The Dun & Bradstreet
Employee Assistance Program
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 and flexible spending account benefits to eligible active employees of Dun & Bradstreet and its related companies who participate in the plan, and their dependents. The Dun & Bradstreet Employee Assistance Program (EAP) for active Dun & Bradstreet employees (the "EAP") is part of The Dun & Bradstreet Corporation Welfare Benefit Plan and provides employee assistance benefits. This document summarizes Dun & Bradstreet's EAP, as in effect on January 1, 2026, unless otherwise noted, for employees and their eligible dependents. It describes the benefits as they apply to 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 EAP. If you have any questions about your benefits, please contact the Dun & Bradstreet Benefits Center. See the section "How to Reach Your EAP Service Provider" at the beginning of this SPD for contact information.

The legal plan document provides additional information about the administration of the EAP. 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 EAP.

The Company pays an outside provider (the "EAP Provider") a fixed fee pursuant to an administrative services agreement, and the EAP Provider assumes full responsibility for providing the benefits and claims adjudication.

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

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

HOW TO REACH YOUR EAP SERVICE PROVIDER

Here is how you can reach your Dun & Bradstreet EAP Service provider:

Provider	Contact Information
EAP Provider: ■ Aetna Resources for Living	■ 1-888-238-6232 ■ www.resourcesforliving.com Username and Access Code are both: dnb

ABOUT YOUR PARTICIPATION

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

Who Is Eligible

All employees employed by Dun & Bradstreet or a related company that participates in the EAP are eligible for EAP benefits.

Dependent Eligibility

Members of an eligible employee's household are also entitled to use the EAP. This includes anyone who lives with the employee, including the employee's spouse, domestic partner, dependent children under age 26, adult children and housemates.

When Coverage Begins

Coverage for you and your eligible dependents will begin on your employment date.

Paying for Coverage

Dun & Bradstreet pays the full cost of coverage for you and your eligible dependents.

When Coverage Ends

Coverage under the EAP will end for you at the end of the month when any one of the following occurs:

- You terminate employment for any reason,
- Dun & Bradstreet terminates the EAP,
- You are no longer eligible for benefits, or
- You die.

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

- Dun & Bradstreet terminates all dependent coverage under the EAP,
- Dun & Bradstreet terminates the EAP,
- Your dependent is no longer eligible for benefits,
- Your coverage terminates, 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 EAP, coverage will end on the date of the EAP termination. You or your eligible dependents may be able to continue Dun & Bradstreet EAP coverage through the Consolidated Omnibus Budget Reconciliation Act (COBRA).

HOW THE EAP WORKS

Confidentiality

The Dun & Bradstreet EAP offers you and members of your household with confidential personal assistance with personal situations which become overwhelming. You may elect to call the EAP yourself for assistance, or your immediate supervisor may ask you to seek help from an EAP counselor if your job performance is impacted by your personal concerns.

Please note that voluntary use of the EAP is confidential and no information regarding your self-referral will be released to Dun & Bradstreet without your prior written consent.

Whenever participation in the EAP or compliance with program recommendations are required by Dun & Bradstreet as part of employee counseling or in conjunction with a formal warning or disciplinary action, the EAP Provider will release the following information to Dun & Bradstreet, provided you sign a written release to do so:

- Whether or not you kept the appointment,
- Whether you have complied with and completed recommendations for treatment.
- Whether or not you will require time off from work for treatment.

The EAP Provider, by law, must disclose credible threats of serious harm to self or others, including child, elder and disabled-person abuse.

What is Covered

The primary reason for offering you an EAP is to provide you with the resources necessary to deal with any personal issues that may affect your job performance and well-being.

Through the confidential assistance available from professional counselors and, if necessary, with referred treatment options, you and/or members of your household may obtain assistance in finding resolutions to personal issues which may interfere with emotional well-being or job performance, including but not limited to:

- Relationships — marriage, family, friends and coworkers,
- Addiction — alcohol, drugs, gambling,
- Depression and anxiety,
- Emotional concerns,
- Co-dependence,
- Work,
- Legal matters,
- Housing,
- Parenting,
- Lifestyle,
- Grief and loss,
- Stress,
- Adult children of alcoholics,
- Financial,
- Daycare,
- Retirement, and
- Eating disorders.

The Dun & Bradstreet EAP provides the following types of services, which are described below:

- Telephone counseling,

- Short-term counseling
- Chat therapy
- Referrals to community resources
- Legal resources
- Identity theft resolution services
- Financial resources
- Mind Companion Self-Care

Telephone Counseling

Under the EAP, you and your eligible dependents have access to a behavioral health assessment by telephone. See the section "How to Reach Your EAP Service Provider" at the beginning of this SPD for contact information. EAP consultants are available 24 hours a day, seven days a week. When you call, an EAP consultant will work with you to:

- **Clarify the problem** — Help you understand the issues that caused you to seek help,
- **Identify options** — Explore alternatives for addressing the problem,
- **Develop a plan** — Determine a course of action customized to meet your needs, and
- **Help you follow through** — Work with you to help you achieve your treatment goals.

The EAP consultant will refer you to a community resource or another behavioral health care provider (See the section "Referrals" in this SPD for more information).

Short Term Counseling

During the telephone assessment, your EAP consultant may recommend face-to-face or tele video confidential counseling sessions. The program covers up to five face-to-face or tele video EAP sessions per problem type.

During the face-to-face or tele video counseling, the EAP counselor may:

- Provide feedback to help you put your problem in perspective.
- Help you with your coping skills.
- Serve as someone you can talk to in times of stress.

In some cases, follow-up sessions may be necessary. If you use all five sessions and need further assistance, the EAP consultant will refer you to other behavioral health resources.

Chat Therapy

Members can use chat therapy to connect with a counselor virtually. With chat therapy you share secure text messages whenever you like and your counselor will respond within one working day up to five days a week.

Referrals

Your EAP consultant may refer you to another community resource or behavioral health provider in these instances:

- He or she determines that you need long-term or more intensive assistance beyond the scope of the EAP.
- You have used up all five of your face-to-face or tele video sessions for a specific problem and need further assistance.

Legal Resources

Members receive a 30-minute telephonic or face-to- face attorney consultation, per each new issue, for any number of issues. There is a 25 percent discount with the attorney or mediator beyond the initial 30 minutes.

Identity Theft Resolution

Provides members with a 60-minute free consultation with a highly trained Fraud Resolution Specialist™ and conducts seven emergency response activities. Also, provides members with a free "ID Theft Emergency Response Kit™".

Financial Resources

Members receive a 30-minute telephonic financial consultation, per each new issue, per year. Members may also access online resources such as articles and calculators.

Mind Companion Self-Care

We now provide Mind Companion Self-Care, a unique online emotional wellness portal utilizing CCBT (Cognitive Computerized Cognitive Behavioral Therapy). It can help your employees with mild or moderate depression, anxiety, relationships, and other issues via a self-progressing personalized program. The program offers practical ways to improve emotional and overall well-being through eLearning programs, simple tools, trusted resources and daily motivation.

If appropriate, the EAP Provider may refer you to a medical service provider for further care. In the event of such a referral, you should check with your medical plan provider, if any, to determine if the expenses resulting from this additional care will be covered under your medical plan. You will be responsible for any expenses not covered by your medical plan.

How to Receive Benefits

Here's how you can receive EAP benefits:

- **Call EAP:** You will be connected with an EAP consultant who can assist you with your concerns. See the section "How to Reach Your EAP Service Provider" at the beginning of this SPD for contact information.
- **Receive counseling or advice**: In most cases you will be able to speak with an EAP consultant immediately.

Schedule a face-to-face or tele video assessment: The EAP consultant will schedule an appointment for a confidential assessment session as quickly as possible. Every effort will be made to accommodate your location and work schedule.

Refer you to a qualified professional, if applicable. The EAP consultant will refer you to a qualified professional in your community if you need additional assistance.

Self – service through Access Plus: The EAP also offers capabilities that allow for quick and easy access to a provider through self-service scheduling and automated authorizations through Access Plus. Members can search and filter based on their individual preferences, view provider biographies online, and have consultations to find a best fit provider. Access Plus is an outcome driven clinical network partnering with diverse counselors who offer a broad range of clinical interventions using best-in-class assessments.

What is Not Covered

The EAP does not cover the following services:

- Services provided before you were covered under the EAP,
- Face-to-face or tele video assessment sessions in excess of five sessions per problem type,
- Services not provided or coordinated by the EAP, and
- Medical expenses you incur as the result of a referral to a medical plan service provider.
- Diagnostic testing and/or treatment.
- Visits with psychiatrist, including medication management.
- Prescription medications.
- Services for remedial education.
- Inpatient, residential treatment, partial hospitalizations, intensive outpatient.
- Ongoing counseling for a chronic diagnosis that requires long term care.

- Biofeedback.
- Hypnotherapy.
- Aversion therapy.
- Examination and diagnostic services required to meet employment, licensing, insurance coverage, travel needs.
- Services with a non-contracted EAP provider.
- Fitness for duty evaluations.
- Legal representation in court, preparation of legal documents, or advice in the areas of taxes, patents, or immigration, except as otherwise described in this document.
- Investment advice (nor does the plan loan money or pay bills).

ADDITIONAL RULES THAT APPLY TO THE EAP

The following rules apply to the EAP.

Qualified Medical Child Support Order (QMCSO)

The EAP 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 EAP to cover a child of a participant under the EAP. 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 EAP's procedure for determining if the order is valid. Coverage under the EAP 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 EAP Service Provider" at the beginning of this SPD for contact information.

PLAN ADMINISTRATION

This information about the administration of the Dun & Bradstreet Employee Assistance Program 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 Dun & Bradstreet Employee Assistance Program.

Plan Name

The name of the plan is The Dun & Bradstreet Corporation Welfare Benefit Plan. The Dun & Bradstreet Employee Assistance Program 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 Dun & Bradstreet Employee Assistance Program 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 Dun & Bradstreet Employee Assistance Program is a welfare benefit plan providing behavioral health benefits.

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 (prior to July 1, 2026)
For a current 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 Dun & Bradstreet Employee Assistance Program 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 Dun & Bradstreet Employee Assistance Program.

EAP Provider

Dun & Bradstreet has contracted with an EAP service provider to provide EAP services.

The name, address, and telephone number of the EAP Provider are:

Aetna Resources For Living

151 Farmington Avenue RSAA

Hartford, CT 06156

1-888-238-6232

The Plan Administrator has delegated to the EAP Provider full discretion to determine all matters relating to service 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:

Aetna Resources for Living

Re: Dun & Bradstreet EAP

151 Farmington Avenue RSAA

Hartford, CT 06156

1-888-238-6232

Legal process may also be served on the Plan Administrator. See the section "Plan Administrator" for more information.

Identification Numbers

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

Plan Year

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

Organization Providing Administrative Services

Dun & Bradstreet has delegated day-to-day operations of the Dun & Bradstreet Employee Assistance Program 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 cost of providing Dun & Bradstreet Employee Assistance Program coverage is paid from the general assets of Dun & Bradstreet. Dun & Bradstreet has contracted with the EAP Provider to administer the Dun & Bradstreet Employee Assistance Program.

Plan Document

This SPD is intended to help you understand the main features of the Dun & Bradstreet Employee Assistance Program. The legal plan document provides additional information about the administration of the Dun & Bradstreet Employee Assistance Program. 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 Dun & Bradstreet Employee Assistance Program, in whole or in part, by action of the Plan Benefits Committee appointed by the Company's Board of Directors. Dun & Bradstreet Employee Assistance Program amendment, modification, suspension or termination may be made for any reason, and at any time.

Limitation on Assignment

Your rights and benefits under the plan cannot be assigned, sold or transferred to your creditors or anyone else.

CONTINUATION OF COVERAGE

COBRA Continuation

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 EAP. It may also become available to your spouse and dependent children who are covered under the EAP when they would otherwise lose such coverage.

The EAP provides extended coverage at no cost automatically for the entire period that you or your dependent would be entitled to elect COBRA continuation coverage following a qualifying event. This means that:

- EAP coverage will continue automatically for an additional 18 months if you or your dependents lose coverage because your employment terminates (other than on account of your gross misconduct). This coverage will be extended for up to an additional 11 months if you or your dependents become disabled for Social Security Administration purposes.

- EAP coverage will continue automatically for up to an additional 36 months if your dependents lose coverage because of your death or divorce or legal separation or your child stops being eligible for coverage as a "dependent child."

You and your dependents will not be required to elect or pay for EAP COBRA continuation coverage following a qualifying event. After this period ends, you will not be entitled to any additional EAP coverage. If you have any questions, you should contact the Dun & Bradstreet Benefits Center.

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 who enter military service. Upon reinstatement, you are entitled to the seniority, rights and benefits associated with the position held at the time employment was interrupted, plus additional seniority, rights and benefits that would have been attained if employment had not been interrupted.

During your military leave, EAP coverage will continue automatically for you and your eligible dependents for 24 months after your leave begins (even if your military leave ends during this period and you do not return to work). At the end of the 24-month period, your EAP coverage will terminate unless you return (or have already returned) to work at that time. Any COBRA continuation period for which you or your dependents are eligible will run concurrently with any USERRA continuation period. Therefore, after this 24-month period ends, you and/or your dependents will not be entitled to elect continued EAP coverage through COBRA.

If your EAP coverage terminates while on military leave, you are entitled to reinstated health coverage with no waiting periods or exclusions (however, an exception applies to service-related disabilities) when you return from leave.

In general, to be eligible for the rights guaranteed by USERRA, you must:

- Return to work on the first full, regularly scheduled workday following military service, your safe transport home, and an eight-hour rest period 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 military service is from 31 to 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 their EAP benefits shall continue 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;
- 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"); or
- 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.

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

CLAIMS AND APPEALS PROCESS

This section describes procedures for filing claims and your rights to appeal an adverse benefit determination under the EAP. The Claims Administrator is the EAP Provider. See the section "Plan Administration" for the name and address of the EAP Provider.

Filing Claims Under the Plan

You may file claims for plan benefits, and appeal adverse claim decisions, either yourself or through an authorized representative. All claims must be submitted in writing to the Claims Administrator.

An "authorized representative" means a person you authorize, in writing, to act on your behalf. You must follow the Plan's procedures for appointing an authorized representative. The Plan will also recognize a court order giving a person authority to submit claims on your behalf. Appointing an individual or entity as your authorized representative is not an assignment of rights or benefits under the EAP and any such appointment does not waive the Plan's anti-assignment provisions.

The Claims Administrator is responsible for determining all claims for EAP 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.

If You Receive an Adverse Benefit Determination

If your claim is denied in whole or in part, you will receive a written notice of the denial from the Claims Administrator not later than 30 days after receipt of the claim. This time period 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 30 day period. For example, it 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).

You will be notified of any adverse benefit determination. This notice will include:

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

Procedures for Appealing an Adverse Benefit Determination

If you receive an adverse benefit determination, you may ask for a review. 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. 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 60 days after the appeal is received.

You have certain rights with respect to your appeal, including 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 to your claim for benefits. For this purpose, 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 EAP 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.
- 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 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.

The Claims Administrator's notice of an adverse benefit determination on appeal will contain all of the following information:

- The specific reason(s) for the adverse benefit determination.
- References to the specific EAP provisions on which the benefit determination is based
- 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.
- A statement describing any voluntary appeal procedures offered by the EAP and your right to obtain the information about such procedures, and a statement of your right to bring an action under ERISA.
- 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 behavioral health 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 EAP to your specific circumstances, or a statement that such explanation will be provided free of charge upon 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 exhaust this EAP's administrative claims and appeals procedure before bringing a suit in court. 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 must be filed within two years after receiving an adverse benefit determination or, if the requirement to exhaust your administrative remedies in a timely manner does not apply, within two years of the date the claim arose. In addition, it must only be brought or filed in a federal court in the Middle District of Florida.

Failure to follow this EAP'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.

Discretionary Authority

The Plan Administrator and the Claim Administrator (with respect to all matters delegated to the Claims Administrator) have the exclusive discretionary authority to construe and to interpret the EAP, 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 EAP will be provided 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 EAP, 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.

- Reduction or elimination of exclusionary periods of coverage for preexisting conditions under your group health plan, if you have creditable coverage from another plan. You should be provided a certificate of creditable coverage, free of charge, from your group health plan or health insurance issuer when you lose coverage under the plan, when you become entitled to elect COBRA continuation coverage, when your COBRA continuation coverage ceases, if you request it before losing coverage, or if you request it up to 24 months after losing coverage. Without evidence of creditable coverage,

you may be subject to preexisting condition exclusion for 12 months (18 months for late enrollees) after your enrollment date in your coverage.

Prudent Actions by Plan Fiduciaries

In addition to creating rights for plan participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate your plan, called "fiduciaries" of the plan, have a duty to do so prudently and in the interest of you and other plan participants and beneficiaries. No one, including your employer 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 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 EAP 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.

For details about HIPAA privacy regulations and your rights with regard to this information, please contact your local Human Resources representative.

NO GUARANTEE OF EMPLOYMENT

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

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