The Dun & Bradstreet Dental Plan
Summary Plan Description
for Active Employees

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The Dun & Bradstreet Corporation Welfare Benefit Plan provides health care, life, accident, disability, employee assistance, flexible spending account and legal insurance benefits to eligible active employees of Dun & Bradstreet and its related companies who participate in the plan, and their dependents. The Dun & Bradstreet Dental Plan for active employees (the "Dental Plan" or "Plan") is a part of The Dun & Bradstreet Corporation Welfare Benefit Plan and provides dental benefits to active employees. This document summarizes the Dun& Bradstreet Dental Plan, as in effect on March 15, 2024, unless otherwise noted, for eligible active employees and their eligible dependents. It describes the benefits as they apply to eligible participants and serves as the summary plan description (SPD) for these benefits.

Dun & Bradstreet encourages you to read this SPD carefully and share it with your eligible dependents covered under the Dental Plan. If you have any questions about your benefits, please contact the Dun & Bradstreet Benefits Center. See the section, "How to Reach Your Dental Plan Service Provider" at the beginning of this SPD for contact information.

The legal plan document provides additional information about the administration of the Dental Plan. If there is any difference between the information in this SPD and in the legal plan document, or if there are details not covered in this SPD, the legal plan document will determine how to resolve these issues.

Important Information

The Dun & Bradstreet Corporation ("Dun & Bradstreet" or the "Company") is the Plan Sponsor of the Dental Plan.

The dental coverage provided under the Dental Plan is self-insured by Dun & Bradstreet and Dun & Bradstreet has contracted with an insurance company (the "Claims Administrator") to perform claims processing and other administrative services.

Day-to-day operations of the Dental Plan have been delegated to the Benefits Center for The Dun & Bradstreet Corporation (the "Dun & Bradstreet Benefits Center").

You can contact the Claims Administrator or the Dun & Bradstreet Benefits Center if you have questions or need more information. See the section "How to Reach Your Dental Plan Service Provider" at the beginning of this SPD for contact information.

HOW TO REACH YOUR DENTAL PLAN SERVICE PROVIDER

Here is how you can reach your Dun & Bradstreet Dental Plan service provider:

Provider	Contact Information
Administrative Services:	
■ Dun & Bradstreet Benefits Center at Fidelity	1-877- 362-8953 (or 1-888-343-0860 for the hearing impaired) http://netbenefits.fidelity.com
Claims Administrator:	
■ Delta Dental	http://www.deltadentalnj.com 1-800-663-6435 Delta Dental of New Jersey, Inc. P.O. Box 16354 Little Rock, AR 72231

ABOUT YOUR PARTICIPATION

This section contains important information about your participation in the Dental Plan, including eligibility information, when coverage begins, coverage levels, paying for coverage, reducing coverage and when coverage ends.

Who Is Eligible

You are eligible for coverage under the Dental Plan if you meet all of the following conditions:

- You are an active full-time or part-time employee employed by Dun & Bradstreet or a related company that participates in the Dental Plan with Dun & Bradstreet's approval, and
- You are regularly scheduled to work 20 or more hours per week.

If you are classified by a Dun & Bradstreet company as a temporary employee, intern, leased employee, or an independent contractor, you are not eligible to participate in the Dental Plan.

In addition, if you are not classified as an eligible employee by a Dun & Bradstreet company, but are later reclassified as such either by action of the Plan Administrator or by a governmental or judicial authority, you will be deemed to have become an employee eligible to participate in the Dental Plan only prospectively and not retroactively to the date on which you are found to have first become an employee, assuming all other eligibility requirements are met.

Dependent Eligibility

Your eligible dependents are also eligible for coverage under the Dental Plan if you enroll for coverage.

Eligible dependents include:

- Your legal spouse, (not including your divorced spouse) or your same-sex or opposite-sex domestic partner,
- Your or your spouse's/domestic partner's eligible dependent children until December 31 of the year in which they turn 26, and

- Your or your spouse's/domestic partner's unmarried eligible dependent child, regardless of age, who is mentally or physically disabled and incapable of earning his or her own living,

Eligible children may include:

- Biological children,
- Adopted children (eligible as of the date of birth if legally adopted before birth; otherwise, eligible as of the date they are placed in your home),
- Stepchildren,
- Foster children, and
- Children placed in your care by court order/legal guardianship.

You may not cover a dependent if he or she is also covered as a Dun & Bradstreet employee.

Children Who Are Incapacitated

Unmarried, disabled children age 26 and older, who cannot support themselves, are eligible for continued coverage if the following criteria are met:

1. he or she was covered under the Dun & Bradstreet Dental Plan before age 26, and
2. the proof of disability was approved by the Claims Administrator within the time period required by the Claims Administrator, which may be before the end of the year in which your dependent reached age 26.

For this purpose, the Claims Administrator will be:

(i) Aetna if your child is also enrolled in the Dun & Bradstreet Medical Plan or

(ii) Delta Dental if your child is not enrolled in the Dun & Bradstreet Medical Plan.

If Delta Dental is making the determination of whether your unmarried disabled child is eligible to continue to participate in the Dental Plan, you must provide Delta Dental proof of your child's disability. This proof must be attached to the first claim submitted after your dependent has reached age 26. If Aetna is making the determination of whether your

unmarried disabled child is eligible to continue to participate in the Dental Plan, you should refer to the SPD for the Medical Plan for information about what information must be provided.

If the Claims Administrator does not certify your child's disability, his or her coverage will terminate as of the last day of the year in which he or she turns age 26 subject to his or her right to elect COBRA continuation coverage (discussed later in this SPD). As a condition of this extended coverage, the Plan Administrator may require that a physician chosen by the Plan Administrator examine your child at no cost to you. You may also be required to provide periodic proof that your child continues to meet these conditions of incapacity and dependency. Failure to provide such proof within the required period will result in termination of your child's coverage. The Claims Administrator will review and re-certify eligibility for continued coverage at its discretion from time to time. If you are unable to meet these requirements for reasons beyond your control, please contact the Dun & Bradstreet Benefits Center.

Domestic Partner Eligibility

Your domestic partner may be eligible for coverage under the Dental Plan. In order for you to cover your domestic partner, you and your partner must either:

- Have registered properly your domestic partnership with an approved governmental domestic partnership registry

or

- Be at least 18 years old,
- Share a committed and exclusive relationship for at least six months,
- Not be married to another person,
- Not be related by marriage or blood, which would otherwise prohibit legal marriage in the state of residence, and
- Live together in the same household.

or

- Enter into a civil union in accordance with the laws of a state which permits couples to enter into civil unions.

If any of the above eligibility requirements are no longer being met, domestic partner coverage ends. You must notify the Dun & Bradstreet Benefits Center immediately. See the section "How to Reach Your Dental Plan Service Provider" at the beginning of this SPD for contact information. The domestic partner who no longer has coverage may be eligible for continuation coverage as if he or she were an eligible spouse under COBRA.

Dependent Eligibility Verification Documentation

The Plan reserves the right to conduct audits and reviews of all dependent eligibility to ensure that individuals covered by the Plan meet the eligibility requirements. Currently, these verifications are administered by a third-party administrator, Gainwell, but the administrator may change from time to time.

When you first enroll a dependent in the Plan, you will be asked to provide documentation which provides proof that your dependent satisfies the applicable eligibility requirements. This includes any dependent that you enroll in the Plan when you first become eligible after your date of hire, as well as any dependent that you enroll following a qualifying life event (i.e., marriage, birth) or during the annual Open Enrollment (OE) period in the fall. As part of the audit process, Gainwell will send you a letter requesting certain documents intended to prove that your dependent is eligible under the terms of the Plan. Required documentation may include a government-issued marriage certificate, government-issued birth certificate, and a Federal tax return. If a dependent that you enrolled is ineligible or you fail to verify the dependent's eligibility, he or she will be dropped from coverage under the Plan and COBRA continuation coverage will not be offered.

When Coverage Begins

You must enroll for dental coverage within 31 days of your first date of employment or the date you first become eligible. If you enroll within the 31 days, your coverage is effective the day you began employment with a Dun & Bradstreet company or the date you became eligible for dental coverage under the Dental Plan. Coverage for your covered dependent(s) starts the same day your coverage begins, if you have enrolled for dependent coverage.

If you do not choose to participate in the Dental Plan when you first become eligible, you must wait until the next annual enrollment, unless you have an eligible family status change or another qualifying mid-year event in accordance with IRS rules. See the section, "Making

Changes During the Year" in this SPD for information on changing coverage during the year.

Coverage Levels

The Dental Plan offers the following levels of coverage:

- You only,
- You and one dependent, or
- You and two or more dependents.

Paying for Coverage

At this time, you and Dun &Bradstreet share the cost of dental coverage. You pay your share of the cost for coverage through before-tax payroll deductions, except if you cover a domestic partner (or a domestic partner's dependent) you are required to pay for coverage on an after-tax basis as described below. Additional information is provided below.

Before-Tax Contributions

Before-tax contributions are deducted from your pay before federal income and Social Security (FICA) taxes, and in most cases, before state and local taxes, are withheld. This lowers your taxable income and, as a result, reduces the taxes you pay. However, because of IRS rules, you can only change your before-tax choices during annual enrollment, except when certain events occur, including a "qualified family status change." If you experience a change in family status, any change you make to your dental coverage must be as the result of and consistent with your family status change. See the section "Making Changes During the Year" in this SPD for information on qualified family status changes and other events that may allow you to change your elections mid-year. Also, since before-tax contributions reduce your taxable income, there may be a small impact on the Social Security benefits you earn, although in most cases your tax savings outweigh any minor reduction.

Cost of Coverage for Domestic Partners and their Child(ren)

Dun & Bradstreet pays the same amount for a domestic partner as it does for a spouse. However, when you enroll your domestic partner or your partner's child(ren) in coverage, the IRS considers the Company's contribution toward the cost of coverage provided to your

domestic partner or your partner's child(ren) as a taxable benefit (unless they qualify as your tax dependent), which means it is reported as imputed income on your paycheck and is subject to ordinary federal, state, local and FICA taxes. This also means that the premium that you pay to cover your domestic partner and/or your partner's child(ren) is deducted post-tax.

If your domestic partner and his/her child(ren) qualifies as your tax dependent under Section 105(b) of the Internal Revenue Code, please request to complete the Certification of Domestic Partner Tax Dependents form. This form must be submitted during annual Open Enrollment (for coverage effective January 1) or within 30 days of either enrolling your dependent when you are a new hire or the tax status of your dependent has changed for health care purposes.

For additional information about covering your domestic partner and your domestic partner's child(ren), you may contact the Dun& Bradstreet Benefits Center. See the section "How to Reach Your Dental Plan Service Provider" at the beginning of this SPD for contact information.

When Coverage Ends

Coverage under the Dental Plan will end for you when any one of the following occurs:

- You cancel coverage,
- You terminate employment for any reason,
- Dun & Bradstreet terminates this plan,
- You are no longer eligible for benefits,
- You fail to make the required contributions on a timely basis, or
- You die.

Your dependent's dental coverage will end for the following reasons:

- Dun & Bradstreet terminates all dependent coverage under this plan,
- Dun & Bradstreet terminates this plan,
- Your dependent becomes covered as a Dun & Bradstreet employee,
- Your dependent is no longer eligible for benefits,
- You fail to make the required contributions on a timely basis,
- Your coverage terminates, or
- You or your dependent dies.

In general, coverage will end at the end of the month in which the event occurs, *except* if Dun & Bradstreet terminates the Dental Plan, coverage will end on the date of the Dental Plan termination. You or your eligible dependents may be able to continue your Dun & Bradstreet dental coverage through the Consolidated Omnibus Budget Reconciliation Act (COBRA). In special situations described below, you may be able to continue your coverage beyond your termination of employment without electing COBRA. See the section "When Your Employment Ends" later in this SPD.

Your coverage (or your dependent's coverage) will also terminate on the date you revoke your election for such coverage (which generally must be prospectively) provided the revocation is otherwise permitted under the terms of the Plan.

If the Plan Administrator determines that you or your dependent have engaged in fraud or have intentionally misrepresented a material fact in connection with the Dental Plan, including enrollment and participation, your coverage and/or your dependent's coverage will be terminated on the date specified by the Plan Administrator.

MAKING CHANGES DURING THE YEAR

Qualified Changes in Family Status

You are not permitted to change your election for coverage once the plan year has begun except in certain circumstances.

You may be able to change your election during the middle of the year if you experience an approved qualified family status change. Approved qualified family status changes under the Dental Plan include:

- A change in your legal marital status (such as marriage, divorce, death of spouse and annulment) or domestic partner status (i.e. your domestic partner meets or fails to meet the domestic partner criteria),
- A change in the number of your dependents (such as through birth, death, adoption and placement for adoption),
- Your dependent's meeting (or failing to meet) the Dental Plan's dependent eligibility rules,
- A change in residence for you, your spouse/domestic partner or your dependent (the change must affect your eligibility for coverage).

Any change you make as a result of a qualified change in family status must be permitted by law and consistent with the qualifying event. Benefit changes are consistent with the event only if they:

- Result in your, your spouse's/domestic partner's or your dependent's gaining or losing eligibility to participate in the Dental Plan or the plan of your spouse's/domestic partner's or your dependent's employer, and
- Are on account of and correspond with the gain or loss of coverage. For example, generally, if you have or adopt a child, you can add the child to the Dental Plan, but you would not be able to drop dental coverage unless it is to enroll in your spouse's or domestic partner's plan.

You will have **31 days** from the date of your change in your family status to change your Dental Plan elections. Otherwise, you must wait until the next annual enrollment. To make the change, contact the Dun & Bradstreet Benefits Center. See the section "How to Reach Your Dental Plan Service Provider" at the beginning of this SPD for contact information.

Other Permissible Mid-Year Election Changes

Other events which may allow you to make a mid-year election change include:

- Changes consistent with the special enrollment rights under the Health Insurance Portability and Accountability Act (HIPAA).
- Changes due to the Children's Health Insurance Program Reauthorization Act (CHIPRA).
- Changes required by a judgment, decree or order, including a qualified medical child support order (QMCSO), resulting from a divorce, legal separation, annulment or change in legal custody. If the order directs you to cover the child, you may enroll the child (and yourself) in the Dental Plan. If the order directs someone other than you to cover the child, you may drop coverage for the child.
- Changes due to entitlement (or loss of entitlement) to Medicare or Medicaid. If you, your spouse/domestic partner or a covered dependent becomes entitled to Medicare or Medicaid (becomes enrolled), you may drop or reduce coverage for that individual. If you, your spouse/domestic partner or a dependent loses entitlement to Medicare or Medicaid, you may enroll or increase coverage for that individual (and yourself) in the Dental Plan.
- Cost Changes
  - Automatic changes. If the cost of your Dental Plan increases (or decreases) during a period of coverage and, under the terms of the Dental Plan, you are required to make a corresponding change in your payments, the Plan Administrator may, on a reasonable and consistent basis, automatically make a prospective increase (or decrease) in your elective contributions for the Dental Plan,

— Significant cost changes. If the cost charged to you for a benefit package option significantly increases or decreases during a period of coverage, you may make a corresponding change in election under the Dental Plan. For example, you can commence participation in the option with a decrease in cost. In the case of an increase in cost, you can revoke an election for that coverage and receive coverage under another benefit option providing similar coverage or drop coverage if no other benefit option providing similar coverage is available,

- Coverage Changes

— Significant curtailment without loss of coverage. If you or your spouse/domestic partner or dependent has a significant curtailment of coverage under the Dental Plan that is not a loss of coverage, you may revoke your election for that coverage and elect to receive coverage under another benefit package option providing similar coverage. A significant curtailment without a loss of coverage includes a significant increase in the deductible, the copayment or the out-of-pocket limit,

— Significant curtailment with loss of coverage. If you or your spouse/domestic partner or dependent has a significant curtailment that is a loss of coverage under the Dental Plan, you may revoke your election under the Dental Plan and elect either to receive coverage under another benefit package option providing similar coverage or to drop coverage if no similar benefit package option is available. A loss of coverage means a complete loss of coverage under the benefit package option or other coverage option — such as the elimination of a benefit package option, or an individual's losing all coverage under the option by reason of an overall lifetime or annual limitation. In addition, the Plan Administrator, in its discretion, may treat the following as a loss of coverage:

  – A substantial decrease in the dental care providers available under the benefit package option (such as a substantial decrease in the number of dentists participating in a preferred network);

  – A reduction in benefits for a specific type of dental condition or treatment with respect to which you, your spouse/domestic partner or your dependent is currently in a course of treatment; or

- Any other similar fundamental loss of coverage.

— Addition or improvement of a benefit package option. If a new benefit package option or other coverage option is added, or if coverage under an existing benefit coverage option is significantly improved during a period of coverage, you may revoke your election under the Dental Plan and make an election for coverage under the new or improved benefit option. This provision applies whether or not you have previously made an election under the Dental Plan or have previously elected the benefit option.

— Change in coverage under another employer plan. You may make a prospective election change that is on account of and corresponds with a change made under another employer plan if either:

- The other cafeteria plan or qualified benefits plan permits its participants to make an election change that would be permitted under applicable IRS regulations; or
- This Dental Plan permits you to make an election for a plan year which is different from the plan year under the other cafeteria plan or qualified benefits plan (i.e., different open enrollment period).

■ Changes consistent with taking leave under the Family and Medical Leave Act (FMLA). If you take leave under the FMLA, you may revoke your election under this Dental Plan and make such other election for the remaining portion of the period of coverage as may be provided for under the FMLA.

To make an election change on account of one of the events described above, in most cases, you must make the election change within 31 days of the event. For additional information, contact the Dun & Bradstreet Benefits Center.

Special Enrollment Rights

If you or your dependents declined coverage under the Dental Plan because you or they have dental coverage elsewhere, and one of the following events occurs, you have 31 days from the date of the event to enroll yourself and/or your dependents in the Dental Plan:

■ You and/or your dependents lose the other dental coverage because eligibility was lost for reasons including divorce, death, termination of employment or reduced work

hours change in residence, change in eligibility or satisfaction of the other coverage's lifetime maximum (but not due to failure to pay premiums on a timely basis, voluntary termination of coverage or termination of coverage for cause),

- The employer contributions to the other coverage have stopped, or
- The other coverage was COBRA and the maximum COBRA coverage period ends.

As an employee, you may enroll your new spouse within 31 days of your marriage and a new child within 31 days of his or her birth, adoption or placement for adoption. In addition, if you are not enrolled in the Dental Plan as an employee, you also must enroll in the Dental Plan when you enroll any of these dependents. And, if your spouse /domestic partner is not enrolled in the Dental Plan, you may enroll him or her in the Dental Plan when you enroll a child due to birth, adoption or placement for adoption.

In the case of birth, adoption or placement for adoption, marriage or the establishment of an eligible domestic partner relationship coverage is retroactive to the date of the event.

Examples of Situations Where You Can Make Changes to Your Dental Coverage During the Year

The following table provides some examples of the types of changes you may be able to make to your Dental Plan coverage if you experience a qualified change in your family status. Whenever you experience a change in family status you should notify the Dun & Bradstreet Benefits Center to determine the kinds of changes you can make to your Dental Plan benefits. See the section "How to Reach Your Dental Plan Service Provider" at the beginning of this SPD for contact information. In all cases the election change must be permitted under applicable tax laws.

Dun& Bradstreet's contributions towards the cost of providing coverage for your domestic partner and other dependents may be considered imputed income in certain situations. See the section "Cost of Coverage for Domestic Partners and Child(ren) of Your Domestic Partner" in this SPD for more information.

Status Change	Allowable Changes to Your Coverage	Allowable Changes to Your Dependent Coverage (You must be enrolled in coverage to enroll your dependents)
Marriage or establishment of an eligible domestic partner relationship	■ You can waive out of your current dental coverage to enroll under your spouse's or domestic partner's plan. ■ You can enroll in dental coverage for the first time along with your spouse/domestic partner.	■ You may add your new spouse/domestic partner and/or your and your spouse's/domestic partner's dependent child(ren) as dependents under your Dental Plan.
Divorce or end of an eligible domestic partner relationship	■ If you are not enrolled in the Dental Plan because you were enrolled in your spouse's/domestic partner's plan, you can enroll for the first time.	■ If your spouse or domestic partner is covered under the Dental Plan, you must terminate coverage for the divorced spouse or domestic partner (he or she may be eligible for coverage under COBRA). ■ You can enroll your dependents who were previously enrolled in and lose eligibility for your spouse's/domestic partner's plan in the Dun & Bradstreet Dental Plan.
Birth, adoption or change in custody of a dependent child	■ You can waive out of your current coverage to enroll in your spouse's/domestic partner's plan. ■ If you are not enrolled in the Dental Plan, you can enroll for the first time along with your new child(ren).	■ You may add your new child(ren), along with your spouse/domestic partner not previously enrolled to your Dental Plan.
Death of a spouse/domestic partner or dependent	■ If you are not enrolled in the Dental Plan because you were enrolled in your spouse's/domestic partner's dental plan, you can enroll for the first time.	■ Coverage for your spouse/domestic partner or dependent will end. ■ You can enroll your dependents who were previously enrolled in your spouse's/domestic partner's dental plan.
Loss of your spouse's/domestic partner's coverage because his or her employment ends or changes	■ If you are not enrolled in the Dental Plan, you can enroll for the first time.	■ You may add your spouse/domestic partner along with your or your spouse's/domestic partner's dependent child(ren) covered under your spouse's/domestic partner's former plan to your current Dental Plan.
Your spouse/domestic partner obtains	■ You may waive out of your current dental coverage to	■ You may terminate coverage under the Dental Plan for your

coverage because his or her employment begins or changes	enroll under your spouse's or domestic partner's plan.	spouse/domestic partner and your covered dependents so they can enroll in the spouse's/domestic partner's dental plan.
The issuance of a Qualified Medical Child Support Order (QMCSO) for a dependent child	■ If you are not enrolled in the Dental Plan, you must enroll in order to cover your dependent child(ren).	■ You may add coverage for your dependent child(ren), as required by the QMCSO.
Termination of coverage under another employer's COBRA coverage, through no fault of your own	■ If you are not enrolled in the Dental Plan, you can enroll for the first time.	■ You may add your spouse/domestic partner along with any of your or your spouse's/domestic partner's dependent children covered under your spouse's/domestic partner's former plan to your current Dental Plan.

WHEN YOUR EMPLOYMENT ENDS

In most cases, your coverage will terminate at the end of the month in which your employment ends. In special circumstances, your coverage may continue beyond that date. The following chart describes some of the special circumstances in which your coverage under the Dental Plan may continue. If these special circumstances do not apply to you, you will be given an opportunity to continue coverage for yourself and your dependents by electing and paying for COBRA coverage (unless your employment was terminated for gross misconduct). See the section "COBRA Continuation" in this SPD for more information.

If You…	What Happens to Your Dental Plan Coverage
Are approved for an LTD leave prior to January 1, 2021 and you terminate employment at a time when you: ■ Are totally and permanently disabled (as determined by the Dun & Bradstreet LTD Plan claims administrator); and ■ Have completed 10 years of Eligibility Service (as defined below) after age 22.	You may continue Dental Plan coverage for you and your eligible dependents. In order to continue dental coverage: ■ The Dun & Bradstreet LTD Plan claims administrator must certify, in its complete discretion, your ongoing long-term disability; *and* ■ You must make the necessary contributions on a timely basis to pay the cost of continued dental coverage. If your benefits under the Dun &Bradstreet LTD Plan terminate for any reason, your continued participation in the Dental Plan will terminate at the end of the month in which your long-term disability benefits terminate.
Are approved for LTD leave on or after January 1, 2021 and terminate employment at a time when you: ■ Are totally and permanently disabled (as determined by the Dun & Bradstreet LTD Plan claims administrator).	You may continue Dental Plan coverage for you and your eligible dependents for a period of 6 months. In order to continue dental coverage: ■ The Dun & Bradstreet LTD Plan claims administrator must certify, in its complete discretion, your ongoing long-term disability; *and* ■ You must make the necessary contributions on a timely basis to pay the cost of continued dental coverage. At the end of the 6 month period, your coverage will terminate and you will be offered an opportunity to continue coverage for yourself and your dependents by electing and paying for COBRA coverage. See the section "COBRA Continuation" in this SPD for more information. If your benefits under the Dun & Bradstreet LTD Plan terminate for any reason, your continued participation in the Dental Plan will terminate at the end of the month in which

If You…	What Happens to Your Dental Plan Coverage
	your long-term disability benefits terminate
Die	Dun & Bradstreet will continue to cover your eligible dependent(s), at no cost, for six months beyond the end of the month in which you died, provided your covered dependents continue to meet the eligibility criteria of the Dental Plan. This six-month period is counted as part of any period of COBRA coverage to which your covered dependent(s) may be entitled. See the section "COBRA Continuation" in this SPD for more information.

Eligibility Service

For employees employed full-time or part-time with 20 or more hours per week, years of Eligibility Service is defined as the number of years between the date you start working at Dun & Bradstreet and the date you leave the Company. Each month or partial month counts as one-twelfth of a year.

Leave of Absence. If you take an authorized, approved leave of absence (including military leave), this period will count towards Eligibility Service if you resume your employment at the end of such leave of absence or within the period prescribed by law for the exercise of employment rights.

YOUR DENTAL PLAN

Delta Dental PPO℠ plus Premier®

When you receive **Covered Services** from a **Delta Dental PPO℠ Dentist**, the **Dentist** has agreed to accept the least of the actual charge for the service, the filed fee, or the fee in the applicable Delta Dental PPO℠ Schedule as payment in full. You will be responsible for the coinsurance percent that corresponds to the **Covered Service**. Using a **Delta Dental PPO℠ Dentist** will mean lower cost to you.

You may also choose to receive Covered Services from a Delta Dental Premier® Participating Dentist who is not a Delta Dental PPO℠ Dentist. The Delta Dental Premier® Participating Dentist has agreed to accept the least of the actual charge for the service, the filed fee, or the Participating Dentist Maximum Allowable Charge (PMAC) established by Delta Dental as payment in full. If you receive Covered Services from a Delta Dental Premier®) Participating Dentist, the Plan's payment is based on the PMAC. You will be responsible for the coinsurance percent that corresponds to the Covered Service.

If you choose to receive services from a Non-Participating Dentist, the Plan's benefit payment may be based on the least of the Dentist's actual charge or the Non-Participating Dentist Maximum Allowable Charge (NMAC). You will pay the difference between the amount paid by the Plan and the full amount charged by the Non-Participating Dentist.

You can generally save on your out-of-pocket costs by receiving Covered Services from a Delta Dental Participating Dentist. A Delta Dental Premier® Participating Dentist helps reduce your financial responsibility by limiting fees to the PMAC. But your out-of-pocket costs will be even lower when you receive Covered Services from a Delta Dental PPO℠ Dentist whose fees are limited to the contracted Delta Dental PPO℠ Schedule.

Your benefit levels may vary based on the network in which your Dentist participates as indicated in the "Your Benefits" section of this SPD.

How Your Dental Plan Works

Before visiting the Dentist, check to see whether your Dentist is a Participating Dentist with Delta Dental. At the time of your first appointment, tell your Dentist that you are covered under a dental plan administered by Delta Dental of NJ.

After your Dentist performs an examination, he or she may submit a Pre-Treatment Estimate of benefits to Delta Dental to determine how much of the charge for any future work will be your responsibility.

Before treatment is started, be sure you discuss with your Dentist the total amount of his or her fee. Although Pre-Treatment Estimates are not required, you are strongly encouraged to ask your Dentist to submit a Pre-Treatment Estimate for treatment costing $300 or more. This is especially important when using a Non-Participating Dentist because the Pre-Treatment Estimate lets you know in advance how much of the costs are your responsibility. Please keep in mind that a Pre-Treatment Estimate is only an estimate and not a guarantee of benefits or payment.

Locating a Dentist

There are two easy ways to locate a Delta Dental Participating Dentist. You can either:

• Call 1-800-663-6435

8:00 AM-6:30 PM ET Monday-Thursday

8:00 AM – 5:00PM ET Friday, or

• Search the Internet at http://www.deltadentalnj.com

By calling the toll-free number, you can obtain a customized list of Participating Dentists within the geographic area of your request. The list will be mailed to your home.

By searching on the Internet, you can obtain a list of Participating Dentists in a specific town. The list can be downloaded immediately, and you can search for as many towns as needed.

Using either method, you can request a list of Participating Dentists within a designated area. You can specify listings of General Dentists only or specialists only. Participating Dentist information can be obtained for Dentists nationwide.

Why Select a Participating Dentist?

- All Participating Dentists have agreed, in writing, to abide by Delta Dental's claims processing procedures. Participating Dentists have agreed to accept the least of their actual charge, their prefiled fee, or Delta Dental's maximum allowable fee for the program as payment in full and to not charge patients for amounts in excess of those indicated in the "patient payment" portion of the Explanation of Benefits.
- Participating Dentists will usually maintain a supply of Claim Forms (also referred to as Attending Dentist's Statements) in their office. You may be asked to complete a portion of the form when you visit.
- Participating Dentists will complete the rest of the form, including a description of the services that were performed or will be performed in the case of a Pre-Treatment Estimate, and require that you sign the Claim Form in the appropriate place. If your Dentist submits claims electronically to Delta Dental, you will need to authorize your Dentist to maintain your signature on file.
- Participating Dentists will mail, fax, or electronically submit the Claim Form, together with the appropriate diagnostic materials, directly to our offices for processing.
- Participating Dentists agree to abide by Delta Dental processing policies. For example, Participating Dentists agree not to bill separate charges for infection control measures. Non-Participating Dentists are not bound by such policies.
- Participating Dentists will, in the case of dental services which have been completed, receive payment directly from Delta Dental for that portion of the Treatment Plan which is covered by your dental program. You will receive an Explanation of Benefits with a detailed description of covered benefits and the amount of your payment obligation.

- If you visit a Non-Participating Dentist, you will be responsible for payment. The Plan will reimburse you for the portion of your services covered by your program and you will be responsible to pay the portion of the Dentist's bill that exceeds the Plan's benefit payment.

Check with your Dentist to confirm whether he or she participates in the Delta Dental program under which you are covered. While a Dentist may participate with Delta Dental, he or she may not participate in all of Delta Dental's programs.

Your Benefits

Here is a look at how some commonly used services are covered your Dental Plan. Contact the Claims Administrator for a complete list of covered services. See the section "How to Reach Your Dental Plan Service Provider" at the beginning of this SPD for contact information.

	If you use a	
Feature	***Delta Dental PPO℠ Dentist***	***Delta Dental (Premier®) Participating Dentist or Out-of-Network (Non-Participating Dentist)***
Calendar Year Deductible Individual Family (family Deductible is accumulated by individual Deductibles)	N/A N/A	$50 $150
Preventive Care & Diagnostic Services Exams – two periodic exams and two limited oral exams per Calendar Year Cleanings – twice per Calendar Year per person, ages 14 and older are considered adults X-Rays – full mouth series or panoramic (either one, once in five years) X-rays-Bitewing (twice per Calendar Year) per person under age 19 and at most (once per Calendar Year) per person age 19 and older X-rays-single films (multiple x-rays on the same date of service will not exceed the benefit of a full-mouth series) Fluoride Treatment (twice per Calendar Year, for eligible children to age 19, combinations with cleanings are applied to time limits for both) Space Maintainers (once per space for missing posterior primary teeth, for children under age 14) Consultations are counted as exams for purposes of frequency limitations Sealants (1st and 2nd permanent, decay-free molars, once in a lifetime, for children to age 16)	The plan pays 100% of negotiated fees	The plan pays 100% of eligible charges after deductible is met

Basic Care and Other Services Fillings - Composite and Amalgam. Payment is allowed for one restoration per tooth surface in 365 days Extractions, Oral Surgery (impacted wisdom teeth claims should first go to medical carrier) Endodontics (root canals on permanent teeth once per lifetime per tooth) General Periodontics (have specific frequency limitations, Pre-Treatment Estimate is strongly recommended - e.g. surgery once per 24 months)	The plan pays 80% of negotiated fees	The plan pays 80% of eligible charges after deductible is met
Major Care Surgical Periodontics (have specific frequency limitations, Pre-Treatment Estimate is strongly recommended - e.g. surgery once per 36 months) Crowns and crown-related procedures (post and core, core buildup, etc., once every five years, permanent teeth only, for ages 12 and older) Bridgework (once every five years, for ages 16 and older) (bridges with four or more missing teeth in that arch may be given a partial denture subject to the Alternate Treatment Limitation) Full & Partial Dentures (either one, once every five years, partial dentures for ages 16 and older) (fixed bridges and removable partial dentures are not benefits in the same arch; benefits will be provided for the removable partial denture only) Repair of Dentures (Repair of existing prosthetic appliances) Inlays (inlays are only payable when done in conjunction with an onlay; by themselves they are subject to the Alternate Treatment Limitation of a Composite filling) Implants (once every 60 months (5 years) ages 19 and older	The play pays 60% of negotiated fees, no deductible	The plan pays 50% of eligible charges after deductible is met

Annual Benefit Maximum In- and out-of-network combined annual benefit may not exceed $2,000 per covered family member. (Orthodontia has a separate maximum as noted below)	$2,000 per covered family member	$1,500 per covered family member
Carryover Max Feature Maximum benefit that can be used during the coverage period to qualify for an additional accumulated benefit. Maximum amount that can be accumulated and carried into the next coverage period. Maximum amount that can be accumulated at any point in time	$1,000 $500 $2,000	$750 $375 $1,500
Orthodontia In- and out-of-network combined lifetime benefit may not exceed $2,000 per covered family member.	Plan pays 50% of negotiated fees up to $2,000 lifetime maximum (no deductible) per covered family member (children and adults)	Plan pays 50% of eligible charges up to $1,000 lifetime maximum (no deductible). Adult Ortho only covered in PPO and Premier networks. No Adult Ortho coverage if using an Out of Network provider
Oral Health Enhancement	Up to 2 additional cleanings and/or periodontal maintenance procedures in one Calendar Year if there is a history of periodontal surgery and/or periodontal scaling and root planing.	
Integrated Care Option	Up to two additional Prophylaxes and/or periodontal maintenance procedures in any combination per Calendar Year if you have diabetes or cardiovascular disease or are a pregnant woman.	

Alternate Treatment Limitation

The Alternate Treatment Limitation provision is applied when there are two dentally acceptable ways to treat a dental condition and both procedures are covered. In such cases your benefit is based on the treatment that costs less and you may use the Plan's payment towards the treatment you choose. Since the Plan's payment is the same no matter which treatment you choose, you may have higher out-of-pocket expenses if you choose the treatment that costs more

Oral Health Enhancement Option

The Plan's Oral Health Enhancement Option ("OHE") covers up to four dental cleanings and/or periodontal maintenance procedures in any combination per Calendar Year if you have had certain periodontal (gum) services in the past.

These services will be covered at the same percentage as specified in the Your Benefits Plan section. For the additional dental cleaning and/or periodontal maintenance procedures to be covered, you must have had the following dental services in the past:

• Periodontal surgery for any or all partial or complete quadrants;

• Periodontal scaling and planing for any or all partial or complete quadrants;

You will automatically qualify for the additional benefits if Delta Dental processed a claim for periodontal surgery or periodontal scaling and root planing services for you.

Otherwise, you can provide proof that you have had these services in the past in one of

the three ways:

1. Send a copy of an explanation of benefits from a prior insurance carrier that shows the most recent date(s) of periodontal surgery or periodontal scaling and root planing.

2. Send a copy of a bill from the treating Dentist that clearly shows the most recent date(s) of either periodontal surgery or periodontal scaling and root planing.

3. Have your Dentist complete the "Oral Health Enhancement Option Qualification Form" and fax, mail, or email the form to Delta Dental of New Jersey.

The Oral Health Option Qualification Form can be found under the "Forms" section of the Delta Dental of New Jersey Web Site (www.deltadentalnj.com). Any oral examination associated with the additional cleaning and/or periodontal maintenance procedure is not covered by the Plan. You will be financially responsible for the entire cost of any oral examination performed with the additional procedures.

Integrated Care Option

In order to be eligible for benefits under the Integrated Care Option, a covered person must:

(a) have a diagnosis of diabetes or cardiovascular disease from a physician or be a woman who is pregnant ("qualifying conditions") and

(b) have submitted proof to the Plan of the diagnosis referenced to in (a) above

and the date thereof within 365 days of the performance of the service for which a

benefit is sought.

Notwithstanding any frequency limitations for examinations, prophylaxes and periodontal maintenance procedures specified in the Your Benefits Plan section, a person eligible for benefits under the Integrated Care Option shall be eligible to receive up to 4 prophylaxes and/or periodontal maintenance procedures in any combination per Calendar Year.

With respect to women who are pregnant, coverage for the examinations Prophylaxis and/or periodontal maintenance procedures beyond the frequency limitations described in the "Your Benefits" section of this SPD, shall expire on the actual delivery date reported by the physician. The maximum number of examinations Prophylaxis and/or periodontal maintenance procedures under the Integrated Care Option and the Oral Health Enhancement Option in any combination per Calendar Year shall be 4.

The coinsurance percent payable by the Plan for all examinations prophylaxes and periodontal maintenance procedures and periodontal scaling and root planing covered due to the enhanced allowance set forth in the Integrated Care Option shall be the same as specified in the Your Benefits Plan Section.

Pre-Treatment Estimate

Before treatment is started, be sure you discuss with your Dentist the total amount of his or her fee. Although Pre-Treatment Estimates are not required, you are strongly encouraged to ask your Dentist to submit a Pre-Treatment Estimate for treatment costing $300 or more. This is especially important when using a Non-Participating Dentist because the Pre-Treatment Estimate lets you know in advance how much of the costs are your responsibility. Please keep in mind that a Pre-Treatment Estimate is only an estimate and not a guarantee of benefits or payment.

What Is Not Covered

The Dental PPO plan option does not cover certain services, some of which are listed below. Please contact the Claims Administrator to confirm whether or not your service will be covered. See the section "How to Reach Your Dental Plan Service Provider" at the beginning of this SPD for contact information.

Non-Covered Services and Supplies
• To be eligible for coverage, a service must be required for the prevention, diagnosis, or treatment of a dental disease, injury, or condition. Services not dentally necessary are not covered benefits. The fact that a procedure is prescribed by your Dentist does not make it dentally necessary or eligible under this program. The Plan can request proof (such as x-rays, pathology reports, or study models) to determine whether services are necessary. Failure to provide this proof may cause adjustment or denial of any procedure performed. • Services for injuries or conditions which are compensable under Workers Compensation • Employers Liability Laws; services provided to the eligible patient by any Federal or State Government Agency or provided without cost to the eligible patient by any municipality, county, or other political subdivision. • Services with respect to congenital or developmental malformations (including TMJ), cosmetic surgery, and dentistry for purely cosmetic reasons (e.g., bleaching, veneers, or crowns to improve appearance). • Services provided in order to alter occlusion (change the bite); replace tooth structure lost by wear, abrasion, attrition, abfraction, or erosion; splint teeth; or treat or diagnose jaw joint and muscle problems (TMJ). • Specialized or personalized services (e.g., overdentures and root canals associated with overdentures, gold foils) are excluded and a benefit will be allowed for a conventional procedure (e.g., benefiting a conventional denture towards the cost of an overdenture and the root canals associated with it. The patient is responsible for additional costs.) • Prescribed drugs, analgesics (pain relievers), fluoride gel rinses, and preparations for home use. • Procedures to achieve minor tooth movement. • Experimental procedures, materials, and techniques and procedures not meeting generally accepted standards of care. • Educational services such as nutritional or tobacco counseling for the control and prevention of oral disease. Oral hygiene instruction or any equipment or supplies required. • Any service that has not been performed by a person duly licensed as an oral surgeon or as a Dentist in the state in which the treatment was rendered or by their auxiliary personnel who are duly licensed to perform the services at their direction. • Charges for hospitalization including hospital visits or broken appointments, office visits, and house calls. • Services performed prior to effective date or after termination of coverage. Benefits are payable based on the **Completion Date** of treatment. • Services performed for diagnosis such as laboratory tests, caries tests, bacterial studies, diagnostic casts, or photographs. • Temporary procedures and appliances, pulp caps, inhalation of nitrous oxide, analgesia, local anesthetic, and behavior management. • A subset of a more comprehensive service or procedures or preparations which are part of or included in the final restoration (bases, acid etch, or micro abrasion).

Non-Covered Services and Supplies

- Transplants.
- Periodontal charting, chemical irrigation, delivery of local chemotherapeutic substances, application of desensitizing medicine, synthetic bone grafts, and guided tissue regeneration.
- Post removal (not in conjunction with root canal therapy).
- Completion of Claim Forms, providing documentation, requests for pre-determination, and services submitted for payment more than twelve (12) months following completion.
- Separate fee for infection control and OSHA compliance.
- Maxillofacial surgery and prosthetic appliances.
- Expenses for replacement of a lost, missing or stolen prosthetic device or other duplicate appliance.
- Expenses for services or supplies for which no charge is made that the **Covered Person** is legally obligated to pay or for which no charge would be made in the absence of dental expense coverage.
- Expenses for myofunctional therapy.
- Surgical procedures to correct congenital malformations or development malformations, and procedures, appliances or restorations solely for cosmetic purposes or to increase vertical dimension, restore occlusion or restore tooth structure lost by attrition, or related to TMJ, TMD or occlusal equilibration
- Any endodontic, periodontal, oral surgical and restorative procedures related to overdentures.
- Synthetic graft materials or extraoral grafts.
- Periodontal scaling when provided in conjunction prophylaxis.
- Periodontal splinting and/or crown and bridgework used in conjunction with periodontal splinting.
- Expenses for services or supplies for accidental injury.
- Expenses which are incurred in connection with any injury or disease arising out of the ownership, maintenance or use of a motor vehicle, except as required by NJAC 11:3-37.3. For expenses incurred in connection with any injury or disease arising out of the ownership, maintenance, or use of a motor vehicle, this Dental Plan shall be secondary.
- Duplicative Dental Services performed on the same day.
- The Plan will not coordinate benefits unless the other plan provides benefits for dental services.
- Specialized techniques including but not limited to swing locks, dolder bars, special staining, halder bars, connector bars, metal bases, cone beam capture imaging interpretation and manipulation, ridge augmentation and/or preservation.
- Dental Services submitted for payment as part of a Claim which has knowingly inaccurate information pertinent to the Claim (such as the Dental Service actually rendered, the date of service, the existence of other coverage, or the fee for the Dental Service).
- Tooth preparation; acid etching; temporary restorations and crowns; bases; direct and indirect pulp caps; polishing; caries removal; microabrasion; endodontic working, final treatment, and follow up radiographs; occlusal adjustments; post removal; gingivectomy In Conjunction With restorations; impressions; lab fees and material; local anesthesia services in conjunction with operative or surgical procedures, and other Dental Services which the Plan considers to be part of a more Comprehensive Dental Service.
- Dental Services for which the Dentist does not normally charge.
- Sales taxes on Dental Services.
- All other services not specifically included in this SPD as a Covered Service.

Non-Covered Services and Supplies

The following are additional exclusions relating to specific types of services:

Diagnostic and Preventive Services

- Procedures primarily for the purpose of plaque control (except prophylaxis), oral hygiene, dietary instructions or other diagnostic tests not specifically mentioned, including but not limited to, laboratory tests, susceptibility tests and periodontal susceptibility tests.

Basic Services

- One (1) restoration in each tooth surface irrespective of the number of combinations of restorations placed and replacement is limited to once in a twelve (12)-month period.

Periodontics

- Curettage is not an eligible service in conjunction with periodontal surgery.
- Periodontal Prophylaxis will only be an eligible service after active Periodontal Therapy has been performed. Any combination of Preventative Prophylaxis and Periodontal Prophylaxis will be limited to two (2) in a calendar year.

Prosthodontics

- Any procedures, restorations or appliances associated with periodontal splinting.
- Personalization, characterization and precision attachments.

Orthodontics

- The replacement and/or repair of any appliance furnished under a treatment plan.
- After the completion of orthodontic services as set forth in a treatment plan, any further orthodontic services rendered to the same individual.
- Orthodontic surgery (orthognathic surgery).
- Tooth guidance appliance, minor tooth movement and preprosthetic orthodontics, such as molar uprighting.

Implants

- Implants, abutments, or crowns for other than natural missing teeth.
- Implants, abutments, or crowns for third molars.
- Provisional crowns done with an implant.
- Any implant intended to replace a single missing tooth unless the teeth abutting the missing tooth space are intact, unrestored, or minimally restored.
- Any implant if either abutment tooth requires a crown or is reasonably expected to require a crown.
- Periodontal and oral surgery procedures (other than extractions) in conjunction with surgical implant placement or in association with salvage attempts of a failing implant.
- Computerized tomography (CT) scans, surgical stents, surgical guides, sinus lifts, ridge preservation or augmentation in an extraction site in preparation for an implant procedure.
- Implants done to restore a space beyond the normal complement of natural teeth (for example, placing two implants in the space of #19).

If you have questions about whether a service is covered, please contact the Claims Administrator to confirm whether or not your service will be covered. See the section "How to Reach Your Dental Plan Service Provider" at the beginning of this SPD for contact information.

Filing a Claim

If you use a participating provider for care, the provider should file the claim for you. For out-of-network benefits, you must file claims for reimbursement. You must attach proper documentation of your claim including the provider's name, the date services are received and any bills or receipts. By providing a complete claim, you will avoid unnecessary delays in processing.

Dental claim forms are available from the Dun & Bradstreet Benefits Center via the Internet. See the section "How to Reach Your Dental Plan Service Provider" at the beginning of this SPD for contact information. Dental benefits are generally payable to you. However, the Dental Plan has the right to pay the provider directly.

Claims Filing Deadline

You must file all claims for dental expenses within 12 months of when you incurred the expense. If you do not file claims on a timely basis, your claims will not be eligible for reimbursement and the Claims Administrator will deny the claim.

Expenses are generally considered to be "incurred" on the date of service — not the date of the invoice. In addition, the service must be completed to be considered a covered expense. Exceptions to this guideline are services received for the following:

- Root canal therapy — incurred as of the date the canals are permanently filled
- Dentures — incurred as of the date the teeth are prepared for treatment.

If you have questions about claims, you can call the Claims Administrator.

If You Do Not Present Claims Reimbursement Checks for Payment

If you do not present claims reimbursement checks for payment within 24 months after the date reimbursement was issued, the reimbursement will be cancelled.

ADDITIONAL RULES THAT APPLY TO THE DENTAL PLAN

The following rules apply to the Dental Plan.

Qualified Medical Child Support Order (QMCSO)

The Dental Plan will comply with all the terms of a qualified medical child support order (QMCSO). A QMCSO is an order or judgment from a court or administrative body that directs the plan to cover a child of a participant under the health plan. Federal law provides that a medical child support order must meet certain form and content requirements in order to be a qualified medical child support order. When an order is received, each affected participant and each child (or the child's representative) covered by the order will be given notice of the receipt of the order and a copy of the Dental Plan's procedure for determining if the order is valid. Coverage under the Dental Plan pursuant to a medical child support order will not become effective until the Plan Administrator determines that the order is a QMCSO. If you have any questions or would like to receive a copy of the written procedure for determining whether a QMCSO is valid, please contact the Dun & Bradstreet Benefits Center. See the section "How to Reach Your Dental Plan Service Provider" at the beginning of this SPD for contact information.

Coordination of Benefits If You Are Covered by More than One Dental Plan

Generally, if you are covered by more than one group dental plan and in some cases a group medical plan your expenses will be shared between the plans, up to the full amount of the allowable charges. Make sure you inform your Dentist that you are covered by more than one plan. If you are covered by more than one dental benefit plan, you or your Dentist should file all your claims with each plan and provide each plan with information regarding the other plans under which you are covered.

If you are covered by more than one Delta Dental of New Jersey plan, you or your Dentist just need to submit the claim once, and Delta Dental will coordinate your benefits. If you are covered by this Plan and another group plan, you or your Dentist need to submit the claim to the primary group plan. After the primary group plan has issued a statement of benefits, you or your Dentist should send that statement of benefits to the second group plan along with a Claim Form.

In situations where you have other coverage, the Dental Plan has a provision to ensure that payments from all of your group dental plans do not exceed the amount the Dental Plan would pay if it were your only coverage.

The rules described here apply to the Dun & Bradstreet Dental Plan. The following rules do not apply to any private, personal insurance you may have.

Determining Primary Coverage

As an active Dun & Bradstreet employee, the Dental Plan will consider claims for your dental expenses first. Even if you or a covered dependent becomes entitled to Medicare while you are an active employee, the Dental Plan will remain the primary plan. (Different rules apply if your employment has terminated or if you are receiving long-term disability benefits from Dun & Bradstreet.)

To determine which dental plan pays first as the primary plan, here are some general guidelines:

If the claim is for:	This Plan Pays First…	This Plan Pays Second…
You	Dun & Bradstreet plan	Spouse/domestic partner's plan
Your spouse/domestic partner	Spouse/domestic partner's plan	Dun & Bradstreet plan
Your dependent children	See below	See below

If you are covered by another dental plan that has no benefit coordination rules, that plan will pay benefits before your Dun & Bradstreet Dental Plan pays benefits. If both plans coordinate benefits, the plan that covers you or your spouse/domestic partner as an employee (rather than as a dependent) is primary.

If you and your spouse/domestic partner are also covered under each other's plans, and you and your spouse/domestic partner both cover your children, then:

- The primary plan for your children's coverage is determined by the birthday rule. This means your children's primary coverage is under the plan of the parent whose birthday occurs first in the plan year. For example, if your birthday is April 1 and your spouse/domestic partner's birthday is October 1, your plan is primary for your children.
- If you are divorced or separated, a court decree may establish which parent is financially responsible for your children's health care. In that instance, that parent's plan is primary. If not specified, primary coverage is provided in the following order by the plan of the:
  - Parent with custody
  - Step-parent married to the parent with custody
  - Parent without custody

  Otherwise, the plan that has covered the child longer is primary.

NON-DUPLICATION OF BENEFITS

If the Dun & Bradstreet Dental Plan is secondary, your Dun & Bradstreet Dental Plan coverage will ensure that, in total, you receive benefits up to what you would have received with the Dun & Bradstreet Dental Plan as your only source of coverage (but not in excess of that amount). In other words, the Dental Plan does not allow duplication of benefits. A summary of coordination rules (how the Dun & Bradstreet Dental Plan coordinates coverage with another group plan to ensure non-duplication of benefits) is provided below. If you have questions, contact the Claims Administrator for help. See the section "How to Reach Your Dental Plan Service Provider" at the beginning of this SPD for contact information.

How Benefits Coordinate

When the Dun & Bradstreet Dental Plan is the secondary coverage, here's how the benefits are coordinated:

- Submit claims for covered expenses to the primary coverage plan first.
- Then, when you receive an Explanation of Benefits (EOB) statement from the primary plan that shows how your claim was processed, submit a copy of it along with your claim form to the Claims Administrator. Only eligible expenses covered by the Dun & Bradstreet Dental Plan will be considered.
- The Dun & Bradstreet Dental Plan then calculates what the benefit would be if the Dun & Bradstreet Dental Plan were the primary plan. If the primary plan paid less, the Dun & Bradstreet Dental Plan will pay the difference. If the primary plan paid the same amount or greater, no additional benefits will be paid by the Dun & Bradstreet Dental Plan. *Your reimbursement from both plans cannot exceed the amount that the Dun & Bradstreet Dental Plan would have paid in the absence of other coverage.*

PLAN ADMINISTRATION

This information about the administration of the Dental plan is provided in compliance with the Employee Retirement Income Security Act (ERISA) of 1974, as amended. While you should not need these details on a regular basis, the information may be useful if you have specific questions about your Dental plan.

Plan Name

The name of the plan is The Dun & Bradstreet Corporation Welfare Benefit Plan. The Dental Plan is one part of this plan.

Plan Sponsor

The Dun & Bradstreet Corporation is the Plan Sponsor of The Dun & Bradstreet Corporation Welfare Benefit Plan, of which the Dental Plan is a part. The name, address and telephone number of the Plan Sponsor are:

The Dun & Bradstreet Corporation
5335 Gate Parkway
Jacksonville, FL 32256
1-800-234-3867

This plan is a group health plan providing dental benefit.

Participating Employers

As of January 1, 2024, the participating employers are:

The Dun & Bradstreet Corporation

Dun & Bradstreet Credibility Corporation

Dun & Bradstreet, Inc.

MDM Technology USCo, LLC (from December 15, 2025 to July 1, 2026)

For a complete list, please contact the Plan Administrator.

Plan Administrator

The name, address and telephone number of the Plan Administrator are:

The Plan Administration Committee
The Dun & Bradstreet Corporation
100 Campus Drive, 3rd Floor West
Florham Park, NJ 07932
1-973-921-5500

The administration of the Dental Plan will be under the supervision of the Plan Administrator. To the fullest extent permitted by law, the Plan Administrator (or its delegee Claims Administrator) will have the exclusive right to determine all matters relating to eligibility, coverage, determination, interpretation and operation of the Dental Plan.

Claims Administrator

The dental coverage provided under the Dental Plan is self-insured by Dun & Bradstreet, and Dun & Bradstreet has contracted with third party administrators (the "Claims Administrator") to perform claims processing and other administrative services.

The name, address and telephone number of the Claims Administrator are:

Delta Dental of New Jersey, Inc.

P.O. Box 16354

Little Rock, AR 72231

Customer Service Department: 1-800-663-6435

The Plan Administrator has delegated to the Claims Administrator full discretion to determine all matters relating to dental claims, up to and including final appeals. Any determination by the Plan Administrator, or any authorized delegate, shall be final and binding.

Agent for Service of Legal Process

The name, address and telephone number of the agent for service of legal process are:

The Plan Administration Committee
The Dun & Bradstreet Corporation
100 Campus Drive, 3rd Floor West
Florham Park, NJ 07932
1-973-921-5500

Identification Numbers

The Employer Identification Number (EIN) assigned by the Internal Revenue Service to Dun & Bradstreet is 22-3725387. The plan number for The Dun & Bradstreet Corporation Welfare Benefit Plan is 501.

Plan Year

The plan year for the Dental Plan is January 1 through December 31.

Organizations Providing Administrative Services

Day-to-day operations of the Dental Plan have been delegated to the Dun & Bradstreet Benefits Center. The name, address and telephone number of the Dun & Bradstreet Benefits Center are:

Dun & Bradstreet's Benefits Center at Fidelity
P.O. Box 770003
Cincinnati, OH 45277
1-877-362-8953
http://netbenefits.fidelity.com

Plan Funding

The Dental Plan is a self-insured plan. Benefits from this plan are paid from participant contributions, as applicable, and from the general assets of Dun & Bradstreet, as needed. Dun & Bradstreet has contracted with third party administrators to administer this plan.

Plan Document

This SPD is intended to help you understand the main features of the Dental Plan. The legal plan document provides additional information about the administration of the Dental Plan. If there is any difference between the information in this SPD and in the legal plan document, or if there are details not covered in this SPD, the legal plan document will determine how to resolve these issues.

Future of the Plan

Dun & Bradstreet reserves the right to amend, modify, suspend or terminate the plan, in whole or in part, by action of the Compensation Committee of the Company's Board of Directors (or any delegate from time to time). Plan amendment, modification, suspension or termination may be made for any reason, and at any time.

Limited Authorization of Payments

To the extent allowed by the Claims Administrator, you may authorize the Claims Administrator to make payments directly to a health care provider for covered services. Further, even without such an authorization, the Claims Administrator may make direct payments to a health care provider for covered services pursuant to the Claims Administrator's rules and procedures as of the applicable time.

Authorizations of payments to a health care provider or direct payments to a health care provider are not assignments of benefits. Even though you may authorize a health care provider to receive a payment or reimbursement of covered services and even though the Claims Administrator may pay a health care provider directly for payments or reimbursements of covered services, in no event will any such authorizations, payments or reimbursements to or on behalf of a health care provider cause the provider to become a Plan participant or Plan beneficiary (or assignee of a participant or beneficiary) under ERISA

No Assignment of Rights and Benefits

Your rights and benefits under the Plan cannot be assigned, sold or transferred to any person, including your health care provider. For this purpose, your Plan rights and benefits, include, without limitation, the right to file an administrative appeal, the right to sue following a denied administrative appeal, and any other Plan rights and benefits, whether actual or

potential. Any purported assignment of rights and/or benefits under the Plan shall be void and shall not apply to the Plan. Further, a payment or reimbursement of covered services by the Claims Administrator to a health care provider (whether pursuant to an authorization or otherwise) will not waive the application of this provision. The application of this provision does not affect your right to appoint an authorized representative. See the Authorized Representative provisions in the Claims and Appeals Process Section for additional information.

Health Care Provider Agreements not Binding on the Plan

Sometimes your health care provider requests that you sign various agreements and other documentation as a condition of receiving health care services from the provider. Any agreement, assignment or other document executed by you and a health care provider (or executed by parties that include you and a health care provider, but that do not include the Plan Administrator) are not binding on and will have no legal effect whatsoever on the Plan or the Claims Administrator. Further, a payment or reimbursement of covered services by the Claims Administrator to a health care provider (whether pursuant to an authorization or otherwise) will not waive the application of this provision.

CONTINUATION OF COVERAGE

COBRA Continuation

This section contains important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Dental Plan. **This section generally explains COBRA continuation coverage, when it may become available to you and your covered spouse and dependent children, and what you need to do to protect the right to receive it.**

The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage may become available to you when you would otherwise lose coverage under the Dental Plan. It may also become available to your spouse and dependent children who are covered under the Dental Plan when they would otherwise lose such coverage.

What is COBRA Continuation Coverage

COBRA continuation coverage is a continuation of plan coverage when you would otherwise lose such coverage because of a life event known as a "qualifying event."

Specific qualifying events are listed below. After a qualifying event, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." You, your spouse, and your dependent children could become qualified beneficiaries if covered under the Dental Plan at the time of a qualifying event, and such coverage is lost because of the qualifying event. Additionally, a child who is born to or adopted or placed for adoption with you (the covered employee) during the COBRA continuation coverage period is also considered a qualified beneficiary, provided that you elected COBRA continuation coverage for yourself. Under the Dental Plan, qualified beneficiaries must pay for the COBRA continuation coverage they elect, as described later in this notice.

COBRA Qualifying Events

If you are an employee, you will become a qualified beneficiary if you lose coverage under the Dental Plan because either one of the following qualifying events happens:

- Your hours of employment are reduced; or
- Your employment ends for any reason other than your gross misconduct.

If you are the spouse of an employee, you will become a qualified beneficiary if you lose coverage under the Dental Plan because any of the following qualifying events happens:

- Your spouse dies;
- Your spouse's hours of employment are reduced;
- Your spouse's employment ends for any reason other than his or her gross misconduct;
- Your spouse becomes entitled to (i.e., enrolled in) Medicare benefits as a retiree (under Part A, Part B, or both); or
- You become divorced from your spouse.

Your dependent children will become qualified beneficiaries if they lose coverage under the Dental Plan because any of the following qualifying events happens:

- The parent-employee dies;
- The parent-employee's hours of employment are reduced;
- The parent-employee's employment ends for any reason other than his or her gross misconduct;
- The parent-employee becomes entitled to (i.e., enrolled in) Medicare benefits as a retiree (Part A, Part B, or both);
- The parents become divorced; or
- The child stops being eligible for coverage under the plan as a "dependent child."

For this purpose, "lose coverage" means to cease to be covered under the same terms and conditions as in effect immediately before the qualifying event. For example, any increase in the premium or contribution that must be paid by you (or your covered spouse or dependent children) for coverage under the Dental Plan that results from the occurrence of a qualifying event is a loss of coverage.

Giving Notice that a COBRA Qualifying Event (or Second Qualifying Event) Has Occurred

The Dental Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Dun & Bradstreet Benefits Center (on behalf of the Plan Administrator) has been timely notified that a qualifying event has occurred. In other words, to notify the Plan Administrator, call the Dun & Bradstreet Benefits Center. See the section "How to Reach Your Dental Plan Service Provider" at the beginning of this SPD for contact information. When the qualifying event is the employee's termination of employment (other than for gross misconduct) or reduction of work hours, or death of the employee, or the employee's becoming entitled to Medicare benefits as a retiree (under Part A, Part B, or both), the employer will notify the Plan Administrator of the qualifying event by contacting the Dun & Bradstreet Benefits Center. See the section "How to Reach Your Dental Plan Service Provider" at the beginning of this SPD for contact information.

Important Note: For the other qualifying events (divorce of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), you or your spouse must notify the Plan Administrator by contacting the Dun & Bradstreet Benefits Center within 60 days after the later of:

- The date of qualifying event (or second qualifying event);
- The date the qualified beneficiary loses (or would lose) coverage under the Dental Plan as a result of the qualifying event (or second qualifying event). You must notify the Plan Administrator by calling the Dun & Bradstreet Benefits Center. See the section "How to Reach Your Dental Plan Service Provider" at the beginning of this SPD for contact information.

Failure to provide timely notice will result in ineligibility for COBRA.

How is COBRA Continuation Coverage Provided

Once the Dun & Bradstreet Benefits Center (on behalf of the Plan Administrator) receives timely notice that a qualifying event has occurred, COBRA continuation coverage will be offered (through a "COBRA Continuation Coverage Election Notice") to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered employee may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation coverage on behalf of their children.

If coverage under the Dental Plan is changed for active employees, the same changes will be provided to individuals receiving COBRA continuation coverage. Qualified beneficiaries also may be able to change their coverage elections during the annual enrollment periods, if a change in status occurs, or at other times under the Dental Plan to the same extent that similarly situated non-COBRA employees or retirees may do so.

Duration of COBRA Continuation Coverage

COBRA continuation coverage is a temporary continuation of health coverage. When the qualifying event is the employee's termination of employment (other than for gross misconduct) or reduction of work hours, COBRA continuation coverage for the employee and the employee's covered spouse and dependent children generally lasts for only up to a total of **18 months**.

When the qualifying event is the death of the employee, the employee becoming entitled to (i.e., enrolled in) Medicare benefits as a retiree (under Part A, Part B, or both), or your divorce, COBRA continuation coverage for the employee's spouse and/or dependent children (but not the employee) lasts for up to a total of **36 months**. Also, the employee's dependent children are entitled to COBRA continuation coverage for up to **36 months** after losing eligibility as a dependent child under the terms of the Dental Plan.

There are three ways in which the 18-month period of COBRA continuation coverage due to the employee's termination of employment or reduction of work hours can be extended.

- **Employee's Medicare Entitlement Occurs Prior to a Qualifying Event That is Employee's Termination of Employment or Reduction of Work Hours** — When

the qualifying event is the employee's termination of employment (other than for gross misconduct) or reduction of work hours, and the employee became entitled to (i.e., enrolled in) Medicare benefits less than 18 months before the qualifying event (even if Medicare entitlement was not a qualifying event for the employee's spouse or dependent children because their coverage was not lost), COBRA continuation coverage for qualified beneficiaries other than the employee lasts until 36 months after the date of the employee's Medicare entitlement. For example, if the employee becomes entitled to Medicare eight months before the date on which employment terminates, COBRA continuation coverage for the employee's covered spouse and dependent children can last up to 36 months after the date of Medicare entitlement, which is equal to 28 months after the date of the qualifying event (36 months minus eight months).

- **Disability Extension** — If either you, your spouse or any of your dependent children covered under the Dental Plan is determined by the Social Security Administration (SSA) to be disabled on the date of the employee's termination of employment or reduction of work hours, or at any time during the first 60 days of COBRA continuation coverage due to such qualifying event, each qualified beneficiary (whether or not disabled) may be entitled to receive up to an additional 11 months of COBRA continuation coverage, for a total maximum of **29 months**. The disability would have to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of continuation coverage. To qualify for this disability extension, you must notify the Plan Administrator (by calling the Dun & Bradstreet Benefits Center) of the person's disability status BOTH:

Within 60 days after the latest of:

- The date of the disability determination by the SSA,
- The date on which the qualifying event occurs,
- The date on which you lose (or would lose) coverage under the plan, or

- The date on which you are informed of both the responsibility to provide this notice and the Dental Plan's procedures for providing such notice to the Plan Administrator, AND

Before the original 18-month COBRA continuation coverage period ends. You must provide a copy of the Social Security Disability Determination. Also, if Social Security determines that the qualified beneficiary is no longer disabled, you are required to notify the Plan Administrator by calling the Dun & Bradstreet Benefits Center within 30 days after this determination. **If these procedures are not followed or if the notice is not provided in writing to the Plan Administrator within the required period, you will not receive a disability extension of COBRA continuation coverage.** See the section "How to Reach Your Dental Plan Service Provider" at the beginning of this SPD for contact information.

- **Second Qualifying Event Extension** — If the employee's spouse and/or dependents experience a second qualifying event while receiving the initial 18 months of COBRA continuation coverage, the employee's spouse and dependent children (but not the employee) can get up to 18 additional months of COBRA continuation coverage, for a maximum of **36 months**, if timely notice of the second qualifying event (by calling the Dun & Bradstreet Benefits Center) is given to the Dental Plan. See the section "How to Reach Your Dental Plan Service Provider" at the beginning of this SPD for contact information.

  This extension may be available to the employee's spouse and any dependent children receiving COBRA continuation coverage if the employee or former employee dies, becomes entitled to (i.e., enrolled in) Medicare benefits as a retiree (under Part A, Part B, or both), or gets divorced, or if the dependent child stops being eligible under the Dental Plan as a dependent child, but only if the event would have caused the spouse or dependent child to lose coverage under the Dental Plan had the first qualifying event not occurred. If a second qualifying occurs at any time during the 29-month disability continuation period (as described above), then each qualified beneficiary who is the employee's spouse or dependent child (whether or not disabled) may further extend COBRA continuation coverage for seven more months, for a total of up to 36 months from the employee's termination of employment or reduction of work hours. (See the section "Giving Notice that a COBRA Qualifying Event (or Second Qualifying Event)

has Occurred" in this SPD for important details on the proper procedures and timeframes for giving this notice to the Plan Administrator). **If these procedures are not followed or if the notice is not provided in writing to the Dun & Bradstreet Benefits Center (on behalf of the Plan Administrator) within the required 60-day period, you will not receive an extension of COBRA continuation coverage due to a second qualifying event.**

The table below provides a summary of the COBRA provisions outlined in this section.

Qualifying Events That Result in Loss of Dental Coverage	Maximum Continuation Period		
	Employee	**Spouse**	**Child**
Employee's reduction of work hours (e.g., full-time to part-time)	18 months	18 months	18 months
Employee termination of employment for any reason (other than gross misconduct)	18 months	18 months	18 months
Employee or Employee's covered spouse or dependent child is disabled (as determined by the Social Security Administration) at the time of the qualifying event or becomes disabled within the first 60 days of COBRA continuation that begins as a result of termination or reduction in work hours, and provides proper notice	29 months	29 months	29 months
Employee dies	N/A	36 months	36 months
Employee and spouse divorce and provide proper notice	N/A	36 months	36 months
Employee becomes entitled to Medicare within 18 months prior to termination of employment or reduction in work hours (even if such Medicare entitlement was not the qualifying event for the covered spouse or dependent child because their coverage was not lost)	N/A	36 months*	36 months*
Child no longer qualifies as a dependent under the terms of the Dental Plan, and you provide proper notice	N/A	N/A	36 months

*36-month period is counted from the date the employee becomes entitled to Medicare.

Electing COBRA Continuation Coverage

You and/or your covered spouse and dependent children must choose to continue coverage within 60 days after the later of the following dates:

- The date you and/or your covered spouse and dependent children would lose coverage under the Dental Plan as a result of the qualifying event; or
- The date Dun & Bradstreet notifies you and/or your covered spouse and dependent children (through a "COBRA Continuation Coverage Election Notice") of your right to choose to continue coverage as a result of the qualifying event.

Paying for COBRA Continuation Coverage

Cost: Generally, each qualified beneficiary is required to pay the entire cost of COBRA continuation coverage. The cost of COBRA continuation coverage is 102% of the cost to the group health plan (including both employer and employee contributions) for coverage of a similarly situated plan participant or beneficiary who is not receiving COBRA continuation coverage. With regards to the 11-month disability extension of COBRA continuation coverage, the cost of coverage for the 19th through 29th months of coverage is:

- 150% of the cost of group health plan coverage for all family members participating in the same coverage option as the disabled individual, and
- 102% for any family members participating in a different coverage option than the disabled individual, except as provided in the next sentence. If a second qualifying event occurs during the first 18 months of coverage, the 102% rate applies to the full 36 months even if the qualified beneficiary is disabled. However, if a second qualifying event occurs during the otherwise applicable disability extension period (that is, during the 19th through 29th month), then the cost of coverage for the 19th through 36th months of coverage is:
  - The 150% rate for all family members participating in the same coverage option as the disabled qualified beneficiary, and
  - The 102% rate for any family members in a different coverage option than the disabled qualified beneficiary.

Special COBRA rights may apply if you lose coverage because of termination of employment or a reduction in hours or employment and you qualify for a "trade readjustment allowance" or "alternative trade adjustment assistance" under a federal law called the Trade Act of 2002. Generally, in this situation, you may be entitled to a second

opportunity to elect COBRA continuation coverage for yourself and certain family members (if you did not already elect COBRA continuation coverage), but only within a limited period of 60 days (or less) and only during the six months immediately after your initial loss of coverage. In addition, eligible individuals can take a tax credit equal to 72.5% of the premiums paid for qualified health insurance, including COBRA coverage. Eligible individuals who elect to claim this tax credit will not be eligible for a premium subsidy through the Marketplace.

If you qualify or may qualify for assistance under the Trade Act, please contact the Plan Administrator for additional information. You must contact the Benefits Center promptly after qualifying for assistance under the Trade Act or you will lose these special COBRA rights. More information can be found by visiting www.doleta.gov/tradeact/ or www.irs.gov/HCTC.

Premium Due Dates: If you elect COBRA continuation coverage, you must make your initial payment for continuation coverage (including all premiums due but not paid) not later than 45 days after the date of your election. (This is the date the COBRA Election Notice is post-marked, if mailed.) If you do not make your initial payment for COBRA continuation coverage within 45 days after the date of your election, you will lose all COBRA continuation coverage rights under the Dental Plan. **Payment is considered made on the date it is sent to the Dun & Bradstreet Benefits Center (on behalf of the Dental Plan).**

After you make your initial payment for COBRA continuation coverage, you will be required to make periodic payments for each subsequent coverage period. The premium due date and exact amount due for each coverage period for each qualified beneficiary will be shown in COBRA Election Notice you receive. Although periodic payments are due on the dates shown in the COBRA Election Notice, you will be given a grace period of 30 days after the first day of the coverage period to make each periodic payment. Your COBRA continuation coverage will be provided for each coverage period as long as payment for that coverage period is made before the end of the grace period for that payment.

If you elect COBRA continuation coverage, but then fail to make an initial or periodic payment before the end of the 45 or 30 day grace period, respectively, for that coverage period, you will lose all rights to COBRA continuation coverage under the Dental Plan, and

such coverage will be terminated retroactively to the last day for which timely payment was made (if any).

When COBRA Continuation Coverage Ends

COBRA continuation coverage for any person will end when the first of the following occurs:

- The applicable 18, 29 or 36-month COBRA continuation coverage period ends;
- Any required premium is not paid on time;
- After the date COBRA continuation coverage is elected, a qualified beneficiary first becomes covered (as an employee or otherwise) under another group health plan (not offered by Dun & Bradstreet) that does not contain any exclusion or limitation affecting a qualified beneficiary's preexisting condition, or the other group health plan's preexisting condition limit or exclusion does not apply or is satisfied because of the HIPAA rules;
- After the date COBRA continuation coverage is elected, a qualified beneficiary first becomes entitled to (i.e., enrolled in) Medicare benefits (under Part A, Part B, or both). This does not apply to other qualified beneficiaries who are not entitled to Medicare.
- In the case of extended COBRA continuation coverage due to a disability, there has been a final determination, under the Social Security Act, that the qualified beneficiary is no longer disabled. In such a case, the COBRA continuation coverage ceases on the first day of the month that begins more than 30 days after the final determination is issued, unless a second qualifying event has occurred during the first 18 months;
- For newborns and children adopted by or placed for adoption with you (the employee) during your COBRA continuation coverage, the date your COBRA continuation coverage period ends unless a second qualifying event has occurred; or
- Dun & Bradstreet ceases to provide any group health plan for its employees.

COBRA continuation coverage may also be terminated for any reason the Dental Plan would terminate coverage of a participant or beneficiary not receiving COBRA continuation coverage (such as fraud).

If You Have Questions

Questions concerning your Dental Plan or your COBRA continuation coverage rights should be addressed to the contact or contacts identified below. For more information about your rights under ERISA, including COBRA, the Health Insurance Portability and Accountability Act (HIPAA), and other laws affecting group health plans, visit the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) website at www.dol.gov/ebsa or call their toll-free number at 1-866-444-3272.

Keep Your Plan Informed of Address Changes

In order to protect your rights, as well as the rights of your spouse and dependent children, you should keep the Dun & Bradstreet Benefits Center informed of any changes in the addresses of your spouse and/or dependent children. You should also keep a copy, for your records, of any notices you send to the Dun & Bradstreet Benefits Center. See the section "How to Reach Your Dental Plan Service Provider" at the beginning of this SPD for contact information.

Continuation of Coverage for Employees in the Uniformed Services

The Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA) guarantees certain rights to eligible employees with regards to military service. If you go on a qualifying military leave of absence, you are generally entitled to participate in any rights under benefits not based on seniority that are available to employees on comparable non-military leaves. Upon reinstatement to active employment with your employer, you are generally entitled to the seniority, and all seniority-based rights and benefits associated with the position that you held at the time your employment was interrupted, plus the additional seniority; and seniority-based rights and benefits that you would have attained with reasonable certainty if your employment had not been interrupted.

If you take a qualifying military leave of absence, you may continue your dental coverage by paying the same amount charged to active employees for the same coverage.

The maximum period of continuation coverage available to you and your eligible dependents is the lesser of the 24-month period beginning on the date your leave begins, or the length of the period of your military service (plus the time allowed to apply for reemployment). Your coverage will end sooner than that if you fail to pay the required premium when it is due.

When you go on military leave, your work hours are reduced. As a result, you and your covered dependents may become eligible for COBRA. Any COBRA continuation period for which you are eligible will run concurrently with any USERRA continuation period for which you are eligible.

If you choose not to continue your dental coverage while on military leave, you are generally entitled to reinstate your dental coverage with no waiting periods or exclusions (however, an exception applies to service-related injuries or illnesses) when you return to active employment with your employer.

To be eligible for the reemployment rights guaranteed by USERRA, you must meet certain requirements. One of these requirements is that you generally must return to active employment with your employer (or reapply for employment with your employer, as applicable) within the following time frames:

- Return to work no later than the beginning of the first full, regularly scheduled work day following military service, including an 8-hour rest period after you return home from your military service, if you are on a military leave of less than 31 days,
- Return to or reapply for employment within 14 days of completion of such period of duty, if your period of military service is more than 30 days and less than 180 days, or
- Return to or reapply for employment within 90 days of completion of your period of duty, if your military service lasts more than 180 days.

See your Human Resources representative for more information on applicable military leaves of absence.

Continuation of Coverage While on a Family and Medical Leave

Under the federal Family and Medical Leave Act (FMLA), employees are generally allowed to take up to 12 weeks of unpaid leave (26 weeks in the case of a military caregiver leave) for certain family and medical situations and continue their elected dental coverage benefits during this time.

If you are eligible, you can take up to 12 weeks of unpaid leave (26 weeks in the case of a military caregiver leave) in a 12-month period for the following reasons:

- For the birth and care of your newborn child or a child that is placed with you for adoption or foster care,
- For the care of a spouse, child, or parent who has a serious health condition,
- For your own serious health condition,
- For a qualifying exigency relating to the active duty, or call to active duty, of a family member who is a member of the US Armed Forces or of the reserves and who is deployed to a foreign country, or
- To care for a family member who is a member of the US Armed Forces or a veteran and who is being treated for or recovering from a serious injury or illness incurred or aggravated by service in the course of active duty (known as a "military caregiver leave").

Depending on the state you live in, the number of weeks of leave available to you for family and medical reasons may vary based on state law requirements.

Your participation in the Dental Plan will continue while you are on an approved FMLA leave (paid or unpaid) as long as you pay the required premium for coverage in a timely manner. If your leave is unpaid, you will be billed for the cost of coverage under the Dental Plan. If you do not pay the required premium in a timely manner, your coverage will terminate.

If you are on an unpaid FMLA leave of absence, you also have the right to terminate your coverage during your leave of absence and reinstate your coverage if you return to work at the end of the FMLA leave. If you do not return to work at the end of the FMLA leave and

your leave of absence is not extended, your coverage under the Dental Plan will terminate unless you qualify for extended coverage. See the section "When Your Employment Ends" earlier in this SPD for more information. If your coverage terminates, you may be able to continue coverage for yourself and your dependents by electing and paying for COBRA coverage (unless your employment was terminated for gross misconduct). See the section "COBRA Continuation" in this SPD for more information.

Continuation of Coverage While on an Employer-Approved Leave of Absence

If you take an approved leave of absence (whether paid or unpaid), your coverage under the Dental Plan will continue at active rates during your approved leave of absence subject to timely payment of the required premium, with the exception of an FMLA or USERRA leave where you may choose to decline your benefit continuation.

If your leave of absence is paid, the cost of your coverage will be deducted from your pay. If your leave of absence is unpaid, you will be responsible for submitting payments for the required premium on a timely basis to continue coverage, otherwise your coverage will be terminated. The Dun &Bradstreet Benefits Center will bill you on a monthly basis for the cost of coverage starting the first of the month following the start of your approved unpaid leave. Payroll deductions will resume the first of the month following your return from the approved unpaid leave.

Your coverage may terminate before the end of your approved leave of absence if any of the other termination events described in the section "When Coverage Ends" occur, including your failure to pay the required contributions for coverage on a timely basis.

CLAIMS AND APPEALS PROCESS

This section describes claims filing procedures and your rights to appeal under the Dental Plan. The box below is a summary of the Dental Plan process for appealing a denied claim or other adverse benefit determination. See the beginning of this section "Plan Administration" for the name and address of the Claims Administrator.

1st level appeal:

Urgent Care, you must file your appeal within 180 days of receipt of claim denial. You'll be notified of determination as soon as possible but no later than 36 hours from receipt of appeal.

Pre-Service, you must file your appeal within 180 days of receipt of claim denial. You'll be notified of determination as soon as possible but no later than 15 days from receipt of appeal.

Post-Service, you must file your appeal within 180 days of receipt of claim denial. You'll be notified of determination as soon as possible but no later than 30 days from receipt of appeal.

2nd level appeal:

Urgent Care, you must file your appeal within 60 days of receipt of 1st level appeal denial. You'll be notified of determination as soon as possible but no later than 36 hours from receipt of appeal.

Pre-Service, you must file your appeal within 60 days of receipt of 1st level appeal denial. You'll be notified of determination as soon as possible but no later than 15 days from receipt of appeal.

Post-Service, you must file your appeal within 60 days of receipt of 1st level appeal denial. You'll be notified of determination as soon as possible but no later than 30 days from receipt of appeal.

Note: If applicable state law requires the Plan to take action on a claim or appeal in a shorter timeframe, the shorter period will apply.

Here are the key steps and detailed procedures for the claims and appeal process:

Filing Dental Claims Under the Plan

Under the Plan you may file claims for Plan benefits, and appeal adverse claim determinations either yourself or through an authorized representative. Any reference to "you" in this Appeals Process includes you and your Authorized Representative. Additional information regarding appointment of an Authorized Representative is below.

All claims must be submitted in writing except for urgent care claims which may be initiated by a call to the Claims Administrator's Customer Service Department. You may download a Claim Form from the Delta Dental web site (www.deltadentalnj.com) and submit a claim using that form. Your claim can be faxed to 1-800-324-7939 or submitted by mail to: Delta Dental of New Jersey, P.O. Box 16354, Little Rock, AR 72231. Your dentist can also submit a claim on your behalf.

If your claim is denied in whole or in part, you will receive a written notice of the denial from the Claims Administrator. The notice will explain the reason for the denial and the appeal procedures available under the Plan.

The Claims Administrator is responsible for determining all claims for dental benefits. The Plan Administrator will determine all eligibility claims and other similar non-benefit claims. The Plan Administrator will respond to all such claims within the time frames and in the manner that claims for benefits are decided, but you must submit the claim to the Plan Administrator, not to the Claims Administrator. All appeals of such claims must also be filed with the Plan Administrator within 180 days of the denial. The Plan Administrator will respond to all such appeals within the time frames and in the manner described below.

Authorized Representative

You may appoint an authorized representative to act on your behalf for purposes of the Dental Plan.

If you need to appoint an authorized representative for purposes of a claim or appeal relating to benefits, you must follow the rules and procedures of the Claims Administrator for such claim or appeal. To the extent the Claims Administrator has no rules or procedures, your appointment of an authorized representative must:

- Be in writing and dated;
- Clearly indicate the authorized representative, the scope of the appointment and any limitations on the authorized representative;
- Be signed by you and notarized by a notary public;

- Satisfy any other legal requirement applicable to appointments under state or federal law; and
- Be approved by the Plan Administrator (or its delegate) in writing.

The Dental Insurance Plan will also recognize a court order appointing a person as your authorized representative. The Plan Administrator may also provide different rules and procedures for an appointment of an authorized representative in emergency situations or for attorneys.

Appointing an individual or entity as your authorized representative is not an assignment of rights or benefits under the Plan and any such appointment (whether pursuant to the rules of the Claims Administrator or the Plan Administrator) does not waive the Plan's anti-assignment provisions.

Time Frame for Claim Determinations

Urgent Care Claims

If the Plan requires advance approval of a service, supply or procedure before a benefit will be payable, and if the Plan or your dentist determines that it is an urgent care claim, you will be notified of the decision not later than 72 hours after the claim is received.

"A claim involving urgent care" is any claim for dental care or treatment with respect to which the application of the time periods for making non-urgent care determinations could seriously jeopardize the life or health of the claimant or the ability of the claimant to regain maximum function, or, in the opinion of a dentist with knowledge of the claimant's medical condition, would subject the claimant to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim.

If there is not sufficient information to decide the claim, you will be notified of the information necessary to complete the claim as soon as possible, but not later than 24 hours after receipt of the claim. You will be given a reasonable additional amount of time, but not less than 48 hours, to provide the information, and you will be notified of the decision not later than 48 hours after the end of that additional time period (or after receipt of the information, if earlier).

Other Claims (Pre-Service and Post-Service)

If the Plan requires you to obtain advance approval of a service, supply or procedure before a benefit will be payable, a request for advance approval is considered a pre-service claim. You will be notified of the decision not later than 15 days after receipt of the pre-service claim.

For other claims (post-service claims), you will be notified of an adverse benefit determination not later than 30 days after receipt of the claim. Ana adverse benefit determination is any denial or reduction or termination of a benefit, or a failure to provide or make a payment, in whole or in part, for a benefit.

For a pre-service or a post-service claim, these time periods may be extended up to an additional 15 days due to circumstances outside the Plan's control. In that case, you will be notified of the extension before the end of the initial 15 or 30 day period. The notice will include the reason(s) requiring the extension and the date a decision is expected regarding the claim. For example, they may be extended because you have not submitted sufficient information, in which case you will be notified of the specific information necessary and given an additional period of at least 45 days after receiving the notice to furnish that information. You will be notified of the Plan's claim decision no later than 15 days after the end of that additional period (or after receipt of the information, if earlier).

For pre-service claims which name a specific claimant, dental condition, and service or supply for which approval is requested, and which are submitted to a Plan representative responsible for handling benefit matters, but which otherwise fail to follow the Plan's procedures for filing pre-service claims, you will be notified of the failure within 5 days (within 24 hours in the case of an urgent care claim) and of the proper procedures to be followed. The notice may be oral unless you request written notification.

If an extension is necessary for pre- and post-service claims due to your failure to submit necessary information, the Dental Plan's time frame for making a benefit determination is stopped from the date the Claims Administrator sends you an extension notification until the date you respond to the request for additional information. If the Claims Administrator does not receive the requested information from you within 45 days of the date the Claims

Administrator sends you the request, your claim will be considered without such additional information and the resulting claim determination by the Claims Administrator will be final.

If You Receive an Adverse Benefit Determination

If your claim is denied or you receive any other adverse benefit determination, the Claim Administrator will notify you. The notice will include:

- The specific reason(s) for the adverse benefit determination.
- References to the specific Dental Plan provisions on which the benefit determination is based.
- A description of any additional material or information needed to process the claim and an explanation of why that material or information is necessary.
- A description of the Dental Plan's appeal procedures (including an explanation of how to initiate an appeal) and the time limits applicable to those procedures, including a statement of your right to bring a civil action under ERISA after an appeal of an adverse benefit determination.
- Any internal rule, guideline, protocol or other similar criterion relied upon in making the adverse benefit determination, or a statement that a copy of this information will be provided free of charge to you upon request.
- If the adverse benefit determination was based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the adverse determination, applying the terms of the Dental Plan to your medical circumstances, or a statement that such explanation will be provided free of charge upon request.
- If the adverse benefit determination concerns a claim involving urgent care, a description of the expedited review process applicable to the claim.

Filing an Appeal of an Adverse Benefit Determination for a Dental Claim

As a participant in the Dun & Bradstreet Dental Plan, you have the right to file an appeal if your claim is denied or you receive some other adverse benefit determination. This includes appeals regarding:

- Certification of dental care services
- Claim payment
- Plan interpretation
- Benefit determination
- Eligibility

Appeals must be filed in writing with the Claims Administrator at the following address:

Delta Dental of New Jersey, Inc.
Attn: Formal Appeals Department
P.O. Box 15132
Little Rock, AR 72231

If your appeal is of an urgent nature, you may call the Claims Administrator's Customer Service Department at the toll-free phone number on your ID card. Your request should include the group name (that is, your employer), your name, Member ID or other identifying information shown on the front of the Explanation of Benefits form, and any other comments, documents, records and other information you would like to have considered, whether or not submitted in connection with the initial claim.

You will have 180 days following receipt of an adverse benefit decision to appeal the decision to the Claims Administrator. If you fail to request a review of an adverse benefit determination within this time frame, it shall be conclusively determined for all purposes that the denial of the claim was correct.

You will be notified of the decision not later than 30 days (for pre-service claims) or 60 days (for post-service claims) after the appeal is received. You may submit written comments, documents, records and other information relating to your claim, whether or not the comments, documents, records or other information were submitted in connection with the

initial claim. A copy of the specific rule, guideline or protocol relied upon in the adverse benefit determination will be provided free of charge upon request by you or your authorized representative. You may also request that the Plan provide you, free of charge, copies of all documents, records and other information "relevant" to the claim (as that term is defined by ERISA).

In addition, you have the right to:

- A review that takes into account all comments, documents, records and other information submitted by you related to the claim, regardless of whether the information was submitted or considered in the initial benefit determination.

- A review that does not defer to the initial adverse benefit determination and that is conducted neither by the individual who made the adverse determination, nor that person's subordinate.

- A review in which the named fiduciary consults with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment, and who was neither consulted in connection with the initial adverse benefit determination, nor the subordinate of any such individual. This applies only if the appeal involves an adverse benefit determination based in whole or in part on a medical judgment (including whether a particular treatment, drug or other item is experimental).

- The identification of medical or vocational experts whose advice was obtained in connection with the adverse benefit determination, regardless of whether the advice was relied upon in making the decision.

If your claim involves urgent care, an expedited appeal may be initiated by a telephone call to the Customer Service Department. The Claims Administrator's Customer Service Department telephone number is on your Identification Card. You or your authorized representative may appeal urgent care claim denials either orally or in writing. All necessary information, including the appeal decision, will be communicated between you or your authorized representative and the Plan by telephone, facsimile, or other similar method. You will be notified of the decision not later than 36 hours after the appeal is received.

Filing a Second Appeal of an Adverse Benefit Determination for a Dental Claim

If you are dissatisfied with the appeal decision on a claim involving urgent care, you may file a second level appeal with the Claims Administrator. You will be notified of the decision not later than 36 hours after the appeal is received.

If you are dissatisfied with a pre-service or post-service appeal decision, you may file a second level appeal with the Claims Administrator within 60 days of receipt of the level one appeal decision. The Claims Administrator will notify you of the decision not later than 15 days (for pre-service claims) or 30 days (for post-service claims) after the appeal is received.

Exhaustion of Administrative Remedies and Limitations on Actions

If you do not agree with the final determination on review, you have the right to bring a civil action under Section 502(a) of ERISA, if applicable. You must use and fully exhaust all of your actual or potential rights under this Dental Plan's administrative claims and appeals procedure by filing an initial claim and seeking a timely appeal of any adverse benefit determination before bringing suit or any other legal action against or with respect to the Plan and/or the Plan Administrator. This relates to claims for benefits, eligibility and to any other issue, matter or dispute (including any plan interpretation or amendment issue). Any such suit or other legal action must be filed within the earliest of the following - (1) two years after receiving an adverse benefit determination on review or (2) two years of the date the claim arose. If the Plan decides an appeal is untimely, the Plan's latest decision on the merits of the underlying reimbursement request or benefit request is the final decision date. If the suit or other legal action does not relate to a claim for benefits, it must be brought within two years of the date you have actual or constructive knowledge of the claim. In addition, the suit or other legal action must only be brought or filed in a federal court in the Middle District of Florida. Failure to follow this Dental Plan's administrative claims and appeals procedures in a timely manner will cause you to lose your right to sue regarding an adverse benefit determination. This means that any claim, action or suit filed in court or in another tribunal will generally be dismissed.

In any action or consideration of a claim in court or in another tribunal following exhaustion of the Plan's claims procedures, the subsequent action or consideration shall be limited to the maximum extent permissible to the record that was before the Plan Administrator or

Claims Administrator in the claims procedure process. Upon review by any court or other tribunal, the exhaustion requirement is intended to be interpreted to require exhaustion in as many circumstances as possible.

Discretionary Authority

The Plan Administrator and the Claim Administrator (with respect to any matters delegated to the Claims Administrator) have the exclusive discretionary authority to construe and to interpret the Plan, to decide all questions of eligibility for benefits and to determine the amount of such benefits, and their decisions on such matters are final and conclusive. Any interpretation or determination made pursuant to such discretionary authority shall be given full force and effect. Benefits under the Dental Plan will be paid only if the Plan Administrator or the Claims Administrator, as applicable, decides in its discretion that a participant is entitled to them.

YOUR RIGHTS UNDER ERISA

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

Receive Information About Your Plan and Benefits

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

- Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the plan, including insurance contracts and copies of the latest annual report (Form 5500 Series) and updated summary plan description. The Plan 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 Coverage

- Continue group health coverage for yourself, spouse or dependents if there is a loss of coverage under the plan as a result of a qualifying event. You or your dependents may have to pay for such coverage. Review this summary plan description and the documents governing the plan for the rules governing your COBRA continuation rights.

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 or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a plan benefit or exercising your rights under ERISA.

Enforce Your Rights

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

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

If you have a claim for benefits that is denied or ignored, in whole or in part, you may file a suit in a state or federal court but only after you have exhausted the plan's claims and appeals procedure as described in the section "Claims and Appeals Process." 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 a federal court.

If it should happen that plan fiduciaries misuse the plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

Assistance with Your Questions

If you have any questions about your plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of the Employee Benefits Security Administration (EBSA), U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, 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.

HIPAA PRIVACY RIGHTS AND PROTECTED HEALTH INFORMATION

The Dun & Bradstreet Corporation has certain legal obligations regarding the privacy of your personal health care information according to the provisions of the Health Insurance Portability and Accountability Act of 1996 (HIPAA). Dun & Bradstreet or any Dun & Bradstreet company that participates in the Dental Plan may only use and disclose protected health information it receives in ways that are permitted by, required by and consistent with the HIPAA privacy regulations. This includes, but is not limited to, the right to use and disclose participant's protected health information in connection with payment, treatment and health care operations.

NO GUARANTEE OF EMPLOYMENT

Your participation in, eligibility for or your right to benefits under the Dental Plan described in this booklet is no guarantee of continued employment with Dun & Bradstreet or any Dun & Bradstreet company that participates in the Dental Plan.

In accordance with ERISA, this booklet provides a summary plan description of the Dental Plan, a part of The Dun & Bradstreet Corporation Welfare Benefit Plan. The information in this booklet does not constitute a commitment to continued employment.

Dun & Bradstreet reserves the right to change, modify or terminate any of the plans at any time.

GLOSSARY OF OTHER IMPORTANT TERMS

Alternate Treatment Limitation

A provision that allows the benefit determination to be based on an alternative procedure that is generally less expensive than the one provided or proposed. Patient financial liability is dependent upon the treatment chosen.

Amalgam

A silver material used to fill cavities that is placed on the tooth surface that is used for chewing because it is a particularly durable material.

Benefit Maximum

The total dollar limit that the plan will pay toward Covered Services for each Covered Person during the Plan Year.

Birthday Rule

A standard used for coordination of benefits stipulating that the primary payor of benefits for dependent children is determined by the parents' birth dates. Regardless of which parent is older, the dental benefits program of the parent whose birthday falls first in a Calendar Year is considered primary.

Bitewing

A dental x-ray showing approximately the coronal (crown) halves of the upper and lower jaw.

Calendar Year

For benefit determinations based on a Calendar Year, this refers to the period of one year beginning with January 1 and ending December 31.

Carryover Max Feature

A benefit option that enables Covered Persons to carry over part of the unused standard Benefit Maximum in one coverage period to increase the amount of benefits available in subsequent coverage periods subject to certain requirements and limitations.

Claim Form

The paper form the Dentist must file for reimbursement for services rendered.

Coordination of Benefits (COB).

A method of integrating benefits payable under more than one plan.

Completion Date.

The date a procedure is completed. It is the insertion date for dentures and partial dentures. It is the cementation date (regardless of the type of cement used) for inlays, onlays, crowns, and fixed bridges.

Composite

White resin material used to fill cavities. It is used primarily because the color more closely resembles the natural tooth than does the color of Amalgam.

Consultation

A discussion between the patient and the Dentist where the Dentist offers professional advice for the proposed Treatment Plan.

Covered Person

Means an individual who is eligible for and enrolled in the Plan.

Covered Services

The dental services that are listed in the "Your Benefits" section of this SPD. Covered Services are eligible for payment of benefits and are subject to applicable limitations and exclusions.

Deductible

The amount you must pay each year for Covered Services before the Plan pays anything.

Delta Dental Participating Specialist

A state-licensed Dentist who has a written agreement with Delta Dental to perform services and receive payment under this program. A Delta Dental Participating Specialist holds a specialty permit in endodontics, periodontics, prosthodontics, oral surgery, or orthodontics; limits his/her practice to that specialty; and has registered with Delta Dental as a specialist.

Delta Dental (Premier®) Participating Dentist

A state-licensed Dentist who has a written agreement with Delta Dental to perform services and receive payment under this program.

Delta Dental PPOSM Dentist

A state-licensed Dentist who has a written agreement with Delta Dental to perform services and receive payment under this program.

Dentist

A person licensed to practice dentistry by the appropriate authority in the area where the dental service is given.

Explanation of Benefits (EOB)

A statement from the Plan that you will receive after a claim is processed describing how the Plan determined the benefit for the dental services submitted on the claim or stating the information the Plan requires before a benefit determination can be made.

General Dentist

A state-licensed Dentist who provides a full range of dental services for the entire family.

Integrated Care Option

A benefit option that provides coverage for additional dental cleanings and periodontal maintenance procedures beyond the normal frequency limits for Covered Persons who have a diagnosis of diabetes or cardiovascular disease from a physician or are a woman who is pregnant.

Interactive Voice Response system (IVR)

Provide benefit, eligibility, remaining Benefit Maximum and Deductible information, and history of your recent claims 24 hours a day, 7 days a week.

Non-Participating Dentist Maximum Amount Used for Benefit Calculation (NMAC)

The highest fee as determined by the Plan for purposes of calculating the payment amount for services performed by Non-Participating Dentists.

Non-Participating Dentist

A state-licensed Dentist who does not have a written participation agreement with Delta Dental.

Oral Health Enhancement Option

A benefit option that provides coverage for additional dental cleanings and periodontal maintenance procedures beyond the normal frequency limits for Covered Persons who received certain periodontal services in the past.

Participating Dentist

A state-licensed Dentist who has a written agreement with a Delta Dental Plan to perform services and receive payment under an applicable program. Delta Dental Participating Dentists include: Delta Dental PPOSM Dentists, Delta Dental (Premier®) Participating Dentists, and Delta Dental Participating Specialists.

Participating Dentist Maximum Approved Charge (PMAC)

The highest fee as determined by Delta Dental for purpose of compensating Delta Dental (Premier®) Participating Dentist for services.

Pre-Treatment Estimate

Pre-authorized estimate of services detailing payment of allowable benefits.

Prophylaxis

Prevention of disease by removal of calculus, stains, and other extraneous materials from the teeth. The cleaning of the teeth by a Dentist or dental hygienist.

Pro-rated

When orthodontic coverage begins after treatment has begun, payments are divided proportionately over the course of the treatment and the Plan's payment is based on the portion during which the Covered Person has coverage.

For covered orthodontic services, benefits for in process orthodontic services will be prorated so that the Plan pays a benefit based on the length of time the Covered Person is covered under this Plan as compared to the total amount of time for which the Covered Person will have received those dental services. For example, if the dental services plan is for twenty-four (24) months and (10) months of treatment have already been performed prior to the Covered Person being covered under this Plan, the Plan will make payments of one fourteenth (1/14th) of the balance that remains, based upon the monthly calculation

described above. Payments will stop at the earlier of the completion of the dental services or the date when the person is no longer a Covered Person.

Sealant

An adhesive material bonded to the tooth surface to retard decay by shielding the tooth from exposure to the oral environment. This includes preventive resin restorations.

Treatment Plan

A written report prepared by a Dentist showing the Dentist's recommended treatment of any dental disease, defect, or injury.