The Merck Dental Plan

Your Summary Plan Description

Flex/Retiree

Effective January 1, 2009
Released: October 17, 2008
This Summary Plan Description describes the Merck & Co., Inc. Dental Plan (“the Merck Dental Plan” or the “the Plan”), which is part of the Merck Flexible Benefits Program (or “Flex”) and the Merck Retiree Choice Program as it applies to:

- Non-Union employees of Merck & Co., Inc.; Merck Holdings, Inc.; Merck and Company Incorporated; KBI Enterprises, Inc.; Rosetta Inpharmatics, Inc.; Merck HDAC Research, LLC; Abmaxis, Inc.; Glycofi, Inc.; Sirna Therapeutics, Inc. and former non-Union employees of those entities who are considered to be “Retirees.”

- Union employees of Merck & Co., Inc., who are members of the following collective bargaining units: Graphic Communications Local 4C; International Brotherhood of Teamsters, Local 107; International Union of Operating Engineers and its Local 68; Merck Independent Union; The Inter-Union Council comprised of the following collective bargaining units: International Chemical Workers Union and its Local 94 and Local 609; United Steelworkers Union and its Locals 4-575 and 10-580; and UNITE and former Union employees of Merck & Co., Inc. who were members of those collective bargaining units (or their predecessors) when they were employed by Merck & Co., Inc. and who are considered to be “Retirees.”

- Former Union employees of Merck & Co., Inc., who were members of the United Steelworkers Union Local 10-086 collective bargaining unit (or its predecessor) when they were employed by Merck & Co., Inc. and who are considered to be “Retirees.”

This Summary Plan Description (SPD) does not apply to any employee or former employee of Merck (or its subsidiaries or joint ventures) other than those identified above. Other groups should refer to their specific SPD.

About This Summary Plan Description

This SPD merely summarizes the benefits and benefit coverage levels provided under the Merck Dental Plan. Decisions regarding appropriate treatment (e.g., level of care) are always left to the discretion of the patient and his/her dentist.

This SPD replaces the Dental SPD dated January 2002, as applicable, entitled “The Merck Benefits Book — Your Dental Benefits” and all summaries of material modifications applicable to it dated before January 1, 2009. This SPD reflects the provisions of the Merck Dental Plan in effect as of January 1, 2009.

Merck reserves the right to amend the Merck Dental Plan in whole or in part or to completely discontinue the Merck Dental Plan at any time.

Frequently Used Terms

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

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

Your Dental Plan Options

Through the Flexible Benefits Program, Eligible Employees may enroll themselves and their Eligible Dependent(s) for coverage under the Merck Dental Plan. Through the Retiree Choice Program, Retirees may enroll themselves and their Eligible Dependent(s) who are Dependent(s) of Record for coverage under the Merck Dental Plan. Eligibility to elect a particular option depends on your employment status and, for certain options, your geographic area.

The Merck Dental Plan offers the following coverage options:

- **Merck Comprehensive Care Dental option or Merck Preventive Care option.** These options are generally traditional fee-for-service options that are administered by Aetna and allow you the freedom to receive care from any licensed dentist or specialist. In addition, if you receive care from a dentist participating in the Aetna Preferred Provider Organization (PPO) network, your out-of-pocket costs are generally lower than if you receive care from an Out-of-Network dentist.

- **Merck Healthplex DPO or Aetna DMO options.** These dental plan organizations (DPOs) operate like health maintenance organizations (HMOs). You select a primary care dentist (PCD) from a specific network of dentists and specialists. Your PCD provides preventive and restorative care and refers you to specialists within the network, if necessary. There is no annual Deductible. You can elect either the Healthplex DPO or Aetna DMO options if you live in the applicable service area.

- **No Coverage option.** Eligible Employees and Retirees may waive coverage under the Merck Dental Plan by electing this option.
## Benefit Contacts and Resources

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

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<td>If you’re an Eligible Employee:</td>
<td>Merck Benefits Service Center’s Phone Line</td>
<td>800-66-MERCK (800-666-3725) TDD: 800-343-0860</td>
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<td>- Enroll in your benefits when first hired or during annual enrollment</td>
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<td>- Report a Life Event change</td>
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<td>Merck Benefits Service Center’s Phone Line</td>
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<td>If you’re a Retiree:</td>
<td>Merck Benefits Service Center’s Phone Line</td>
<td>800-66-MERCK (800-666-3725) TDD: 800-343-0860</td>
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<tr>
<td>- Enroll in your benefits</td>
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<td>- Report a Life Event change</td>
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<td>- Enroll in Automatic Bank Withdrawal for your Retiree Choice contributions</td>
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<td>If you’re an active, Eligible Employee:</td>
<td>Merck HR Website (active Employees)</td>
<td>Intranet site: [http:// hr.merck.com](http:// hr.merck.com)</td>
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<td>- Access information and updates about all of Merck’s benefits</td>
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<td>- View the <em>Merck Benefits Book</em></td>
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<td>- Obtain forms</td>
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<td>If you’re enrolled in either the Merck Comprehensive Care option or the Merck Preventive Care option</td>
<td>Aetna</td>
<td>800-541-6711 <a href="http://www.aetna.com">www.aetna.com</a></td>
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<td>- Ask a specific coverage question</td>
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<td>If you’re enrolled in the Healthplex DPO</td>
<td>Healthplex</td>
<td>800-982-5529</td>
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<td>If you’re enrolled in the Aetna DMO</td>
<td>Aetna</td>
<td>800-843-3661 <a href="http://www.aetna.com">www.aetna.com</a></td>
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<td>Ask a payroll-related question</td>
<td>Merck HR Service Center</td>
<td>866-MRK-HR4U (866-675-4748)</td>
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<td>Get assistance as a new hire</td>
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<td>Ask general HR policy questions</td>
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### Key Point — Enrolling in Dental Benefits

Enrollment in the Merck Dental Plan is through Fidelity Investments — the service provider for administration of Merck’s Health & Insurance and Merck Savings Plan benefits. Eligible Employees can enroll in their dental benefits online or by phone. During the year, Retirees must enroll by calling the Merck Benefits Service Center. Please see “How to Enroll” in the About Flex Dental Benefits or About Retiree Dental Benefits sections for detailed enrollment instructions.
Merck Benefits Service Center

To help you with enrollment, general benefits information and questions, the Merck Benefits Service Center is available to you virtually 24 hours a day, 7 days a week online through Fidelity NetBenefits® or by phone. The Merck Benefits Service Center is administered by Fidelity Investments, the service provider for administration of Merck’s Health & Insurance and Merck Savings Plan benefits.

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

Fidelity NetBenefits is your source for benefit transactions and information virtually 24 hours a day, 7 days a week. Each time you log in to NetBenefitsSM you need to enter your Social Security number and Personal Identification Number (PIN). (See “Establishing a PIN” in the Key Point below for directions on setting up your PIN for the first time.) If you prefer to use a Customer ID — an identifier that you create — in place of your Social Security number, you may also establish that from the NetBenefits login page.

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

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

KEY POINT — ESTABLISHING A PIN

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

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

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

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

**Flex Dental Eligibility**

If you are an Eligible Employee, you and your Eligible Dependent(s) are eligible for coverage in the Merck Dental Plan as of your date of hire (or rehire) if you are a:

- Regular Full-Time Employee;
- Regular Part-Time Employee;
- Transferred Employee; or
- Merck Temporary Employee (coverage under the Merck Preventive Care option only).

You are *not eligible* for coverage under the Merck Dental Plan if you are a:

- Casual Employee;
- U.S. Expatriate;¹;
- Any class of Excluded Person; or
- Graduate, Intern or Cooperative Student Associate.

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

You and your Covered Dependent(s) must be enrolled in the same Merck Dental Plan option, even if you reside in different locations.

¹ U.S. Expatriates are not eligible for the dental coverage under the Merck Dental Plan described in this SPD. However, they are eligible for dental coverage through Merck under a program insured by Cigna International.
Eligible Dependent(s) Under Flex

As an Eligible Employee, you can enroll your Eligible Dependent(s) for coverage under the Merck Dental Plan. For coverage to apply to your Eligible Dependent(s), they must be enrolled as Covered Dependent(s) under the Merck Dental Plan. Your Eligible Dependent(s) are:

- Your spouse or Same-Sex Domestic Partner (If your spouse/Same-Sex Domestic Partner is a Non-Flex-Eligible Union Employee, he/she does not qualify as a dependent);
- Your or your Same-Sex Domestic Partner’s unmarried children up to age 19 (up to age 25 if full-time students) who are dependent on you for more than half of their support. Children mean your:
  - Biological children,
  - Stepchildren, including your spouse’s/Same-Sex Domestic Partner’s biological children, foster children, legally adopted children and children for whom your spouse/Same-Sex Domestic Partner is legal guardian, in each case who are not also your biological children, foster children, legally adopted children and children for whom you are legal guardian,
  - Foster children,
  - Legally adopted children (eligibility begins on the date of placement for adoption or commencement of legal obligation to provide support in anticipation of adoption),
  - Children for whom you are legal guardian, or
  - Those for whom coverage is required by a Qualified Medical Child Support Order (QMCSO).

Student Eligibility

Your dependent child is considered a full-time student if he/she carries at least 12 credits per semester or is considered a full-time student by the educational institution in which your child is enrolled. You will need to notify the Merck Benefits Service Center of your child’s student status within 30 days of his/her 19th birthday to continue coverage. If you fail to notify the Merck Benefits Service Center within 30 days that your child is a full-time student, coverage for that child will end and he/she will not be re-enrolled for coverage until the next annual enrollment period, unless there is a Life Event that permits earlier enrollment. See “When Life Changes.”

If your dependent child age 19 or older (up to age 25) enrolls as a full-time student sometime after dental coverage was stopped due to lack of full-time student status, you may re-enroll your child for coverage under the Merck Dental Plan, provided you do so within the time limits applicable to enrolling a new Eligible Dependent.

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 19 (or age 25 if a full-time student), provided the child’s disability begins before the date the child reaches the age at which coverage would otherwise end. You will need to provide proof of your child’s disability to the Claims Administrator at least 60 days before the date coverage is scheduled to end and annually thereafter. To continue coverage, the Claims Administrator also reserves the right to have a physician of its choice examine your child once a year. For more information on how to contact the Claims Administrator, see the “Administrative Information” chapter.

Qualified Medical Child Support Order

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 Merck’s procedures governing QMCSO determinations, free of charge, by calling the Merck HR Service Center at 866-MRK-HR4U (866-675-4748).
Spouses/ Same-Sex Domestic Partners Who Work for Merck
If you and your spouse/Same-Sex Domestic Partner (or your former spouse/Same-Sex Domestic Partner or his/her spouse/Same-Sex Domestic Partner) work (or worked) for the Company, special provisions apply when enrolling Eligible Dependent(s) for coverage. See “Merck Couples Under the Flexible Benefits Program.”

Adding Eligible Dependent(s) 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.”

Same-Sex Domestic Partnerships Under Flex
Merck extends coverage under the Merck Dental Plan to Eligible Employees’ Same-Sex Domestic Partners and Same-Sex Domestic Partners’ eligible dependent children. (See “Eligible Dependent(s) Under Flex” in this chapter for a definition of eligible dependent children.) To elect Same-Sex Domestic Partner benefits through Merck, you and your partner must meet the Company’s definition of a Same-Sex Domestic Partnership.

Merck defines Same-Sex Domestic Partners as two people in a spouse-like relationship who share an ongoing, exclusive, emotionally committed relationship (and intend to do so indefinitely) and meet all of the following criteria:

- Are the same sex;
- Are at least age 18 and mentally competent to enter into a legal contract;
- Are not related by blood or adoption to a degree closer than permitted by state law for marriage;
- Are not legally married to — or the domestic partner of — anyone else;
- Are jointly responsible for each other’s welfare, financial and other obligations;
- Reside together in the same household — and have done so for at least 12 months; and
- Have registered the same-sex relationship — if residing in a state/municipality that permits such registration or are legally married if permitted to do so under applicable law.

Additional Taxable Income
Under current federal income tax laws, the value of providing medical and dental benefits to a Same-Sex Domestic Partner and his/her eligible dependent children is considered taxable to you — unless they are considered your dependents for purposes of federal income taxes. This means you will pay federal, state and local income taxes, as well as employment taxes, on an additional amount of Company-provided coverage throughout the year. This type of taxable income is known as imputed income, and Merck will report it on your W-2 form at the end of each year.

It’s important for you to understand the tax implications of covering a Same-Sex Domestic Partner and/or his/her eligible dependent children. You may wish to consult a tax advisor to determine the full tax and financial effect of electing this coverage. For more information, see “Paying for Flex Dental Benefits.” You can obtain more information about Same-Sex Domestic Partner benefits by calling the Merck Benefits Service Center at 800-66-MERCK.
KEY POINT — ENROLLING A SAME-SEX DOMESTIC PARTNER IN A DPO OR DMO

To elect Same-Sex Domestic Partner benefits through Merck, you and your partner must meet Merck’s definition of a Same-Sex Domestic Partnership. Before enrolling a Same-Sex Domestic Partner (and/or his/her eligible dependent children) in the Healthpex DPO or Aetna DMO options, be sure to:

- Confirm that you meet both Merck’s and the DPO’s or DMO’s requirements for a Same-Sex Domestic Partnership; and
- Provide proof or documentation, as required.

For more details, contact the DPO or DMO directly (see “Benefit Contacts and Resources”).

Right to Audit Dependent Eligibility

By electing coverage for your dependent(s) (either by affirmative election or through the default process), you are confirming that they meet the Plan’s dependent eligibility requirements and agree to notify the Merck Benefits Service Center within 30 days of an event that causes any of these dependent(s) 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 Dependent(s)’ continued eligibility.

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

Enrolling in Flex Dental Benefits

Coverage Tiers

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

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

If both you and your spouse/Same-Sex Domestic Partner work, or worked, for Merck, special provisions apply to the Coverage Tier you are eligible to elect. See “Merck Couples Under the Flexible Benefits Program” for details.
**Merck Dental Plan Options**

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

- Merck Comprehensive Care Dental option;
- Merck Preventive Care option;
- Healthplex DPO option;
- Aetna DMO option; or
- No Coverage option.

**KEY POINT — OPTIONS VARY BY LOCATION**

Whether you’re eligible for the Healthplex DPO or Aetna DMO options depends on your geographic area. To find out the Dental Plan options that are available to you and their costs, review your Enrollment Worksheet on Fidelity NetBenefits at [http://netbenefits.fidelity.com](http://netbenefits.fidelity.com). You may also call the Merck Benefits Service Center at 800-66-MERCK to learn more about the Dental Plan options for which you may be eligible.

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**If You Waive Coverage**

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

In addition, if during the year you qualify for Long-Term Disability (LTD) Benefits, you will have No Coverage under the Merck Dental Plan while you are receiving LTD Benefits until the following annual enrollment, unless you have a Life Event that allows you to make a Permitted Plan Change that permits you to elect coverage. See “When Life Changes.” Also, you and your Eligible Dependent(s) cannot continue coverage under COBRA should you have a qualifying event during the year.

**State Mandates**

The Merck Dental Plan is governed by the Employee Retirement Income Security Act of 1974 (ERISA). Certain states may have provisions that Merck is not required to follow. For more information, contact the Merck Benefits Service Center at 800-66-MERCK.
Enrollment for Newly Hired or Rehired Full-time and Part-time Employees
As an Eligible Employee, you are automatically enrolled for Employee Only coverage under the Merck Comprehensive Care option as of your date of hire or rehire.

Changing Your Dental Plan Option within 30 Days of Your Hire or Rehire Date
You may elect to change your Dental Plan option within 30 days of your hire/rehire date through NetBenefits at [http://netbenefits.fidelity.com](http://netbenefits.fidelity.com) or by calling the Merck Benefits Service Center at 800-66-MERCK. As long as you enroll for coverage within 30 days of your hire/rehire date, your coverage will be effective as of your hire/rehire date. See “How to Enroll” for more detailed instructions.

Enrolling Your Dependent(s) within 30 Days of Your Hire or Rehire Date
You may enroll your Eligible Dependent(s) for coverage (with an effective date of your hire/rehire date) under the same dental option you choose within the first 30 days of your hire/rehire date. As long as you enroll your Eligible Dependent(s) for coverage within 30 days of your hire/rehire date, their coverage will be effective as of your hire/rehire date.

If You Do Not Enroll within 30 Days of Your Hire Date
If you do not elect to change your Dental Plan option or enroll your Eligible Dependent(s) within 30 days of your date of hire/rehire, you will have Employee Only coverage under the Merck Comprehensive Care option for the remainder of the Plan Year. You will not be able to add your Eligible Dependent(s) or change Dental Plan options until the next annual enrollment period, unless you experience a Life Event that allows you to make a mid-year Permitted Plan Change or you qualify for the special enrollment option. See “When Life Changes” and “Special Enrollment Under HIPAA for Eligible Employees” for more information.

**KEY POINT — LIFE EVENTS**

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

- You give birth to or adopt a child;
- You get married or divorced (or meet the eligibility requirements for or end a Same-Sex Domestic Partnership);
- Your covered child reaches the maximum coverage age;
- Your covered child who is over age 19 ceases to be a full-time student;
- One of your dependents dies;
- Your spouse’s/Same-Sex Domestic Partner’s employment status changes; or
- You relocate out of your network service area.

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

If you are a Transferred Employee, at Merck’s discretion you will be:

- Automatically enrolled in the coverage option closest to your prior dental coverage, as determined by Merck; or
- Automatically enrolled in the Merck Comprehensive Care option.

The Eligible Dependent(s) whom you covered under your prior dental coverage are automatically enrolled in the coverage option under which you are automatically enrolled if your dental coverage was administered through a Merck entity.

**Changing Your Coverage within 30 Days of Your Transfer Date**

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

If you do not change your option within the first 30 days of your Transfer Date, you will not be able to change your option until the next annual enrollment period, unless you experience a Life Event that allows you to make a mid-year Permitted Plan Change. See “When Life Changes.”

**Enrollment for Merck Temporary Employees**

If you are a Merck Temporary Employee, you are automatically enrolled for Employee Only coverage in the Merck Preventive Care option as of your date of hire or rehire.

As a Merck Temporary Employee, you are only eligible for coverage under the Merck Preventive Care option and cannot change Dental Plan options or waive coverage by electing the No Coverage option.

**Enrolling Your Dependent(s) within 30 Days of Your Hire Date**

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

If you don’t enroll your Eligible Dependent(s) within 30 days of your hire/rehire date, you will not be able to add them to your coverage at a later time, unless you experience a Life Event that allows you to make a mid-year Permitted Plan Change or you qualify for the special enrollment option. See “When Life Changes” and “Special Enrollment Under HIPAA for Eligible Employees” for more information.

**How to Enroll**

You enroll in the Merck Dental Plan through the Merck Benefits Service Center, which is administered by Fidelity Investments — the service provider for administration of Merck’s Health & Insurance and Merck Savings Plan benefits. You have the convenience of enrolling in your dental benefits either online or by phone, as described on the next page.
Online through Fidelity NetBenefits at http://netbenefits.fidelity.com
Once you’ve established your PIN and logged in to NetBenefits, follow these steps for enrolling in your dental benefits:

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

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

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

When Flex Coverage Begins

- Eligible Employees. Your dental coverage under the Flexible Benefits Program begins on your date of hire or rehire. As long as you enroll your Eligible Dependent(s) in coverage within 30 days of your date of hire or rehire, your Eligible Dependent(s)’ coverage also begins on your date of hire or rehire.

- Transferred Employees. Dental coverage for you and your Covered Dependent(s) under the Flexible Benefits Program continues without interference on your Transfer Date. If you change your coverage option within 30 days of your Transfer Date, your new coverage begins on your Transfer Date. If you add Eligible Dependent(s) to your dental coverage within 30 days of your Transfer Date, your Eligible Dependent(s)’ coverage begins on your Transfer Date.

- Merck Temporary Employees. Your dental coverage under the Flexible Benefits Program begins on your date of hire or rehire. As long as you enroll your Eligible Dependent(s) in coverage within 30 days of your date of hire or rehire, your Eligible Dependent(s)’ coverage will also begin on your date of hire or rehire.

I.D. Cards
As soon as administratively feasible after you are enrolled for coverage, you will receive an I.D. card directly from the dental carrier, unless you elected the No Coverage option.
Paying for Flex Dental Benefits

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

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

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

Transferred Employees
If you are a Transferred Employee, you contribute toward the cost of your dental coverage as of your Transfer Date. For the month in which your Transfer Date occurs, any difference in your employee contribution between your former dental plan and your new Merck Dental Plan option under the Flexible Benefits Program will be adjusted in your paycheck as soon as administratively feasible.

Merck Temporary Employees and LTD Employees
If you are a Merck Temporary Employee or an LTD Employee, coverage in the Merck Dental Plan is provided at no cost to you and your Covered Dependent(s).

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

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

Financial Considerations for Same-Sex Domestic Partner Coverage
You and Merck share the cost of covering a Same-Sex Domestic Partner and/or his/her eligible dependent children — the same as you would for coverage of a spouse and your own eligible dependent children. However, there are additional financial and tax implications to consider. For example, if you elect dental coverage for your Same-Sex Domestic Partner and/or his/her eligible dependent children, in most cases you’ll pay more in taxes than you would if you were covering a spouse and your own eligible dependent children.
About Flex Dental Benefits

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

- Employees and their Eligible Dependent(s) (as defined under the federal tax code) are not considered taxable income to the employee.
- Same-Sex Domestic Partners and their eligible dependent children are considered taxable income to the employee — unless the individuals are the employee’s dependent(s) for federal income tax purposes.

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

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

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

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

- You initially declined coverage for yourself and your Eligible Dependent(s) (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.

Please note that while existing federal law does not extend HIPAA rights to your Same-Sex Domestic Partner and his/her covered dependent children, Merck does permit Same-Sex Domestic Partners and their covered dependent children to enroll under this special enrollment provision.
To request special enrollment through HIPAA, you must contact the Merck Benefits Service Center at 800-66-MERCK within 30 days of the event. Note that the rules regarding Life Event changes may be more generous than those under HIPAA. See “Making Changes to Your Flex Coverage.”

**Merck Couples Under the Flexible Benefits Program**

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

**KEY POINT — SAME SEX DOMESTIC PARTNERS**

In general, for purposes of the rules related to Merck couples under the Merck Dental Plan, your Same-Sex Domestic Partner is treated as your spouse — and as stepparent to your eligible dependent children. And, your Same-Sex Domestic Partner’s eligible dependent children are treated as your stepchildren.

**No Duplicate Merck Coverage**

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

You, your spouse/Same-Sex Domestic Partner, your former spouse/Same-Sex Domestic Partner, or his/her spouse/Same-Sex Domestic Partner may choose to cover different dependent(s) under different plans by selecting different Coverage Tiers. For example, if your spouse is a Merck employee (other than a Non-Flex-Eligible Union Employee), you may choose Employee Only coverage to cover yourself under the Merck Dental Plan and Employee + Child(ren) or Employee + Spouse/Same Sex Domestic Partner + Child(ren) to cover all Eligible Dependent(s) under the Merck Dental Plan.

**Merck Couples Eligible for the Flexible Benefits Program**

If you and your spouse/Same-Sex Domestic Partner both participate in the Flexible Benefits Program, you must decide who will cover your spouse/Same-Sex Domestic Partner and/or your Eligible Dependent(s) for purposes of the Merck Dental Plan. You and your spouse/Same-Sex Domestic Partner each may enroll in Employee Only coverage. Or one spouse/Same-Sex Domestic Partner may enroll as 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/Same-Sex Domestic Partner's coverage, it is your responsibility to ensure that your spouse/Same-Sex Domestic Partner elects the correct Coverage Tier. You will not be able to make enrollment changes until the next annual enrollment period, unless you experience a Life Event that allows you to make a Permitted Plan Change, even if you elected No Coverage in error.

**Covering Your Eligible Dependent(s)**

If you wish to cover your spouse/Same-Sex Domestic Partner and any dependent children, you must choose Employee + Spouse/Same Sex Domestic Partner + Child(ren). Remember, the Employee + Child(ren) Coverage Tier allows your spouse/Same-Sex Domestic Partner to cover a dependent child without providing coverage for you. In no event can you and your spouse/Same-Sex Domestic Partner each cover your dependent children.
You and your spouse/Same-Sex Domestic Partner may choose to cover different dependent(s) under different benefit plans by selecting different Coverage Tiers. For example, you can choose Employee Only to cover yourself under the Merck Dental Plan and Employee + Spouse/Same-Sex Domestic Partner + Child(ren) to cover all Eligible Dependent(s) under the Merck Medical Plan.

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

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

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

For your children:
- If you elect dependent coverage, your eligible dependent children may be covered under the option you select for yourself under the Merck Dental Plan, but your spouse/Same-Sex Domestic Partner must consent to this choice by calling a Fidelity Customer Service Associate at 800-66-MERCK between 8:30 A.M. and midnight, Eastern time, Monday through Friday (excluding New York Stock Exchange holidays).
- If you choose Employee Only coverage, your spouse/Same-Sex Domestic Partner must actively enroll the children under his/her Union dental plan.

Please note the provisions listed above also apply if your current spouse and ex-spouse both work for Merck. For example, if your current spouse is a Flex-Eligible Union Employee and your former spouse is a Non-Flex-Eligible Union Employee, they cannot both cover your dependent children.

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

If you are an Eligible Employee married to an LTD Employee, you and your Eligible Dependent(s) are eligible for coverage under your spouse’s/Same-Sex Domestic Partner’s coverage option as dependent(s).

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

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

If you are an Eligible Employee married to a Retiree, you and your Eligible Dependent(s) may be eligible for coverage under the Retiree’s coverage as a dependent, provided you and your Eligible Dependent(s) are Dependent(s) of Record (for more information, see “Eligible Dependent(s) Under Retiree Choice”)

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2009 Merck Dental Plan for Flex/Retiree
Released October 17, 2008
Making Changes to Your Flex Coverage

Annual Enrollment Under Flex
Each year during annual enrollment, you may elect to make changes to your Dental Plan coverage or keep your current dental elections, subject to its continued availability. Generally, the benefit elections you make will remain in effect for the entire Plan Year (January 1st – December 31st) unless you or your Eligible Dependent(s) 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 January 1st 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 option (subject to its continued availability) and Coverage Tier.

Each year, you will be notified of the annual enrollment procedures, coverage costs and timeframes for enrolling in or changing your elections for the upcoming Plan Year. Since Merck may make changes to the Merck 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 NetBenefits at http://netbenefits.fidelity.com.

Between annual enrollment periods, you and your Eligible Dependent(s) may change or enroll in (if you had waived coverage) dental coverage only if you or your Eligible Dependent(s) 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.

Please note: If you are a Merck Temporary Employee, or an LTD Employee who was a Merck Temporary Employee at the time you began receiving LTD Benefits, you are not permitted to make changes to your Dental Plan coverage during the annual enrollment period. You may add an Eligible Dependent or drop a Covered Dependent from your dental coverage or change your Coverage Tier as a result of a Life Event that allows you to make a Permitted Plan Change. You may not change your Dental Plan option for any reason.

If You Move Out of Your Coverage Area

If you are an Eligible Employee enrolled in either the Healthplex DPO or Aetna DMO options and you move out of the network area, you must make a new election within 30 days after the date of the move. If you do not make a new election within that period, you and your Covered Dependent(s) will automatically be enrolled in the Merck Comprehensive Care Plan, effective as of the date you moved, and your contributions will be adjusted accordingly. For more information, call the Merck Benefits Service Center at 800-66-MERCK.

When Life Changes

Life Events & Permitted Plan Changes
During the year, you may be eligible to make certain changes to your Dental Plan coverage if you experience a Life Event that allows you to make Permitted Plan Changes. Any requested change to your coverage must be consistent with the Life Event.
In general, Life Events may include:

- A change in your legal marital status, including marriage, divorce or legal separation/annulment (in states where legal separation equals divorce).
- Meeting all of the criteria for a Same-Sex Domestic Partnership as defined by Merck, or ending a Same-Sex Domestic Partnership.
- Gaining a new Eligible Dependent through birth, adoption or placement for adoption.
- Your Eligible Dependent losing eligibility as a result of reaching the maximum coverage age, losing student status, marriage or other similar circumstances.
- The death of your dependent or spouse/Same-Sex Domestic Partner.
- A change to the employment status of your spouse/Same-Sex Domestic Partner or 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).
- Your spouse/Same-Sex Domestic Partner or dependent terminating or commencing employment.
- A change in the place of residence for you, your spouse/Same-Sex Domestic Partner or dependent.

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

- If you elected either the Healthplex DPO or Aetna DMO option and you move out of the applicable coverage area, you must change your Dental Plan option.
- If another employer’s dental plan allows for a change in your Eligible Dependent’s coverage (either during that plan’s open enrollment period or due to a mid-year election change permitted under that employer’s plan), you may be able to make a corresponding election change under the Merck Dental Plan.
- If the Merck 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 spouse/Same-Sex Domestic Partner or a 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 Merck 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 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 option, you must wait until the annual enrollment period.
How to Make a Permitted Plan Change
If you have a Life Event that allows you to make a Permitted Plan Change, you must request your change within 30 days of the event through NetBenefits at http://netbenefits.fidelity.com or by calling the Merck Benefits Service Center at 800-66-MERCK. Any requested change to your coverage must be consistent with the Life Event. If you do not make your request within 30 days, you will have to wait until the next annual enrollment period 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 Fidelity Investments within 30 days of 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 Fidelity Investments within 30 days, you will not be permitted to make a change until the next annual enrollment period.

KEY POINT — HOW TO ENROLL A NEW CHILD
To enroll your new child under your Merck Dental Plan coverage option, you must contact the Merck Benefits Service Center online through NetBenefits at http://netbenefits.fidelity.com or by calling 800-66-MERCK. You cannot enroll your child by calling your dental coverage carrier directly. Even if your Coverage Tier will not change, you must enroll your child through the Merck Benefits Service Center in order for your child to receive dental coverage.

If You Take a Leave of Absence
- Approved Paid Leave of Absence. If you take an approved paid leave of absence, Merck will continue to deduct your portion of the cost of dental coverage through payroll deductions. Deductions will be on a pre-tax basis.
- Approved Unpaid Leave of Absence. If you take an approved unpaid leave of absence, at Merck’s discretion, you will either be billed for your portion of the cost of coverage during your leave or the amount will accumulate and you will be billed at the end of your leave. For employees who return to work at the expiration of a leave, any accumulated amounts will be deducted from your initial paychecks. If you fail to pay premiums to continue coverage in the time and manner specified by Merck, your coverage will end and you will not be able to re-enroll for coverage unless and until you return to active employment.

If You Are a Flex-Eligible Union Employee Who Goes on Layoff
If you are placed on layoff, there are two different ways to continue coverage:
- Continue Your Current Dental Coverage. You may continue the Merck dental coverage you had on the date your layoff begins for the duration of your layoff. If you decide to continue your benefits coverage under this option, you will receive a monthly billing invoice for 100% of the cost to continue your coverage, as well as a 2% administrative fee. Payment for continued coverage is due on the first of the month to maintain coverage for that month. If you want to elect this option, you must call the Merck Benefits Service Center at 800-66-MERCK within 30 days from the date of your benefits continuation letter to make your election. If you do not call within the 30 days, you will not be able to continue coverage under this option. If you fail to pay premiums to continue coverage in the time and manner specified by Merck, your coverage will end and you will not be able to re-enroll for coverage unless and until you return to active employment.
- Continue Your Dental Coverage under COBRA. As an alternative, you may elect to continue your dental coverage for a period of 18 months under COBRA. If you want to elect this option, you must call the Merck Benefits Service Center at 800-66-MERCK and make your elections within 60 days from the date your layoff begins or the date of your COBRA notification, whichever is later. If you
About Flex Dental Benefits

do not call the Merck Benefits Service Center and make your election by this date, you will not be eligible to continue your dental coverage under the COBRA option. For more information about your COBRA rights, see the “COBRA” section of the Administrative Information chapter.

If at the time you go on layoff you are eligible for continuation of 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 will continue without interruption while you are receiving LTD Benefits. You may only make changes to your dental coverage — elect a new Dental Plan option, add an Eligible Dependent or drop a Covered Dependent — during the annual enrollment period, unless you experience a Life Event that allows you to make a Permitted Plan Change. Dental coverage for you and your Covered Dependent(s) is provided at no cost to you while you are receiving LTD Benefits.

Any period of dental coverage provided to you and/or your Covered Dependent(s) while you are receiving LTD Benefits is included in the period for which you and/or your Covered Dependent(s) may be eligible for continuation coverage under COBRA. See the “COBRA” section in the Administrative Information chapter.

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

If You Are Eligible for Dental Coverage as a Retiree
If you become a Retiree while receiving LTD Benefits, your dental coverage as an LTD Employee will end and your coverage as a Retiree will begin, on the date you become a Retiree. If you become a Retiree before you begin receiving LTD benefits, you will be eligible for coverage as a Retiree, not as an LTD employee. In either case, you will be billed as a Retiree in accordance with the billing procedures established under the Retiree Choice Program, effective the first of the month following or coincident with the date of your retirement.

If You Retire and Elect Merck Dental Coverage
If you become a Retiree, you and your Eligible Dependent(s) who are your Dependent(s) of Record are eligible for post-retirement dental coverage as of your retirement date under the Retiree Choice Program. As a Retiree, you must pay required Retiree Choice contributions for coverage in the time and manner specified by the Plan Administrator. For information about dental coverage under the Retiree Choice Program, see the “About Retiree Choice Dental Benefits” chapter.

If You Retire and Decline Dental Coverage
As a Retiree, you may elect the No Coverage option. If you elect the No Coverage option, you will not receive dental coverage in retirement, unless you enroll for coverage during the next annual enrollment or experience a loss of prior coverage that allows you to re-enroll for Merck dental coverage mid-year under the Retiree Choice Program.

If you do not choose to cover your Dependent(s) of Record as of your retirement date, you can elect to cover them in the future provided they meet the definition of Eligible Dependent at enrollment. During retirement, you cannot cover any individual as a dependent who was not previously listed as a Dependent of Record.
KEY POINT — DEPENDENT(S) OF RETIREE(S) MAY ALSO OPT OUT

When you choose No Coverage for yourself, you are also choosing it for your Eligible Dependent(s). You may cover your dependent(s) at a future date, provided they meet the definition of Eligible Dependent and they were previously listed as a Dependent of Record.

When Flex Dental Coverage Ends

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

- The end of the month following the month in which your employment terminates, unless you qualify as a Retiree;
- The end of the month following the month in which your employment terminates, unless you are eligible for LTD Benefits;
- The end of the month following 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 (after the expiration of any grace period) you fail to pay the required employee contributions for coverage, unless you are otherwise eligible to default to coverage requiring no contributions;
- The date, after the expiration of any grace period, the required contributions for coverage are not paid; or
- The date the Merck Dental Plan is terminated by the Company.

Your Covered Dependent(s)' Coverage ends on the earliest of:

- The date your coverage ends for any reason. Coverage may continue in the event of your death through COBRA or under the terms applicable to Survivor Coverage.
- The date your Covered Dependent no longer qualifies as an Eligible Dependent under the Merck Dental Plan (such as the date the child turns 19 and is no longer a full-time student, see “Eligible Dependent(s) Under Flex” in the About Flex Dental Benefits chapter). Coverage for dependent children who are full-time students will terminate on the earlier of:
  - Your dependent child’s 25th birthday; or
  - The end of the month following the month your child graduates.
- The date, after the expiration of any grace period, the required employee contributions for coverage are not paid.
- The date the Merck Dental Plan is terminated by the Company.

If a Covered Dependent Loses Eligibility Status

You must notify Merck when a Covered Dependent is no longer eligible for coverage by changing your dependent’s status online at [http://netbenefits.fidelity.com](http://netbenefits.fidelity.com) or by contacting the Merck Benefits Service Center at [800-66-MERCK]. If you do not notify Merck when a Covered Dependent becomes ineligible for coverage, you may be required to reimburse the Merck Dental Plan for any or all costs incurred by the Plan to cover your ineligible dependent. You may also be subject to disciplinary action, up to and including termination. Additionally, if you fail to notify Merck within 60 days of the event, your dependent may lose eligibility to continue coverage under COBRA (or if applicable, continuation coverage available to Same-Sex Domestic Partners and their eligible dependent children).

Please note that coverage for that dependent will end in accordance with the Plan’s provisions regardless if you have notified the Company. For example, if you cover your spouse as a dependent under the Merck 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 Merck Benefits Service Center by phone or through NetBenefits.

**Continuing Your Coverage Through COBRA**

If you or your Covered Dependent loses dental coverage under the Merck Flexible Benefits Program, 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 Same-Sex Domestic Partner and his/her covered dependent children, Merck offers continuation of dental coverage in certain cases. For continuation of coverage options available to Same-Sex Domestic Partners and their eligible dependent children, see “Continuation of Dental Care Coverage for Same-Sex Domestic Partners” in the Administrative Information chapter.

**Flex Coverage for Surviving Dependent(s) in the Event of Your Death**

**Length and Cost of Coverage for Surviving Dependent(s)**

If you die while employed by the Company and at that time you do not have at least 25 years of Adjusted Service or you are not eligible to be a Retiree, coverage for your surviving Eligible Dependent(s) continues for as long as they would otherwise continue to qualify as dependent(s) under the Merck Dental Plan, up to a maximum of two years from your date of death. Coverage is provided at no cost for up to two years, then your Eligible Dependent(s) may be eligible to continue your coverage through COBRA. For more information see “COBRA.”

However, if when you die you are employed by the Company and have at least 25 years of Adjusted Service, or you are eligible to be a Retiree under the Merck Dental Plan, coverage for your surviving Eligible Dependent(s) continues for as long as they would otherwise continue to qualify as Eligible Dependent(s) under the Merck Dental Plan. The cost for coverage is the same as the cost of coverage for those receiving LTD Benefits.

To determine if an employee was eligible to be a Retiree on his/her date of death for purposes of determining eligibility for dental benefits for surviving dependent(s), the employee must have met the age and service requirements applicable to a non-disability retirement under the Retirement Plan on his/her date of death.

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

**Dependent Eligibility for Surviving Dependent(s)**

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

**Your Surviving Dependent(s)’ Dental Plan Coverage**

Coverage for your surviving Eligible Dependent(s) continues under the option in which you 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 Eligible Dependent(s) may elect any option that would have otherwise been available to you.
or remain in the same coverage. All surviving Eligible Dependent(s) must be enrolled in the same option.

If you had elected the No Coverage option, your surviving Eligible Dependent(s) may elect one of the Merck Dental Plan’s other coverage options by calling the Merck Benefits Service Center at 800-66-MERCK within 30 days of the date of your death. If they do not make an election within 30 days of the event, they will automatically be covered under the Merck Comprehensive Care option and unable to make changes until the next annual enrollment period, unless they experience a Life Event that would allow them to make a Permitted Plan Change.

**KEY POINT — REPORTING A DEATH**

In the event of the death of an Eligible Employee, Retiree, Covered Dependent or Dependent of Record, please call Fidelity Survivor Services at 800-666-3725.

**Changing Coverage During Annual Enrollment for Surviving Dependent(s)**

If you are a surviving Eligible Dependent, you have the opportunity to change your Dental Plan option and Coverage Tier every year during annual enrollment. Merck will inform you of any changes to the Merck Dental Plan and the procedures for making enrollment changes. Generally, the benefit elections you make will remain in effect for the entire Plan Year (January 1st through December 31st) unless you experience a Life Event that allows you to make a Permitted Plan Change.
About Retiree Choice Dental Benefits

This section provides Retirees with important information about dental coverage under the Retiree Choice Program, including eligibility, enrollment, contributions and how you can make changes to your benefits.

Retiree Choice Dental Benefits

If you are a Retiree who is eligible for the Retiree Choice Program, you and your Dependent(s) of Record are eligible for Retiree dental coverage.

Retiree Choice Dental Eligibility

You are considered a Retiree for purposes of the Merck Dental Plan, but not necessarily for purposes of any other Merck benefit plan, if you are an Eligible Employee on the date your employment with Merck ends and you meet the definition of Retiree (see the “Glossary” for a complete definition). As a Retiree, you can elect or decline coverage for yourself and your Eligible Dependent(s) who are your Dependent(s) of Record.

If You Were Rehired

If you retire from the Company and are later rehired by the Company you will retain your status as a Retiree when your employment with the Company subsequently ends, though you will be subject to the rules in effect on the date of your subsequent retirement.

If You Retire Due to Disability Retirement

If your employment with Merck, including its subsidiaries, ends on or after January 1, 2003, due to disability retirement under the Retirement Plan and on that date you do not have at least 10 Years of Service but you have at least 10 years of Credited Service under the Retirement Plan, you will not be eligible for benefits as a Retiree under the Retiree Choice Program. However, you will be eligible for benefits under the Merck Dental Plan on the same terms and conditions, as they may be amended from time to time, as the benefits available to an LTD Employee. For a description of those benefits, see “If You Receive LTD Benefits” in the About Flex Dental Benefits chapter.

Eligible Dependent(s) Under Retiree Choice

You may be permitted to cover your Eligible Dependent(s) under your Retiree Choice dental option. To be eligible for post-retirement dental coverage, your Eligible Dependent(s) must be registered as Dependent(s) of Record in Fidelity Investments’ dependent database within 30 days of your retirement date. Only Eligible Dependent(s) registered as Dependent(s) of Record will be eligible for coverage under the Retiree Choice Program. For this reason, it’s very important that you register your Eligible Dependent(s) as Dependent(s) of Record, even if you do not intend to cover them under your Retiree Choice dental option when you first retire.
Dependent of Record
For purposes of the Retiree Choice Program, generally a Dependent of Record is an Eligible Dependent as of the Retiree’s retirement date whom the Retiree registers on Fidelity Investments’ dependent database within 30 days of retirement. (If you retired prior to March 31, 2007, please see the Key Point below for special provisions affecting your Dependent(s) of Record.) An otherwise Eligible Dependent who is not registered as a Dependent of Record within 30 days of retirement is not, and will never be, eligible for coverage as a dependent under the Retiree Choice Program.

If you do not choose to enroll your Dependent(s) of Record in your Retiree Choice dental option as of your retirement date, you can elect to cover them in the future provided they meet the definition of Eligible Dependent at the time you wish to enroll them. During retirement you cannot cover any individual as a dependent who is not a Dependent of Record. This means that you may not register new dependent(s) as Dependent(s) of Record after the specified initial timeframe, even if you experience a Life Event in retirement such as getting married.

For more details, including guidelines for the Eligible Dependent(s) you may register as Dependent(s) of Record, see the definition of “Dependent(s) of Record” in the Glossary.

KEY POINT — DEPENDENT(S) OF RECORD IN RETIREMENT
For purposes of the Retiree Choice Program, a Dependent of Record is an Eligible Dependent whom you register — at the time of your retirement from Merck — as a current or future potential Covered Dependent. If you do not register that individual within 30 days of your retirement date, that person will never qualify as a Dependent of Record and therefore will not be eligible to be your Covered Dependent during your retirement.

In order to register someone as a Dependent of Record, the person must meet the established criteria for an Eligible Dependent, as defined under the Merck Dental Plan on your retirement date. See “Dependent(s) of Record” in the Glossary for a complete definition.

How to Register a Dependent of Record
Your Covered Dependent(s) who are enrolled for coverage under the Merck Dental Plan on your retirement date will automatically be registered as your Dependent(s) of Record.

- To register an Eligible Dependent as a new Dependent of Record — i.e., an Eligible Dependent who was not covered under the Merck Dental Plan on your retirement date — you must call the Merck Benefits Service Center at 800-66-MERCK within 30 days of your retirement date.
- If you retired prior to April 1, 2007, please see the Key Point below for special provisions affecting your Dependent(s) of Record.

KEY POINT — DEPENDENT OF RECORD IF YOU RETIRED BEFORE APRIL 1, 2007
If you are a Retiree who retired prior to April 1, 2007, your Dependent(s) of Record are Eligible Dependent(s) (as of March 31, 2007) whom you registered on Fidelity NetBenefits by March 31, 2007. Any Covered Dependent(s) who were enrolled for coverage under your Retiree Choice dental benefits on March 31, 2007, were automatically registered as your Dependent(s) of Record.

Adding Eligible Dependent(s) to Your Retiree Coverage
You may add an Eligible Dependent who is a Dependent of Record or drop a Covered Dependent at any time. You may not add any individual who is not a Dependent of Record. For more information, see “Making Changes to Your Retiree Choice Coverage.”
**Same-Sex Domestic Partnerships Under Retiree Choice**
Retirees may be eligible to cover Same-Sex Domestic Partners and their eligible dependent children under Retiree Choice. To be eligible for coverage under Retiree Choice, the Same-Sex Domestic Partner and his/her dependent children must be Dependent(s) of Record.

For purposes of Dependent(s) of Record, Eligible Dependent(s) do not include the Retiree’s Same-Sex Domestic Partner and his/her Same-Sex Domestic Partner’s children if the Retiree:
- Retired on or before January 1, 2003 (June 1, 2003, for those who were IUC Members; July 1, 2004, for those who were Non-Flex-Eligible Union Employees); or
- Retired after January 1, 2003 (June 1, 2003, for those who were IUC Members; July 1, 2004 for those who were Non-Flex-Eligible Union Employees) but before April 1, 2007, and did not cover those individuals while an active employee immediately prior to the Retiree’s retirement date and continuously thereafter during retirement through April 1, 2007.

**KEY POINT — COVERING YOUR SAME-SEX DOMESTIC PARTNER**

If you retired before April 1, 2007, as a Retiree under the Retiree Choice Program you cannot add coverage for a Same-Sex Domestic Partner or his/her eligible dependent children under Retiree Choice.

If you retire on or after April 1, 2007, as a Retiree under the Retiree Choice Program you have 30 days from your retirement date to register a Same-Sex Domestic Partner or his/her eligible dependent children as a current or future potential Covered Dependent. If you do not register that individual within 30 days of your retirement date, that person will never qualify as a Dependent of Record and therefore will not be eligible to be your Covered Dependent during your retirement.

**Additional Taxable Income**
Under current federal income tax laws, the value of providing medical and dental benefits to a Same-Sex Domestic Partner and his/her eligible dependent children is considered taxable to you — unless they are considered your dependents for purposes of federal income taxes. This means you may be required to pay federal, state and local income taxes on an additional amount of Company-provided coverage. This type of taxable income is known as imputed income, and Merck will notify you at the end of each year of the annual income attributed to Same-Sex Domestic Partner dental coverage.

It’s important for you to understand the tax implications of covering a Same-Sex Domestic Partner and/or his/her eligible dependent children. You may wish to consult a tax advisor to determine the full tax and financial effect of electing this coverage. For more information, see “Paying for Retiree Choice Dental Benefits.” More information about Same-Sex Domestic Partner benefits is available by calling the Merck Benefits Service Center at 800-66-MERCK.

**Enrolling in Retiree Choice Dental Benefits**

**Who You May Cover Under Retiree Choice**
For the Merck Dental Plan, Retirees may choose one of the following Coverage Tiers:
- Retiree Only
- Retiree + Spouse/Same-Sex Domestic Partner
- Retiree + Child(ren)
- Retiree + Spouse/Same-Sex Domestic Partner + Child(ren)

Note: A Retiree’s ability to select a Coverage Tier is limited based on the individuals who are listed as his/her Dependent(s) of Record.
If both you and your spouse/Same-Sex Domestic Partner work, or worked, for Merck, special provisions apply to the Coverage Tier you are eligible to elect. See “Merck Couples Under the Retiree Choice Program.”

Enrollment Under Retiree Choice
If you were enrolled for dental coverage as an active employee, you will be automatically enrolled in the Comprehensive Care Plan option as of your retirement date. The Coverage Tier in which you were enrolled as an Eligible Employee will be mapped to the same level Coverage Tier as a Retiree.

Please note that the No Coverage option is available to Retirees (effective January 1, 2008). If you had waived coverage as an Eligible Employee, you will have 30 days from your date of retirement to elect into coverage. If you do not elect coverage within 30 days, you will automatically continue with the No Coverage option as of your retirement date. See the Key Point below for how to make coverage changes.

KEY POINT — HOW TO MAKE CHANGES TO YOUR RETIREE CHOICE COVERAGE

- **Within 30 Days of your Retirement Date**: You may change your Merck Dental Plan coverage and Coverage Tier within 30 days of your retirement date for changes to be retroactive to your retirement date. You also have 30 days to register your Eligible Dependent(s) as Dependent(s) of Record so that they may be Covered Dependent(s) at retirement or in the future.

- **During Annual Enrollment**: You may be able to change from the No Coverage option to the Comprehensive Care option or from the Comprehensive Care option to the No Coverage option. See “Making Your Retiree Choice Dental Contribution Payments.”

- **With Proof of Loss of Other Coverage**: If you elect the No Coverage option, you can re-enroll for Retiree Choice dental coverage mid-year as long as you provide proof of coverage loss and complete the change within 30 days of your coverage loss.

- **At Any Time**: You can change from the Comprehensive Care option to the No Coverage option, change Coverage Tier and add Eligible Dependent(s) who are Dependent(s) of Record or drop Covered Dependent(s) from coverage at any time. Changes will be effective as soon as administratively feasible, but no later than the first of the month following the date of the change. You cannot change from the No Coverage option to the Comprehensive Care option during the year unless you provide proof of coverage loss and enroll within 30 days of your coverage loss.

To make changes, call the Merck Benefits Service Center at 800-66-MERCK.

You may choose from the following Dental Plan options:

- Merck Comprehensive Care Dental option
- No Coverage option

Adding or Dropping Dependent(s) to Your Retiree Coverage
Your Covered Dependent(s) who were enrolled for coverage under your Merck Dental Plan option on your retirement date will automatically be covered under the Retiree Choice Comprehensive Care option as of your retirement date. You may drop a Covered Dependent at any time of year. You may add an Eligible Dependent at any time of the year, provided he/she is a Dependent of Record. You may not add new dependent(s) to your coverage unless they are Dependent(s) of Record.

When Retiree Choice Coverage Begins
As a Retiree, your dental coverage under Retiree Choice begins as of your retirement date. Your Covered Dependent(s) who are enrolled in your Dental Plan option immediately prior to your retirement date will automatically be covered under the Retiree Choice Comprehensive Care option without interruption. If you change your Coverage Tier, add an Eligible Dependent or drop a Covered
Dependent within 30 days of your retirement date, your new enrollment and Retiree Choice dental contribution will go into effect as of your retirement date.

If you make a change to your Coverage Tier or remove Covered Dependent(s) or add Eligible Dependent(s) who are Dependent(s) of Record at any other time during your retirement, your new elections will take effect as soon as administratively feasible, which is typically the first of the month following the date you made an enrollment change. The change in Retiree Choice dental contributions will take effect the first of the month following your enrollment change.

I.D. Cards
As soon as administratively feasible after you are enrolled for coverage, you will receive an I.D. card directly from the dental carrier.

Paying for Retiree Choice Dental Benefits
As a Retiree, you pay monthly contributions toward the cost of dental coverage for yourself and your Covered Dependent(s). To determine your Retiree Choice dental contributions, call the Merck Benefits Service Center at 800-66-MERCK. Retiree Choice dental contributions may change from year to year. Merck will inform you, typically during the annual enrollment period in the fall, if there are any Retiree Choice dental contribution changes.

In general, your monthly contributions toward the cost of Retiree dental coverage are based on the dependent(s) you cover and whether you elect coverage.

Making Your Retiree Choice Dental Contribution Payments
You will receive a billing invoice from the Merck Benefits Service Center every month for the cost of all benefits in which you’re enrolled, including Retiree Choice dental. Payments are due on the first day of each month to continue coverage for that month.

If you fail to pay your required contributions for your coverage under Retiree Choice within the time and manner specified by Merck, your coverage under the Merck Dental Plan will terminate effective as of the contribution due date. You may re-enroll in the Plan during the next Annual Enrollment or during the year with proof of coverage loss and within 30 days of your coverage loss.

KEY POINT — IF YOU LOST COVERAGE BEFORE JANUARY 1, 2008, YOU ARE PERMANENTLY INELIGIBLE

If you lost Retiree Choice dental coverage before January 1, 2008, you are permanently ineligible for coverage as a Retiree under the Merck Dental Plan.

Alternate Payment Arrangements
- **Prepayment:** You may pre-pay your coverage at any time — this will show as a credit on your monthly invoices.
- **Automatic Bank Withdrawal:** You can arrange to have your contributions for your coverage under Retiree Choice deducted directly from your bank account. This convenient and easy-to-use option means you don’t have to mail checks or worry about payments arriving on time. To sign up for Automatic Bank Withdrawal, log on to NetBenefits or call the Merck Benefits Service Center at 800-66-MERCK.
About Retiree Choice Dental Benefits

KEY POINT — CANCELLED CHECK OR BANK STATEMENT SERVES AS PAYMENT RECEIPT

Please note that your cancelled check or bank statement serves as confirmation of payment. The Merck Benefits Service Center will not mail statements verifying that your contributions for coverage under Retiree Choice have been made.

Merck Couples Under the Retiree Choice Program

If both you and your spouse/ Same-Sex Domestic Partner (or your former spouse/ Same-Sex Domestic Partner or his/her spouse/ Same-Sex Domestic Partner) work, or worked, for the Company, there are certain rules about the coordination of dependent coverage under Retiree Choice. If you are a Merck couple, call the Merck Benefits Service Center at 800-66-MERCK for assistance.

Same-Sex Domestic Partners

In general, for purposes of the rules related to Merck couples under the Merck Dental Plan, your Same-Sex Domestic Partner is treated as your spouse — and as stepparent to your eligible dependent children. And, your Same-Sex Domestic Partner’s eligible dependent children are treated as your stepchildren.

No Duplicate Merck Coverage

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

You, your spouse/ Same-Sex Domestic Partner, your former spouse or his/her spouse may choose to cover different dependent(s) under different plans by selecting different Coverage Tiers. For example, you can choose Retiree Only to cover yourself under the Merck Medical Plan and Retiree + Spouse/ Same-Sex Domestic Partner + Child(ren) to cover all Eligible Dependent(s) who are Dependent(s) of Record under the Merck Dental Plan.

If Your Spouse/ Same-Sex Domestic Partner Is an Eligible Employee, LTD Employee or Retiree

If you are a Retiree who is married to an Eligible Employee or LTD Employee, you and your Eligible Dependent(s) may be covered under your spouse’s Dental Plan as a dependent. If you are a Retiree who is married to a Retiree, you and your Eligible Dependent(s) may be covered under your spouse’s Retiree Choice coverage, provided you and your Eligible Dependent(s) are Dependent(s) of Record of your spouse. Anyone who is not a Dependent of Record cannot be covered under Retiree Choice.

However, if for any reason your spouse fails to pay the contributions required to continue your coverage as a dependent in the time and manner specified by Merck or if your spouse drops coverage for you for any reason, your coverage under the Retiree Choice Program will end. See “Making Your Retiree Choice Dental Contribution Payments.”

If you are a Retiree and married to an employee who is eligible for LTD Benefits but who is a Non-Flex-Eligible Union Employee, your spouse/ Same-Sex Domestic Partner does not qualify as an Eligible Dependent under your Retiree Choice coverage even if he/she is a Dependent of Record. Likewise, you are not an Eligible Dependent under his/her Union coverage.
To determine eligibility for your dependent children, see “If Your Spouse/Same-Sex Domestic Partner Is a Non-Flex-Eligible Union Employee.”

If Your Spouse/ Same-Sex Domestic Partner Is a Non-Flex-Eligible Union Employee
If you are a Retiree who is married to, or in a Same-Sex Domestic Partnership with, a Merck employee who is a Non-Flex-Eligible Union Employee, your spouse/Same-Sex Domestic Partner does not qualify as an Eligible Dependent and may not be covered under your Retiree Choice dental coverage even if he/she is a Dependent of Record. Likewise, you are not an Eligible Dependent under your spouse’s/ Same-Sex Domestic Partner’s Union coverage.

For your children:

- If you choose dependent coverage, your eligible dependent children who are Dependent(s) of Record will be covered under the Comprehensive Care option, but your spouse/Same-Sex Domestic Partner must consent to this choice by completing and submitting a Spousal Consent Form (available on http://netbenefits.fidelity.com).
- If you choose Retiree Only coverage, your spouse/Same-Sex Domestic Partner must actively enroll their children under his/her dental plan.

Please note the provisions listed above also apply if your current spouse and ex-spouse both work for Merck. For example, if your current spouse is a Flex-Eligible Union Employee and your former spouse is a Non-Flex-Eligible Union Employee, they cannot both cover your dependent children.

Making Changes to Your Retiree Choice Coverage
Changing Other Than From the No Coverage Option
Under Retiree Choice, you may change from the Comprehensive Care option to the No Coverage option, change Coverage Tier and drop Covered Dependent(s) or add Eligible Dependent(s) who are Dependent(s) of Record at any time and for any reason. For Retirees who retired before April 1, 2007, special rules apply to adding dependent coverage for Same-Sex Domestic Partners and dependent children of Same-Sex Domestic Partners.

Coverage changes generally take effect prospectively (looking forward) as soon as administratively possible, and generally no later than the first of the month following the date you requested your change through the Merck Benefits Service Center. Any change in contributions for coverage under Retiree Choice will be effective the first of the month following the date the change in coverage is effective. To make a change to your Retiree Choice coverage, contact the Merck Benefits Service Center at 800-66-MERCK.

Changing From the No Coverage Option
If you elect the No Coverage option, you can elect the Comprehensive Care coverage option during the annual open enrollment period. That change in coverage and increase in contributions will be effective as of the first day of the following year.

If you elect the No Coverage option, you can elect the Comprehensive Care coverage option mid-year only if you provide proof of coverage loss and you complete your re-enrollment within 30 days of your coverage loss. That change in coverage and increase in contribution will be effective as soon as administratively feasible, and generally no later than the first of the month following the date you requested your change through the Merck Benefits Service Center.
Changing Coverage for Your Same-Sex Domestic Partner If You Retired Before April 1, 2007

If you retired before April 1, 2007, you cannot add coverage for a Same-Sex Domestic Partner or his/her eligible dependent children.

Changing Coverage for Your Same-Sex Domestic Partner If You Retire on or after April 1, 2007

If you intend to cover your Same-Sex Domestic Partner and/or his/her eligible dependent children for dental benefits under the Retiree Choice Program, you have 30 days from your retirement date to register them as a current or future potential Covered Dependent. If you do not register that individual within 30 days of your retirement date, that person will never qualify as a Dependent of Record and therefore will not be eligible to be your Covered Dependent during your retirement.

When Retiree Choice Dental Coverage Ends

Your coverage in the Merck Dental Plan under the Retiree Choice Program ends on the earliest of:

- The end of the month following 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;
- The date, after the expiration of any grace period, you fail to pay the required contributions for coverage; or
- The date the Merck Dental Plan is terminated by the Company.

Your Covered Dependent(s)’ coverage ends on the earliest of:

- The date your coverage ends for any reason. Coverage may continue in the event of your death through COBRA, or under the terms applicable to survivor coverage.
- The date your Covered Dependent no longer qualifies as an Eligible Dependent under the Merck Dental Plan (such as the date the child turns 19 and is no longer a full-time student, see “Eligible Dependent(s)” Under Flex in the About Flex Dental Benefits chapter). Coverage for dependent children who are full-time students will terminate on the earlier of:
  - Your dependent child’s 25th birthday; or
  - The end of the month following the month your child graduates.
- The date, after the expiration of any grace period, your required contribution for coverage is not paid.
- The date the Merck Dental Plan is terminated by the Company.

If a Covered Dependent Loses Eligibility Status

You must notify the Merck Benefits Service Center when a Covered Dependent is no longer eligible for coverage by calling the Merck Benefits Service Center at 800-66-MERCK to change your dependent’s status. If you do not notify the Merck Benefits Service Center when a Covered Dependent becomes ineligible for coverage, you may also be required to reimburse the Merck Dental Plan for any or all costs incurred by the Plan to cover your ineligible dependent. You may also be subject to loss of coverage. Additionally, if you fail to notify the Merck Benefits Service Center within 60 days of the event, your dependent may lose eligibility to continue coverage under COBRA (or if applicable, continuation coverage available to Same-Sex Domestic Partners and their eligible dependent children).

Please note that coverage for that dependent will end in accordance with the Plan’s provisions regardless if you have notified the Company. For example, if you cover your spouse as a dependent under the Merck 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 Merck Benefits Service Center by phone or through NetBenefits.
Continuing Your Coverage Through COBRA

If you or your Covered Dependent loses dental coverage under the Merck Flexible Benefits Program or the Merck Retiree Choice Program, you may be eligible to continue your coverage through COBRA. For more information see the “COBRA” section of the Administrative Information chapter.

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

Coverage for Surviving Dependent(s) in the Event of a Retiree’s Death

KEY POINT — REPORTING A DEATH

In the event of the death of an Eligible Employee, Retiree, Covered Dependent or Dependent of Record, please call Fidelity Survivor Services at 877-208-0807.

Eligibility for Survivor Coverage

If you are a Retiree covered under the Merck Dental Plan when you die, your surviving Eligible Dependent(s) who are Dependent(s) of Record continue to be eligible for coverage under Retiree Choice as of your date of death. Your surviving dependent(s) who are not your Dependent(s) of Record are not eligible for coverage under the Plan in the event of your death.

Length of Survivor Coverage

Your surviving Dependent(s) of Record continue to be eligible for coverage under Retiree Choice for so long as they would otherwise continue to qualify as Eligible Dependent(s) under the Merck Dental Plan. Your surviving spouse/Same-Sex Domestic Partner who is your Dependent of Record will continue to qualify as your Eligible Dependent even if he/she remarries or forms another Same-Sex Domestic Partnership.

Surviving Spouse/ Same-Sex Domestic Partner

If your surviving Dependent(s) of Record include your surviving spouse/Same-Sex Domestic Partner, he/she may elect to cover at least himself/herself as of your date of death. Thereafter, he/she can elect to cover as dependent(s) under his/her survivor coverage any other individual who is your Dependent of Record and who otherwise qualifies as an Eligible Dependent at the time of enrollment. He/she cannot cover any other individuals as dependent(s) under his/her survivor coverage.

If your surviving spouse/Same-Sex Domestic Partner does not pay for coverage in the time and manner specified by Merck, his/her coverage and that of any Covered Dependent(s) (and any other Eligible Dependent(s) who are the Retiree’s Dependent(s) of Record but who are not Covered Dependent(s) at that time and who have not otherwise elected Retiree Only coverage) will terminate effective as of the contribution due date. He/she may re-enroll in the Plan during the next Annual Enrollment or during the year with proof of coverage loss and within 30 days of coverage loss. See “Making Your Retiree Choice Dental Contribution Payments.”

If your surviving spouse/Same-Sex Domestic Partner is a Covered Dependent as of your date of death, coverage under the Comprehensive Care option will continue. At that time, the Coverage Tier will change to Retiree Only if he/she is your only surviving Dependent of Record or Retiree + Child(ren) if your surviving dependent children are Covered Dependent(s) on your date of death and your
surviving spouse/Same-Sex Domestic Partner wants to continue their coverage as his/her dependent(s). If he/she does not want to continue their coverage as his/her dependent(s), they can elect their own survivor coverage, as explained in the “Surviving Dependent Children” section below.

If your surviving spouse/Same-Sex Domestic Partner is your Dependent of Record but is not a Covered Dependent at your date of death, he/she will have the opportunity to enroll in Retiree Choice as of your date of death.

**Surviving Dependent Children**

If your surviving Dependent(s) of Record include your surviving spouse/Same-Sex Domestic Partner and Eligible Dependent(s) who are your dependent children, the children can either be covered under your surviving spouse/Same-Sex Domestic Partner’s survivor coverage as dependent(s) or they can elect their own individual survivor coverage. If they elect their own individual coverage, they can only each elect Retiree Only coverage.

If your surviving Dependent(s) of Record only include Eligible Dependent(s) who are your dependent children, each surviving child must elect their own coverage (Retiree Only) as of your date of death.

If your surviving dependent children who elect Retiree Only coverage do not pay for coverage in the time and manner specified by Merck, their coverage will terminate effective as of the contribution due date. They may re-enroll in the Plan during the next Annual Enrollment or during the year with proof of coverage loss and within 30 days of coverage loss. If your surviving dependent children do not elect Retiree Only coverage but instead are Covered Dependent(s) under your surviving spouse’s/Same-Sex Domestic Partner’s coverage (or are not his/her Covered Dependent(s) but are Eligible Dependent(s) who are your Dependent(s) of Record) and your surviving spouse/Same-Sex Domestic Partner does not pay for coverage in the time and manner specified by Merck, coverage (and eligibility for coverage) under Retire Choice will terminate. See “Making Your Retiree Choice Dental Contribution Payments.”

If your surviving child is a Covered Dependent as of your date of death, coverage under the Comprehensive Care option will continue. If your surviving child is your Dependent of Record but is not a Covered Dependent at your date of death, he/she will have an opportunity to enroll in Retiree Choice as of your date of death.

**Coverage Tiers for Survivor Coverage**

If your surviving Dependent(s) of Record include your surviving spouse/Same-Sex Domestic Partner, he/she may elect to cover at least himself/herself as of your date of death. If he/she elects to cover himself/herself only, coverage would be Retiree Only.

If your surviving Dependent(s) of Record include your surviving spouse/Same-Sex Domestic Partner and eligible dependent children, your surviving spouse/Same-Sex Domestic Partner may elect to cover some or all of the dependent children together with himself/herself as a group under Retiree + Child(ren). If he/she does not elect to cover all of your eligible dependent children who are your Dependent(s) of Record, he/she can later elect to cover them, provided at that time they satisfy the definition of Eligible Dependent. Alternatively, each dependent child who is a Dependent of Record can elect to be covered individually under Retiree Only coverage. Surviving children cannot elect to cover one another as dependent(s), therefore, they cannot elect Retiree + Child(ren).
Changing Survivor Coverage Other Than From the No Coverage Option
At any time, a surviving spouse/Same-Sex Domestic Partner may change from the Comprehensive Care option to the No Coverage option, drop Covered Dependent(s) or add Eligible Dependent(s) who are the Retiree’s Dependent(s) of Record, provided the individual otherwise qualifies as an Eligible Dependent at the time of enrollment. He/she cannot cover any other individuals as dependents under his/her survivor coverage. A surviving dependent child who is covered as Retiree Only may change from the Comprehensive Care option to the No Coverage option at any time but cannot cover any other individuals as dependents under his/her survivor coverage, even if those individuals are the Retiree’s Dependent of Record.

Coverage changes generally take effect prospectively (looking forward) as soon as administratively possible, and generally no later than the first of the month following the date you requested your change through the Merck Benefits Service Center. Any change in contributions for coverage will be effective as of the first of the month following or coincident with the date the change in coverage is effective. To make a change to Retiree Choice coverage, contact the Merck Benefits Service Center at 800-66-MERCK.

Changing Survivor Coverage From the No Coverage Option
If your survivor elects the No Coverage option, he/she can elect the Comprehensive Care option during the annual open enrollment period. That change in coverage and increase in contributions will be effective as of the first day of the following year.

If your survivor elects the No Coverage option, he/she can elect the Comprehensive Care coverage option mid-year only if he/she provides proof of coverage loss and he/she completes re-enrollment within 30 days of the coverage loss. That change in coverage and increase in contribution will be effective as soon as administratively feasible, and generally no later than the first of the month following the date he/she requested the change through the Merck Benefits Service Center.

Cost of Survivor Coverage
Your surviving spouse/Same-Sex Domestic Partner who is a Dependent of Record will pay the contribution rate applicable to Retirees.

Failure to pay for coverage in the time and manner specified by Merck will cause coverage to end effective as of the payment due date. Survivors may re-enroll in the Plan during the next annual open enrollment or during the year with proof of loss of other coverage and within 30 days of the loss of the other coverage. See “Making Your Retiree Choice Dental Contribution Payments.”

Merck Couples
If your surviving spouse/Same-Sex domestic Partner is an employee of the Company or a Retiree, special rules apply. For more information, your survivor should call the Merck Benefits Service Center at 800-66-MERCK and speak to a Customer Service Associate, Monday through Friday (excluding New York Stock Exchange holidays), between 8:30 A.M. and midnight, Eastern time.
Merck Comprehensive Care Option

The Merck Comprehensive Care option allows you the freedom to receive dental care from any licensed dentist.

**KEY POINT — PRE-TREATMENT PLAN**

Before starting a non-emergency dental treatment for which the charge is expected to be more than $100, a pre-treatment estimate is advisable.

**About the Merck Comprehensive Care Option**

The Merck Comprehensive Care option provides you with coverage for dental care that you receive from any licensed dentist. The Merck Comprehensive Care option features the Aetna Preferred Provider Organization network. The provisions (Deductibles, Coinsurance, and annual maximum) are the same whether your dentist participates in the Aetna network or not. However, if you receive care from a dentist participating in the Aetna network, your out-of-pocket costs will be lower than if you receive care from an Out-of-Network dentist.

The Merck Comprehensive Care option provides coverage for all 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 Merck Comprehensive Care option:

- You may receive care from any licensed dentist of your choice.
- Every time you need care, you have the choice to see an In-Network or Out-of-Network provider. However, if you do obtain care from an Out-of-Network provider, you will likely pay more for those services.
- For diagnostic care, dental coverage begins immediately — you don’t have to meet any Deductible amount.
- For basic dental care, major care and orthodontics, you must meet a per person Deductible before the Plan pays for In-Network or Out-of-Network coverage.
How the Merck Comprehensive Care Option Works

The Merck Comprehensive Care option provides you with access to a national network of providers — Aetna Preferred Provider Organization Network. Each time you receive care for covered expenses you have a choice of obtaining care In-Network, using one of Aetna’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 Aetna providers. Participating providers will file the claim on your behalf and will accept the plan allowance as payment in full.

Whether you use a network provider or not, the Plan pays 100% of covered charges for diagnostic and preventive care. Before benefits can be paid in a calendar year, you and/or your Covered Dependent(s) must meet the $25 per person Deductible. The Deductible does not apply to diagnostic and preventive care services. However, the Deductible does apply to basic, major and orthodontia services.

In-Network Benefits

You receive the highest level of benefits available under the Merck Comprehensive Care option when you use an In-Network provider. Every time you visit a dentist who participates in the Aetna 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 Aetna network, their services are negotiated; therefore they never exceed the R&C Limit.

Out-of-Network Benefits

Each time you need care, you can choose to see a provider who does not belong to the Aetna 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 Aetna network.

**KEY POINT — IMPORTANT BENEFIT TERMS**

| Important benefit terms, such as Annual Deductible, Coinsurance and Reasonable and Customary (R&C) Limit are defined in the “Glossary” on page 73. |
## Merck Comprehensive Care Option At a Glance

<table>
<thead>
<tr>
<th>For These Types of Services</th>
<th>The Merck Comprehensive Care Option Pays¹</th>
<th>You Pay</th>
</tr>
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<tbody>
<tr>
<td>Diagnostic and preventive care</td>
<td>100% of covered charges up to an annual maximum benefit²</td>
<td>$0</td>
</tr>
<tr>
<td> Routine exams (two per calendar year)</td>
<td></td>
<td></td>
</tr>
<tr>
<td> X-rays (two per calendar year)</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>
<td></td>
</tr>
<tr>
<td> Sealants</td>
<td></td>
<td></td>
</tr>
<tr>
<td> Space maintainers</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Basic care</td>
<td>80% of covered charges once you satisfy the Annual Deductible, up to an annual maximum benefit³</td>
<td>A per-person Annual Deductible plus the remaining 20%³</td>
</tr>
<tr>
<td> Fillings (other than gold)</td>
<td></td>
<td></td>
</tr>
<tr>
<td> Extractions</td>
<td></td>
<td></td>
</tr>
<tr>
<td> Root canals</td>
<td></td>
<td></td>
</tr>
<tr>
<td> Periodontics (up to eight visits per calendar year, including up to two periodontal maintenance visits)</td>
<td></td>
<td></td>
</tr>
<tr>
<td> Denture repair</td>
<td></td>
<td></td>
</tr>
<tr>
<td> Oral surgery</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Major care</td>
<td>50% of covered charges once you satisfy the Annual Deductible, up to a maximum lifetime benefit of $1,500</td>
<td>A per-person Annual Deductible plus the remaining 50%³ plus any amount in excess of the maximum lifetime benefit of $1,500</td>
</tr>
<tr>
<td> Gold fillings and inlays</td>
<td></td>
<td></td>
</tr>
<tr>
<td> New or replacement dentures and bridgework (certain limits apply)</td>
<td></td>
<td></td>
</tr>
<tr>
<td> Crowns</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Orthodontics</td>
<td>50% of covered charges once you satisfy the Annual Deductible, up to a maximum lifetime benefit of $1,500</td>
<td>A per-person Annual Deductible plus the remaining 50%, plus any amount in excess of the maximum lifetime benefit of $1,500</td>
</tr>
</tbody>
</table>

### Plan Maximums

You and/or your Covered Dependent(s) have a $1,500 lifetime maximum for orthodontic expenses and an annual maximum benefit of $2,000 per person for all other covered charges.

If you reach your $2,000 benefit maximum in a calendar year, no further dental benefits will be paid until the following year, except for orthodontic charges up to the $1,500 lifetime maximum.

### Merck Comprehensive Care Option Covered Services

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

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¹ In-Network percentages are based on negotiated fees with Aetna PPO dentists. Out-of-network percentages are based on Reasonable and Customary (R&C) Charges. See “Determining the R&C Amount for a Covered Charge” on page 38.

² Combined annual maximum of $2,000.

³ Combined Annual Deductible of $25.
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 Dental Plan 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 Merck Comprehensive Care 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 Aetna Member Services (see “Benefit Contacts and Resources” on page 2) to see if the fee to be charged is more than the R&C charge.

- If it is more, Aetna 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, Aetna 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 Aetna, 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 Merck Comprehensive Care option at work for you. Assume you have covered dental expenses in a calendar year as follows:

<table>
<thead>
<tr>
<th>For these Expenses...</th>
<th>Total Covered Charges</th>
<th>The Merck Comprehensive Care Option Pays...</th>
<th>You Pay...</th>
</tr>
</thead>
<tbody>
<tr>
<td>Two check-ups,</td>
<td>$100</td>
<td>$100</td>
<td>$0</td>
</tr>
<tr>
<td>including x-rays</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>and cleanings</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Two fillings</td>
<td>$80</td>
<td>$44 (80% after the Deductible)</td>
<td>$36 (the $25 Deductible plus your 20% Coinsurance)</td>
</tr>
<tr>
<td>A crown replacement</td>
<td>$225</td>
<td>$112.50 (50% assuming the Deductible has been paid)</td>
<td>$112.50 (50% Coinsurance)</td>
</tr>
<tr>
<td>Total</td>
<td>$405</td>
<td>$256.50</td>
<td>$148.50</td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th>For these Expenses...</th>
<th>Total Covered Charges</th>
<th>The Merck Comprehensive Care Option Pays...</th>
<th>You Pay...</th>
</tr>
</thead>
<tbody>
<tr>
<td>Orthodontia/braces</td>
<td>$3,000</td>
<td>$1,487.50 (50% after the Deductible)</td>
<td>$1,512.50</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 $100, a pre-treatment plan is advisable.

A pre-treatment plan is a written report made by your dentist describing his or her 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 Merck Comprehensive Care 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 Aetna, the Claims Administrator (see Benefit Contacts and Resources).

**Alternate Treatment**

Although there are sometimes several ways of treating a dental problem, the Dental Plan 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 Dental Plan for those services and supplies determined by the Claims Administrator to be in excess of those which are adequate and appropriate for that problem. For example, if your dentist recommends (and you proceed with) a porcelain restoration for a tooth and the Claims Administrator determines than an amalgam restoration is adequate and appropriate, you will receive benefits under the Dental Plan as if you had received an amalgam restoration.

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

**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:
- Clinical oral examinations (two per calendar year);
- X-rays (two per calendar year);
- Tests and laboratory examinations;
- Routine cleanings (two per calendar year);
- Fluoride treatments (two per calendar year);
- Sealants;
- Space maintainers; and
- Professional consultation (dentist-to-dentist).

Basic Care Services
The following is a list of covered basic care services and limitations:
- Amalgam restorations (including polishing);
- Silicate restorations;
- Acrylic or plastic restorations;
- Endodontics:
  - Pulp capping,
  - Pulpotomy,
  - Root canal therapy (includes treatment plan, clinical procedures, and follow-up care) and periapical services, and
  - Other endodontic procedures;
- Periodontics (up to eight visits per calendar year, including up to two periodontal maintenance visits):
  - Surgical services, and
  - Adjunctive periodontal services;
- Case pattern section (includes all necessary diagnostic, surgical, and adjunctive services):
  - Gingivitis and periodontitis,
  - Repairs to dentures, and
  - Appliances for tooth guidance;
- 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.):
  - 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; and
Anesthesia:
- General,
- Professional visits,
- Drugs prescribed in connection with services covered under the Merck Dental Plan, and
- Miscellaneous services.

**Major Care Services**
The following is a list of covered major care services and limitations:
- 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; and
- 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.

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 five 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 Medically Necessary or payable under the Merck Comprehensive Care option. The fact that a dentist has prescribed, ordered, recommended, or approved a service or supply does not, in itself, make it Medically Necessary.

The following exclusions apply to all the benefits described in the Merck Comprehensive Care option. 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 Merck;
- Expenses for services covered by the Merck Preferred Provider Organization option (Merck PPO), Merck 80/20 option, Merck 80/20 Out-of-Area option, Retiree Catastrophic option or Health Maintenance Organization options under the Merck Medical Plan, whether or not you are enrolled in those options;
- Any dental surgery or other dental service performed inpatient or outpatient 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 five 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” on page 39);
- Charges submitted more than two years after charges were incurred, 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; and
- Services that, to any extent, are payable under any medical benefits including HMOs.

In limited circumstances, certain dental services and procedures that are not covered under the Merck Comprehensive Care option may be covered under the Merck PPO option, Merck 80/20 option, Merck 80/20 Out-of-Area option or Retiree Catastrophic option under the Merck Medical Plan. Therefore, if you elect an HMO option under the Merck Medical Plan, you will not be covered for these services and procedures unless your HMO provides such coverage.

**How to File a Claim**

To be reimbursed for treatment or services received from an Out-of-Network dentist, you must complete and submit a claim form to the Claims Administrator at the following address:

Claims Administrator for the Merck Dental Plan
Aetna
P.O. Box 14094
Lexington, KY 40512-4094

Claim forms are available online through the Merck HR website at [http://hr.merck.com](http://hr.merck.com). See “Benefit Contacts and Resources” on page 2. You must submit your claim form within two years of the date care was received.

You will receive a written notice from the Claims Administrator or its delegate regarding your claim within 90 days of its receipt by the Claims Administrator. If an extension is required to process your claim, you will receive notice of the need for an extension (not to exceed an additional 90 days), before
the end of the initial 90-day period, explaining the reasons for the delay. If you are not furnished notice within the 90-day period, your claim will be considered denied.

If you receive treatment or services from a dentist in the PPO, Aetna will pay the dentist directly — you do not need to pay the provider and then submit a claim form and wait for reimbursement. The dentist will bill you directly for your share of the cost (any Deductible or Coinsurance amounts).

**Appealing a Claim**

If the Claims Administrator denies all or part of your claim, you will be notified in writing. The notice will include:

- Specific reasons why the claim was denied;
- Specific references to applicable provisions of the plan document on which the denial is based;
- A request for any additional information required to reconsider the claim and an explanation of why this information is needed; and
- An explanation of how to appeal for reconsideration of the Claims Administrator’s decision.

You have a right to review all documentation that was used to make a decision about your claim. If you disagree with the Claims Administrator’s decision, you have 60 days after receiving the notice of denial to file a written appeal to the Claims Administrator at the following address:

Aetna Dental Customer Resolution Team  
P.O. Box 14080  
Lexington, KY 40512

Your claim will be reconsidered and you will receive written notice of the decision within 60 days after your appeal was received, unless special circumstances require an extension for reviewing, in which case written notice of such extension will be furnished to you before the expiration of the initial 60-day period. In that case, the decision will be made no later than 120 days after your appeal was received. This notice will include the reason for the decision, with references to pertinent plan provisions. If the decision on your appeal is not given to you within the applicable time period, your appeal will be considered denied.

This procedure applies to you or any other person who has a right to benefits under the Merck Dental Plan.
Merck Preventive Care Option

The Merck Preventive Care option allows you the freedom to receive diagnostic and preventive dental care from any licensed dentist.

About the Merck Preventive Care Option

The Merck Preventive Care option provides you with coverage for dental care that you receive from any licensed dentist. The Merck Preventive Care option features the Aetna Preferred Provider Organization network. The provisions (Deductibles, Coinsurance, and annual maximum) are the same whether your dentist participates in the Aetna network or not. However, if you receive care from a dentist participating in the Aetna network, your out-of-pocket costs will be lower than if you receive care from an Out-of-Network dentist.

The Merck Preventive Care option provides coverage for diagnostic and preventive dental services like routine exams and cleanings.

Key Features

In general, under the Merck Preventive Care option:

- You may receive care from any licensed dentist of your choice.
- Every time you need care, you have the choice to see an In-Network or Out-of-Network provider. However, if you do obtain care from an Out-of-Network provider, you will likely pay more for those services.
- For diagnostic care, dental coverage begins immediately — you don’t have to meet any Deductible amount.
- Coverage is not provided for basic dental care, major care and orthodontics.

How the Merck Preventive Care Option Works

The Merck Preventive Care option provides you with access to a national network of providers — the Aetna Preferred Provider Organization Network. Each time you receive care for covered expenses you have a choice of obtaining care In-Network, using one of Aetna’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 Aetna providers. Participating providers will file the claim on your behalf and will accept the plan allowance as payment in full.

Whether you use a network provider or not, the Plan pays 100% of covered charges for diagnostic and preventive care. The Plan does not provide coverage for basic dental care, major care and orthodontics.
**In-Network Benefits**
You receive the highest level of benefits available under the Merck Preventive Care option when you use an In-Network provider. Every time you visit a dentist who participates in the Aetna 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 Aetna network, their services are negotiated; therefore they never exceed the R&C Limit.

**Out-of-Network Benefits**
Each time you need care, you can choose to see a provider who does not belong to the Aetna 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 Aetna network.

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**KEY POINT — IMPORTANT BENEFIT TERMS**
Important benefit terms, such as Annual Deductible, Coinsurance and Reasonable and Customary (R&C) Limit are defined in the “Glossary” on page 73.

**Merck Preventive Care Option At a Glance**

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<td></td>
<td></td>
</tr>
<tr>
<td>Space maintainers</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Annual Maximum**
You and/or your Covered Dependent(s) have an annual maximum benefit of $2,000 per person for all other covered charges. If you reach your $2,000 benefit maximum in a calendar year, no further dental benefits will be paid until the following year.

**Merck Preventive Care Option Covered Services**
The Merck Preventive Care option reimburses covered charges for covered dental services from Out-of-Network dentists at a percentage of Reasonable and Customary (R&C) Charges. Covered charges for covered dental services from In-Network dentists are reimbursed based on negotiated reduced fees with PPO dentists.

For example, assume the Plan pays 100% and the R&C charge for a certain covered preventive care service is $100. If your Out-of-Network dentist charges you $120 for that service, the Merck Dental Plan will only pay $100 — that is 100% of the $100 R&C charge.

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¹ In-Network percentages are based on negotiated fees with Aetna PPO dentists. Out-of-network percentages are based on Reasonable and Customary (R&C) charges. See "Determining the R&C Amount for a Covered Charge," page 46.
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 $20, the amount above the R&C charge.

The Merck Preventive Care option does not reimburse you for charges for non-covered dental services. See “Dental Services Not Covered” below.

**Determining the R&C Amount for a Covered Charge**

Anytime your dentist recommends a surgical or diagnostic procedure, you can call Aetna Member Services (see “Benefit Contacts and Resources” on page 2) to see if the fee to be charged is more than the R&C charge.

- If it is more, Aetna 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, Aetna 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 Aetna, 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.

**Covered Dental Services**

Only diagnostic and preventive care services are covered under the Merck Preventive Care option. The following is a list of covered routine diagnostic and preventive care services and limitations:

- Clinical oral examinations (two per calendar year);
- X-rays (two per calendar year);
- Tests and laboratory examinations;
- Routine cleanings (two per calendar year);
- Fluoride treatments (two per calendar year);
- Sealants;
- Space maintainers; and
- Professional consultation (dentist-to-dentist).

**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 Medically Necessary or payable under the Merck Preventive Care option. The fact that a dentist has prescribed, ordered, recommended, or approved a service or supply does not, in itself, make it Medically Necessary.

The following exclusions apply to all the benefits described in the Merck Preventive Care option. Benefits are not provided for:

- Charges for basic, major and orthodontic dental care expenses;
- 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 Merck;
- Expenses for services covered by the Merck Preferred Provider Organization option (Merck PPO), Merck 80/20 option, Merck 80/20 Out-of-Area option, Retiree Catastrophic option or Health Maintenance Organization options under the Merck Medical Plan, whether or not you are enrolled in those options;
- Any dental surgery or other dental service performed inpatient or outpatient 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 connected with vertical alterations or training in dental hygiene or plaque control;
- 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;
- Claims submitted more than two years after charges were incurred, 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; and
- Services that, to any extent, are payable under any medical benefits including HMOs.

**How to File a Claim**

To be reimbursed for treatment or services received from an Out-of-Network dentist, you must complete and submit a claim form to the Claims Administrator at the following address:

Claims Administrator for the Merck Dental Plan  
Aetna  
P.O. Box 14094  
Lexington, KY 40512-4094

Claim forms are available online through the Merck HR website at [http://hr.merck.com](http://hr.merck.com). See “Benefit Contacts and Resources” on page 2. You must submit your claim form within two years of the date care was received.

You will receive a written notice from the Claims Administrator or its delegate regarding your claim within 90 days of its receipt by the Claims Administrator. If an extension is required to process your claim, you will receive notice of the need for an extension (not to exceed an additional 90 days), before the end of the initial 90-day period, explaining the reasons for the delay. If you are not furnished notice within the 90-day period, your claim will be considered denied.

If you receive treatment or services from a dentist in the PPO, Aetna will pay the dentist directly — you do not need to pay the provider and then submit a claim form and wait for reimbursement. The dentist will bill you directly for your share of the cost (any Deductible or Coinsurance amounts).
Appealing a Claim
If the Claims Administrator denies all or part of your claim, you will be notified in writing. The notice will include:

- Specific reasons why the claim was denied;
- Specific references to applicable provisions of the plan document on which the denial is based;
- A request for any additional information required to reconsider the claim and an explanation of why this information is needed; and
- An explanation of how to appeal for reconsideration of the Claims Administrator’s decision.

You have a right to review all documentation that was used to make a decision about your claim. If you disagree with the Claims Administrator’s decision, you have 60 days after receiving the notice of denial to file a written appeal to the Claims Administrator at the following address:

Aetna Dental Customer Resolution Team
P.O. Box 14080
Lexington, KY 40512

Your claim will be reconsidered and you will receive written notice of the decision within 60 days after your appeal was received, unless special circumstances require an extension for reviewing, in which case written notice of such extension will be furnished to you before the expiration of the initial 60-day period. In that case, the decision will be made no later than 120 days after your appeal was received. This notice will include the reason for the decision, with references to pertinent plan provisions. If the decision on your appeal is not given to you within the applicable time period, your appeal will be considered denied.

This procedure applies to you or any other person who has a right to benefits under the Merck Dental Plan.
Merck DPO Options

The Merck Dental Plan Organization (DPO) options operate like health maintenance organizations.

About the Merck DPO Options

Merck currently offers two managed dental coverage options. They are:

- **Healthplex DPO** — all services are provided through International Healthcare Services, Inc., a licensed New Jersey Dental Provider Organization, by a network of neighborhood dentists and full-service dental centers throughout New Jersey.
- **Aetna DMO** — All services are provided by Aetna Dental Maintenance Organization through a nationwide network of dentists. Due to variations in state licensing and filings, the offering entity and DMO coverage plan names vary by state.

You may elect either the Healthplex DPO or Aetna DMO option if you live in the applicable service area. The options for which you are eligible appear on your NetBenefits Enrollment Worksheet on Fidelity NetBenefits at [http://netbenefits.fidelity.com](http://netbenefits.fidelity.com). You may also call the Merck Benefits Service Center at 800-66-MERCK to find out which options are available to you.

All benefits, limitations and exclusions for the DPO and DMO options are listed in their respective member brochures and contracts. Upon request, the DPO or DMO will supply you with the written materials concerning:

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

You must receive dental care treatment or services from a participating DPO or DMO dentist. Any services received outside the applicable network are not covered. A directory of providers in your area will be provided to you at no cost at your request. You may also locate participating DPO or DMO dentists by calling Healthplex or Aetna or visiting the applicable website. For more information about the Healthplex DPO or Aetna DMO, contact the providers directly. See “Benefit Contacts and Resources” on page 2.

If you enroll in either the Healthplex DPO or Aetna DMO option and you move out of the coverage area, you must make a new dental coverage election within 30 days after the date you move. If you do not make a new election within that period, you and any covered Eligible Dependent(s) will automatically be enrolled in the Comprehensive Care option (Preventive Care option for Part-Time Employees), effective as of the date you moved, and your contribution will be adjusted accordingly. To make a new election you
must request your change through NetBenefits at [http://netbenefits.fidelity.com](http://netbenefits.fidelity.com) or by calling the Merck Benefits Service Center at 800-66-MERCK. See “Making Changes to Your Flex Coverage” on page 17 for more information.

**How to File a Claim**

Under the Merck DPO options, Healthplex or Aetna will pay the dentist directly. You do not need to pay the provider, submit a claim form and wait for reimbursement. The dentist will bill you directly for your share of the cost, if any.

**Appealing a Claim**

If the Claims Administrator denies all or part of your claim, you will be notified in writing. The notice will include:

- Specific reasons why the claim was denied;
- Specific references to applicable provisions of the plan document on which the denial is based;
- A request for any additional information required to reconsider the claim and an explanation of why this information is needed; and
- An explanation of how to appeal for reconsideration of the Claims Administrator’s decision.

You have a right to review all documentation that was used to make a decision about your claim. If you disagree with the Claims Administrator’s decision, you have 60 days after receiving the notice of denial to file an appeal. Contact your DPO and follow their appeals procedure.

If you are enrolled in the Healthplex DPO:

Healthplex DPO  
1030 St. Georges, Suite LL3  
Avenel, NJ 07001

If you are enrolled in the Aetna DMO:

Aetna Dental Customer Resolution Team  
P.O. Box 14080  
Lexington, KY 40512

Your claim will be reconsidered and you will receive written notice of the decision within 60 days after your appeal was received, unless special circumstances require an extension for reviewing, in which case written notice of such extension will be furnished to you before the expiration of the initial 60-day period. In that case, the decision will be made no later than 120 days after your appeal was received. This notice will include the reason for the decision, with references to pertinent plan provisions. If the decision on your appeal is not given to you within the applicable time period, your appeal will be considered denied.

This procedure applies to you or any other person who has a right to benefits under the Merck Dental Plan.
Administrative Information

This section contains information on the administration and funding for the Merck 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 Merck 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 Dependent(s) are covered by the Merck Dental Plan and by certain other types of coverage, the Merck Dental Plan will coordinate your benefits with other coverage. The Merck Dental Plan coordinates benefits with these types of coverage:

- Group insurance (e.g., group coverage sponsored by another employer, a college, an association, etc.) whether the coverage:
  - Pays benefits on an insured or uninsured basis, or
  - Provides benefits on a prepaid or managed care basis (e.g., 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(s), the secondary plan(s), may then pay some of the difference between what the primary plan paid and the total covered expenses.

Keep in mind that in most cases, you and your Covered Dependent(s) 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/Same-Sex Domestic Partner is covered under his/her employer’s plan and as a Covered Dependent under the Merck Dental Plan, the Merck Dental Plan is secondary. If your spouse/Same-Sex Domestic Partner submits expenses to the Merck Dental Plan, and the amount payable by the Merck Dental Plan is less than or equal to what your spouse’s/Same-Sex Domestic Partner’s plan would have paid, the Merck Dental Plan will pay nothing. The Merck Dental Plan never pays more than the amount which, when added to the amount paid by the primary coverage, equals the amount the Merck Dental Plan would have paid had it been the primary plan.
KEY POINT — MAXIMUM BENEFIT PAID WHEN COORDINATING COVERAGE

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

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

If you are an Eligible Employee or a Retiree 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/Same-Sex Domestic Partner if the spouse/Same-Sex Domestic Partner can obtain coverage through his/her own employer.

Coordinating Benefits in General

The Merck 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.
- If you are covered under both plans as a Retiree, the plan that covered you the longest as an active employee pays first.
- 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 Merck Dental Plan will pay an amount which, when added to the amount paid by the primary plan, equals the amount the Merck 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 Merck Dental Plan would pay an amount which, when added to the amount paid by the primary plan, equals the amount the Merck 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 Merck 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 Merck 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 Merck Dental Plan. Depending on the coordination of benefit provisions of the other plan, you may or may not receive additional benefits. Note, however, that in states where personal injury coverage is available under an automobile insurance policy (e.g., New Jersey), the Merck Dental Plan will assume that you and your Covered Dependent(s) elected such personal injury coverage. As a result, the Merck 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 Merck 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.

COBRA

A federal law, the Consolidated Omnibus Budget Reconciliation Act (COBRA) requires that most employers sponsoring group health plans offer Eligible Employees, Retirees and their Eligible Dependent(s) 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 Same-Sex Domestic Partner and his/her Covered Dependent children, Merck offers continuation of dental coverage in certain cases. For continuation of coverage options available to Same-Sex Domestic Partners, see “Continuation of Dental Coverage for Same-Sex Domestic Partners.”

You do not have to show that you are insurable to choose COBRA coverage. However, you will have to pay the entire premium for your COBRA coverage. There is a 30-day grace period for the payment of the regularly scheduled premium (other than the initial premium which must be paid by its due date). You should be aware that in some of the situations outlined in this SPD, Merck automatically extends coverage at no cost to you or your Eligible Dependent(s) for a period after coverage under the Merck Dental Plan would otherwise end (e.g., coverage provided to surviving Eligible Dependent(s) under certain circumstances). This coverage is included in the period for which you or your Eligible Dependent(s) may be eligible for continuation coverage under COBRA. For example, if your Eligible Dependent(s) are eligible for 36 months of continuation coverage under COBRA due to your death and Merck provides 24 months of coverage to them under the Merck Dental Plan at no cost to them as surviving Eligible Dependent(s), then they will have 12 months of continuation coverage under COBRA remaining for which they must pay premiums.

KEY POINT — YOUR COVERAGE OPTION UNDER COBRA

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

If you are an Eligible Employee of the Company covered by the Merck 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 Merck Benefits Service Center at 800-66-MERCK.

If you are the spouse of an Eligible Employee or Retiree and are covered by the Merck 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 Merck 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, or a Retiree 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 Merck Dental Plan is lost for any of the following five reasons (qualifying events):

- The death of the employee or Retiree;
- 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 or Retiree;
- The employee or Retiree becoming enrolled in Medicare; or
- The dependent becoming no longer eligible for coverage under the Plan.

Certain Retirees, and their Covered Dependent(s), also may be eligible for COBRA coverage if Merck commences a bankruptcy proceeding and those individuals lose coverage.

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 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 Dependent(s) are covered by the Merck Dental Plan 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 Dependent(s) lose coverage under the Merck 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 Merck Dental Plan in anticipation of your employment termination.

**KEY POINT — IN THE EVENT OF YOUR DEATH**

If you die while you are a participant in the Merck Dental Plan, your Covered Dependent(s) may be eligible to continue to receive dental coverage from Merck. This coverage runs concurrent with COBRA coverage. For information, see “Coverage for Surviving Dependent(s) in the Event of Your Death.”

**Your Duties Under the Law**

You or a family member have the responsibility of informing the Merck Benefits Service Center (the COBRA Administrator) of a divorce, legal separation or a child losing dependent status under the Merck 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). If you, or a family member, fail to provide this notice to Merck during this 60-day notice period, any Covered Dependent who loses coverage will not be offered the option to elect COBRA coverage.

To notify Merck of a Covered Dependent losing coverage due to divorce, legal separation or a child losing dependent status, contact Fidelity Investments online through NetBenefits or by calling the Merck Benefits Service Center at 800-66-MERCK. Additionally, you must notify Merck by calling the Merck Benefits Service Center if a covered dependent child leaves, or graduates from, school and is no longer a student.
KEY POINT — LOSING DEPENDENT STATUS

A dependent child can lose dependent status in a variety of ways including, but not limited to:
- Reaching a limiting age;
- Graduation from or dropping out of school;
- Getting married; or
- Obtaining gainful employment.

For Parents of Graduating Seniors:
Children are covered until age 19 (or age 25, if they are full-time students). If your child is turning age 19 and will continue to be a full-time student, you are responsible for calling the Merck Benefits Service Center to declare your child’s status as a full-time student. If you fail to call within 30 days of your child’s 19th birthday, your child’s coverage will be terminated. You will not be able to re-enroll your child (even if he/she is a full-time student) until the next annual enrollment period, unless you have a Life Event that allows you to make a mid-year Permitted Plan Change.

If your child will not continue as a full-time student and you are interested in continued coverage for your child under COBRA, you must notify the Merck Benefits Service Center within 60 days of your child’s 19th birthday. Failure to request COBRA benefits within the specified timeframe will result in no COBRA coverage for your child.

Call the Merck Benefits Service Center at 800-66-MERCK for more information.

For your spouse and each child, the following information is required for COBRA:
- Full name;
- Mailing address;
- Date of birth;
- Relationship to you; and
- Social Security number.

Once you, your spouse or your dependent child has notified the Merck Benefits Service Center of the event resulting in the loss of coverage, COBRA information and an election form for continuation coverage will be mailed within 14 days by the COBRA Administrator. After you receive the information and election form, you and your Eligible Dependent(s) 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 Dependent(s) fail to notify the Merck Benefits Service Center of a divorce, legal separation or a child losing dependent status and any claims are mistakenly paid for expenses incurred after the date coverage would normally be lost due to the event, then you and your Covered Dependent(s) will be required to reimburse the Plan for any claims mistakenly paid.

KEY POINT — IF YOU MOVE

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

Merck’s Duties Under the Law

Merck will cause the COBRA Administrator to notify Qualified Beneficiaries of the right to elect continued coverage automatically (without any action required by you or a 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 he/she would lose coverage because of one of the events described earlier, or, if later, 60 days after the COBRA Administrator provides the Qualified Beneficiary with notice of the right to elect COBRA coverage. A third party, such as a health care provider, also may elect and pay for coverage on behalf of a Qualified Beneficiary. If COBRA coverage is not elected within the time period described above, the Qualified Beneficiary will lose the right to elect COBRA coverage.

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

**Separate Elections**
Each Qualified Beneficiary has an independent election right to elect COBRA coverage. For example, if there is a choice among types of coverage under the plan, each Qualified Beneficiary who is eligible for COBRA coverage is entitled to make a separate election among the types of coverage. Thus, a spouse or dependent child is entitled to elect COBRA coverage even if you do not make that election. Similarly, a spouse or dependent child may elect different coverage from the coverage you elect.

**Types of Coverage You Will Receive and Changes to Coverage**
If you choose COBRA coverage, Merck is required to give you coverage that is identical to the coverage provided under the Plan to similarly situated non-COBRA beneficiaries/Retirees or Covered Dependent(s). If the coverage for similarly situated non-COBRA beneficiaries/Retirees or Covered Dependent(s) is modified, your coverage will be modified in the same manner. “Similarly situated non-COBRA beneficiaries” means the individuals receiving coverage under the Plan who are receiving coverage for a reason other than due to the rights under COBRA and who, based on all the facts and circumstances, are most similarly situated to the situation of the Qualified Beneficiary immediately before the qualifying event.

As a Qualified Beneficiary, you will have the same opportunity to change your benefit elections as similarly situated non-COBRA beneficiaries. This means that you will be eligible to participate in the Plan’s annual open enrollment and you are subject to the Plan’s rules regarding mid-year changes. You also have the same right as active Eligible Employees to enroll Eligible Dependent(s) 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). For Qualified Beneficiaries, who are similarly situated Retirees, this means you may only enroll Eligible Dependent(s) who are the Retiree’s Dependent(s) of Record.

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

**Duration of COBRA Coverage**

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

If you experience an employment termination or reduction in hours following Medicare enrollment, however, your 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);
- If you lose 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 Merck 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 Dependent(s) 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 Merck of this new determination within 30 days of the date it is made.

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

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

1. Merck 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 covered — after the date COBRA is elected — under another group health plan (whether or not as an employee) that does not contain any applicable exclusion or limitation with respect to any pre-existing condition of the individual or that does not apply to (or is satisfied by) such person by reason of the Health Insurance Portability and Accountability Act of 1996. (COBRA coverage ends only for the person covered by the other group dental plan.)
4. The Qualified Beneficiary becomes enrolled in Medicare after the date COBRA is elected. (COBRA coverage ends only for the person enrolled in Medicare.)
5. 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).

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

Paying for COBRA Coverage

You do not have to show that you are insurable to choose COBRA coverage. However, under the law, you may be required to pay the full amount of the cost of covering an active employee (and his/her Eligible Dependent(s), if applicable), plus a 2% administrative fee (for a total of 102% of the cost of coverage). If your coverage is extended from 18 to 29 months for disability, you may be required to pay up to 150% of the cost of covering an active employee (and his/her Eligible Dependent(s), 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 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 Dependent(s) or drop Covered Dependent(s) 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 in writing immediately at the address listed below. Fidelity Investments is the COBRA Administrator. If you have questions about your COBRA rights, call the Merck Benefits Service Center at 800-66-MERCK.

All notices and other communications regarding COBRA and the Merck 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 Same-Sex Domestic Partners

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

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

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

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

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

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

<table>
<thead>
<tr>
<th>Event</th>
<th>Same-Sex Domestic Partner</th>
<th>Employee's/ Same-Sex Domestic Partner's Covered Dependent Children</th>
</tr>
</thead>
<tbody>
<tr>
<td>Employee terminates employment for any reason (except gross misconduct)</td>
<td>18 months¹</td>
<td>18 months¹</td>
</tr>
<tr>
<td>Employee dies</td>
<td>36 months</td>
<td>36 months</td>
</tr>
<tr>
<td>Same-sex domestic partnership ends</td>
<td>36 months</td>
<td>36 months</td>
</tr>
<tr>
<td>Disabled employee becomes entitled to Medicare (and dependent(s) lose coverage)</td>
<td>36 months</td>
<td>36 months</td>
</tr>
<tr>
<td>Child is no longer an Eligible Dependent under Merck’s Plans</td>
<td>Not applicable</td>
<td>36 months</td>
</tr>
</tbody>
</table>

Your Rights Under HIPAA

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) is a federal law that is designed to make it easier for you and your Covered Dependent(s) to have continued group health coverage when changing jobs. As HIPAA is a federal law, the definitions of marriage (a legal Union between one man and one woman) and a spouse (a husband or wife who is a member of the opposite sex), as described in the Defense of Marriage Act of 1996 (DOMA) apply.

Special Enrollment Period

Under HIPAA, you have special enrollment rights under certain circumstances. If you are an Eligible Employee and you declined enrollment in the Merck Dental Plan because you had alternative health coverage, you may be eligible to enroll in the Merck Dental Plan without waiting until the next annual enrollment period for yourself and your Eligible Dependent(s). Eligible Employees and their Eligible Dependent(s) may be eligible for the special enrollment period if:

- You initially declined coverage for yourself and your Eligible Dependent(s) (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 premiums 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 premiums or for cause) or employer contributions toward the cost of coverage terminated.

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

To request special enrollment through HIPAA, you must contact the Merck Benefits Service Center at 800-66-MERCK within 30 days of the event. Please note that the rules regarding Life Event changes may

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.
be more generous than those required to be provided under HIPAA. See “Making Changes to Your Flex Coverage.” HIPAA special enrollment rules do not apply to Retirees and their Eligible Dependent(s).

**HIPAA Certificate of Coverage**

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

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

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

**HIPAA-Like Provisions for Same-Sex Domestic Partners**

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

- The special enrollment period (described in “Special Enrollment Under HIPAA for Eligible Employees”); and
- A coverage certification verifying coverage under the Merck Dental Plan (described above).

**Your Rights Under USERRA**

If you are serving in the military and are covered under the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA), you will continue to participate and be eligible to receive benefits under the Plan in accordance with USERRA rules and regulations.
Your Rights Under ERISA

As a participant in the Merck 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 Merck 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 Pension and Welfare Benefit 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 summary plan description. The administrator may make a reasonable charge for the copies.

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

Continue Group Health Care

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

Prudent Actions by Plan Fiduciaries

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

Enforcing Your Rights

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

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of plan documents or the latest annual report from the Plan and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator.
If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or federal court. In addition, if you disagree with the Plan’s decision or lack thereof concerning the qualified status of a medical child support order, you may file suit in federal court. If it should happen that the Plan fiduciaries misuse the Plan’s money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

Assistance with Your Questions
If you have any questions about the Merck 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 Pension and Welfare Benefits 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 202-219-8776 or accessing their website at http://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 “Benefit 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” health claims.** These are claims that if not processed quickly (within 72 hours) the life or health of the patient is jeopardized. The Claims Administrator will notify you or your doctor of the Plan’s decision no later than 72 hours after your claim is received, unless you fail to provide sufficient information to determine whether, or to what extent, benefits are covered or payable under the Plan.

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

- **“Post-service” health claims.** These are claims involving the payment or reimbursement of costs for care that has already been provided. For non-urgent, post-service health claims, The Claims Administrator will notify you or your doctor of the decision no later than 15 days after your claim is received.
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, or not Medically Necessary. 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 “Benefit 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 “Benefit 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 Medically Necessary or appropriate — the review will be done in consultation with a healthcare professional who has appropriate training and experience in the relevant field of medicine involved in the medical...
judgment, who was not consulted in connection with the previous adverse claim determination and who is not that person’s subordinate.

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

- **Post-service appeals.** The Claims Administrator will provide notice of the appeal decision within 30 days following receipt of your appeal.
- **Pre-service appeals.** The Claims Administrator will provide notice of the appeal within 15 days following receipt of your appeal.
- **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 36 hours after 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 Aetna upholds an adverse benefit determination at the first level of appeal, you or your authorized representative have the right to file a voluntary second appeal, also called a level two appeal. The appeal must be submitted within 60 calendar days following the receipt of notice of a level one appeal.

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

- **Pre-service appeals** (may include concurrent care claim reduction or termination). Aetna shall issue a decision within 15 calendar days of receipt of the request for a level two appeal.
- **Post-Service appeals.** Aetna shall issue a decision within 30 calendar days of receipt of the request for a level two appeal.
- **Urgent Care appeals** (may include concurrent care claim reduction or termination). Aetna shall issue a decision within 36 hours 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.
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.

Grievance Resolution Process for DPOs
All Merck DPOs have a grievance resolution process designed to promptly address member problems. If you have a problem, call the DPO’s Member Services. The DPO will promptly address your inquiry. If you are dissatisfied, the next step is to file a formal, written grievance with the DPO. For information about the specific grievance resolution process for the DPO, contact the DPO’s Member Services and ask for a copy of the grievance resolution procedure.

Claims and Appeals for Eligibility to Participate in the Merck 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 a particular coverage option, Coverage Tier, add a dependent, etc.), you, your beneficiary or your authorized representative may request reconsideration under the Plan. All requests for reconsideration shall be submitted in writing to the Plan Administrator at the following address:

Merck & Co., Inc.
Attn: Plan Administrator (RY32-517)
P.O. Box 2000
Rahway, NJ 07065

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

If your claim for eligibility involves whether an incapacitated child is eligible to participate in the Plan as an Eligible Dependent, you need to follow the claims and appeals procedure for the Dental Plan option in which you are enrolled. Please note that all requests for reconsideration regarding participation by the incapacitated child must be submitted in writing to the Claims Administrator for the option in which you are enrolled. See “Benefit Contacts and Resources for Written Appeals” for address information.
**Benefit Contacts and Resources for Written Appeals**
The following chart lists the appeals address for each of the available Merck 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 the Claims Administrator at this Address</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Benefit Appeals</strong></td>
<td></td>
</tr>
<tr>
<td>• Merck Comprehensive Care option</td>
<td>Claims Administrator and fiduciary for the Merck Dental Plan: Aetna P.O. Box 14080 Lexington, KY 40512</td>
</tr>
<tr>
<td>• Merck Preventive Care option</td>
<td></td>
</tr>
<tr>
<td><strong>Eligibility Appeals</strong></td>
<td></td>
</tr>
<tr>
<td>For all Plan options</td>
<td>Plan Administrator for the Merck Dental Plan: Merck &amp; Co., Inc. Attn: Plan Administrator (RY32-517) P.O. Box 2000 Rahway, NJ 07065</td>
</tr>
<tr>
<td><strong>DPO Option Appeals</strong></td>
<td></td>
</tr>
<tr>
<td>Healthplex DPO</td>
<td>Healthplex DPO 1030 St Georges, Suite LL3 Avenel, NJ 07001</td>
</tr>
<tr>
<td>Aetna DMO</td>
<td>Aetna Dental Customer Resolution Team P.O. Box 14080 Lexington, KY 40512</td>
</tr>
</tbody>
</table>

**Plan Disclosure Information**

**Employer/ Sponsor**
Merck & Co., Inc. sponsors the Merck Dental Plan. The employer identification number assigned to Merck & Co., Inc. by the IRS is #22-1109110. The address and phone number for Merck & Co., Inc. is:

Merck & Co., Inc.  
Attn: Plan Administrator (RY32-517)  
P.O. Box 2000  
Rahway, NJ 07065  
Telephone: **866-MRK-HR4U** (866-675-4748)
**Plan Administrator/ Claims Administrator**

The Plan Administrator for the Merck Dental Plan is Merck & Co., Inc. Administration of the Merck Dental Plan is the responsibility of the Plan Administrator. The Claims Administrators determine eligibility for benefits under the Merck Dental Plan in accordance with the official Dental Plan document(s). For the list of Claims Administrators, see the “Plan Funding and Administration” chart.

Merck & Co., Inc. as Plan Administrator has the exclusive discretionary authority to:

- Construe and interpret the provisions of the Merck Dental Plan;
- Make factual determinations;
- Decide all questions of eligibility for benefits;
- Determine the amount of such benefits;
- Resolve issues arising in the administration, interpretation and/or application of the Merck Dental Plan;
- Correct any defects;
- Reconcile any inconsistencies; and
- Supply any omissions with respect to the Merck Dental Plan.

The Plan Administrator’s decisions on such matters are final and conclusive. Merck & Co., Inc. as Plan Administrator has reserved the right to delegate all or any portion of its discretionary authority described above to a representative (e.g., Claims Administrator) and upon such delegation such representative’s decisions on such matters are final and conclusive. Any interpretations or determinations made pursuant to such discretionary authority of the Plan Administrator or its representative will be upheld in judicial review unless it is shown that the interpretation or determination was an abuse of discretion. Merck has delegated all of its discretionary authority described above to the Claims Administrator(s) identified in the Plan Funding and Administration Chart. The determination of such Claims Administrator(s) with respect to the benefits set forth next to their name under the column “Benefits Type” are final and binding.

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

The Plan Administrator may be contacted through the Company’s HR Services Department as follows:

Merck & Co., Inc.  
Attn: Plan Administrator (RY32-517)  
P.O. Box 2000  
Rahway, NJ 07065  

Telephone: **866-MRK-HR4U** (866-675-4748)
Agent for Service of Legal Process
If, for any reason, you want to seek legal action against the Merck Dental Plan, you can serve legal process on Merck & Co., Inc. by directing such service to Senior Director, HR Services at the following address:

Merck & Co., Inc.  
Attn: Plan Administrator (RY32-517)  
P.O. Box 2000  
Rahway, NJ 07065

Service of legal process may also be made upon Merck & Co., Inc., the Plan Administrator or the Trustee.

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

State Street Bank and Trust Company  
One International Place  
Boston, MA 02110

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>Type of Administration</th>
<th>Insured or Self-Insured</th>
</tr>
</thead>
</table>
| The Merck & Co., Inc. Medical Plan for Non-Union Employees, which is part of the Merck & Co., Inc. Medical, Dental and Long-Term Disability Program for Non-Union Employees | 502 | • Merck Comprehensive Care option  
• Merck Preventive Care option | Aetna | Contract Administration | Self-insured by Merck¹ |
| Plan type:  
Employee welfare program providing group dental coverage | | | | | |
| The Merck & Co., Inc. Medical Plan for Union Employees, which is part of the Merck & Co., Inc. Medical, Dental and Long-Term Disability Program for Union Employees | 540 | COBRA | Fidelity Investments | Contract Administration | N/A |
| Plan type:  
Employee welfare program providing group dental coverage | | | | | |

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 Funding and Administration (continued)

<table>
<thead>
<tr>
<th>Official Plan Name and Plan Type</th>
<th>Plan Number</th>
<th>Benefits Type</th>
<th>Claims Administrator</th>
<th>Type of Administration</th>
<th>Insured or Self-Insured</th>
</tr>
</thead>
<tbody>
<tr>
<td>DPO Options</td>
<td></td>
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<tr>
<td>The Merck &amp; Co., Inc. Medical Plan for Non-Union Employees, which is part of the Merck &amp; Co., Inc. Medical, Dental and Long-Term Disability Program for Non-Union Employees</td>
<td>502</td>
<td>Healthplex DPO</td>
<td>Healthplex DPO</td>
<td>Insurance Company Administration</td>
<td>Insured by DPO</td>
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<tr>
<td>Plan type: Employee welfare program providing group dental coverage</td>
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<tr>
<td>The Merck &amp; Co., Inc. Medical Plan for Union Employees, which is part of the Merck &amp; Co., Inc. Medical, Dental and Long-Term Disability Program for Union Employees</td>
<td>540</td>
<td>Aetna DMO</td>
<td>Aetna</td>
<td>Insurance Company Administration</td>
<td>Insured by DMO</td>
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<tr>
<td>Plan type: Employee welfare program providing group dental coverage</td>
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Trust

In general, the benefits provided to participants in the Merck Dental Plan may be funded by contributions made by Merck (and/or certain affiliates of Merck) and/or the participants to one or more trusts. Merck 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 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.

No Right to Employment

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

Plan Amendment or Termination

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

Any amendment, termination or other action by Merck with respect to the Merck Dental Plan shall be by a duly adopted resolution of the U.S. Compensation and Benefits Committee of Merck with the concurrence of Merck’s Chief Executive Officer or may be made by any person duly authorized to take such action on their behalf. Amendments may be retroactive. No amendment or termination shall reduce the amount of any benefit otherwise payable under the Merck Dental Plan for charges incurred prior to the effective date of such amendment or termination.

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

For two years following a “change in control” (as defined in the Separation of Benefits Plan) the material terms of the Merck 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 his/her claim for relief in an action regarding an impermissible amendment (other than ordinary claims for benefits).

Plan Documents

This SPD is intended merely as a summary of the official plan document(s). In the event of any disagreement between this summary and the official plan document(s), as they may be amended from time-to-time, the provisions of the plan document(s) will govern.

Plan Year

The Plan Year for the Merck Dental Plan ends on December 31st of each year. The financial records of the Merck 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.

Adjusted Service. For an employee who had no breaks in service as an employee, Adjusted Service is a period of time calculated from the employee’s original hire date with the Company (or certain subsidiaries of Merck) to the date the employee’s employment with the Company ends. For an employee who had one or more breaks in service as an employee, Adjusted Service is a period of time calculated from a date after the employee’s original date of hire which acts to give credit for service with the Company (or certain subsidiaries of Merck) for period(s) of service with the Company (or certain subsidiaries of Merck) rendered before the break(s) in service to the date the employee’s employment with the Company ends.

No credit is given for service for any of the following:

- While an Excluded Person;
- Unless otherwise specifically provided, with a joint venture of the Company (or its subsidiaries); or
- Unless otherwise specifically provided, with an acquired entity before the date the entity is acquired by the Company (including its subsidiaries).

Contact the Merck HR Service Center at 866-MRK-HR4U (866-675-4748) for more information.

Adjusted Service Date. The date reflected on Merck’s employee data system from which an employee’s Adjusted Service is calculated.

Base Pay. Your annual rate of compensation (before any pre-tax deductions for the Employee Savings and Security Plan, the Employee Stock Purchase & Savings Plan or the Flexible Benefits Program), excluding bonuses, overtime, shift differential or other extra pay. For employees of covered collective bargaining units, Base Pay includes cost of living adjustments (COLAs).

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

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

COBRA Administrator. Fidelity Investments is the COBRA Administrator.

Coinsurance. The percentage of covered expenses that you are required to pay after you have met your Deductible.
**Company.** Individually or collectively, Merck & Co., Inc.; Merck Holdings, Inc.; Merck and Company Incorporated; KBI Enterprises, Inc.; Rosetta Inpharmatics, Inc.; Merck HDAC Research, LLC; Abmaxis, Inc.; Glycofi, Inc., Sirna Therapeutics, Inc. and Merck and Company Incorporated.

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

For Eligible Employees:
- Employee Only
- Employee + Spouse/Same-Sex Domestic Partner
- Employee + Child(ren)
- Employee + Spouse/Same-Sex Domestic Partner + Child(ren)

For Retirees:
- Retiree Only
- Retiree + Spouse/Same-Sex Domestic Partner
- Retiree + Child(ren)
- Retiree + Spouse/Same-Sex Domestic Partner + Child(ren)

*Note: A Retiree’s ability to select a Coverage Tier may be limited based on the individuals who are his/her Dependent(s) of Record.*

**Covered Dependent(s).** Your Eligible Dependent(s) (for Retirees, your Eligible Dependent(s) who are your Dependent(s) of Record) whom you have enrolled for coverage under the Merck Dental Plan in the time and manner specified by Merck. See “Eligible Dependent(s) Under Flex” in the About Flex Dental Benefits chapter and “Retiree Choice Dental Eligibility” in the About Retiree Choice Dental Benefits chapter.

**Credited Service.** As defined and determined under the Retirement Plan.

**Deductible.**

*Annual Deductible.* Under the Merck Comprehensive Care option, the amount of money you pay each year before the Merck Dental Plan begins to pay benefits for covered dental expenses for you and your Covered Dependent(s). The Annual Deductible does not apply to diagnostic and preventive services covered under the Merck Dental Plan.

**Dependent(s) of Record.** Those individuals who are:
- Eligible Dependent(s) of a Retiree as of the Retiree’s retirement date and are registered by the Retiree within 30 days of the Retiree’s retirement date on Fidelity Investments’ dependent database; and
- Eligible Dependent(s) who are covered by the Retiree as Covered Dependent(s) on his/her retirement date.

Individuals cease to be Dependent(s) of Record on the date that they no longer satisfy the definition of Eligible Dependent. A Retiree’s Eligible Dependent(s) who are not registered by the Retiree as Dependent(s) of Record within 30 days of retirement are not eligible for coverage as a dependent of the Retiree.
KEY POINT — DEPENDENT(S) OF RECORD IN RETIREMENT

If you retired prior to April 1, 2007, your Dependent(s) of Record are Eligible Dependent(s) (as of April 1, 2007) whom you registered on Fidelity NetBenefits by March 31, 2007. Any Covered Dependent(s) who were enrolled for coverage under your Retiree Choice dental benefits on March 31, 2007, were automatically registered as your Dependent(s) of Record.

If you retire on or after April 1, 2007, to be a Dependent of Record, you must register your Eligible Dependent at the time of your retirement from Merck — as a current or future potential Covered Dependent. If you do not register that individual within 30 days of your retirement date, that person will never qualify as a Dependent of Record and therefore will not be eligible to be your Covered Dependent during your retirement.

For purposes of Dependent of Record, Eligible Dependent(s) include the Retiree’s:

- Eligible dependent children between ages 19 and 25 who are not full-time students as of the Retiree’s retirement date; provided, however, that such dependent children are not eligible to be enrolled for coverage as Covered Dependent(s) unless and until they regain full-time student status.
- Spouse/Same-Sex Domestic Partner who is a Non-Flex-Eligible Union Employee; provided, however, that such individual is not eligible to be enrolled for coverage as a Covered Dependent until their status as a Non-Flex Eligible Union Employee ends.

For purposes of Dependent of Record, Eligible Dependent(s) exclude the Retiree’s Same-Sex Domestic Partner and his/her Same-Sex Domestic Partner’s children if the Retiree:

- Retired on or before January 1, 2003 (June 1, 2003 for those who were IUC Members; July 1, 2004 for those who were Non-Flex-Eligible Union Employees); or
- Retired after January 1, 2003 (June 1, 2003 for those who were IUC Members; July 1, 2004 for those who were Non-Flex-Eligible Union Employees) but before April 1, 2007 and did not cover those individuals while an active employee immediately prior to the Retiree’s retirement date and continuously thereafter during retirement through April 1, 2007.

Only Dependent(s) of Record can be a Retiree’s Covered Dependent(s).

Eligible Dependent(s).

- Your spouse or Same-Sex Domestic Partner\(^1\) — If your Spouse/Same-Sex Domestic partner is a Non-Flex-Eligible Union Employee, he/she does not qualify as a dependent.
- Your, or your Same-Sex Domestic Partner’s, unmarried children\(^1\) up to age 19 (up to age 25 if full-time students) who are dependent on you for more than half of their support. Children mean your:
  - Biological children;
  - Stepchildren, including your spouse’s/Same-Sex Domestic Partner’s biological children, foster children, legally adopted children and children for whom your spouse/Same-Sex Domestic Partner is legal guardian, in each case who are not also your biological children, foster children, legally adopted children and children for whom you are legal guardian;
  - Foster children;
  - Legally adopted children (eligibility begins on the date of placement for adoption or commencement of legal obligation to provide support in anticipation of adoption);
  - Children for whom you are legal guardian; and
  - Those for whom coverage is required by a Qualified Medical Child Support Order (QMCSO).

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\(^1\) Same-Sex Domestic Partners and Their Children: If you are a Retiree, your Same-Sex Domestic Partner and his/her dependent children may not qualify as Eligible Dependent(s). See “Dependent(s) of Record.”
Student Eligibility

Your dependent child is considered a full-time student if he/she carries at least 12 credits per semester or is considered a full-time student by the educational institution in which your child is enrolled. You will need to notify the Merck Benefits Service Center of your child’s student status within 30 days of his/her 19th birthday to continue coverage. If you fail to notify the Merck Benefits Service Center within 30 days that your child is a full-time student, coverage for that child will end and he/she may not be re-enrolled for coverage until the next annual enrollment period, unless there is a Life Event that permits earlier enrollment.

If your dependent child age 19 or older (up to age 25) enrolls as a full-time student sometime after dental coverage was stopped, you may re-enroll your child for coverage under the Merck Dental Plan, provided you do so within the time limits applicable to enrolling a new Eligible Dependent.

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 19 (or age 25 if a full-time student), provided the child’s disability begins before the date the child reaches the age at which coverage would otherwise end. You will need to provide proof of your child’s disability to the Claims Administrator at least 60 days before the date coverage is scheduled to end and annually thereafter. To continue coverage, the Claims Administrator also reserves the right to have a physician of its choice examine your child once a year. For more information on how to contact the Claims Administrator, see the “Administrative Information” chapter.

Qualified Medical Child Support Order

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 Merck’s procedures governing QMCSO determinations, free of charge, by calling the Merck HR Service Center at 866-MRK-HR4U (866-675-4748).

Spouses/Same-Sex Domestic Partners Who Work for Merck

If you or your spouse/Same-Sex Domestic Partner (or your former spouse/Same-Sex Domestic Partner or his/her spouse/Same-Sex Domestic Partner) work (or worked) for the Company, special provisions apply when enrolling Eligible Dependent(s) for coverage. See “Merck Couples Under the Flexible Benefits Program” and “Merck Couples Under the Retiree Choice Program.”

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

Excluded Employees. Collectively, Casual Employees, U.S. Expatriates, and Intern/Graduate/Cooperative Student Associates and Non-Flex-Eligible Union Employees.

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

Flex-Eligible-Union Employees. Eligible Employees who are members of one of the following collective bargaining units: Graphic Communications Local 4C; International Brotherhood of Teamsters, Local 107; International Union of Operating Engineers and its Local 68; Merck Independent
Union; The Inter-Union Council comprised of the following collective bargaining units: International Chemical Workers Union and its Local 94 and Local 609; United Steelworkers Union and its Locals 4-575 and 10-580 and UNITE.

**Flexible Benefits Program.** The Merck & Co., Inc. Flexible Benefits Program which offers a variety of benefit options, including medical, dental, vision, long-term disability, long-term care coverage, life insurance, health care and dependent care accounts and a financial planning benefit.

**In-Network.** A provider, or the covered services and supplies provided by a provider, who has an agreement with the Plan to furnish covered services or supplies.

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

**IUC Members.** Eligible Employees and/or Retirees who are or were members of the Inter-Union Council comprised of the following collective bargaining units: International Chemical Workers Union and its Local 94 and Local 609; United Steelworkers Union and its Locals 4-575 and 10-580 (or its predecessors) and UNITE.

**Length of Service.** The period of service with the Company (including its subsidiaries but excluding its joint ventures) from the later of your Adjusted Service Date or your 40th birthday until the date your employment ends. However, “Length of Service” means period of service with the Company (including its subsidiaries but excluding its joint ventures) from your Adjusted Service Date if:

- You were an employee of the Company (including its subsidiaries but excluding its joint ventures) on, and at least age 50 as of, January 1, 2003 (January 1, 2004 if you are a Non-Flex-Eligible Union Employee) and you do not have a break in service with the Company (including its subsidiaries) after January 1, 2003 (January 1, 2004 if you are a Non-Flex-Eligible Union Employee); or
- You had a break in service with the Company (including its subsidiaries) after age 45 and before April 1, 2002, had returned to work at the Company (including its subsidiaries but excluding its joint ventures) by, and was an employee of the Company (including its subsidiaries but excluding its joint ventures) as of, April 1, 2002 and do not have a break in service with the Company (including its subsidiaries) after April 1, 2002.

No credit is given for service for any of the following:

- While you are an Excluded Person;
- Unless otherwise specifically provided, with a joint venture of the Company (or its subsidiaries); or
- Unless otherwise specifically provided, with an acquired entity before the date the entity is acquired by the Company (including its subsidiaries).

Contact the Merck HR Service Center for more information.

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

**LTD Benefits.** Income replacement benefits provided under the Merck & Co., Inc. Medical, Dental and Long-term Disability Plan for Union Employees or the Merck & Co., Inc. Medical, Dental and Long-term Disability Plan for Non-Union Employees, as applicable.
**LTD Employee.** An employee who is receiving LTD Benefits who on the day he/she became eligible for LTD Benefits was considered by the Company to be a Regular Full-Time Employee, Regular Part-Time Employee, Merck Temporary Employee or a U.S. Expatriate.

**Medically Necessary.** A dental service or supply that a dental provider, exercising prudent clinical judgment, would provide to a patient for the purpose of preventing, evaluating, diagnosing or treating an illness, injury, disease or its symptoms. In addition, the service or supply must:

- Be provided in accordance with “generally accepted standards of dental practice”;
- Be clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for the patient’s illness, injury or disease;
- Not be primarily for the convenience of the patient or dental provider; and
- Not be more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that patient’s illness, injury, or disease.

For these purposes “generally accepted standards of dental practice” means standards that are based on credible scientific evidence published in peer-reviewed literature generally recognized by the relevant dental community, or otherwise consistent with dental specialty society recommendations and the views of dentists practicing in relevant clinical areas and any other relevant factors.

**Merck Temporary Employee.** An employee hired and paid by the Company (rather than an agency) for a specific position in the United States for a designated length of time which is normally not more than 24 consecutive months in duration, who is committed to leave the Company at the end of that time and is not a Non-Flex-Eligible Union Employee and is not an Excluded Employee.

**Non-Flex-Eligible Union Employee.** An employee of Merck who is a member of the United Steelworkers Union Local 10-86 (or its predecessor).

**Out-of-Network.** A provider, or the services and supplies provided by a provider, who does not have an agreement with the Plan 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 Flex Dental Benefits chapter or contact the Merck Benefits Service Center.

**Plan Administrator.** Merck & Co., Inc.

**Plan Year.** The calendar year, January 1st through December 31st, on which the records of the Plan are kept.

**Qualified Beneficiary.** For the purposes of COBRA:

- An employee, former employee and his/her spouse and Eligible Dependent(s) 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 Merck Dental Plan and that the Plan Administrator determines to be qualified under applicable law.

Reasonable and Customary (R&C) Limit. R&C charges are determined by Aetna, the Claims Administrator of the plan. Generally, R&C charges are based on nationwide claims data compiled by the Health Insurance Association of America (“HIAA”). HIAA collects prevailing provider fees from millions of dental claims processed by member insurers. Then, actual fees for a given dental service or procedure, in a given geographic area, are organized highest-to-lowest. A percentile within this array is established by the insurer of the plan (usually between the 70th and 90th percentile) and the actual charge at that percentile is determined to be the maximum R&C charge for that particular service in that particular area for that particular plan. The 90th percentile has been established as the maximum R&C charge for the Merck Dental Plan. HIAA frequently updates its database; therefore, R&C amounts may change from time-to-time.

Regular Full-Time Employee. An employee employed by the Company in the United States on a scheduled basis for a normal work week, is not classified as Part-Time, Merck Temporary or Casual, is not a Non-Flex-Eligible Union Employee and is not an Excluded Person.

Regular Part-Time Employee. An employee employed by the Company in the United States who works on a scheduled basis for less than the number of regularly scheduled hours for his/her site and who is not a Non-Flex-Eligible Union Employee and is not an Excluded Employee.

Retiree. You are considered a Retiree for purposes of the Merck Dental Plan (but not necessarily for purposes of any other Merck benefit plan) if you are (or were) an Eligible Employee on the date your employment with Merck ends (or ended) or you are (or were) a Non-Flex-Eligible Union Employee and:

If your employment with Merck (including its subsidiaries) ended before January 1, 2003 (before January 1, 2004 if you are a Non-Flex-Eligible Union Employee) and you are not rehired by Merck (including its subsidiaries) on or after January 1, 2003 (on or after January 1, 2004 if you are a Non-Flex-Eligible Union Employee) and on the date your employment ended:

- Other than due to disability retirement under the Retirement Plan:
  - If you were hired or rehired on or after January 1, 1989, you were at least age 55 with at least 10 years of Credited Service accrued under the Retirement Plan; or
  - If you were hired before January 1, 1989 and did not experience a break in service thereafter, you were either:
    > At least age 55 with at least 10 years of Credited Service accrued under the Retirement Plan; or
    > At least age 65, regardless of Length of Service; and
  - Your employment ended on the last day of a month and you completed all the paperwork required for retirement by the Plan Administrator by the deadline established by the Plan Administrator.

- Due to disability retirement under the Retirement Plan:
  - If you were hired or rehired on or after January 1, 1989, you had at least 10 years Credited Service accrued under the Retirement Plan; or
  - If you were hired before January 1, 1989 and did not experience a break in service thereafter, you were either:
Glossary

> At least age 55 with at least 10 years of Credited Service accrued under the Retirement Plan; or
> At least age 65, regardless of Length of Service; and
- Your employment ended on any day of a month and you completed all the paperwork required for retirement by the Plan Administrator by the deadline established by the Plan Administrator.

If your employment with Merck (including its subsidiaries) ends (or ended) on or after January 1, 2003 (on or after January 1, 2004 if you are a Non-Flex-Eligible Union Employee) and on the date your employment ends (or ended):

- Other than due to disability retirement under the Retirement Plan:
  - You were at least age 55 with at least 10 Years of Service; and
  - Your employment ended on the last day of a month and you completed all the paperwork required for retirement by the Plan Administrator by the deadline established by the Plan Administrator.
- Due to disability retirement under the Retirement Plan:
  - You had at least 10 Years of Service; and
  - Your employment ended on any day of a month and you completed all the paperwork required for retirement by the Plan Administrator by the deadline established by the Plan Administrator.

If your employment with Merck (including its subsidiaries) ends (or ended) on or after January 1, 2003 (on or after January 1, 2004 if you are a Non-Flex-Eligible Union Employee) due to disability retirement under the Retirement Plan and on that date you do (or did) not have at least 10 Years of Service but you have (or had) at least 10 years of Credited Service under the Retirement Plan, you will not be eligible for benefits as a Retiree under the Retiree Choice Program. However, you will be eligible for benefits under the Merck Dental Plan on the same terms and conditions, as they may be amended from time to time, as the benefits available to a Flex-Eligible Employee on LTD. For a description of those benefits, see the “About Flex Dental Benefits” chapter of this Summary Plan Description.

To determine if an employee was eligible to be a Retiree on his/her date of death for purposes of determining eligibility for dental benefits for surviving dependent(s), the employee must have met the age and service requirements applicable to a non-disability retirement described above on his/her date of death. To be considered a Retiree, you must pay the premium required for coverage in the time and manner specified by Merck from time to time.

Retiree Choice Program (Retiree Choice). A program that provides medical and dental benefit coverage to persons who meet the definition of Retirees under the program.

Retirement Plan. The Retirement Plan for Salaried Employees of Merck & Co., Inc. or the Retirement Plan for Hourly Employees of Merck & Co., Inc., as applicable.

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

- Are the same sex;
- Are at least age 18 and mentally competent to enter into a legal contract;
- Are not related by blood or adoption to a degree closer than permitted by state law for marriage;
- Are not legally married to — or the domestic partner of — anyone else;
- Are jointly responsible for each other’s welfare, financial and other obligations;
- Reside together in the same household — and have done so for at least 12 months; and
- Have registered the same-sex relationship — (if residing in a state/municipality that permits such registration or are legally married if permitted to do so under applicable law).

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

**Transferred Employee.** An employee of Merck (or its subsidiaries) or former Merck employee who has been continuously employed by Merial, LLC as of the date the individual’s employment with Merck ended and, in either event, who is transferred to a position as a Regular Full-Time Employee or a Regular Part-Time Employee and who is not an Excluded Person.

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

**Years of Service.** Period of service with the Company (including its subsidiaries but excluding its joint ventures) from the later of your Adjusted Service Date or your 40th birthday until the date your employment ends. However, “Years of Service” means years of Credited Service accrued under the Retirement Plan if:
- You were an employee of the Company (including its subsidiaries but excluding its joint ventures) on, and at least age 50 as of, January 1, 2003 (January 1, 2004 if you are a Non-Flex-Eligible Union Employee) and you do not have a break in service with the Company (including its subsidiaries) after January 1, 2003 (January 1, 2004 if you are a Non-Flex-Eligible Union Employee); or
- You had a break in service with the Company (including its subsidiaries) after age 45 and before April 1, 2002, had returned to work at the Company (including its subsidiaries but excluding its joint ventures) by, and was an employee of the Company (including its subsidiaries but excluding its joint ventures) as of, April 1, 2002 and do not have a break in service with the Company (including its subsidiaries) after April 1, 2002.

No credit is given for service for any of the following:
- While an Excluded Person;
- Unless otherwise specifically provided, with a joint venture of the Company (or its subsidiaries); or
- Unless otherwise specifically provided, with an acquired entity before the date the entity is acquired by the Company (including its subsidiaries).

Contact the Merck HR Service Center for more information.
The information contained herein has been provided by Merck and is solely the responsibility of Merck.