MERCK DENTAL PLAN SUMMARY PLAN DESCRIPTION

Effective Jan. 1, 2018
Released Oct. 10, 2017
This Summary Plan Description (SPD) describes the dental benefits provided under the Merck Medical, Dental, Life Insurance and Long Term Disability Plan as it applies to:

- U.S.-based\(^1\) employees of the wholly owned U.S. subsidiaries of Merck & Co., Inc. (excluding Telerx Marketing, Inc., Comsort, Inc., Vree Health LLC, HRM Weight Management Services Corp. and Merck Global Health Innovation Fund, LLC and each of their subsidiaries) and excluding employees subject to a collective bargaining agreement with the United Steelworkers Union Local 10-00086, and

- U.S. Expatriates on assignment in a U.S. territory and residents of a U.S. territory on assignment in the U.S.

A list of the collective bargaining units whose members are eligible to participate in dental benefits under the Merck Medical, Dental, Life Insurance and Long Term Disability Plan as described in this SPD is included as Exhibit A.

**Frequently Used Terms**

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

The dental benefits described in this SPD provided under the Merck Medical, Dental, Life Insurance and Long Term Disability Plan are referred to in this SPD as the “Dental Plan” or “Plan.”

**About This SPD**

This SPD does not apply to any employee or former employee of Merck & Co., Inc. or its subsidiaries or joint ventures other than those specified above.

This SPD merely summarizes the benefits and benefit coverage levels provided under the Dental Plan effective Jan. 1, 2018, to the employees described above. Decisions regarding appropriate treatment (e.g., level of care) are always left to the discretion of the patient and the patient’s dentist.

This SPD reflects the provisions of the Dental Plan in effect as of Jan. 1, 2018. It replaces the SPD effective Jan. 1, 2017, entitled “Merck Dental Plan Summary Plan Description” and all summaries of material modifications applicable to it dated before Jan. 1, 2018.

**Excluded From This SPD**

Dental benefits are also provided under the Merck Medical, Dental, Life Insurance and Long Term Disability Plan to:

- U.S.-based\(^1\) employees of the wholly owned U.S. subsidiaries of Merck & Co., Inc. (excluding Telerx Marketing, Inc., Comsort, Inc., Vree Health LLC, HRM Weight Management Services Corp. and Merck Global Health Innovation Fund, LLC and each of their subsidiaries) who are on assignment outside the U.S., other than those on assignment in a U.S. territory, which benefits are insured by Cigna Global Health Benefits, and

\(^1\) A U.S.-based employee is an employee whose home country is designated in Merck’s employee database as one of the 50 U.S. states or District of Columbia (and includes employees on temporary international assignment outside one of the 50 U.S. states or District of Columbia) and excludes employees whose home country is designated in Merck’s employee database as a U.S. territory (e.g., Puerto Rico, Guam and U.S. Virgin Islands) or a country outside one of the 50 U.S. states or District of Columbia even if the employee is on temporary international assignment in one of the 50 U.S. states, District of Columbia or in a U.S. territory.
• Non-U.S.-based\textsuperscript{1} employees of the wholly owned subsidiaries of Merck & Co., Inc. (excluding Telerx Marketing, Inc., Comsort, Inc., Vree Health LLC, HMR Weight Management Services Corp. and Merck Global Health Innovation Fund, LLC and each of their subsidiaries) who are on assignment outside their home country, including in the U.S., other than those who are residents of a U.S. territory on assignment in the U.S., which benefits are insured by Cigna Global Health Benefits.

Benefits for those groups described in the bullets above are NOT described in this SPD but are described in separate SPDs. For active dental benefits insured by Cigna Global Health Benefits, see the Cigna International Medical and Dental Plan SPD. To receive a copy of the SPDs that describe the benefits provided to these employee groups, contact the Merck Benefits Service Center at Fidelity at 800-66-MERCK (800-666-3725).

Right to Amend or Terminate the Plan

The Plan Sponsor reserves the right to amend the Merck Medical, Dental, Life Insurance and Long Term Disability Plan, including but not limited to the dental benefits provided under the Dental Plan, in whole or in part or to completely discontinue the Merck Medical, Dental, Life Insurance and Long Term Disability Plan or the Dental Plan at any time.

\textsuperscript{1} A U.S.-based employee is an employee whose home country is designated in Merck’s employee database as one of the 50 U.S. states or District of Columbia (and includes employees on temporary international assignment outside one of the 50 U.S. states or District of Columbia) and excludes employees whose home country is designated in Merck’s employee database as a U.S. territory (e.g., Puerto Rico, Guam and U.S. Virgin Islands) or a country outside one of the 50 U.S. states or District of Columbia even if the employee is on temporary international assignment in one of the 50 U.S. states, District of Columbia or in a U.S. territory.
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INTRODUCTION

YOUR DENTAL BENEFITS

The Dental Plan offers you the option to choose the Comprehensive Dental Plan option or to waive dental coverage. This section provides a brief overview of the Comprehensive Dental Plan option and resources that are available to you as an Eligible Employee.

Comprehensive Dental Plan Coverage

Eligible Employees may enroll themselves and their Eligible Dependents for coverage under the Dental Plan:

- **The Comprehensive Dental Plan option.** A traditional fee-for-service plan that is administered by MetLife and allows you the freedom to receive care from any licensed dentist or specialist. In addition, if you receive care from a dentist participating in the MetLife Preferred Dentist Program (PDP) Plus network, your out-of-pocket costs are generally lower than if you receive care from an Out-of-Network dentist.

- **No Coverage option.** Eligible Employees may waive coverage under the Dental Plan by electing this option.

Benefits Contacts and Resources

Several vendors administer and help answer questions about the Dental Plan. This chart will help you decide who to contact, depending on your needs.

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KEY POINT — ENROLLING IN DENTAL COVERAGE

Enrollment in the Dental Plan is through the Merck Benefits Service Center at Fidelity — the service provider for administration of Merck’s health and insurance benefits. Eligible Employees can enroll in their dental coverage online or by phone. Please see “How to Enroll” in the “About Dental Benefits” section of this SPD for detailed enrollment instructions.

Merck Benefits Service Center at Fidelity

The Merck Benefits Service Center at Fidelity (“Benefits Service Center”) can help you with enrollment and eligibility information and questions. It is administered by Fidelity Investments and is available online and by phone.

Online:
Fidelity NetBenefits® at http://netbenefits.com/merck
If you have an existing NetBenefits account, use the same username/login information you used previously.

By Phone:
800-66-MERCK (800-666-3725) or TDD at 888-343-0860
Customer Service Representatives are available Monday through Friday (excluding New York Stock Exchange holidays) between 8:30 a.m. and 8:30 p.m. ET. For overseas calls, dial your country’s toll-free AT&T USADirect® access number, then enter 800-666-3725. In the U.S., call 800-331-1140 to obtain AT&T USADirect access numbers.

KEY POINT — CONTACTING THE MERCK BENEFITS SERVICE CENTER AT FIDELITY

To contact the Benefits Service Center, online or by phone, you will need a password. Your password provides security to ensure that only you can access your benefits information. Keep your password in a confidential place.

You can establish your password directly online or by calling the Benefits Service Center.

If you have an existing NetBenefits account, use the same username/password information you used previously. If you have forgotten your username or password, you will need to reset it using “Having trouble with your username or password?” on the login page. When you change your username or password, the change will apply to all your Fidelity accounts and services going forward.
GENERAL INFORMATION

ABOUT DENTAL BENEFITS

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

Dental Eligibility

If you are an Eligible Employee, you and your Eligible Dependents are eligible for coverage in the Dental Plan as of your date of hire, rehire or transfer.

You are not eligible for coverage under the Dental Plan if you are not an Eligible Employee or you are an Excluded Employee or Excluded Person.

Eligible Dependents

As an Eligible Employee, you can enroll your Eligible Dependents for coverage under the Dental Plan. For coverage to apply to your Eligible Dependents, they must be enrolled as Covered Dependents under the Dental Plan. See the Glossary for the definition of Eligible Dependent.

Adding Eligible Dependents to Your Coverage

Between annual enrollment periods, you are permitted to add an Eligible Dependent or delete a Covered Dependent only if you have a Life Event that allows you to make a Permitted Plan Change or constitutes circumstances requiring enrollment under HIPAA. See “When Life Changes” and “Special Enrollment Under HIPAA for Eligible Employees.”

Domestic Partnerships

The Plan Sponsor extends coverage under the Dental Plan to Eligible Employees’ Domestic Partners and Domestic Partners’ Eligible Dependent Children. (See “Glossary” for a definition of Eligible Dependents.) To elect Domestic Partner benefits, you and your partner must meet the Company’s definition of a Domestic Partnership.

Additional Taxable Income

Under current federal income tax laws, the value of providing medical and dental benefits to a Domestic Partner and a Domestic Partner’s Eligible Dependent Children is considered taxable to you — unless they are considered your dependents for purposes of federal income taxes. This means you will pay federal, state and local income taxes, as well as employment taxes, on the full value of coverage provided to your Domestic Partner and your Domestic Partner’s Eligible Dependent Children by the Company or by you with your Before-Tax deductions throughout the year. This type of taxable income is known as imputed income, and your Employer will report it on your W-2 form at the end of each year.

KEY POINT — IMPUTED INCOME — DOMESTIC PARTNERS

Coverage for Domestic Partners may be subject to imputed income for federal, state and local income tax purposes.

If you believe your Domestic Partner and/or your Domestic Partner’s Eligible Dependent Children are your dependents for federal tax purposes, please contact the Benefits Service Center.
It’s important for you to understand the tax implications of covering a Domestic Partner and/or your Domestic Partner’s Eligible Dependent Children. You may wish to consult a tax advisor to determine the full tax and financial effect of electing this coverage. For more information, see “Paying for Dental Coverage.” You can obtain more information about Domestic Partner benefits by calling the Merck Benefits Service Center at 800-66-MERCK (800-666-3725).

Right to Audit Dependent Eligibility

By electing coverage for your dependents (either by affirmative election or through the default process), you are confirming that they meet the Plan’s dependent eligibility requirements and agree to notify the Benefits Service Center within 60 days of an event that causes any of these dependents to no longer meet the definition of an Eligible Dependent in the Plan.

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

If you do not promptly provide documentation sufficient to verify your Covered Dependents’ continued eligibility or if the Company determines that any of the information you provide (or provided) regarding your Covered Dependents is untrue, incomplete or misleading, or if you fail to promptly notify the Benefits Service Center of an individual’s loss of eligibility, the Company may take such action as it deems appropriate under the circumstances. If permitted by applicable law, those actions may include, but are not limited to, the retroactive termination of benefits for your ineligible dependent, requiring you to repay the Plan for any benefits/contributions paid with respect to your ineligible dependent and subjecting you to disciplinary action.

**KEY POINT — DEPENDENTS MAY LOSE ELIGIBILITY IN MEDICAL PLAN ELIGIBILITY AUDIT**

A dependent eligibility audit will be required when you enroll a dependent for coverage under a Company-sponsored medical plan. However, if the audit determines that your dependent does not meet the requirements to be an “Eligible Dependent” under the terms of the medical plan (either because you do not timely submit the required documentation or because the auditor determines that the documentation submitted is insufficient to verify your dependent’s status as an “Eligible Dependent” under the terms of the medical plan), causing that dependent to lose medical plan coverage, that dependent will be dropped from coverage under this Plan as well.

Enrolling in Dental Coverage

Coverage Tiers

For the Comprehensive Dental Plan option, Eligible Employees may choose from one of four levels of coverage:

- Employee Only
- Employee + Spouse/Domestic Partner
- Employee + Child(ren), or
- Employee + Spouse/Domestic Partner + Child(ren).

If both you and your Spouse/Domestic Partner work, or worked, for the Company, special provisions apply to the Coverage Tier you are eligible to elect. See “Merck Couples Enrollment Rules” for details.
Comprehensive Dental Plan Coverage

You may choose either to be covered under the Comprehensive Dental Plan option or to waive coverage. If you choose coverage, the Coverage Tiers for which you are eligible appear on http://netbenefits.com/merck. You may also call the Benefits Service Center for more information. As discussed further below, if you fail to make an election or to waive coverage, you will automatically be enrolled in Employee Only coverage under the Comprehensive Dental Plan option.

If You Waive Coverage

Eligible Employees may waive coverage by selecting the No Coverage option. If you elect the No Coverage option because you have other coverage through your Spouse’s/Domestic Partner’s plan, be sure to check the rules of your Spouse’s/Domestic Partner’s plan in advance. Some employers will not allow an employee to cover a Spouse/Domestic Partner if the Spouse/Domestic Partner can obtain coverage through the Spouse’s/Domestic Partner’s own employer. Electing No Coverage means that you waive coverage in the Dental Plan.

Enrollment

As an Eligible Employee or a Transferred Employee, unless you take affirmative action during your 30-day Initial Enrollment Period, you are automatically enrolled for Employee Only coverage under the Comprehensive Dental Plan option as of your date of hire, rehire or transfer, as applicable.

If You Enroll in Your Dental Option Within Your 30-Day Initial Enrollment Period

You may elect or waive Dental Plan coverage within your 30-day Initial Enrollment Period, through the Benefits Service Center, online or by phone. As long as you enroll for coverage within the 30-day Initial Enrollment Period, your coverage will be effective as of your hire, rehire or Transfer Date. See “How to Enroll” for more detailed instructions.

Enrolling Your Dependents Within Your 30-Day Initial Enrollment Period

You may enroll your Eligible Dependents for coverage (with an effective date of your hire, rehire or Transfer Date) under the same dental coverage you choose within your 30-day Initial Enrollment Period. As long as you enroll your Eligible Dependents for coverage within your 30-day Initial Enrollment Period, their coverage will be effective as of your hire, rehire or Transfer Date.

If You Do Not Enroll Within Your 30-Day Initial Enrollment Period

If you do not elect to change your Dental Plan coverage, waive coverage or enroll your Eligible Dependents within your 30-day Initial Enrollment Period, you will have Employee Only coverage under the Comprehensive Dental Plan option for the remainder of the Plan Year. You will not be able to add your Eligible Dependents, drop coverage or change Dental Plan coverage until the next annual enrollment period unless you experience a Life Event that allows you to make a mid-year Permitted Plan Change or you qualify for the special enrollment option. See “When Life Changes” and “Special Enrollment Under HIPAA for Eligible Employees” for more information.

If You Are Rehired Within the Same Calendar Year

You will be automatically re-enrolled for coverage at the same coverage tier with the same Eligible Dependents (assuming they continue to meet the Plan’s eligibility requirements) you had in effect on your last date of employment. If you choose to do so, you may elect a different coverage tier, add Eligible Dependents, drop Covered Dependents or waive coverage by selecting the No Coverage option, provided you do so within the 30-day time frame applicable to newly hired employees.
KEY POINT — LIFE EVENTS
You are permitted to make certain Plan changes during the year only if you have certain Life Events — for example:

- The birth or adoption of a child
- You get married or divorced (or meet the eligibility requirements for or end a Domestic Partnership)
- Your covered child reaches the maximum coverage age
- One of your dependents dies, or
- Your Spouse’s/Domestic Partner’s employment status changes.

See “When Life Changes” for information about how your dental coverage may be affected by certain Life Events.

How to Enroll
You enroll in the Dental Plan through the Benefits Service Center either online or by phone.

Online
http://netbenefits.com/merck

Follow these steps:

- Log on to NetBenefits and click “Review Your Checklist” at the top of the home page.
- Under the Starting at Merck section, expand the “Set up your health and insurance benefits” section, and then click “Enroll.”
- Before you select your benefits, click Review to update your dependent information. To enroll, change or decline your coverage, click Review next to each benefit offering.
- When you’re satisfied with your selections, click Save and Submit.
  - A confirmation screen will display the elections you submitted. Print this page for your records as evidence of your successful enrollment.

KEY POINT — COMPLETING ENROLLMENT IS YOUR RESPONSIBILITY
When you enroll, it is your responsibility to complete all the required steps described above. You should print a copy of your enrollment confirmation statement and keep it with your important papers as evidence of your successful completion of the enrollment process.

By Phone
Customer Service Representatives can take your benefit elections by phone between 8:30 a.m. and 8:30 p.m. ET, Monday through Friday (excluding New York Stock Exchange holidays). Once you enroll by phone, it’s a good idea to confirm your benefit elections online and print your confirmation statement. If you are unable to print your confirmation statement and you would like to request a paper copy, you can contact the Benefits Service Center.

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

When Coverage Begins

Eligible Employees and Transferred Employees

Your dental coverage begins on your date of hire, rehire or transfer. As long as you enroll your Eligible Dependents in coverage within 30 days of your date of hire, rehire or transfer, your Eligible Dependents’ coverage also begins on your date of hire, rehire or transfer.

ID Cards

You will not receive an ID card if you enroll for dental coverage. Instead, when you make an appointment, simply tell the dentist that you have coverage from MetLife and your employer is Merck. Alternatively, if you want to print an ID card, visit www.MetLife.com/mybenefits and follow the instructions.

If you see a provider in the PDP Plus network, generally your dentist will submit your claim to MetLife. If you use a dentist that is not in the PDP Plus network, you may need to file a claim form with MetLife. If you want your provider to submit your claim on your behalf, be sure to ask.

Paying for Dental Coverage

Eligible Employees and Transferred Employees

You and your Employer share the cost of your dental coverage, with your Employer paying the majority of the cost. You pay your share of the cost through regular Before-Tax payroll deductions. Your cost is based on the Coverage Tier you choose (Employee Only; Employee + Spouse/Domestic Partner; Employee + Child(ren); Employee + Spouse/Domestic Partner + Child(ren)) and your status as a part-time or full-time employee.

Your employee contributions start the first of the month following or coincident with your date of hire/rehire or Transfer Date, as applicable, although your coverage begins as of your date of hire/rehire or Transfer Date, as applicable. This first period of your dental coverage is paid for by the Company.

Current employee contributions for the different coverage levels are available online at http://netbenefits.com/merck, or you may request a paper copy by calling the Benefits Service Center at 800-66-MERCK (800-666-3725). Employee contributions may change from year to year. The Company will inform you, typically during the annual enrollment period, if there are any employee contribution changes.

LTD Employees

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

• For Legacy Merck LTD Employees disabled before Jan. 1, 2011, coverage in the Dental Plan is provided at no cost to you and your Covered Dependents.

• For Legacy Schering-Plough LTD Employees disabled before Jan. 1, 2005, coverage in the Dental Plan is provided at no cost to you and your Covered Dependents.

• For Legacy OBS LTD Employees disabled before Jan. 1, 2009, coverage in the Dental Plan is provided at no cost to you and your Covered Dependents.

• For all other LTD Employees, coverage in the Dental Plan is offered at the same rates as active employees.
Becoming an LTD Employee is not a Life Event that allows you to make a Permitted Plan Change.

If you are an LTD Employee who is eligible for and elects dental coverage, you will receive an invoice directly from the Benefits Service Center for the cost of dental coverage. Generally, contributions made by an LTD Employee toward the cost of dental coverage are made on an After-Tax basis. In all events, it is your responsibility to be sure that you pay the required cost on a timely basis to continue your coverage. If you fail to pay for your coverage on a timely basis, your coverage will end and you will not be eligible to re-enroll for coverage until the next annual enrollment period for coverage effective the following Jan. 1 or mid-year if you experience a Life Event that allows you to make a Permitted Plan Change.

**Before-Tax Contributions**

If you receive a paycheck from your Employer, your contributions toward the cost of dental coverage are deducted from your paycheck on a Before-Tax basis through the Merck & Co., Inc. Cafeteria Plan. This means your contributions come out of your pay before federal income and Social Security taxes are deducted. Before-Tax contributions save you money by reducing your gross salary, which lowers your taxable income and, therefore, the amount of income tax you must pay. In most states (except, for example, New Jersey), you also pay no state taxes on your contributions.

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

**Employees on Leaves of Absence or Layoff**

If you take a leave of absence or go on layoff, see “Making Changes to Your Coverage” for more information.

**Special Enrollment Under HIPAA for Eligible Employees**

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

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

- You have gained a dependent (Spouse or child) through marriage, birth, adoption or placement for adoption.

However, you must request enrollment within 30 days after the occurrence of any of the events described above. The effective date of coverage as a result of the special enrollment right will be the date of the event itself, but changes to your contribution amount will take effect the first of the month following or coincident with the date of notification.

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

Please note that while existing federal law does not extend HIPAA rights to your Domestic Partner and your Domestic Partner’s Covered Dependent Children, the Plan Sponsor does permit Domestic Partners and their Covered Dependent Children to enroll under this special enrollment provision.

To request special enrollment through HIPAA, you must contact the Benefits Service Center within 30 or 60 days of the event, as applicable. Note that the rules regarding Life Event changes may be more generous than special enrollment rights. See “Making Changes to Your Coverage.”

**Merck Couples**

If both you and your Spouse/Domestic Partner (or your former Spouse/Domestic Partner or that person’s Spouse/Domestic Partner) work, or worked, for the Company, there are certain rules about the coordination of dependent dental coverage.

**KEY POINT — DOMESTIC PARTNERS**

In general, for purposes of the rules related to Merck couples under the Dental Plan, your Domestic Partner is treated as your Spouse — and as stepparent to your Eligible Dependent Children. And, your Domestic Partner’s Eligible Dependent Children are treated as your stepchildren.

**No Duplicate Merck Coverage**

If both you and your Spouse/Domestic Partner (or your Dependent Children, or your former Spouse/Domestic Partner) are eligible for coverage under this Plan, there are certain rules about the coordination of dependent coverage. If you are a Merck couple, call the Benefits Service Center for assistance.

**Merck Couples Enrollment Rules**

If you and your Spouse/Domestic Partner both participate in the Dental Plan, you must decide who will cover your Spouse/Domestic Partner and/or your Eligible Dependents for purposes of the Dental Plan. You and your Spouse/Domestic Partner each may enroll in Employee Only coverage. Or, one Spouse/Domestic Partner may enroll as an Eligible Dependent of the other.

**KEY POINT — ENROLLMENT ELECTIONS FOR MERCK COUPLES**

If you elect the No Coverage option because you plan to be covered as an Eligible Dependent under your Spouse’s/ Domestic Partner’s coverage, it is your responsibility to ensure that your Spouse/Domestic Partner elects the correct Coverage Tier. You will not be able to make enrollment changes until the next annual enrollment period, for coverage effective the following Jan. 1, unless you experience a Life Event that allows you to make a Permitted Plan Change, even if you elected No Coverage in error.

**Covering Your Eligible Dependents**

If you wish to cover your Spouse/Domestic Partner and any Dependent Children, you must choose Employee + Spouse/Domestic Partner + Child(ren). Remember, the Employee + Child(ren) Coverage Tier allows your Spouse/Domestic Partner to cover a Dependent Child without providing coverage for you. In no event can you and your Spouse/Domestic Partner each cover your Dependent Children.

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

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

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

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

For your children:

- If you elect dependent coverage, your Eligible Dependent Children may be covered under your Dental Plan coverage, but your Spouse/Domestic Partner must consent to this choice by calling the Benefits Service Center.

- If you choose Employee Only coverage, your Spouse/Domestic Partner must actively enroll the children under the Spouse/Domestic Partner's union dental plan.

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

If Your Spouse/Domestic Partner Is an LTD Employee

If you are an Eligible Employee married to an LTD Employee, you and your Eligible Dependents are eligible for coverage under your Spouse’s/Domestic Partner’s coverage as dependents.

If you are an Eligible Employee and married to an employee who is eligible for LTD Benefits but who is a Non-Eligible Union Employee, your Spouse/Domestic Partner does not qualify as an Eligible Dependent under your coverage. Likewise, you are not an Eligible Dependent under your Spouse's/Domestic Partner's union coverage. To determine eligibility for your Dependent Children, see “If Your Spouse/Domestic Partner Is a Non-Eligible Union Employee.”

Making Changes to Your Coverage

Annual Enrollment

Each year during annual enrollment, you may elect to make changes to your Dental Plan coverage or keep your current dental elections, subject to the Plan’s continued availability for coverage effective the following Jan. 1. Generally, the benefit elections you make will remain in effect for the entire Plan Year (Jan. 1 – Dec. 31) unless you or your Eligible Dependents experience a Life Event that allows you to make a Permitted Plan Change or you qualify for the HIPAA special enrollment option.

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

Each year, you will be notified of the annual enrollment procedures, coverage costs and timeframes for enrolling in or changing your elections for the upcoming Plan Year. Since the Plan Sponsor may make changes to the Dental Plan at any time, it is important to review your annual enrollment materials carefully when you receive them. You may access annual enrollment materials, obtain contact information, review plan design
changes and confirm most benefits through [http://netbenefits.com/merck](http://netbenefits.com/merck) or by calling the Benefits Service Center at **800-66-MERCK (800-666-3725)**.

Between annual enrollment periods, you and your Eligible Dependents may change or enroll in (if you had waived coverage) dental coverage only if you or your Eligible Dependents experience a Life Event that allows you to make a Permitted Plan Change and the Plan Administrator permits you to make a change in coverage. See “When Life Changes” for more information.

**When Life Changes**

**Life Events and Permitted Plan Changes**

During the year, you may be entitled to make certain changes to your Dental Plan coverage if you, or your Spouse/Domestic Partner or Eligible Dependents, experience a Life Event that allows you to make Permitted Plan Changes. Any requested change to your coverage due to a Life Event generally must be due to an event that affects eligibility for coverage and must be consistent with the Life Event.

In general, Life Events may include:

- A change in your legal marital status, including marriage, divorce or legal separation/annulment (in states where legal separation equals divorce)
- Starting a Domestic Partnership (by meeting all the criteria as defined by the terms of the Plan), or ending a Domestic Partnership
- Gaining a new Eligible Dependent through birth, adoption or placement for adoption or foster care
- Your Eligible Dependent losing eligibility as a result of reaching the maximum coverage age
- The death of your Eligible Dependent
- A change to the employment status of you, your Spouse/Domestic Partner or Eligible Dependent, including the beginning or end of an unpaid leave of absence, an FMLA leave or a change in work status (such as a switch from salaried to hourly pay or full-time to part-time hours) that affects eligibility for benefits
- Your Spouse/Domestic Partner or Eligible Dependent terminating or commencing employment, or
- A change in the place of residence for you, your Spouse/Domestic Partner or dependent.

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

- If another employer’s dental plan allows for a change in your Eligible Dependent’s coverage (either during that plan’s annual enrollment period or due to a mid-year election change permitted under that employer’s plan), you may be able to make a corresponding election change under the Dental Plan.

- If the Dental Plan receives a Qualified Medical Child Support Order (QMCSO) requiring the Plan to provide health coverage to your child or foster child who is your dependent. In this instance, the Plan will automatically change your benefit elections to provide coverage for the child. In the case of a child whom you are required to cover pursuant to a QMCSO, coverage will begin on the date specified in the order, or if none is specified, the date of the order. You may decrease your coverage for that child, if the court order requires the child’s other parent to provide coverage and your Spouse’s or former Spouse’s plan actually provides that coverage.

- If your Eligible Dependent becomes entitled to, or loses entitlement to, coverage under a government institution, Medicare, Medicaid or state children’s health program, you may make corresponding changes to your benefit elections under the Dental Plan.
KEY POINT — IF A PROVIDER CHANGES NETWORKS, IT IS NOT CONSIDERED A LIFE EVENT

If you are an Eligible Employee and your dental care provider or facility decides to drop out of — or start participating in — a participating network of preferred providers, this change in access is not considered a Life Event that would allow you to change your dental election mid-year. If you wish to change your Dental Plan coverage, you must wait until the annual enrollment period for coverage effective the following Jan. 1.

How to Make a Permitted Plan Change

If you have a Life Event that allows you to make a Permitted Plan Change, you must request your change within 30 days after the event through the Benefits Service Center — either online or by phone. Any requested change to your coverage must be consistent with the Life Event. If you do not make your request within 30 days after the event, you will have to wait until the next annual enrollment period for coverage effective the following Jan. 1 to change your dental coverage.

When Permitted Plan Changes Go Into Effect

If you experience a Life Event that permits you to change your Dental Plan coverage during the year, the effective date for the change will be the date of the event itself, provided you notify the Benefits Service Center within 30 days after the event. Any changes to your contribution amount will take effect the first of the month following or coincident with the date of notification. If you fail to notify the Benefits Service Center within 30 days after the event, you will not be permitted to make a change until the next annual enrollment period for coverage effective the following Jan. 1.

KEY POINT — LIFE EVENTS

You must contact the Benefits Service Center within 30 days of a Life Event. If you do not contact the Benefits Service Center within 30 days of the Life Event, you will have to wait until the next annual enrollment period for coverage effective the following Jan. 1 to change your dental coverage.

KEY POINT — HOW TO ENROLL A NEW CHILD

To enroll your new child under your Dental Plan coverage, you must contact the Benefits Service Center. You cannot enroll your child by calling your dental coverage carrier directly. Even if your Coverage Tier will not change, you must timely enroll your child through the Benefits Service Center in order for your child to receive dental coverage. You may be asked to provide proof of your child’s eligibility. Even if your Coverage Tier will not change, for example if you already have Employee + Child(ren) coverage, you must enroll your new dependent in the Plan within 30 days in order to receive dental coverage for your new dependent. If you do not enroll your new dependent within 30 days, you will have to wait until annual enrollment to enroll your new dependent into dental coverage.

If You Take a Leave of Absence

- **Approved Paid Leave of Absence.** If you take an approved paid leave of absence, your Employer will continue to deduct the cost of dental coverage through payroll deductions. Deductions will be on a Before-Tax basis.

- **Approved Unpaid Leave of Absence.** If you take an approved unpaid leave of absence, you will have the option when your leave begins to cancel coverage or continue coverage under the Dental Plan during your unpaid leave. If you elect to continue coverage, you will be billed by the Benefits Service Center starting the first of the month following commencement of your leave for coverage during your leave. For employees who return to work at the expiration of a leave, unpaid amounts for coverage for the period prior
to the first day of the month after your leave will be payable by you upon your return from leave by payroll
deduction.

If you fail to pay contributions to continue coverage in the time and manner specified by the Plan
Administrator, your coverage will end and you will not be able to re-enroll for coverage until the next annual
enrollment (for coverage effective the following Jan. 1) or mid-year if you have a Life Event that allows you
to make a Permitted Plan Change. If you elect to cancel coverage under the Dental Plan when you begin
your unpaid leave, you will not be able to re-enroll for coverage until the next annual enrollment (for
coverage effective the following Jan. 1) or mid-year if you have a Life Event that allows you to make a
Permitted Plan Change.

- While on leave, you will continue to pay the same rates as similarly situated active employees.

If You Are an Eligible Union Employee Who Goes on Layoff

If you are placed on layoff, you may elect to continue your coverage as follows:

- **For the Layoff Period.** You may continue the dental coverage you had in effect on the date your layoff
  begins for the duration of your layoff. If you decide to continue your benefits coverage under this option,
you will receive a monthly billing invoice for 100% of the cost to continue your coverage, as well as a 2%
administrative fee. Payment for continued coverage is due on the first of the month to maintain coverage
for that month. If you want to elect this option, you must call the Benefits Service Center within 30 days
from the date of your benefits continuation letter to make your election. If you do not call within the 30 days,
you will not be able to continue coverage under this option. If you fail to pay the required contributions to
continue coverage in the time and manner specified by the Plan Administrator, your coverage will end and
you will not be able to re-enroll for coverage until the next annual enrollment (for coverage effective Jan. 1)
or mid-year if you have a Life Event that allows you to make a Permitted Plan Change.

- **For the COBRA Period.** You may continue the dental coverage you had in effect on the date your layoff
  begins in accordance with the rules applicable to COBRA for the COBRA period. See the “COBRA”
section of this SPD.

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

If You Receive LTD Benefits

If you are or become an LTD Employee, your dental coverage in effect on the date you become eligible for LTD
Benefits may continue while you are receiving LTD Benefits. See “Paying for Dental Coverage” for more details
about paying for your dental coverage. If you continue your coverage, you may only add an Eligible Dependent
or drop a Covered Dependent during the annual enrollment period, unless you experience a Life Event that
allows you to make a Permitted Plan Change.

If You Had Elected No Coverage

If you had elected No Coverage at the time you qualified for LTD Benefits, you will not receive dental coverage,
unless you enroll for coverage during the next annual enrollment period or experience a Life Event that allows
you to make a Permitted Plan Change.
When Dental Coverage Ends

Your coverage in the Comprehensive Dental Plan ends on the earliest of:

- The end of the month in which your employment terminates, unless you are eligible for dental continuation coverage due to your separation from employment as described in the “Merck US Separation Benefits Plan SPD” or your collective bargaining agreement, if applicable
- The end of the month in which you are no longer eligible to participate
- The day immediately prior to the day your No Coverage option goes into effect
- If you are an LTD Employee, the date you fail to pay the required employee contributions for coverage
- The last day of your dental benefits continuation period as described in the “Merck US Separation Benefits Plan SPD” or your collective bargaining agreement, if applicable, if your employment ends on or after Jan. 1, 2018, and you are eligible for continuation coverage due to your separation from employment on or after Jan. 1, 2018, as described in the “Merck US Separation Benefits Plan SPD” or your collective bargaining agreement, if applicable
- The date the required contributions for coverage are not paid, or
- The date the Dental Plan is terminated by the Plan Sponsor.

Your Covered Dependents’ coverage ends on the earliest of:

- The date your coverage ends for any reason. Coverage may continue under the terms applicable to survivor coverage (See “Coverage for Surviving Dependents in the Event of Your Death”)
- The date your Covered Dependent no longer qualifies as an Eligible Dependent under the Dental Plan (e.g., the date of divorce from your Spouse, the date of the end of your Domestic Partnership or the date your dependent is disqualified for coverage under a dependent eligibility audit)
- The end of the month in which your Covered Dependent Child(ren) no longer qualifies as an Eligible Dependent under the Dental Plan — such as the date your child turns age 26 (see “Eligible Dependents” in the “About Dental Benefits” section)
- The date on which you are notified of your failure to complete the dependent audit request or your dependent is determined to be ineligible based on the audit
- The date the required employee contributions for coverage are not paid, or
- The date the Dental Plan is terminated by the Plan Sponsor.

If coverage for you and/or your Covered Dependents ends under certain circumstances, you may be eligible to continue coverage under COBRA. See “COBRA.”

If a Covered Dependent Loses Eligibility Status

You must notify the Plan Administrator when a Covered Dependent is no longer eligible for coverage by changing your dependent’s status by contacting the Benefits Service Center. If you do not notify the Plan Administrator by one of those methods when a Covered Dependent becomes ineligible for coverage, you may be required to reimburse the Dental Plan for any or all costs incurred by the Plan to cover your ineligible dependent. If permitted by applicable law, you may also be subject to disciplinary action. Additionally, if you fail to notify the Plan Administrator within 60 days of the event, your dependent may lose eligibility to continue coverage under COBRA (or if applicable, continuation coverage available to Domestic Partners and their Eligible Dependent Children).
Please note that coverage for that dependent will end in accordance with the Plan’s provisions regardless if you have notified the Company. For example, if you cover your Spouse as a dependent under the Comprehensive Dental Plan and become divorced, your Spouse’s dental coverage will end as of the date of the divorce regardless of when you notify the Benefits Service Center by phone or through http://netbenefits.com/merck.

Continuing Your Coverage Through COBRA

If you or your Covered Dependent loses dental coverage under the Dental Plan, you may be eligible to continue your coverage through COBRA. For more information see “COBRA.”

Although existing federal law does not extend rights to COBRA coverage to your Domestic Partner and your Domestic Partner’s Covered Dependent Children, the Dental Plan offers continuation of dental coverage in certain cases. For continuation of coverage options available to Domestic Partners and their Eligible Dependent Children, see “Continuation of Dental Care Coverage for Domestic Partners” in the “Administrative Information” section.

Coverage for Surviving Dependents in the Event of Your Death – If You Die Before Jan.1, 2018

If you are an Eligible Employee and die before Jan. 1, 2018, while employed by the Employer, your surviving Covered Dependents on the date of your death are eligible to continue coverage under the Dental Plan as described in this section.

As of Your Date of Death:

- **COBRA:** Your surviving Covered Dependents are eligible to continue coverage under the Dental Plan as it applies to active employees at no cost to them for as long as they continue to meet the requirements of an Eligible Dependent up to a maximum of two years, provided they elect to continue coverage in accordance with COBRA. Coverage provided to your surviving Covered Dependents runs concurrently with the continuation period available under COBRA. (For more information, see “COBRA.”). At the expiration of the up-to-two-year period, your surviving Covered Dependents may elect to continue to participate in COBRA for the remainder of their COBRA continuation period (generally, an additional 12 months) at the full COBRA rate in effect at that time.

  During the COBRA period, your surviving Covered Dependents may add Eligible Dependents who are not Covered Dependents in accordance with rules under COBRA. However, the Plan Administrator reserves the right to require full payment of COBRA contributions to cover Eligible Dependents who are eligible under COBRA rules but are not considered to be surviving Covered Dependents.

**Special Transition Rule:** The maximum two-year period of no-cost coverage is extended one additional year to a maximum three-year period for those surviving Covered Dependents who meet each of the following requirements:

(a) The surviving Covered Dependent is enrolled for coverage under the Dental Plan as of Dec. 31, 2016,

(b) The surviving Covered Dependent’s initial two-year period of no-cost coverage has not expired as of Dec. 31, 2016, and

(c) The surviving Covered Dependent will be at least age 65 and Medicare-eligible during the initial two-year period of no-cost coverage.

If a surviving Covered Dependent satisfies each of these requirements and either covers other surviving Covered Dependents or is covered by another surviving Covered Dependent, the extension will apply to the entire Coverage Tier. This extension runs concurrent with COBRA.
Coverage for Surviving Dependent in the Event of Your Death – If you Die On or After Jan. 1, 2017

If you are an Eligible Employee and die on or after Jan. 1, 2017, while employed by the Employer, your surviving Covered Dependents on the date of your death are eligible to continue coverage under the Dental Plan as described in this section.

As of Your Date of Death:

- **Continuation Coverage**: Your surviving Covered Dependents are eligible to continue coverage under the Dental Plan as it applies to active employees at no cost to them for as long as they continue to meet the requirements of an Eligible Dependent up to a maximum of two years.

At the Expiration of the Up-to-Two-Year Continuation Period

- **COBRA**: Surviving Covered Dependents who remain covered at the end of the two-year continuation period described above are eligible to continue coverage under the Dental Plan in accordance with COBRA, provided they timely elect and pay for such coverage.

Coverage for your surviving Covered Dependents must be under the option in which they were enrolled at the time of your death until the next annual enrollment, unless they experience a Life Event that would allow them to make a Permitted Plan Change. During the next annual enrollment, your surviving Covered Dependents may elect any available option or remain in the same coverage. All surviving Covered Dependents must be enrolled in the same option. However, if during the COBRA period, your Covered Dependents opt out of coverage, they will not be allowed to enroll during the next annual enrollment or at a later date during the COBRA period.

**KEY POINT — REPORTING A DEATH**

In the event of the death of an Eligible Employee or Covered Dependents, please call the Benefits Service Center at **800-66-MERCK (800-666-3725)**.

**U.S. Territory Employees**

If you are a U.S. Territory Employee, the provisions of the Dental Plan described in this SPD apply to you except as follows:

- If you are a U.S. Territory Employee who is a U.S. territory resident on assignment in the U.S.:
  - **Cost of Coverage**: Coverage for you and your Covered Dependents is provided under the Dental Plan at no cost to you.
  - **Survivor Benefits**: In the event of your death while on assignment in the U.S., the provisions of the Dental Plan applicable to surviving Covered Dependents do not apply to your survivors, other than to the extent required by law under COBRA; coverage for your survivors may be available under the terms of your home country dental plan.
HOW THE DENTAL PLAN WORKS

DENTAL PLAN

Dental coverage is offered through the Comprehensive Dental Plan option administered through MetLife. You can elect coverage or no coverage.

KEY POINT — PRE-TREATMENT PLAN

Before starting a non-emergency dental treatment for which the charge is expected to be more than $300, a pre-treatment estimate is advisable.

About the Comprehensive Dental Plan Option

The Comprehensive Dental Plan option provides you with coverage for dental care that you receive from any licensed dentist. The Comprehensive Dental Plan option features the MetLife Preferred Dentist Program (PDP) Plus network. If you receive care from a dentist participating in the MetLife network, your out-of-pocket costs will be lower than if you receive care from an Out-of-Network dentist.

The Comprehensive Dental Plan option provides coverage for most types of dental services, including:

- Diagnostic and preventive dental care, like routine exams and cleanings
- Basic dental care, like fillings and extractions
- Major dental care, like dentures, bridgework and crowns, and
- Orthodontics.

Key Features

In general, under the Comprehensive Dental Plan option:

- You may receive care from any licensed dentist of your choice.
- Every time you need care, you have the choice to see a PDP Plus dentist or an Out-of-Network provider. PDP Plus dentists are providers who have agreed to provide services at reduced fees. If you obtain care from an Out-of-Network provider, you will likely pay more for those services.
- For diagnostic care, dental coverage begins immediately — you don’t have to meet any Deductible amount.
- For basic dental care and major care, you must meet a per person Deductible before the Plan pays for Out-of-Network coverage; the Deductible is waived if you visit an In-Network provider.

KEY POINT — EXAMPLE: SAVE MONEY BY USING AN IN-NETWORK PROVIDER

Let’s say your child needs braces. The average cost nationally is $6,000. Since the orthodontic lifetime maximum is $2,000 per person, the assumption is that it does not matter whether you go In- or Out-of-Network because the Plan pays the same. However, an In-Network orthodontist only charges $4,500 as the pre-negotiated fee for braces. This results in an additional $1,500 in savings to you.

MetLife is the Claims Administrator for the Comprehensive Dental Plan option and has the discretion to make the factual and other determinations necessary to determine if services are covered by the Plan.
KEY POINT — ANNUAL DEDUCTIBLE AND ANNUAL BENEFIT MAXIMUM

Effective Jan. 1, 2016, the annual Deductible is waived for In-Network services, and the annual maximum for In-Network services is increased to $2,500 per covered person. The lifetime limit for orthodontic services remains $2,000 per person.

If you live in an area (as determined by your home ZIP code and MetLife) that has limited or no access to MetLife providers, you may qualify for In-Network benefits even if you visit an Out-of-Network provider. Call MetLife at 888-262-4870 for details.

How the Comprehensive Dental Plan Option Works

The Comprehensive Dental Plan option provides you with access to a national network of providers — the MetLife Preferred Provider Organization network. Each time you receive care for covered expenses, you have a choice of obtaining care In-Network, using one of MetLife’s providers, or Out-of-Network from any other dentist of your choice. While you are not required to use a participating provider, there are advantages to using MetLife providers. In addition to the Deductible being waived if you visit an In-Network provider, participating providers will file the claim on your behalf and will accept the Plan allowance as payment in full.

Whether you use a network provider or not, the Plan pays 100% of covered charges for diagnostic and preventive care up to the Reasonable and Customary (R&C) Limit as discussed below. Before benefits can be paid in a calendar year, you and/or your Covered Dependents must meet the $50 per person Deductible, with a maximum family Deductible of $150 per calendar year if you visit an Out-of-Network provider. The Deductible does not apply to diagnostic, orthodontia and preventive care services, as well as covered services provided by In-Network providers. However, the Deductible does apply to basic and major services performed by Out-of-Network providers.

In-Network Benefits

You receive the highest level of benefits available under the Comprehensive Dental Plan option when you use an In-Network provider. Every time you visit a dentist who participates in the MetLife PDP Plus network, you have the potential to save money. Since the In-Network provider’s fees are negotiated (and generally lower), you are charged less. This means you pay less out of your own pocket for dental care. If you receive services from a provider participating in the MetLife network, the provider’s services are negotiated; therefore, they never exceed the R&C limit. Your Deductible is waived if an In-Network provider is used for covered services.

Out-of-Network Benefits

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

KEY POINT — IMPORTANT BENEFIT TERMS

Important benefit terms, such as Deductible, Coinsurance and Reasonable and Customary (R&C) Limit are defined in the “Glossary.”
# The Comprehensive Dental Plan Option at a Glance

<table>
<thead>
<tr>
<th>Covered Expense</th>
<th>In-Network (PDP Plus Providers)</th>
<th>Out-of-Network (Non-PDP Plus Providers)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Annual Deductible</strong></td>
<td>$0</td>
<td>$50 per person ($150 maximum)</td>
</tr>
<tr>
<td><strong>Diagnostic and preventive care, e.g.:</strong></td>
<td>100% of pre-negotiated rates</td>
<td>100% of R&amp;C limit</td>
</tr>
<tr>
<td>Routine exams (two per calendar year)</td>
<td></td>
<td></td>
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<tr>
<td>X-rays</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cleanings (two per calendar year)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Fluoride treatments (two per calendar year)</td>
<td></td>
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<tr>
<td>Sealants</td>
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<tr>
<td>Space maintainers</td>
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<tr>
<td>Emergency palliative treatment</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Basic restorative care, e.g.:</strong></td>
<td>80% of pre-negotiated rates</td>
<td>80% of R&amp;C limit, after Deductible</td>
</tr>
<tr>
<td>Fillings (other than gold)</td>
<td></td>
<td></td>
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<tr>
<td>Extractions</td>
<td></td>
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<tr>
<td>Root canals</td>
<td></td>
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<tr>
<td>Periodontics (up to eight visits per calendar year, including up to four periodontal maintenance visits), including debridement (once in 36 months)</td>
<td>80% of pre-negotiated rates</td>
<td>80% of R&amp;C limit, after Deductible</td>
</tr>
<tr>
<td>Denture repair</td>
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<tr>
<td>Oral surgery (performed in a dental office)</td>
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<tr>
<td>Anesthesia, including nitrous oxide</td>
<td></td>
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<tr>
<td>Implants (3)</td>
<td></td>
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<tr>
<td>Recements</td>
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</tr>
<tr>
<td><strong>Major services, e.g.:</strong></td>
<td>50% of pre-negotiated rates</td>
<td>50% of R&amp;C limit, after Deductible</td>
</tr>
<tr>
<td>Gold fillings and inlays</td>
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<td></td>
</tr>
<tr>
<td>New or replacement dentures and bridgework (certain limits apply)</td>
<td>50% of pre-negotiated rates</td>
<td>50% of R&amp;C limit, after Deductible</td>
</tr>
<tr>
<td>Crowns</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Appliance to correct harmful habits (e.g., thumb-sucking or tongue-thrusting)</td>
<td>50% of pre-negotiated rates</td>
<td>50% of R&amp;C limit, after Deductible</td>
</tr>
<tr>
<td><strong>Annual Benefit Maximum</strong></td>
<td>$2,500 annually for each covered</td>
<td>$2,000 annually for each</td>
</tr>
</tbody>
</table>

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1 In-Network percentages are based on negotiated fees with MetLife PDP Plus dentists. Out-of-Network percentages are based on R&C Charges. See "Determining the R&C Amount for a Covered Charge."

2 Scaling and root planing are limited to eight quadrants per 24 months. The clinical parameters used for rendering a benefit determination, based on submitted documentation, are as follows: pathologic periodontal pocket depth of 4 mm or greater and evidence of the loss of periodontal ligament attachment (bone loss). In order to be eligible for the periodontal cleanings there has to be a history of at least two quadrants of scaling or osseous surgery.

3 As with any treatment expected to result in charges that exceed $300, you should submit a pre-treatment plan for review prior to undergoing treatment.

4 Expenses incurred to satisfy your annual benefit maximum will count toward both your In-Network and Out-of-Network annual benefit maximum.

5 Combined annual Deductible of $50, to a maximum of $150 per family for Out-of-Network services.
Plan Maximums

Lifetime Maximum

You and/or your Covered Dependents have a $2,000 lifetime maximum per person for orthodontic expenses.

Annual Benefit Maximum

You and/or your Covered Dependents will be covered up to $2,500 per person for In-Network services and up to $2,000 per person for Out-of-Network services. Expenses incurred to satisfy your annual benefit maximum will be credited to both your In-Network and Out-of-Network annual benefit maximum. Expenses in excess of the R&C limit do not count toward the annual benefit maximum. If you reach your annual benefit maximum in a calendar year, no further dental benefits will be paid until the following year, except for orthodontic charges up to the $2,000 per person lifetime maximum.

For example, if you use all of your Out-of-Network annual maximum of $2,000 and then choose to see an In-Network provider for additional covered services, you will be covered for an additional $500 toward your In-Network annual benefit maximum of $2,500.

Dental Covered Services

After you have met the annual Deductible (when applicable), the Comprehensive Dental Plan option reimburses covered charges for Covered Dental Services from Out-of-Network dentists at a percentage of R&C Charges. Covered charges for covered dental services from In-Network dentists are reimbursed based on negotiated reduced fees with PDP Plus dentists.

For example, assume the Plan pays 50% and the R&C Charge for a certain covered dental service is $1,000. If your Out-of-Network dentist charges you $1,200 for that service, the Comprehensive Dental Plan option will only pay $500 — that is 50% of the $1,000 R&C Charge (assuming you have already met your Deductible).

If your covered charges exceed the R&C Charge, you are responsible for paying the additional amount. In the above example, you will be responsible for paying $700, your 50% Coinsurance (50% of the $1,000 R&C charge) plus the amount above R&C ($200). Any charges above the R&C Charge will not count toward your Deductible.

The Comprehensive Dental Plan option does not reimburse you for charges for non-covered dental services. See “Dental Services Not Covered.”

Determining the R&C Amount for a Covered Charge

Anytime your dentist recommends a surgical or diagnostic procedure, you can call MetLife Member Services (see “Benefits Contacts and Resources”) to see if the fee to be charged is more than the R&C Charge.

- If it is more, MetLife will give you the R&C amount so that you can discuss the reasonableness of the fee with your dentist in advance.
• If it is less, MetLife will confirm that the fee to be charged is less than the R&C amount, but will not disclose the R&C amount.

Before calling MetLife, be sure to have the name and description of the proposed dental treatment or service, the “procedure code” and the fee, all of which your dentist can provide.

An Example

Here is an example of the Comprehensive Dental Plan option at work for you. Assume you have covered dental expenses in a calendar year as follows and that you use an In-Network provider.

<table>
<thead>
<tr>
<th>For These Expenses…</th>
<th>Total Covered Charges</th>
<th>Comprehensive Dental Plan Pays…</th>
<th>You Pay…</th>
</tr>
</thead>
<tbody>
<tr>
<td>Two check-ups, including X-rays and cleanings</td>
<td>$250</td>
<td>$250</td>
<td>$0</td>
</tr>
<tr>
<td>Two fillings</td>
<td>$160</td>
<td>$128 (80% of pre-negotiated rates)</td>
<td>$32 (20% of pre-negotiated rate; Deductible is waived)</td>
</tr>
<tr>
<td>A crown replacement</td>
<td>$800</td>
<td>$400 (50% of pre-negotiated rate)</td>
<td>$400 (50% of pre-negotiated rates; Deductible is waived)</td>
</tr>
<tr>
<td>Total</td>
<td>$1,210</td>
<td>$778</td>
<td>$432</td>
</tr>
</tbody>
</table>

Now, let’s take a look at how the Comprehensive Dental Plan option pays for orthodontia expenses incurred in a calendar year:

<table>
<thead>
<tr>
<th>For These Expenses…</th>
<th>Total Covered Charges</th>
<th>Comprehensive Dental Plan Pays…</th>
<th>You Pay…</th>
</tr>
</thead>
<tbody>
<tr>
<td>Orthodontia/Braces</td>
<td>$4,500</td>
<td>$2,000 (50% of pre-negotiated rate, up to lifetime maximum of $2,000)</td>
<td>$2,500</td>
</tr>
</tbody>
</table>

When an Expense Is Incurred

In most cases, a dental charge is incurred on the date the service is performed or the supply is furnished. However, there are times when one overall charge is made for all or part of a course of treatment. For the following procedures, the expense is incurred (and the procedure is considered started) in the case of:

• Dentures or fixed bridgework, the impression is taken
• Crownwork, preparation of the tooth is begun, and
• Root canal therapy, work on the tooth is begun.

Before You Receive Care — Pre-Treatment Plan

Before you receive certain dental services, you are advised to discuss the treatment plan with your dentist to determine what is covered. Before starting a non-emergency dental treatment for which the charge is expected to be more than $300, a pre-treatment plan is advisable. A pre-treatment estimate is not intended for routine dental cleanings or fillings. The pre-treatment estimate is available to help anticipate more costly services like bridge work or implant work.

A pre-treatment plan is a written report made by your dentist describing the dentist’s findings and recommended course of treatment. The treatment plan is sent to the Claims Administrator, who will send both you and your dentist a report indicating the benefits that the Comprehensive Dental Plan option will pay. In determining your benefits, the Claims Administrator may consider alternate dental services that would produce a professionally acceptable result (see “Alternate Treatment”).
This procedure is designed to avoid misunderstandings and gives you an opportunity to plan ahead if you have to pay a portion of the covered charges. If you have any questions about obtaining a pre-treatment plan, call MetLife, the Claims Administrator (see “Benefits Contacts and Resources”).

Alternate Treatment

Although there are sometimes several ways of treating a dental problem, the Comprehensive Dental Plan option limits benefits to those services and supplies considered by the Claims Administrator to be adequate and appropriate to the presenting dental problem. Services and supplies are considered adequate and appropriate if they are customarily used nationwide to treat the disease or injury and are deemed by the dental profession to be appropriate and essential treatment in accordance with broadly accepted national standards of dental practice, taking into account the patient’s total current oral condition.

If your dentist recommends a course of treatment for a dental problem in excess of that which the Claims Administrator determines is adequate and appropriate for that problem, you may proceed with the more expensive course of treatment. However, you will not receive benefits under the Comprehensive Dental Plan option for those services and supplies determined by the Claims Administrator to be in excess of those that are adequate and appropriate for that problem. For example, if your dentist recommends (and you proceed with) a porcelain crown for a tooth and the Claims Administrator determines that a metal crown is adequate and appropriate, you will receive benefits under the Comprehensive Dental Plan option as if you had received a metal crown.

You may want to submit a pre-treatment plan to the Claims Administrator to determine the extent of coverage under the Comprehensive Dental Plan option.

Covered Dental Services

Dental services are categorized into three types of services — diagnostic and preventive care, basic care and major care. Following are descriptions of covered services and limitations by category.

Diagnostic and Preventive Care Services

The following is a list of covered routine diagnostic and preventive care services and limitations:

- Emergency palliative treatment
- Consultations (two per calendar year)
- Clinical oral examinations (two per calendar year)
- Bitewing X-rays (two per calendar year for children and one per calendar year for adults)
- Panorex (full mouth) X-rays (once every 36 months)
- Tests and laboratory examinations
- Routine cleansings (two per calendar year)
- Fluoride treatments (two per calendar year)
- Sealants
- Space maintainers, and
- Professional consultation (dentist-to-dentist).

Basic Restorative Care

The following is a list of covered basic care services and limitations:

- Recements
• Amalgam restorations (including polishing)
• Resin-based composite fillings
• Endodontics:
  - Pulp capping
  - Pulpotomy
  - Root canal therapy (includes treatment plan, clinical procedures and follow-up care) and periapical services, and
  - Other endodontic procedures.
• Periodontics:
  - Scaling and root planing are limited to eight quadrants per 24 months.
  - The clinical parameters used for rendering a benefit determination, based on submitted documentation, are as follows: pathologic periodontal pocket depth of 4 mm or greater and evidence of the loss of periodontal ligament attachment (bone loss).
  - Surgery is limited to eight quadrants per 36 months.
  - Debridement is limited to once every 36 months.
• Case pattern section (includes all necessary diagnostic, surgical and adjunctive services):
  - Gingivitis and periodontitis, and
  - Repairs to dentures.
• Extractions — includes local anesthesia and routine postoperative care
• Other surgical procedures applied to teeth (oral surgery performed in the office, even when performed by a DMD, is considered dental; oral surgery performed any place other than the office is considered medical and may be considered for payment under medical benefits):
  - Alveoloplasty (surgical preparation of ridge for dentures)
  - Surgical excision — excision of reactive inflammatory lesions (scar tissue or localized congenital lesions)
  - Excision of tumors
  - Removal of cysts and neoplasms, and
  - Surgical incision.
• Other repair procedures
• Adjunctive general services:
  - Unclassified treatment
• Charges for occlusal guards, and
• Anesthesia:
  - General
  - Nitrous oxide, and
  - Professional visits.
Major Services

The following is a list of covered major care services and limitations:

- Appliances to treat harmful habits such as thumb-sucking and tongue-thrusting
- Gold foil restorations
- Gold inlay restorations
- Porcelain restorations
- Crowns — single restorations only
- Complete and partial dentures — including six months post-delivery care
- Additional units for partial dentures
- Adjustments to dentures (if after six months of initial placement)
- Replacement of missing teeth
- Prosthodontics, fixed:
  - Fixed bridges (each abutment and each pontic constitutes a unit in a bridge)
  - Bridge pontics
  - Retainers
  - Crowns
  - Orthodontics, or
- Replacement or alteration of full or partial dentures and bridgework, including relining crowns/bridges/onlays/inlays/veneers/implants/implant prosthetics/dentures/post and cores/crown build-ups — every seven years (note that for dentures, including relining and rebasing, services must be provided after six months of initial placement), and
- Dentures or bridgework being replaced due to natural structural changes in the mouth, loss of abutments or dentures that are worn and no longer serviceable must be at least seven years old. (Certain other restrictions may apply. You will want to have your dentist submit a pre-treatment plan to see what expenses are covered.)

Dental Services Not Covered

Benefits are not provided for services and supplies not medically necessary for the diagnosis or treatment of dental illness or injury. Dental work must be performed by a dentist licensed to practice in the state or by a legally qualified physician. A dentist is a doctor of dental surgery or a doctor of medical dentistry.

The Claims Administrator reserves the right to determine whether, in its judgment, a service or supply is eligible for payment under the Dental Plan. The fact that a dentist has prescribed, ordered, recommended or approved a service or supply does not, in itself, make it eligible for payment.

The following exclusions apply to all the benefits described in the Dental Plan. Benefits are not provided for:

- Charges incurred in a veteran’s hospital, paid by a government agency or done at no cost to the patient
- Charges for dental work or supplies furnished by an employer, mutual benefit association or similar group, or furnished in connection with your employment with your Employer
- Expenses for services covered by the Merck Preferred Provider Organization options (the Merck PPO — Horizon BCBS or the Merck PPO — Aetna Choice POS II), or HMO for residents of Hawaii or Kaiser for California under the Merck Medical Plan, whether or not you are enrolled in those options
- Any dental surgery or other dental service performed on an inpatient or outpatient basis in a hospital or an ambulatory surgical facility
- Charges for cosmetic dental work
- Replacement cost of lost or stolen dentures, bridgework or other prosthetic devices
- Charges for orthodontic appliances inserted prior to the effective date of your coverage. However, the Claims Administrator will prorate the orthodontic benefit to cover monthly maintenance/adjustments for that portion of the course of treatment after the effective date
- Charges connected with vertical alterations or training in dental hygiene or plaque control
- Charges for any duplicate prosthetic device or any other duplicate appliance (other than replacement dentures once every seven years)
- Charges for expenses incurred prior to the date your coverage began
- Charges for expenses incurred while covered under the No Coverage option
- Charges for procedures, services and other supplies that are, as determined by the Claims Administrator under its internal procedures, experimental or still under clinical investigation by health professionals (other than to the extent described in “Alternate Treatment”)
- Claims submitted more than 24 months from the date of service, unless it is shown that it was not reasonably possible to furnish the claim within the time limit
- Charges for dental work needed because of active participation in a declared or undeclared war
- Services that, to any extent, are payable under any medical benefits
- Charges for broken appointments
- Charges by the dentist for completing dental forms
- Sterilization supplies
- Services or supplies furnished by a family member
- Charges for treatment of temporomandibular joint (TMJ) dysfunction, except for oral examinations or dental X-rays that may be necessary to make a diagnosis. **Note:** TMJ appliances are not covered by the Comprehensive Dental Plan option, or
- Charges for after-hours visits, unless for an emergency.
IMPORTANT INFORMATION ABOUT THE PLAN

ADMINISTRATIVE INFORMATION

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

Coordination of Benefits

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

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

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

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

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

If the primary plan covers a certain service or supply at the same level as the secondary plan, the secondary plan may not pay any additional benefits for that service or supply. As a result, it may not be to your advantage to be covered by two dental plans. For example, if your Spouse/Domestic Partner is covered under the Spouse/Domestic Partner’s employer’s plan and as a Covered Dependent under the Dental Plan, the Dental Plan is secondary. If your Spouse/Domestic Partner submits expenses to the Dental Plan, and the amount payable by the Dental Plan is less than or equal to what your Spouse’s/Domestic Partner’s plan would have paid, the Dental Plan will pay nothing. The Dental Plan never pays more than the amount that, when added to the amount paid by the primary coverage, equals the amount the Dental Plan would have paid had it been the primary plan.

KEY POINT — MAXIMUM BENEFIT PAID WHEN COORDINATING COVERAGE

The Dental Plan never pays more than the amount that, when added to the amount paid by the primary coverage, equals the amount the Dental Plan would have paid had it been the primary plan.
Coverage Under Your Spouse’s/Domestic Partner’s Plan
If you are an Eligible Employee and you have other coverage, you may choose the No Coverage option. Be sure to check the rules of the other plan in advance. Some employers will not allow an employee to cover a Spouse/Domestic Partner if the Spouse/Domestic Partner can obtain coverage through that person’s own employer.

Coordinating Benefits in General
The Dental Plan coordinates benefits with other coverage in accordance with the rules of the National Association of Insurance Companies. Following are some examples of those rules:

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

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

Coordinating Benefits When Another Managed Care Plan Is Primary
If the primary plan has paid on an In-Network basis (i.e., the member followed that plan’s requirements for In-Network coverage under that plan), then the Dental Plan will pay an amount that, when added to the amount paid by the primary plan, equals the amount the Dental Plan would have paid had it been primary on an In-Network basis. If the primary plan paid on an Out-of-Network basis, the Dental Plan would pay an amount that, when added to the amount paid by the primary plan, equals the amount the Dental Plan would have paid had it been primary on an Out-of-Network basis.

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

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

Overpayment of Benefits

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

Subrogation and Reimbursement

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

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

You also must take any reasonably necessary action to protect the Dental Plan’s subrogation and reimbursement right. That means by accepting benefits from the Dental Plan, you agree to notify the Plan Administrator if and when you institute a lawsuit, or other action, or enter into settlement negotiations with another party (including that party’s insurance company) in connection with or related to the conduct of another party. You also must cooperate with the Plan Administrator’s reasonable requests concerning the Plan’s subrogation and reimbursement rights and must keep the Plan Administrator informed of any important developments in your action. You also agree that a constructive trust, lien or an equitable lien by agreement in favor of the Plan exists with regard to any settlement or recovery from a third person or party.

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

If you or your Covered Dependents receive payment from a third party or that party’s insurance company as a result of an injury or harm due to the conduct of another party and you (or your Covered Dependents) have received benefits from the Dental Plan, the Dental Plan must be reimbursed first. In other words, your (or your Covered Dependents’) recovery from a third party may not compensate you (or your Covered Dependents) fully for all of the financial expenses you have incurred. In addition, the Plan’s right to reimbursement shall not be affected or reduced by the “make whole” doctrine, the “fund” doctrine, the “common fund” doctrine, comparative/contributory negligence, “collateral source” rule, “attorney’s fund” doctrine, regulatory diligence or any other equitable defenses that may affect the Plan’s right to subrogation or reimbursement. For more information on how to contact the Plan Administrator, see “Plan Disclosure Information.”
COBRA

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

Please note that although existing federal law does not extend rights to COBRA coverage to your Domestic Partner and your Domestic Partner’s Covered Dependent Children, the Dental Plan offers continuation of dental coverage in certain cases. For continuation of coverage options available to Domestic Partners, see “Continuation of Dental Coverage for Domestic Partners.”

**KEY POINT — MEDICAL COVERAGE OPTION UNDER COBRA**

When you lose group health coverage, you may have other options available to you for medical coverage — but not dental, vision, or health care FSA coverage — through the Health Insurance Marketplace. By enrolling in medical coverage through the Marketplace, you may qualify for lower costs on your monthly medical coverage premiums and lower out-of-pocket costs for medical care. Additionally, you may qualify for a 30-day special enrollment period for another group health plan for which you are eligible (such as a spouse’s plan), even if that plan generally doesn’t accept late enrollees.

You do not have to show that you are insurable to choose COBRA coverage. However, you will have to pay the entire premium for your COBRA coverage plus a 2% administrative fee. There is a 30-day grace period for the payment of the regularly scheduled premium (other than the initial premium that must be paid by its due date).

**Who May Elect COBRA Coverage**

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

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

- The death of your Spouse
- The termination of your Spouse’s employment (for reasons other than gross misconduct) or reduction in your Spouse’s hours of employment
- Divorce or legal separation from your Spouse (in states where legal separation equals divorce), or
- Your Spouse becoming enrolled in Medicare.
If you are a Dependent Child of an Eligible Employee and are covered by the Plan on the day before the qualifying event, you also are a Qualified Beneficiary and have the right to COBRA coverage if your coverage under the Comprehensive Dental Plan is lost for any of the following reasons (qualifying events):

- The death of the employee
- The termination of the employee’s employment (for reasons other than gross misconduct) or reduction in the employee’s hours of employment
- The divorce or legal separation (in states where legal separation equals divorce) of the employee
- The employee becoming enrolled in Medicare, or
- The dependent becoming no longer eligible for coverage under the Plan.

If You Have a Newborn During Your COBRA Period

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

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

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

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

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

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

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

KEY POINT — IN THE EVENT OF YOUR DEATH

If you die while you are a participant in the Comprehensive Dental Plan option, your Covered Dependents may be eligible to continue to receive dental coverage under the Plan. For information, see “Coverage for Surviving Dependents in the Event of Your Death.”
Your Duties Under the Law

You or a family member have the responsibility of informing the Benefits Service Center (the COBRA Administrator) of a divorce, legal separation or a child losing dependent status under the Dental Plan. This notice must be provided within 60 days from the date of the divorce, legal separation or a child losing dependent status (or, if later, the date coverage would normally be lost because of the event).

To notify the Plan Administrator of a Covered Dependent losing coverage due to divorce, legal separation or a child losing dependent status, contact the Benefits Service Center online or by phone.

If you, or a family member, fail to provide this notice to the Benefits Service Center online or by phone during this 60-day notice period, any Covered Dependent who loses coverage will not be offered the option to elect COBRA coverage.

**KEY POINT — LOSING DEPENDENT STATUS**

A Dependent Child can lose dependent status by reaching age 26. Call the Benefits Service Center for more information.

For your Spouse and each child, the following information is required to enroll in COBRA coverage:

- Full name
- Mailing address
- Date of birth
- Relationship to you, and
- Social Security number.

Once you, your Spouse or your Dependent Child has notified the Benefits Service Center of the event resulting in the loss of coverage, COBRA information and an election form for continuation coverage will be mailed within 14 days by the COBRA Administrator. After you receive the information and election form, you and your Eligible Dependents then have 60 days from the date coverage ends or the date this information package is mailed to you (whichever is later) to accept or decline continuation coverage.

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

**KEY POINT — IF YOU MOVE**

To ensure that you receive the most up-to-date benefits information, it is your responsibility to contact the Benefits Service Center any time you have a change in address to have your address updated.

Merck’s Duties Under the Law

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

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

Time Period for Elections

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

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

Separate Elections

Each Qualified Beneficiary has an independent election right to elect COBRA coverage. For example, if there is a choice among types of coverage options under the Plan, each Qualified Beneficiary who is eligible for COBRA coverage is entitled to make a separate election among the types of coverage options. Thus, a Spouse or Dependent Child is entitled to elect COBRA coverage even if you do not make that election. Similarly, a Spouse or Dependent Child may elect different coverage options from the coverage options you elect.

Types of Coverage You Will Receive and Changes to Coverage

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

As a Qualified Beneficiary, you will have the same opportunity to change your benefit elections as similarly situated non-COBRA beneficiaries. This means that you will be eligible to participate in the Plan’s annual enrollment and you are subject to the Plan’s rules regarding mid-year changes. You also have the same right as active Eligible Employees to enroll Eligible Dependents under the HIPAA special enrollment rules (for example, in the case of a new dependent acquired through marriage, birth or adoption, or a dependent’s loss of other health coverage), if available. If the Plan Sponsor discontinues the Plan or benefit you elected as COBRA coverage, you may be entitled to receive different coverage from Merck & Co., Inc. or its subsidiaries. In addition, if you move out of a network service area for your coverage option, the Company must offer you coverage available to other Company employees in the new geographic area (or coverage available to employees of related companies, if there are no Company employees in the area). If there is no other coverage available for that area, then the Company must offer you other existing coverage that may extend to that area.

Duration of COBRA Coverage

Employment Termination or Reduction in Hours

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

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

Other Qualifying Events

A 36-month period of coverage applies to Spouses and Dependent Children who are Qualified Beneficiaries who experience qualifying events other than due to your termination of employment or reduction in hours. This longer period applies to a loss of coverage due to:

- Your death
- Divorce or legal separation of you and your Spouse (in states where legal separation equals divorce)
- Your loss of benefits because of entitlement to Medicare (your Spouse and dependent may elect COBRA coverage for up to 36 months from the date you became enrolled in Medicare), or
- Your dependent becoming no longer eligible for coverage under the Dental Plan.

Second Qualifying Events

A 36-month period also applies if one of these qualifying events occurs during the initial 18-month COBRA period described above, or during a 29-month COBRA period applicable to disabilities, described below. These events can result in an extension of an 18-month COBRA period to 36 months from the date of employment termination or reduction in hours. You must notify the COBRA Administrator within 60 days of the second qualifying event in order to be eligible for the 36-month COBRA period.

Special Rules for Disability

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

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

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

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

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

1. The Company no longer provides group health coverage to any of its employees.
2. The premium for COBRA coverage is not paid within 30 days of the due date; or the initial premium is not paid within 45 days after the initial election.
3. The Qualified Beneficiary becomes enrolled in Medicare after the date COBRA is elected. (COBRA coverage ends only for the person enrolled in Medicare.)
4. Coverage has been extended for up to 29 months due to disability and there has been a final determination that the individual is no longer disabled (coverage for all Qualified Beneficiaries who received the extension due to disability may end as of the first day of the month that is more than 30 days after such final determination, provided that the termination date is after the end of the initial 18-month period of COBRA coverage).
5. The Qualified Beneficiary becomes covered — after the date COBRA is elected — under another group health plan.

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

Paying for COBRA Coverage

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

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

If you do not make payments on a timely basis as described above, COBRA coverage will terminate as of the last day of the month for which you made a timely payment.

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

If you have any questions about COBRA coverage or the application of the law, please contact the COBRA Administrator at the address listed below. Also, if your marital status has changed, or you, your Spouse or a dependent have changed addresses, or a dependent ceases to be a dependent eligible for coverage under the terms of the Plan, you must notify the COBRA Administrator immediately by phone, online or in writing at the address listed below. Fidelity Investments is the COBRA Administrator. If you have questions about your COBRA rights, call the Benefits Service Center.

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

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

Continuation of Dental Coverage for Domestic Partners

Although existing federal law does not extend rights to COBRA coverage to your Domestic Partner and your Domestic Partner’s Covered Dependent Children, the Plan offers continuation of dental coverage in certain cases. Your Domestic Partner and your Domestic Partner’s Covered Dependent Children will be eligible to elect and pay for continuation of coverage if their benefits are lost under certain circumstances. And, just like COBRA benefits, this continuation of coverage:

- Is available for a maximum of 18, 29 or 36 months, and
- Must be paid for on a monthly basis — with contributions based on the full cost of coverage, plus 2% for administrative costs.

Continuation of coverage generally follows the same rules as COBRA. See the “Continuation of Dental Coverage Summary for Domestic Partners,” which summarizes the events that trigger continuation of coverage benefits for your Domestic Partner and/or your Domestic Partner’s Covered Dependent Children.

For purposes of these COBRA-like benefits, your Domestic Partner and your Domestic Partner’s Eligible Dependent Children who lose dental coverage as a result of certain events (listed in the “Continuation of Dental Coverage Summary for Domestic Partners”) will be treated as if they were Qualified Beneficiaries.

To be eligible for continuation of coverage, you must notify the Benefits Service Center within 60 days of certain events, as shown in the chart on the next page and you must follow the enrollment instructions (and the enrollment timeframes) provided by the Benefits Service Center. You and/or your Covered Dependents will not be eligible for continuation of coverage benefits if the Benefits Service Center is not notified within the 60-day period or if you do not enroll for continuation coverage in accordance with the instructions and timeframe required by the COBRA Administrator.
Continuation of Dental Coverage Summary for Domestic Partners

You must notify the Benefits Service Center (online or by phone) within 60 days of these events for your Domestic Partner and/or your Domestic Partner’s Covered Dependent Children to be eligible for continuation of coverage benefits:

<table>
<thead>
<tr>
<th>Event</th>
<th>Domestic Partner</th>
<th>Employee’s/Domestic Partner’s Covered Dependent Children</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Maximum continuation of coverage period</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Employee terminates employment for any reason (except gross misconduct)</td>
<td>18 months(^1)</td>
<td>18 months(^1)</td>
</tr>
<tr>
<td>Employee dies</td>
<td>36 months</td>
<td>36 months</td>
</tr>
<tr>
<td>Domestic Partnership ends</td>
<td>36 months</td>
<td>36 months</td>
</tr>
<tr>
<td>Disabled employee becomes entitled to Medicare (and dependents lose coverage)</td>
<td>36 months</td>
<td>36 months</td>
</tr>
<tr>
<td>Child is no longer an Eligible Dependent under the Company’s plans</td>
<td>Not applicable</td>
<td>36 months</td>
</tr>
</tbody>
</table>

Your Rights Under HIPAA

See the “Special Enrollment Under HIPAA for Eligible Employees” section of this SPD for information.

Your Rights Under USERRA

The Dental Plan is subject to the “continuation coverage” requirements of the Uniformed Services Employment and Reemployment Rights Act of 1994 (“USERRA”) and will be administered in accordance with USERRA and the military leave rules established by the Plan Administrator. As a result, you will be entitled to continue coverage for yourself and your Eligible Dependents under the Dental Plan during your military leave while you are an employee of an Employer for at least a period of twenty-four (24) months. You do not need to take any action to continue coverage under the Dental Plan for yourself and your Covered Dependents when you begin your military leave. However, if you want to drop or otherwise change your coverage under the Dental Plan when you begin your military leave, you must contact the Benefits Service Center within 30 days after your leave begins. If you do not contact the Benefits Service Center within that 30-day period, your coverage under the Dental Plan will continue as described below.

If you are eligible to continue to receive Base Pay from the Employer during your military leave, coverage will continue in accordance with the Dental Plan’s terms and conditions applicable to an employee on a paid leave of absence. Employee contributions at the active employee rate will continue to be deducted from your pay; to the extent your pay is insufficient to pay the required contributions, unpaid contributions will be accumulated and be payable by you when you return to active employee status. You may drop or otherwise change your coverage during your military leave only during annual enrollment (for coverage changes effective the following Jan. 1) or mid-year if you have a Life Event that allows you to make a Permitted Plan Change and you timely notify the Benefits Service Center.

\(^1\) May be extended to 29 months if your Covered Dependent is determined — by Social Security — to be disabled at any time within the first 60 days of continuation of coverage.
If you are not eligible to continue to receive Base Pay from the Employer during your military leave, coverage will continue while you are an employee of an Employer in accordance with the Dental Plan’s terms and conditions applicable to an employee on an unpaid leave of absence. You will receive a monthly invoice directly from the Benefits Service Center showing the amount of your employee contribution at the active employee rate required to continue coverage. If you do not pay the required monthly employee contribution in the time and manner specified on the invoice, coverage will terminate as of the last day of the month for which employee contributions have been timely received. You will not thereafter be eligible to enroll for coverage until the next annual enrollment period (for coverage effective the following Jan. 1) or mid-year if you have a Life Event that allows you to make a Permitted Plan Change and you timely notify the Benefits Service Center.

If you elect not to continue coverage during a paid or unpaid military leave, you will be entitled to reinstatement of coverage upon your return to active employee status. Coverage provided under USERRA will run concurrently with any coverage provided under COBRA. For more information regarding your rights during a military leave, contact the Benefits Service Center or refer to Merck’s Military Leave Policy, available on Sync or by request from Merck’s My Support Center.

Your Rights Under ERISA

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

Receive Information About Your Plan and Benefits

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

- 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 SPD. The administrator may charge a reasonable fee for the copies.

- Receive a summary of the Plan’s annual financial report, if applicable. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report, if applicable.

Continue Group Health Care

If there is a loss of coverage under the Dental Plan as a result of a qualifying event, you, your Spouse or dependents may have to pay for such coverage. Review this SPD and the documents governing the Plan on the rules governing your COBRA continuation coverage rights.

Reduction or Elimination of Exclusionary Periods of Coverage for Pre-existing Conditions Under Your Group Health Plan, if You Have Creditable Coverage from Another Plan

You should be provided a certificate of creditable coverage, free of charge, from your group health plan or health insurance issuer when you lose coverage under the Plan, when you become entitled to elect COBRA or when your COBRA continuation coverage ceases if you request it up to 24 months after losing coverage. Without evidence of creditable coverage, you may be subject to the pre-existing condition exclusion for 12 months (18 months for late enrollees) after your enrollment date in your coverage.
Prudent Actions by Plan Fiduciaries

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

Enforcing Your Rights

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

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

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

Assistance with Your Questions

If you have any questions about the Dental Plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance of the Employee Benefits Security Administration at:

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

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

Claims and Appeals

If you, your beneficiary or your authorized representative feel that the Claims Administrator has made an error concerning your benefits, you, your beneficiary or your authorized representative have the right to request reconsideration under the Plan in accordance with the following procedure. Please note that all requests for reconsideration shall be submitted in writing to the Claims Administrator. See “Benefits Contacts and Resources for Written Appeals” for address information.
Initial Claim

The Claims Administrator is responsible for evaluating all benefit claims. The Claims Administrator will review your claim in accordance with its standard claims procedures, as required by ERISA. The Claims Administrator has the right to secure independent dental advice and to require other evidence as it deems necessary in order to decide the status of your claim. There are four categories of claims: urgent care claims, pre-service claims, post-service claims and concurrent care claims. Each category has different claims procedures. For many of these procedures, your health care provider may work directly with the Claims Administrator.

- **“Urgent” care claims.** These are claims that, if not processed quickly (within 72 hours), the life or health of the patient is jeopardized. The Claims Administrator will notify you or your dentist of the Plan’s decision no later than 72 hours after your claim is received, unless you fail to provide sufficient information to determine whether, or to what extent, benefits are covered or payable under the Plan.

- **“Pre-service” care claims.** These are claims that must be decided before a patient will be allowed access to health care (for example, pre-authorization requests or referrals). The Claims Administrator will notify you or your dentist of the decision no later than 15 days after your claim is received. This 15-day period may be extended by another 15 days in certain circumstances.

- **“Post-service” care claims.** These are claims involving the payment or reimbursement of costs for care that has already been provided. For non-urgent, post-service health claims, the Claims Administrator has up to 30 days to evaluate and respond to claims for benefits. The 30-day period begins on the date the claim is first filed. This 30-day period may be extended by 15 days, in certain circumstances.

- **“Concurrent” care claims.** These are claims for which the Claims Administrator has previously approved a course of treatment over a period of time or for a specific number of treatments, and the Plan later reduces or terminates coverage for those treatments. Concurrent care claims may fall under any of the above three categories, depending on when the appeal is made. However, the Plan must give you enough advance notice to appeal the claim before a concurrent care decision takes effect.

If Your Claim Is Denied

If the Claims Administrator does not fully agree with your claim, you will receive an “adverse benefit determination,” which is a denial, reduction or termination of a benefit. An adverse benefit determination also means a claim denial on the grounds that the treatment is experimental, investigational, not medically necessary or otherwise not eligible for payment under the Plan. This includes concurrent care determinations. You will receive notice of a denial, which will include:

- The specific reasons for the denial
- The specific Plan provisions on which the denial is based
- A description of any additional information needed to reconsider the claim and the reason this information is needed
- A description of the Plan’s review procedures and the time limits applicable to such procedures
- A statement of your right to bring a civil action under ERISA following a denial on review
- Any internal rules, guidelines, protocols or similar criteria that were used as a basis for the denial, either the specific rule, guideline, protocols or other similar criteria, or a statement that a copy of such information will be made available free of charge upon request
- For a denial based on medical necessity, experimental treatment or other similar exclusions or limits, an explanation of the scientific or clinical judgment used in the decision or a statement that an explanation will be provided free of charge upon request, and
• For a denial involving urgent care, a description of the expedited review process for such claims.

Appealing a Claim

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

Upon your request, you will have access to, and the right to obtain copies of, all documents, records and information relevant to your claim free of charge. You may submit with your appeal any written comments, documents, records and any other information relating to your claim, even if you didn’t include that information with your original claim. See “Benefits Contacts and Resources for Written Appeals.” Reviewers must take all the information into account, even if it was not submitted or considered in the initial decision. The review will not afford any deference to the initial claim determination.

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

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

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

• **Pre-service appeals.** The Claims Administrator will provide notice of the appeal decision within 15 days following receipt of your appeal.

• **Post-service appeals.** The Claims Administrator will provide notice of the appeal decision within 30 days following receipt of your appeal.

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

• The specific reason or reasons for the adverse determination

• References to the specific Plan provisions on which the determination was based

• A statement that you are entitled to receive upon request and free of charge reasonable access to, and copies of, all records, documents and other information relevant to your benefit claim

• If the denial is based on medical necessity, experimental treatment or other similar exclusion or limit, an explanation of the scientific or clinical judgment used in making the decision

• A statement that you have the right to obtain upon request and free of charge, a copy of internal rules or guidelines relied upon in making this determination, and if the determination is based on medical necessity or experimental treatment or similar exclusion or limit, an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to your medical circumstances, and
A statement of your right to bring a civil action under ERISA following an adverse benefit determination on review.

Appealing a Claim for a Second Time

If MetLife upholds an adverse benefit determination at the first level of appeal for pre-service claims or post-service claims, you or your authorized representative have the right to file a voluntary second appeal, also called a level two appeal. (Please note that a level two appeal does not exist for urgent care claims.) The appeal must be submitted within 60 calendar days following the receipt of notice of a level one appeal.

A level two appeal of an adverse benefit determination of a pre-service claim or a post-service claim shall be provided by MetLife personnel not involved in making an adverse benefit determination.

- **Pre-service appeals** (may include concurrent care claim reduction or termination). MetLife shall issue a decision within 15 calendar days of receipt of the request for a level two appeal.

- **Post-service appeals.** MetLife shall issue a decision within 30 calendar days of receipt of the request for a level two appeal.

If you do not agree with the final determination on review, you have the right to bring a civil action, if applicable.

MetLife will provide two full and fair reviews of your appeal. Based on the information submitted, if MetLife does not alter the original decision, you have exhausted your two levels of appeal allowed under the Comprehensive Dental Plan. This determination is the final and binding decision.

Exhaustion of Process

You must exhaust the level one process of the appeal procedure before you initiate any litigation, arbitration or administrative proceeding regarding the denial of your appeal or any matter within the scope of the appeals procedure.

Claims and Appeals for Eligibility to Participate in the Dental Plan

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

Merck Sharp & Dohme Corp.
Attn: Plan Administrator (GSA-HTR)
c/o Merck Benefits Service Center at Fidelity
P.O. Box 770003
Cincinnati, OH 45277-0065

Express mail address:

Merck Sharp & Dohme Corp.
Attn: Plan Administrator (GSA-HTR)
c/o Merck Benefits Service Center at Fidelity
Mail Zone KC1F-L
100 Crosby Parkway
Covington, KY 41015
The Plan Administrator will review your claim and respond to you with a determination. The decision of the Plan Administrator is final and binding.

If your claim for eligibility involves whether an incapacitated child is eligible to participate in the Plan as an Eligible Dependent, you need to follow the claims and appeals procedure for your Comprehensive Dental Plan coverage. Please note that all requests for reconsideration regarding participation by the incapacitated child must be submitted in writing to the Claims Administrator. See the following “Benefits Contacts and Resources for Written Appeals” for address information.

Benefits Contacts and Resources for Written Appeals

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

<table>
<thead>
<tr>
<th>If a Claim Is Denied</th>
<th>Send Your Written Appeal to:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Benefit Appeals</td>
<td>Claims Administrator and fiduciary for the Dental Plan:</td>
</tr>
<tr>
<td></td>
<td>MetLife Group Dental Claims</td>
</tr>
<tr>
<td></td>
<td>P.O. Box 14093</td>
</tr>
<tr>
<td></td>
<td>Lexington, KY 40512-4093</td>
</tr>
<tr>
<td>Eligibility Appeals</td>
<td>Plan Administrator for the Dental Plan:</td>
</tr>
<tr>
<td></td>
<td>Merck Sharp &amp; Dohme Corp.</td>
</tr>
<tr>
<td></td>
<td>Attn: Plan Administrator (GSA-HTR)</td>
</tr>
<tr>
<td></td>
<td>c/o Merck Benefits Service Center at Fidelity</td>
</tr>
<tr>
<td></td>
<td>P.O. Box 770003</td>
</tr>
<tr>
<td></td>
<td>Cincinnati, OH 45277-0065</td>
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<tr>
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<td>Express mail address:</td>
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<td></td>
<td>Merck Sharp &amp; Dohme Corp.</td>
</tr>
<tr>
<td></td>
<td>Attn: Plan Administrator (GSA-HTR)</td>
</tr>
<tr>
<td></td>
<td>c/o Merck Benefits Service Center at Fidelity</td>
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<tr>
<td></td>
<td>Mail Zone KC1F-L</td>
</tr>
<tr>
<td></td>
<td>100 Crosby Parkway</td>
</tr>
<tr>
<td></td>
<td>Covington, KY 41015</td>
</tr>
</tbody>
</table>

Plan Disclosure Information

Employer/Sponsor

Merck Sharp & Dohme Corp. sponsors the Merck Medical, Dental, Life Insurance and Long Term Disability Plan. The employer identification number assigned to Merck Sharp & Dohme by the IRS is #22-1261880. The address and phone number is:

Merck Sharp & Dohme Corp.
Attn: Plan Administrator (GSA-HTR)
c/o Merck Benefits Service Center at Fidelity
P.O. Box 770003
Cincinnati, OH 45277-0065

http://netbenefits.com/merck
Plan Administrator/Claims Administrator

The Plan Administrator for the Merck Medical, Dental, Life Insurance and Long Term Disability Plan is Merck Sharp & Dohme Corp. Administration of the Merck Medical, Dental, Life Insurance and Long Term Disability Plan is the responsibility of the Plan Administrator. The Claims Administrator determines eligibility for dental benefits under the Merck Medical, Dental, Life Insurance and Long Term Disability Plan in accordance with the official Plan documents. MetLife is the Claims Administrator for the Dental Plan.

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

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

The Plan Administrator has reserved the right to delegate all or any portion of its authority described above to a representative. The Plan Administrator has delegated all of its authority described above with respect to authorizing disbursements for benefits on behalf of the Plan and adjudicating claims and appeals for benefits (and handling any resulting lawsuits) under the Dental Plan to the Claims Administrators. That means that the Claims Administrator has the sole authority to determine such matters under the Plan and the Plan Administrator will not and cannot substitute its judgment for that of the Claims Administrators on such matters. It also means the Claims Administrator has all of the discretion described above to the extent it relates to the Claims Administrator’s duties under the Dental Plan — for example, regarding eligibility for benefits, according to the broad discretion set forth above.

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

Contact the Plan Administrator if you have any questions about the Dental Plan other than routine questions
or questions about the filing or status of claims under the Plan. For routine questions, call the Benefits
Service Center. For questions about the filing status of claims, contact the Claims Administrator at the
address listed in “Benefits Contacts and Resources for Written Appeals.”

Agent for Service of Legal Process

If, for any reason, you want to seek legal action against the Dental Plan, you can serve legal process on
Merck Sharp & Dohme Corp. by directing such service to the Office of the General Counsel at the following
address:

Merck Sharp & Dohme Corp.
Attn: Benefits and Executive Compensation Legal Group
2000 Galloping Hill Road
Bldg. K-1, 3rd Floor
Kenilworth, NJ 07033

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

Plan Funding and Administration

The Dental Plan is funded and administered through various sources. The Dental Plan is financed by
contributions from the Company and contributions by participating Eligible Employees through the Merck &
Co., Inc. Cafeteria Plan. Funds may be held in one or more trusts and used to pay benefits, insurance
premiums (if any) and certain Dental Plan expenses. Dental Plan expenses are paid from the trust unless
otherwise paid by the Company from the general assets. The trustee is:

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

Merck & Co., Inc. is responsible for the funding policy of the trusts and for determining the amount of
contributions. The trusts are intended to be tax-exempt under the Internal Revenue Code of 1986, as
amended. Merck & Co, Inc. or its subsidiaries may fund additional benefits through the trust(s) at a later
time. If a trust is terminated, the assets in the trust will be used to pay all existing liabilities. Any remaining
assets may then be used to provide other benefits for employees in accordance with Internal Revenue Code
guidelines.
### Plan Funding and Administration Chart

<table>
<thead>
<tr>
<th>Official Plan Name and Plan Type</th>
<th>Plan Number</th>
<th>Benefits Type</th>
<th>Claims Administrator</th>
<th>Types of Administration</th>
<th>Insured or Self-Insured</th>
</tr>
</thead>
<tbody>
<tr>
<td>Merck Medical, Dental, Life Insurance and Long Term Disability Plan</td>
<td>502</td>
<td>Dental</td>
<td>MetLife</td>
<td>Contract administration</td>
<td>Self-insured by the Company.¹</td>
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<tr>
<td><strong>Plan Sponsor:</strong> Merck Sharp &amp; Dohme Corp.</td>
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<td></td>
<td></td>
<td></td>
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</tr>
<tr>
<td><strong>Plan type:</strong> Employee welfare program providing group dental coverage</td>
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<td></td>
<td></td>
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<td>N/A</td>
</tr>
</tbody>
</table>

#### No Right to Employment

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

#### Plan Amendment or Termination

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

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

If a benefit is terminated and surplus Plan assets, as determined under ERISA, remain after all liabilities have been paid, such surplus shall revert to the Plan Sponsor to the extent permitted under applicable law, unless otherwise stated in the applicable Plan document. If a benefit is terminated and amounts remain which are not ERISA plan assets, such surplus shall revert to the Plan Sponsor.

For two years following a “change in control” (as defined in the Separation Benefits Plan), the material terms of the Dental Plan (including terms relating to eligibility, benefit calculation, benefit accrual, cost to participants, subsidies and rates of employee contributions) may not be modified in a manner that is materially adverse to individuals that participated in the Plan immediately before the “change in control.” During that two-year period, the Company will pay the legal fees and expenses of any participant that prevails on at least one material item of the participant's claim for relief in an action regarding an impermissible amendment (other than ordinary claims for benefits).

¹ These benefits are self-insured by Merck (and certain affiliates of Merck) and are governed by and subject to the Employee Retirement Income Security Act of 1974 (ERISA), as amended (see "Your Rights Under ERISA"). State insurance law does not apply to these benefits. As a result, state-mandated benefits do not apply to these benefits.
Plan Documents

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

Plan Year

The Plan Year for the Dental Plan begins on Jan. 1 and ends on Dec. 31 of each year. The financial records of the Dental Plan are kept on a calendar-year basis.
GLOSSARY

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

After-Tax — Contributions for benefits coverage that are deducted from your pay after federal (and certain state) income and employment taxes are deducted.

Base Pay — Your annual rate of compensation before any Before-Tax deductions, excluding bonuses, overtime, shift differential, incentives, lump sum merit increases, non-recurring incentives, commissions and sales cash incentives, and other forms of special compensation or other extra pay as determined by the Company in its sole discretion. For employees of covered collective bargaining units, Base Pay includes cost of living adjustments (COLA). For Regular Part-Time Employees, Base Pay reflects your regularly scheduled hours. For example, if the annual pay for the position is $100,000 for a 40-hour work week, if your regularly scheduled hours are 24 hours per week, your Base Pay is $60,000.

Before-Tax — Contributions for benefits coverage that are deducted from an employee’s pay before federal and certain state income and employment taxes are deducted.

Casual Employee — A person who may be called by the Employer at any time for employment in the U.S. on a non-scheduled and non-recurring basis, and becomes an employee of the Employer only after reporting to work for the period of time during which the person is working and who is not classified as a Regular Full-Time Employee, Regular Part-Time Employee or Merck Temporary Employee in the Company’s employee database.

Claims Administrator — MetLife.

COBRA Administrator — Merck Benefits Service Center administered by Fidelity Investments.

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

Company — Merck & Co., Inc. and its wholly-owned subsidiaries.

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

- Employee Only
- Employee + Spouse/Domestic Partner
- Employee + Child(ren), and
- Employee + Spouse/Domestic Partner + Child(ren).

Covered Dependents — Your Eligible Dependents whom you have enrolled for coverage under the Dental Plan in the time and manner specified by the Plan Administrator. See “Eligible Dependents” in the “About Dental Benefits” section of this SPD.

Deductible — The amount of money you pay each year before the Dental Plan begins to pay benefits for covered dental expenses for you and your Covered Dependents. The Deductible does not apply to covered diagnostic and preventive services, covered orthodontic services or covered services provided by In-Network providers.

Dental Plan — The dental benefits under the Merck Medical, Dental, Life Insurance and Long Term Disability Plan.
Dependent Child(ren) — See Eligible Dependents.

Domestic Partner/Domestic Partnership — Two people in a Spouse-like relationship who share an ongoing, exclusive, emotionally committed relationship (and intend to do so indefinitely) and meet all of the following criteria:

- Are at least age 18 and mentally competent to enter into a legal contract
- Are not related by blood or adoption to a degree closer than permitted by state law for marriage
- Are not married to another person under statutory or common law of the United States nor in a Domestic Partnership with another person
- Are jointly responsible for each other’s welfare, financial and other obligations, and
- Reside together in the same household — and have done so for at least 12 months.

Eligible Dependents —

- Your Spouse or Domestic Partner. If your Spouse/Domestic Partner is a Non-Eligible Union Employee, your Spouse/Domestic Partner does not qualify as a dependent.

- Your Dependent Children up to the end of the month in which they reach age 26. Dependent Children mean your:
  - Biological children
  - Stepchildren, including your Spouse’s/Domestic Partner’s biological children, foster children, legally adopted children and children for whom your Spouse/Domestic Partner is legal guardian, in each case who are not also your biological children, foster children, legally adopted children and children for whom you are legal guardian
  - Foster children
  - Legally adopted children (eligibility begins on the date of placement for adoption or commencement of legal obligation to provide support in anticipation of adoption)
  - Children for whom you are legal guardian, and
  - Those for whom coverage is required by a Qualified Medical Child Support Order (QMCSO).

While coverage is extended to your children through the last day of the month they reach age 26, your child’s Spouse or your child’s children are not your Eligible Dependents, unless they would otherwise meet the definition of Eligible Dependents.

If you or your Spouse/Domestic Partner (or your former Spouse/Domestic Partner or that person’s Spouse/Domestic Partner) work (or worked) for the Company, special provisions apply. See “Merck Couples.”

If You Have a Child with a Disability
If your Dependent Child is physically or mentally disabled, coverage for the child may continue beyond age 26, provided the child’s disability begins before the date the child reaches the age at which coverage would otherwise end. You will need to provide proof of your child’s disability to the Claims Administrator at least 60 days before the date coverage is scheduled to end and annually thereafter. To continue coverage, the Claims Administrator also reserves the right to have a physician of its choice examine your child once a year. For more information on how to contact the Claims Administrator, see the “Administrative Information” section of this SPD.
Qualified Medical Child Support Order
If a Qualified Medical Child Support Order (QMCSO) requires you to provide coverage, Dependent Children may also include children for whom you do not provide financial support. You may obtain a copy of the Plan Administrator’s procedures governing QMCSO determinations, free of charge, by contacting the Benefits Service Center.

Spouses/Domestic Partners Who Work for Merck
If you or your Spouse/Domestic Partner (or your former Spouse/Domestic Partner or that person’s Spouse/Domestic Partner) work (or worked) for the Company, special provisions apply when enrolling Eligible Dependents for coverage. See “Merck Couples Enrollment Rules.”

Eligible Employees — Regular Full-Time Employees, Regular Part-Time Employees, Merck Temporary Employees, Eligible Union Employees, U.S. Territory Employees and LTD Employees, in each case, who are not Excluded Employees or Excluded Persons.

Eligible Union Employees — All U.S.-based employees of an Employer who are members of a collective bargaining unit identified on Exhibit A, except those who are members of the United Steelworkers Local 10-00086 collective bargaining unit.

Employer — The wholly owned U.S. subsidiaries of Merck & Co., Inc. other than the following entities that are excluded: Telerx Marketing, Inc., Comsort, Inc., Vree Health LLC, HMR Weight Management Services Corp. and Merck Global Health Innovation Fund, LLC and each of their subsidiaries.


Excluded Employees — Casual Employees, U.S. Expatriates (other than those who are U.S. Territory Employees), Intern/Graduate/Cooperative Student Associates, Non-Eligible Union Employees, employees of Telerx Marketing, Inc., Comsort, Inc., Vree Health LLC, HMR Weight Management Services Corp. and Merck Global Health Innovation Fund, LLC and each of their subsidiaries, and employees based outside the U.S. on assignment outside their home country but in the U.S. (other than U.S. Territory Employees).

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

Infotype 35 — A unit of information contained in the Merck & Co., Inc. Human Resources employee data system which reflects your legacy company designation as determined by the Plan Administrator in its sole discretion.

Initial Enrollment Period — The 30-day period that starts when you are hired, rehired or transferred (if you qualify as a Transferred Employee), as applicable; or the date of the cover letter provided in your enrollment materials from the Benefits Service Center, whichever is later.

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1 U.S. Expatriates (other than those on assignment in a U.S. territory) and employees based outside the U.S. on assignment outside their home country but in the U.S. (other than U.S. Territory Employees) are not eligible for the dental coverage under the Dental Plan described in this SPD. However, they are eligible for dental coverage under the Merck Medical, Dental, Life Insurance and Long Term Disability Plan through a program insured by Cigna Global Health Benefits.
In-Network — A provider, or the covered services and supplies provided by a provider, who has an agreement with the Claims Administrator to furnish covered services or supplies.

Intern/Graduate/Cooperative Student Associate — A student hired by an Employer as a participant in the Company Intern/Graduate/Cooperative Associate Program. The student must be designated as a participant in that program at least annually by the Company.

Legacy Merck LTD Employee — An LTD Employee who is coded in the employee database of Merck & Co., Inc. under Infotype 35 with a blank indicator or as S6 Legacy Inspire.

Legacy OBS LTD Employee — An LTD Employee who is coded in the employee database of Merck & Co., Inc. under Infotype 35 as S1 Legacy Organon, S2 Legacy Intervet or S3 Legacy Nobilon.

Legacy Schering LTD Employee — An LTD Employee who is coded in the employee database of Merck & Co., Inc. under Infotype 35 as Legacy S1 Organon, S2 Legacy Intervet or S5 Legacy Schering-Plough or who is a Legacy OBS LTD Employee.

Life Event — Certain events in your life that may allow you to change some of your benefit choices or coverage levels during the year (e.g., marriage, divorce, birth or adoption of a child). For more information about Life Events — and Permitted Plan Changes — see “When Life Changes” in the “About Dental Benefits” section of this SPD or contact the Benefits Service Center.

LTD Benefits — Income replacement benefits provided under the Merck Medical, Dental, Life Insurance and Long Term Disability Plan.

LTD Employee — An employee who is receiving LTD Benefits who on the day the employee became eligible for LTD Benefits was considered by an Employer to be a Regular Full-Time Employee, Regular Part-Time Employee, Eligible Union Employee, Merck Temporary Employee or U.S. Expatriate and not an Excluded Employee or an Excluded Person. LTD Employees shall be eligible for coverage as described in this SPD, but eligibility for this coverage may be amended by Merck at any time.

Merck Temporary Employee — An employee hired and paid by an Employer (rather than an agency) for a specific position in the United States for a designated length of time that is normally not more than 24 consecutive months in duration, who is committed to leave the Employer at the end of that time, who is not classified as a Regular Full-Time Employee, Regular Part-Time Employee or Casual Employee in the Company’s employee database and who is not an Excluded Employee or an Excluded Person.

Non-Eligible Union Employee — An employee of an Employer who is a member of the United Steelworkers Union Local 10-00086.

Out-of-Network — A provider, or the services and supplies provided by a provider, who does not have an agreement with the Claims Administrator to provide covered services or supplies.

Permitted Plan Change — Changes in benefit choices or coverage levels during the year that are consistent with a Life Event and comply with applicable regulations under the Internal Revenue Code and the guidelines established by the Plan Administrator (subject to periodic change). For more information about Permitted Plan Changes — and related Life Events — see “When Life Changes” in the “About Dental Benefits” section of this SPD or contact the Benefits Service Center.

Plan — See definition of Dental Plan.

Plan Administrator — Merck Sharp & Dohme Corp. or its delegate.

Plan Sponsor — Merck Sharp & Dohme Corp.

Plan Year — The calendar year, Jan. 1 through Dec. 31, on which the records of the Plan are kept.
Qualified Beneficiary — For the purposes of COBRA:

- An employee, former employee and that person’s Spouse and Eligible Dependents who are eligible for continuation coverage under COBRA because of their status on the day before a qualifying event, and
- An individual covered by a group health plan, or a dependent of such an individual, as of the day before a qualifying event takes place.

Qualified Medical Child Support Order (QMCSO) — Any judgment, decree or order issued (including a settlement established under state law, which has the force and effect of law in that state) that creates, recognizes or assigns to a child the right to receive benefits for which you are eligible under the Dental Plan and that the Plan Administrator determines to be qualified under applicable law.

Reasonable and Customary (R&C) Charges — An amount determined by the Claims Administrator, in accordance with its internal processes and procedures taking into account all pertinent factors including:

- The complexity of the service
- The range of services provided, and
- The geographic area where the provider is located.

How R&C is calculated varies depending on which plan option you are enrolled in. Contact your Claims Administrator for more details.

Regular Full-Time Employee — An employee employed by an Employer in the United States on a scheduled basis for a normal work week, who is not classified as a Regular Part-Time Employee, Merck Temporary Employee or Casual Employee in the Company’s employee database and who is not an Excluded Employee or an Excluded Person.

Regular Part-Time Employee — An employee employed by an Employer in the United States on a scheduled basis for less than the number of regularly scheduled hours for the employee’s site and is not classified as a Regular Full-Time Employee, Merck Temporary Employee or Casual Employee in the Company’s employee database and is not an Excluded Employee or an Excluded Person.

Spouse — The person recognized as your legal spouse under statutory or common law of the United States.

Transfer Date — The date a Transferred Employee becomes a Regular Full-Time Employee or a Regular Part-Time Employee.

Transferred Employee — An employee of Merck & Co., Inc. (or its subsidiaries) who transfers to a position as an Eligible Employee, and who on the day before was not an Eligible Employee.

U.S. Expatriate — A U.S. citizen or individual with U.S. Permanent Resident status who is employed by a foreign subsidiary of the Company, as a foreign service employee, provided that the individual has not elected coverage under any retirement plan of the foreign subsidiary if the subsidiary is covered by an agreement entered into by the Company, under Section 3121(l) of the Internal Revenue Code (dealing with Social Security benefits), and who is not an Excluded Person.

U.S. Territory Employees — U.S. Expatriates who are on assignment in a U.S. territory (such as Puerto Rico, Guam and the U.S. Virgin Islands, etc.), employees of the Company who are resident in a U.S. territory who are on assignment in the U.S. and certain other employees of the Company on assignment outside of their home country, in each case, whom Cigna Global Health Benefits determines in their sole and absolute discretion would be eligible for medical coverage on or after Jan. 1, 2015 under the portion of the Merck Medical, Dental, Life Insurance and Long Term Disability Plan insured by Cigna Global Health Benefits except that the provision of such coverage to such employees would subject the coverage to the non-expatriate provisions of the Patient Protection and Affordable Care Act (PPACA).
EXHIBIT A

This section lists the collective bargaining units whose members are eligible to participate in dental benefits under the Merck Medical, Dental, Life Insurance and Long Term Disability Plan as described in this SPD.

- International Association of Machinists and Aerospace Workers, District 15, Lodge 315 (Summit, Kenilworth/Union, New Jersey)

- International Chemical Workers Union Council of the United Food and Commercial Workers Union, Local 194-C (Memphis, TN) (only with respect to employees receiving LTD Benefits as of the date of the closing of the sale of Merck’s consumer care business to Bayer AG)

- International Brotherhood of Teamsters, Local 107 (West Point, PA)

- United Steelworkers Union, Local 4-575 (Rahway, NJ)

- International Chemical Workers Union Council of the United Food and Commercial Workers Union, Local 94C (Elkton, VA)

- Mid-Atlantic Regional Joint Board, Workers United, Local 1398 (Elkton, VA)

- The Office and Professional Employees International Union, Local 1937, AFL-CIO, CLC (West Point, PA)

- United Steelworkers, Local 10-580 (Danville, PA)

- International Union of Operating Engineers, Local 68 (Rahway, NJ)
The information contained herein has been provided by Merck & Co., Inc. and is solely the responsibility of Merck & Co., Inc. (and its subsidiaries).

3.MK-H-554C.107