek reimbursement for the out-of-pocket costs I am submitting on the enclosed pharmacy receipt from any other party, including my insurer. I am responsible for reporting the receipt of any refund on BELSOMRA to any insurer, health plan, or other third party who pays for or reimburses any part of the cost of BELSOMRA for which I received refund, as may be required. **I certify that no part of the costs associated with the prescription for which I am seeking a refund was or will be covered under Medicaid (including Medicaid patients enrolled in a qualified health plan purchased through a health insurance exchange [marketplace] established by a state government or the federal government), Medicare, a Medicare Part D, or Medicare Advantage plan (regardless of whether a specific prescription is covered), TRICARE, CHAMPUS, Puerto Rico Government Health Insurance Plan ("Healthcare Reform"), or any other state or federal medical or pharmaceutical benefit program or pharmaceutical assistance program (collectively, "Government Programs").** I understand that if I begin to have coverage under any Government Program or if my state or insurance company prohibits the redemption of coupons for BELSOMRA, I will no longer be eligible to receive a refund. If I am enrolled in a qualified health plan purchased through a health insurance exchange established by a state government or the federal government (QHP), I understand that if the federal government or my state government prohibits coupons for enrollees in QHPs at any time, I will no longer be eligible to receive a refund. I certify that I am an eligible resident of the United States or Puerto Rico. If I am a resident of Massachusetts, I understand that subject to changes in state law, this coupon may become invalid for residents of Massachusetts prior to its expiration date.

I certify that I am the patient identified below and that I am 18 years of age or older. I certify that I took BELSOMRA as prescribed by my doctor for at least a week and was not satisfied.

Patient's signature ______________________________ Date ________________

Patient's name (please print) ______________________________

Patient's date of birth (mm/dd/yyyy) ________ /__________ / ________

Patient's street address ______________________________

Patient's city, state, zip code ______________________________

Patient's phone number ________- ________-________

Patient's email address ______________________________

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