The Dun & Bradstreet Long-Term Disability 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 Long-Term Disability Plan for active employees (the "LTD Plan" or "Plan") is part of The Dun & Bradstreet Corporation Welfare Benefit Plan and provides long-term disability benefits to active employees. This document summarizes the Dun & Bradstreet LTD Plan, as in effect on January 1, 2024, unless otherwise noted, for eligible active employees. 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. If you have any questions about your benefits, please contact the Dun & Bradstreet Benefits Center. See the section "How to Reach Your LTD Plan Service Provider" at the beginning of this SPD for contact information.

The insurance policy and the Dun & Bradstreet legal plan document provide additional information about the administration of the LTD Plan. If there is any difference between the information in this SPD and information in the insurance policy and Dun & Bradstreet legal plan document, or if there are details not covered in this SPD, the insurance policy and the Dun & Bradstreet 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 LTD Plan.

The LTD Plan is fully insured through an outside insurance company (the "Insurance Provider"), which means the Insurance Provider assumes full responsibility for claims adjudication and payment.

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

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

HOW TO REACH YOUR LTD PLAN SERVICE PROVIDER

Here is how you can reach your Dun & Bradstreet Long-Term Disability Plan service providers:

Provider	Contact Information
Administrative Services: ■ Dun & Bradstreet's Benefits Center at Fidelity	■ P.O. Box 770003 Cincinnati, OH 45277 ■ 1-877-362-8953 (or 1-888-343-0860 for the hearing impaired) ■ http://netbenefits.fidelity.com
LTD Plan Insurance Provider: ■ Unum (claims)	*To Report a New Claim or inquire:* ■ 1-866-779-1054

ABOUT YOUR PARTICIPATION

This section contains important information about your participation in the LTD Plan, including eligibility information, when coverage begins, available coverage, paying for coverage, making changes during the year and when coverage ends.

Who Is Eligible

You are eligible for coverage under the LTD 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 LTD 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, leased employee, intern, or an independent contractor, you are not eligible to participate in the LTD 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 LTD 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.

When Coverage Begins

When your LTD Plan coverage begins, depends on when you enroll.

- If you enroll within 31 days of employment or the day you first become eligible for LTD Plan coverage, your coverage is effective the day you began employment with a Dun & Bradstreet company or first became eligible. You must be actively at work and paying for coverage in order for coverage to begin.

- If you enroll after 31 days from your employment date or the date you first became eligible and before the next annual enrollment, your coverage will be effective on the date your Evidence of Insurability (EOI) is approved by the Insurance Provider, as long as you are actively at work and paying for coverage on that date.
- If you enroll during annual enrollment, your coverage will be effective on the following January 1 or the date you are actively at work, if later.
- Your coverage as the result of a qualified change in family status will become effective on the date your enrollment is processed by the Dun & Bradstreet Benefits Center, provided you are actively at work on that date.

See the sections, "Making Changes During the Year" and "Evidence of Insurability" in this SPD for information on changing coverage during the year.

Evidence of Insurability

To enroll without providing Evidence of Insurability (EOI), you must enroll in the LTD Plan within 31 days of your date of hire or the date you first become eligible or during the Company's annual enrollment period. You may also enroll without providing EOI within 31 days of a qualified change in family status, provided your enrollment in the LTD Plan is consistent with the change in family status.

If you do not enroll within 31 days of the date you first become eligible, during annual enrollment or as the result of a qualified change in family status, you will be required to provide EOI subject to approval by the Insurance Provider. If you are required to provide EOI, you will be responsible for any expenses associated with providing EOI.

Paying for Coverage

You pay the full cost of coverage you elect under the LTD Plan based on the group rates obtained by the Company. Your contributions are deducted from your paycheck on an after-tax basis, that is, after federal and state income taxes and FICA taxes are withheld from your paycheck.

Making Changes During the Year

You can make the following changes to your LTD coverage during the year:

- You can cancel coverage at any time.
- You can enroll at any time during the year if you provide Evidence of Insurability (EOI). Your coverage will not go into effect until your Evidence of Insurability is approved, provided you are actively at work and paying for coverage on that date.
- You can enroll without providing Evidence of Insurability if you enroll for coverage during the Company's annual enrollment period or within 31 days of a "qualified change in family status" as described below.

Qualified Changes in Family Status

Qualified family status changes under the LTD Plan include:

- A change in your legal marital status (such as marriage, divorce, death of spouse, legal separation) or domestic partner status (i.e. your domestic partner meets or fails to meet the domestic partner criteria), and
- A change in the number of your dependents (such as through birth, adoption or placement for adoption of a dependent child or death).

When Coverage Ends

Non-Massachusetts Residents: Coverage under the LTD Plan will end for you on the earliest of the following events:

- Date you cancel coverage,
- Date you terminate employment for any reason, including retirement, and you are not disabled as determined by the Insurance Provider at the time,
- Date Dun & Bradstreet terminates the LTD Plan,
- Date you are no longer eligible for benefits,
- End of the period for which you pay the required contributions on a timely basis, or

- Date you die.

Special rules apply for Massachusetts residents who lose coverage on account of termination of employment or cancel coverage. Please refer to the Certificate of Insurance for additional information.

Your 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 LTD Plan.

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

YOUR LONG-TERM DISABILITY BENEFITS

The LTD Plan may continue a portion of your income when you are unable to work because of illness or accidental injury and you are under a doctor's care. The following is a brief description of the benefits provided under the LTD Plan. For complete information, you should review the Certificate of Insurance for the LTD Plan prepared by the Insurance Provider.

CERTIFICATE OF COVERAGE

In the event of a conflict between this summary and the Certificate of Insurance, the Certificate of Insurance will control.

Elimination Period

You must be continuously disabled through your elimination period. Your elimination period is the later of:

- 180 days; or
- the date your insured Short-Term Disability payments end, if applicable.

Benefits begin the day after the elimination period is completed.

Monthly Benefit

Your monthly benefit is 60% of your monthly earnings to a maximum benefit of $15,000 per month. **Your payment may be reduced by deductible sources of income and disability earnings. Some disabilities may not be covered or may have limited coverage under this plan.**

Minimum Monthly Benefit

Your minimum monthly benefit is the greater of (1) $100 or (2) 10% of your gross disability payment.

Maximum Period of Payment

Age at Disability	Maximum Period of Payment
Less than 60	To age 65 but not less than 5 years
60	60 months
61	48 months
62	42 months
63	36 months
64	30 months
65	24 months
66	21 months
67	18 months
68	15 months
69 and over	12 months

Regardless of age, payments and your claim will end on the earliest of the following:

- during the first 24 months of payments, when you are able to work in your regular occupation on a part-time basis and you do not;
- after 24 months of payments, when you are able to work in any gainful occupation on a part-time basis and you do not;
- if you are working and your monthly disability earnings exceed 80% of your indexed monthly earnings, the date your earnings exceed 80%;
- the end of the maximum period of payment;

- the date you are no longer disabled under the terms of the plan, unless you are eligible to receive benefits under Unum's Rehabilitation and Return to Work Assistance program;
- the date you fail to submit proof of continuing disability;
- after 12 months of payments if you are considered to reside outside the United States or Canada. You will be considered to reside outside these countries when you have been outside the United States or Canada for a total period of 6 months or more during any 12 consecutive months of benefits;
- the date you die

Monthly Earnings

Your gross salary or wages you were earning as of your last day of active work before your disability began. Earnings are calculated on a monthly basis. It includes your total income before taxes.

Monthly earnings include:

- Bonuses you earned average just prior to the date disability began or prior 12 month period of employment if less:
- Commissions you earned averaged over the 12 month period before disability began, or over the period of your employment, if less: and
- Contributions you were making through a salary reduction agreement to any of the following:
  - An Internal Revenue Code (IRC) Section 401(k), 403(b) or 457 deferred compensation agreement; and
  - Your fringe benefits under an IRC Section 125 plan.

The term does not include:

- Renewal commissions;
- Overtime pay;
- The Company's contributions on your behalf to any deferred compensation arrangement or pension plan; or
- Any other compensation from the Company

Benefits if You Die or Are Terminally Ill

If you die when you are disabled and entitled to receive a monthly benefit under the LTD Plan and the Insurance Provider receives valid proof of your death, your eligible survivor may receive a single sum payment equal to 6 times your monthly benefit payment if certain

requirements are met. If there are no eligible survivors, payment may be made to your estate.

Alternatively, if you are receiving monthly payments, you may elect to receive your 6-month survivor benefit prior to your death if your physician certifies in writing that you have been diagnosed with a terminal illness or condition and your life expectancy is less than 12 months. For additional information, you should refer to the Certificate of Insurance for the LTD Plan prepared by the Insurance Provider or contact the Insurance Provider. Rehabilitation and Return to Work Assistance Program

The Insurance Provider has a vocational Rehabilitation and Return to Work Assistance program available to assist you in returning to work. To be eligible for rehabilitation services and benefits, you must be medically able to engage in a return to work program. Your claim file will be reviewed by the Insurance Provider rehabilitation professionals to determine if you are eligible for the program. If eligible, the Insurance Provider will pay an additional disability benefit of 10% of your gross disability payment to a maximum benefit of $1,000 per month.

For additional information you should review the Certificate of Insurance or contact the Insurance Provider. See the section "How to Reach Your LTD Plan Service Provider" in this SPD for contact information.

Pre-existing Condition Limitation

If your disability is the result of a pre-existing condition, no benefits will be paid if you become disabled until you have been insured under the LTD Plan for 12 consecutive months after the date your disability insurance takes effect under the plan. For additional information, you should refer to the Certificate of Insurance for the LTD Plan prepared by the Insurance Provider or contact the Insurance Provider.

Limitation for Disabilities Due to Certain Conditions

If you are disabled due to a mental illness (as defined and determined by the Insurance Provider), benefits are limited to a period of 24 months during your lifetime or the maximum benefit period, if less, unless the disability results from dementia which is the result of a stroke, trauma, viral infection, Alzheimer's disease or other similar conditions, as determined by the Insurance Provider.

Temporary Recovery During Your Elimination Period

If you return to work for 30 days or less during your elimination period, those days will count towards your elimination period. However, if you return to work for more than 30 days before completing your elimination period, you must begin a new elimination period.

Recurring Disability

If you temporarily recover, return to work and suffer a relapse related to your prior disability, the disabilities would be considered one period of disability as long as your return to work was for less than 6 consecutive months. In order for long-term disability benefits to begin, you would not have to start another waiting period and your disability benefit would be based on your monthly pay immediately prior to your initial period of disability.

What Is Not Covered

The LTD Plan does not cover disabilities due to or related to any of the following:

- Any intentionally self-inflicted injury,
- Commission of a felony for which you have been convicted,
- War or any act of war (declared or undeclared),
- Loss of a professional license, occupational license or certification; or
- Active participation in a riot.

A benefit will not be paid for any period of disability when you are incarcerated.

Other Services

The LTD Plan offers other services if you become disabled, including a work life assistance program, worksite modification and a social security claimant advocacy program. For additional information regarding these services, you should review the Certificate of Insurance or contact the Insurance Provider. See the section “How to Reach Your LTD Plan Service Provider” in this SPD for contact information.

Filing a Claim

To receive long-term disability benefits, you must file a claim using a form approved by the Insurance Provider. You can obtain a claim form by contacting the Dun & Bradstreet Benefits Center or the Insurance Provider. See the section "How to Reach Your LTD Plan Service Provider" in this SPD for contact information. You should send written notice of a claim within 30 days after the date your disability begins. You must follow the instructions on the claim form, provide all the information required by the Insurance Provider to process your claim and submit all the completed forms to the Insurance Provider within 90 days of the date your disability began. If it is not possible to give proof within 90 days it must be given as soon as is reasonably possible. If you do not receive a claim form within 15 days of your request, you should send proof of your claim to the Insurance Provider without waiting for the form.

Recovery of Overpayments

The Insurance Provider has the right to recover overpayments made to you under the LTD Plan. Overpayments may be recovered by any method selected by the Insurance Provider, which may include:

- Stopping or reducing future LTD Plan benefits payable to you and any other eligible payee;
- Demanding an immediate refund of the overpayment from you; and
- Taking legal action.

If the Insurance Provider makes a payment to you that should have been made by another group plan, the overpayment will be recovered from the insurance company, other organization or individual that received the overpayment.

ADDITIONAL RULES THAT APPLY TO THIS PLAN

How Your Long-Term Disability Benefit Is Taxed

Because you pay for your long-term disability coverage with after-tax money, under current federal tax law any benefit you receive from the LTD Plan should not be considered taxable income to you. Your benefit may be taxed differently under State tax laws. You should consult with a tax adviser regarding your personal situation.

Long-Term Disability Benefits and Your Other Company Benefits

You will need to refer to the SPD for each of the other Dun & Bradstreet benefit plans to determine the plan benefits you will be eligible to receive if you are approved for LTD Plan benefit payments or your employment is terminated while you are receiving LTD benefits. You should also receive information about your other benefits in the event of a long-term disability from the Dun & Bradstreet Benefits Center at Fidelity.

Circumstances That May Result in Denial, Loss or Forfeiture of Benefits

Under certain circumstances, LTD Plan benefits may be denied or reduced from those described in this SPD, for instance if the Insurance Provider determines that you are not disabled as defined by the LTD Plan or your claim is proven to be fraudulent.

PLAN ADMINISTRATION

This information about the administration of the LTD 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 LTD Plan.

Plan Name

The name of the plan is The Dun & Bradstreet Corporation Welfare Benefit Plan. The LTD Plan for active employees 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 LTD 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 welfare benefit plan providing long-term disability benefits.

Participating Employers

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

The Dun & Bradstreet Corporation
Dun & Bradstreet Credibility Corporation
Dun & Bradstreet, Inc.

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 LTD Plan will be under the supervision of the Plan Administrator. To the fullest extent permitted by law, the Plan Administrator will have the exclusive right to determine all matters relating to eligibility, coverage, determination, interpretation and operation of the LTD Plan.

Insurance Provider

Listed below are the name, address and telephone number of the organization that insures the LTD benefits and provides related insurance services. These services include providing plan benefits, administering claims and providing customer service.

Unum Insurance Company
2211 Congress Street,
Portland, Maine 04122
1-866-779-1054

The Plan Administrator has delegated to the Insurance Provider full discretion to determine all matters relating to 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 Plan Administrator is the designated agent for service of legal process. See the section "Plan Administrator" for more information.

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 LTD Plan is January 1 through December 31.

Plan Funding

The LTD Plan is fully insured, which means the Insurance Provider assumes full responsibility for claims adjudication and payment of benefits. Participants pay 100% of the cost of coverage under the LTD Plan.

Plan Document

This SPD is intended to help you understand the main features of the LTD Plan. The insurance policy and Dun & Bradstreet legal plan document provide additional information about the administration of the LTD Plan. If there is any difference between the information in this SPD and in the insurance policy and Dun & Bradstreet legal plan document, or if there are details not covered in this SPD, the insurance policy and Dun & Bradstreet 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.

Limitation on Assignment

Your rights and benefits under the LTD Plan cannot be assigned, sold or transferred to your creditors or anyone else prior to a claim for benefits, except as required by law.

CONTINUATION OF COVERAGE

You may be able to continue coverage under the LTD Plan under certain conditions.

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.

You may continue your long-term disability coverage while on military leave pursuant to USERRA through the end of the month that immediately follows the month in which your leave of absence begins.

If you choose not to continue your long-term disability coverage while on military leave, you are generally entitled to reinstate your 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, 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.

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 LTD 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 LTD Plan. If you do not pay the required premium in a timely manner, your coverage will terminate.

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 LTD Plan will terminate.

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 LTD Plan will continue during your approved leave of absence through the end of the month that immediately follows the month in which your leave of absence begins. If your leave of absence is paid or you are receiving short-term disability benefits, the cost of your coverage will be deducted from your pay or your short-term disability benefits. If your leave of absence is unpaid, you will be responsible for paying the required premium for coverage on a timely basis or your coverage will terminate. You will be billed for the cost of coverage by the Dun & Bradstreet Benefits Center. 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

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

If your claim is denied (in whole or in part), you will receive a written notice of the denial which will explain the reasons for the denial and the appeal procedures available under the Plan. Additional information is provided below.

The Insurance Provider is responsible for determining all claims for benefits under the LTD Plan. 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 Insurance Provider. 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 same manner as claims for LTD benefits.

Authorized Representative

You may appoint an authorized representative to act on your behalf for purposes of the LTD 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 Insurance Provider for such claim or appeal. To the extent the Insurance Provider 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 LTD 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 an Insurance Provider or the Plan Administrator) does not waive the Plan's anti-assignment provisions.

Time Frame for Claim Determinations

The Insurance Provider will notify you of any adverse determination (such as any denial, reduction or termination of a benefit, rescission of disability coverage or a failure to provide or make a payment) within a reasonable period of time, but not later than 45 days after receiving the claim. This 45-day period may be extended for up to 30 days, if the Insurance Provider both determines the extension is necessary due to matters beyond the control of the LTD Plan, and notifies you, before the initial 45-day period expires, of the reason(s) requiring the extension of time and the date by which the LTD Plan expects to render a decision. If, prior to the end of the first 30-day extension period, the Insurance Provider again determines that, due to matters beyond the control of the LTD Plan, a decision cannot be rendered within that extension period, the determination period may be extended for up to an additional 30 days. In such case, the Insurance Provider must notify you, before the first 30-day extension period expires, of the reason(s) requiring the extension of time and the date by which the LTD Plan expects to render a decision.

All extension notices you receive regarding your disability benefits must specifically explain:

- The standards on which entitlement to a benefit is based.
- The unresolved issues that prevent a decision on the claim.
- The additional information needed to resolve those issues.

You have 45 days to provide the specified additional information.

In the event that an extension is necessary due to your failure to submit necessary information, the LTD Plan's time frame for making a benefit determination is tolled (i.e., stopped) from the date the Insurance Provider sends you the extension notification until the date you respond to the request for additional information. If the Insurance Provider does not receive the requested information from you within the required period, your claim will be considered without such additional information and the resulting claim determination by the Insurance Provider will be final. No additional appeals with respect to such claim will be available to you under the terms of the LTD Plan.

If You Receive an Adverse Benefit Determination

The Insurance Provider will provide you with a notification of any adverse benefit determination, which will set forth:

- The specific reason(s) for the adverse benefit determination.
- References to the specific LTD 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 LTD Plan's appeal procedures 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 determination.
- 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 LTD Plan to your medical circumstances, or a statement that such explanation will be provided free of charge upon request.

- An explanation of the basis for disagreeing with or not following (to the extent applicable) (A) the views presented by your health care professionals and vocational professionals who evaluated you, (B) the views of medical or vocational experts whose advice was obtained on behalf of the Plan, without regard to whether the advice was relied upon in making the benefit determination, and (C) a disability determination made by the Social Security Administration.
- Either the specific internal rules, guidelines, protocols, standards or other similar criteria relied upon in making the adverse determination or, alternatively, a statement that such rules, guidelines, protocols, standards or other similar criteria of the LTD Plan do not exist, and
- A statement that you are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to your claim for benefits. For purposes of these claims procedures, a document, record, or other information is treated as "relevant" to your claim if it:
  - Was relied upon in making the benefit determination.
  - Was submitted, considered, or generated in the course of making the benefit determination, regardless of whether such document, record or other information was relied upon in making the benefit determination.
  - Demonstrates compliance with the administrative processes and safeguards required in making the benefit determination.
  - Constitutes a statement of policy or guidance with respect to the LTD Plan concerning the denied benefit for your diagnosis, regardless of whether such statement was relied upon in making the benefit determination.

Procedures for Appealing an Adverse Benefit Determination

You or your authorized representative has 180 days following the receipt of a notification of an adverse benefit determination within which to appeal the determination. In connection with an appeal, you have the right to:

- Submit written comments, documents, records and other information relating to the claim for benefits.

- Request, free of charge, reasonable access to, and copies of all documents, records and other information relevant (as defined above) to your claim for benefits.
  - Constitutes a statement of policy or guidance with respect to the LTD Plan concerning the denied benefit for your diagnosis, regardless of whether such statement was relied upon in making the benefit determination.
- 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.
- If the appeal involves an adverse benefit determination based in whole or in part on a medical judgment, require the named fiduciary to consult 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.
- The identification of medical or vocational experts whose advice was obtained in connection with the adverse benefit determination, without regard to whether the advice was relied upon in making the decision.
- Receive, free of charge, any new or additional evidence considered, relied upon, or generated in making the benefit determination in connection with the claim, as well as any new or additional rationale, as soon as possible and sufficiently in advance of the notice on review to give you a reasonable opportunity to respond prior to that date.

The Insurance Provider will notify you of the LTD Plan’s benefit determination on review within a reasonable period of time, but not later than 45 days after receipt of your request for review by the LTD Plan, unless the Insurance Provider determines that special circumstances require an extension of time. If an extension of time is required, a written notice of the extension must be sent to you before the end of the initial 45-day period. The notice of the extension must indicate the special circumstances and the date by which the Insurance Provider expects to render the determination on review.

In the event an extension is necessary due to your failure to submit necessary information, the LTD Plan's time frame for making a benefit determination on review is stopped from the date the Insurance Provider sends you the extension notification until the date you respond to the request for additional information. If the Insurance Provider does not receive the requested information from you within the required period, your claim will be considered without such additional information and the resulting claim determination by the Insurance Provider will be final. No additional appeals with respect to such claim will be available to you under the terms of the LTD Plan.

The Insurance Provider's notice of an adverse benefit determination on appeal will contain all of the information that was included in the initial claim notice (described above), but it will also include the applicable contractual limitations imposed by the LTD Plan that applies to the right to bring legal action following the appeal, including the calendar date on which such period expires.

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

If you reside in a county where 10% or more of the population is literate in a non-English language (as determined in accordance with data provided by the United States Census Bureau and the United States Department of Labor), the LTD Plan will provide the following language assistance with respect to any claim relating to a determination of disability:

- Oral language services in the applicable non-English language for claims and appeals;
- Upon request, a notice in the applicable non-English language; and
- Provide in English versions of all notices, a statement prominently displayed in any applicable non-English language clearly indicating how to access the language services provided by the LTD Plan.

If the Insurance Provider does not adhere to the federal requirements for handling disability claims and appeals, you will be deemed to have exhausted the claims and appeals procedure

unless such failure was (1) de minimis; (2) nonprejudicial; (3) attributable to good cause or matters beyond the LTD Plan's control; (4) in the context of an ongoing good faith exchange of information; and (5) not reflective of a pattern or practice of non-compliance. Upon written request, you are entitled to an explanation of the LTD Plan's basis for asserting that it meets this standard within 10 days of the Insurance Provider's receipt of your request.

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 LTD 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. You must also comply with any requirements of the Insurance Provider. 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 the LTD Insurance 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 Insurance Provider 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 Insurance Provider (with respect to all matters each such party is authorized to handle) have the exclusive discretionary authority to construe and to interpret the LTD 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 LTD Plan will be paid only if the Plan Administrator or the Insurance Provider, as applicable, decides in its discretion that a participant is entitled to them.

YOUR RIGHTS UNDER ERISA

As a participant in the LTD 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.

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 welfare benefit or exercising your rights under ERISA.

Enforce Your Rights

If a 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 which 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 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 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.

NO GUARANTEE OF EMPLOYMENT

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

In accordance with ERISA, this booklet provides a summary plan description of the LTD 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.