# The Dun & Bradstreet Vision Plan
# Summary Plan Description
# for Active Employees

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Effective January 1, 2026

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 Vision Plan for active employees (the "Vision Plan" or "Plan") is a part of The Dun & Bradstreet Corporation Welfare Benefit Plan and provides vision benefits to active employees. This document summarizes the Dun & Bradstreet Vision Plan, as in effect on January 1, 2026, 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 Vision Plan. If you have any questions about your benefits, please contact the Dun & Bradstreet Benefits Center at Fidelity. See the section, "How to Reach Your Vision Plan Service Provider" at the beginning of this SPD for contact information.

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

The Vision Plan is fully insured through an outside insurance company (the "Insurance Provider"). Dun & Bradstreet has contracted with a third-party vendor (the "Claims Administrator") to perform claims processing and other administrative services with respect to the Vision Plan.

Day-to-day operations of the Vision 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 Vision Service Provider" at the beginning of this SPD for contact information.

# HOW TO REACH YOUR VISION PLAN SERVICE PROVIDER

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

| Provider | Contact Information |
|---|---|
| **Administrative Services:**<br>■ Dun & Bradstreet's Benefits Center at Fidelity | ■ 1-877- 362-8953 (or 1-888-343-0860 for the hearing impaired)<br>■ http://netbenefits.fidelity.com |
| **Claims Administrator:**<br>■ EyeMed Vision Care, LLC | ■ www.eyemed.com<br>■ 1-866-800-5457 (Monday – Saturday, 7:30 am to 11:00 pm EST and Sunday 11:00 am to 8:00 pm EST)<br>■ Submit out-of-network claims to:<br>FAA/EyeMed Vision Care, LLC<br>Attn: OON Claims<br>P.O. Box 8504<br>Mason, OH 45040-7111<br>■ Submit appeals for denied claims to:<br>FAA/EyeMed Vision Care, LLC<br>Attn: Quality Assurance Dept.<br>4000 Luxottica Place<br>Mason, OH 45040<br>Fax: 513.492.3259<br>Email: eyemedqa@eyemed.com |

# ABOUT YOUR PARTICIPATION

This section contains important information about your participation in the Vision 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 Vision Plan if you meet all of the following conditions:

- You are an active full-time or part-time employee employed by a Dun & Bradstreet or a related company that participates in the Vision 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 Vision 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 Vision 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 Vision 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),
- Foster children
- Stepchildren, and
- Children placed in your care by 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 Vision Plan before age 26, and
2. the proof of disability was approved by the Plan Administrator (or the Insurance Provider or Claims Administrator) within the required time period.

If your child's eligibility for continued coverage on account of a disability is not certified, 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 may require that a physician chosen by the Plan Administrator (or the Insurance Provider or Claims 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 Plan may review and re-certify your child's eligibility for continued coverage at its discretion from time to time.

### *Domestic Partner Eligibility*

Your domestic partner may be eligible for coverage under the Vision 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 Vision 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 vision 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 coverage under the Vision 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 Vision 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 Vision 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 pay the full cost of vision coverage. You pay 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 vision 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)*

The cost of the Vision Plan is the same for a domestic partner as it is for a spouse. However, due to IRS regulations, the cost of coverage is treated differently for tax purposes.

You will pay for your share of the cost of ***your coverage*** with pre-tax dollars. If you cover a domestic partner, your contribution for your domestic partner's coverage, as well as coverage for your child(ren) and the child(ren) of your domestic partner, are deducted from your pay on an after-tax basis.

If your domestic partner and his/her child(ren) qualify 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 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 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 Vision Plan Service Provider" at the beginning of this SPD for contact information.

## When Coverage Ends

Coverage under the Vision 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 vision 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 Vision Plan, coverage will end on the date of the Vision Plan termination. You or your eligible dependents may be able to continue your vision 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 Vision Plan.

If the Plan Administrator determines that you or your dependent have engaged in fraud or intentionally misrepresented a material fact in connection with the Vision 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 Vision 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 Vision 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 Vision 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, if you have or adopt a child, you can add the child to the Vision Plan, but you would not be able to drop vision 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 Vision 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 Vision 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 permissible mid-year election change include:

- Changes consistent with the special enrollment rights under the Health Insurance Portability and Accountability Act (HIPAA).
- 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 Vision 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 Vision Plan.
- Cost Changes
  - Automatic changes. If the cost of your Vision Plan increases (or decreases) during a period of coverage and, under the terms of the Vision 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 Vision 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 Vision 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 Vision 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.

— 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 Vision Plan, you may revoke your election under the Vision 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 available participating providers, and

  – 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 Vision 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 Vision 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 Vision 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 Vision 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.

### *Examples of Situations Where You Can Make Changes to Your Vision Coverage During the Year*

The following table provides some examples of the types of changes you may be able to make to your Vision 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 Vision Plan benefits. See the section "How to Reach Your Vision 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.

| 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 vision coverage to enroll under your spouse's or domestic partner's plan. | ■ You may add your new spouse/domestic partner and/or your and your spouse's/domestic partner's |

| Status Change | Allowable Changes to Your Coverage | Allowable Changes to Your Dependent Coverage (You must be enrolled in coverage to enroll your dependents) |
|---|---|---|
| | ■ You can enroll in vision coverage for the first time along with your spouse/domestic partner. | dependent child(ren) as dependents under your Vision Plan. |
| Divorce or end of an eligible domestic partner relationship | ■ If you are not enrolled in the Vision 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 Vision Plan, you must terminate coverage for the divorced spouse or domestic partner (he or she may be eligible for coverage under COBRA).<br>■ You can enroll your dependents who were previously enrolled in and lose eligibility for your spouse's/domestic partner's plan in the Vision 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.<br>■ If you are not enrolled in the Vision 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 Vision Plan. |
| Death of a spouse/domestic partner or dependent | ■ If you are not enrolled in the Vision Plan because you were enrolled in your spouse's/domestic partner's vision plan, you can enroll for the first time. | ■ Coverage for your spouse/domestic partner or dependent will end.<br>■ You can enroll your dependents who were previously enrolled in your spouse's/domestic partner's vision 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 Vision 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) to your current Vision Plan. |
| Your spouse/domestic partner obtains coverage because his or her employment begins or changes | ■ You may waive out of your current vision coverage to enroll under your spouse's or domestic partner's plan. | ■ You may terminate coverage under the Vision Plan for your spouse/domestic partner and your covered dependents so they can enroll in the spouse's/domestic partner's vision plan. |
| The issuance of a Qualified Medical Child Support Order | ■ If you are not enrolled in the Vision Plan, you must | ■ You may add coverage for your dependent child(ren), as required by the QMCSO. |

| Status Change | Allowable Changes to Your Coverage | Allowable Changes to Your Dependent Coverage (You must be enrolled in coverage to enroll your dependents) |
|---|---|---|
| (QMCSO) for a dependent child | enroll in order to cover your dependent child(ren). | |
| Termination of coverage under another employer's COBRA coverage, through no fault of your own | ■ If you are not enrolled in the Vision 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 Vision 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 Vision 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 Vision Plan Coverage |
|---|---|
| ***Are approved for an LTD leave prior to January 1, 2021 and you terminate employment at a time when you:***<br>■ Are totally and permanently disabled (as determined by the Dun & Bradstreet LTD Plan claims administrator); and<br>■ Have completed 10 years of Eligibility Service (as defined below) after age 22. | You may continue Vision Plan coverage for you and your eligible dependents.<br>In order to continue vision coverage:<br>■ The Dun & Bradstreet LTD Plan claims administrator must certify, in its complete discretion, your ongoing long-term disability; *and*<br>■ You must make the necessary contributions on a timely basis to pay the cost of continued vision coverage.<br>If your benefits under the Dun & Bradstreet LTD Plan terminate for any reason, your continued participation in the Vision 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:***<br>■ Are totally and permanently disabled (as determined by the Dun & Bradstreet LTD Plan claims administrator). | You may continue Vision Plan coverage for you and your eligible dependents for a period of 6 months.<br>In order to continue medical coverage:<br>■ The Dun & Bradstreet LTD Plan claims administrator must certify, in its complete discretion, your ongoing long-term disability; *and*<br>■ You must make the necessary contributions on a timely basis to pay the cost of continued vision coverage.<br>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 Vision Plan will terminate at the end of the month in which 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 Vision 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 VISION PLAN

EyeMed Vision Care, LLC ("EyeMed") provides vision care services under the Vision Plan.

## How Your Vision Plan Works

EyeMed offers a network of vision care providers, including independent optometrists, ophthalmologists, opticians and retail outlets such as LensCrafters, Target Optical, and most Pearle Vision, locations. In addition, EyeMed, in conjunction with LCA Vision, offers a laser correction discount provided by the U.S. Laser network to all EyeMed members.

When you use EyeMed providers, your vision expenses are covered as shown in the chart below. You may also receive services from an out-of-network provider, but you will receive a higher level of benefits if you visit an in-network provider.

To locate EyeMed Vision Care providers near you, visit EyeMed's website or call EyeMed. The network name for your plan is the "Insight" network. See the section "How to Reach Your Vision Plan Service Provider" at the beginning of this SPD for contact information.

### *Your Benefits*

| | Your In-Network Cost | Your Out-of-Network Reimbursement |
|---|---|---|
| **Exam** | $0 co-pay | Up to $50 |
| Dilation as necessary | $0 | |
| Refraction | $0 | |
| **Retinal Imaging** | Up to $39 | N/A |
| **Exam Options – Contact Lenses** | | |
| Standard Fit and Follow-Up | Up to $40 | N/A |
| Premium Fit and Follow-Up | 90% of retail price | N/A |
| **Frames** | $0 copay, plus 80% of balance over $150 | Up to $70 |
| **Standard Plastic Lenses** | | |
| Single Vision | $10 copay | Up to $50 |
| Bifocal | $10 copay | Up to $75 |

| | | |
|---|---|---|
| Trifocal | $10 copay | Up to $ 100 |
| Lenticular | $10 copay | Up to $125 |
| Standard Progressive | $35 copay | Up to $75 |
| Premium Progressive | | |
| • **Tier 1** | $45 copay | Up to $75 |
| • **Tier 2** | $55 copay | Up to $75 |
| • **Tier 3** | $70 copay | Up to $75 |
| • **Tier 4** | $35, 80% of charge less $120 allowance | Up to $75 |
| **Standard Lens Options** | | |
| UV coating | $15 | N/A |
| Tint (solid and gradient) | $15 | N/A |
| Standard scratch resistance | $15 | N/A |
| Standard polycarbonate – Adults | $15 copay | Up to $28 |
| [Standard polycarbonate – Kids Under 19 | $0 copay | Up to $28 |
| Standard anti-reflective coating | $45 | N/A |
| Premium anti-reflective coating | | |
| • **Tier 1** | $57 | N/A |
| • **Tier 2** | $68 | N/A |
| • **Tier 3** | 80% of charge | N/A |
| Polarized | 80% of retail price | N/A |
| Photochromatic / Transitions Plastic | $75 | N/A |
| Other add-ons and services | 80% of retail price | N/A |
| **Contact Lenses*** | | |
| Conventional | $0 copay, plus 85% of balance over $150 | Up to $105 |
| Disposable | $0 copay, plus 100% of balance over $150 | Up to $105 |
| Medically necessary | $0 (paid in full by Plan) | Up to $210 |

| | | |
|---|---|---|
| **LASIK or PRK from US Laser Network** | 85% of retail price<br>or<br>95% of promotional price<br>Whichever is less | N/A |
| **Frequency** - based on **Calendar Year** | | |
| Exam | Once every **12** months | Once every **calendar year** |
| Lenses or Contact Lenses | Once every **12** months | Once every **calendar year** |
| Frames | Once every **12** months | Once every **calendar year** |
| **Lasik** | Once Per Lifetime | Once Per Lifetime |

* For prescription contact lenses for only one eye, the Plan will pay one-half of the amount payable for contact lenses for both eyes.

### *Using In-Network and Out-of Network Providers*

You can choose to receive care from an in-network provider who is part of the EyeMed network or from an out-of-network provider. You will receive a higher level of benefits if you visit an in-network provider.

When you make an appointment with an EyeMed participating provider for yourself or your dependent, you should –

- Identify yourself as an EyeMed member and a Dun & Bradstreet employee;
- Provide your name and the unique EyeMed member ID number (located on the front of your ID card).

When you receive services at an EyeMed network provider, the provider will file your claim. You will have to pay the cost of any services or eyewear that exceeds any allowances and any applicable co-payments. You will also owe state tax, if applicable, and the cost of non-covered expenses (for example, vision perception training).

You can request a list of in-network providers, at no charge, by contacting EyeMed. See the section "How to Reach Your Vision Plan Service Provider" at the beginning of this SPD for EyeMed's contact information.

If you elect to use an out-of-network provider, you must pay the provider the full cost of services and supplies you receive at the point of service, and then file a claim with EyeMed for reimbursement up to the out-of-network maximums as outlined in the chart above. Additional information regarding filing claims is located later in this SPD.

### *What is covered*

The following benefits are covered under the Vision Plan:

- One comprehensive eye exam, once every calendar year.
- One basic frame every calendar year
- Basic lenses (standard plastic lenses), once every calendar year. Covered lenses include single, bifocal and trifocal. Progressive (standard and premium) lenses are also covered.
- Elective contact lenses (not prescribed as medically necessary) in lieu of lenses, once every calendar year.
- Medically necessary contact lenses, in lieu of lenses, once every calendar year.

### *Discount Program*

The Vision Plan also provides an in-network discount on products and services once your in-network benefits for the applicable benefit period have been used. The in-network discounts are as follows:

- 40% discount off retail price on additional complete pairs of eyeglasses (frame, lenses and lens options must be purchased at same time), including prescription sunglasses, after benefit has been used.
- 15% discount off retail price on conventional contact lenses after benefit has been used.
- 20% discount off items not covered by the Vision Plan at in-network providers.
- 15% discount off retail price or 5% off promotional price for laser vision correction, including LASIK and photorefractive keratectotomy (PRK), whichever is less, if you

use a participating laser surgeon through the U.S. Laser Network, owned and operated by LCA Vision. Additional information regarding the LASIK and PRK benefit is provided below.

For additional information or to locate a network provider, you should contact EyeMed.

These in-network discounts may not be combined with any other discounts or promotional offers. Discounts do not apply to a provider's professional services, disposable contact lenses or certain brand name vision materials in which the manufacturer imposes a no-discount practice or policy. In addition, discounts on services may not be available at all participating providers. Prior to your appointment, you should confirm with your provider whether discounts are offered.

### *Medically Necessary Contact Lenses*

The Vision Plan provides coverage for medically necessary contact lenses when one of the following conditions exists:

- **Anisometropia** of 3D in meridian powers.
- **High Ametropia** exceeding –10D or +10D in meridian powers.
- **Keratoconus** where the member's vision is not correctable to 20/30 in either or both eyes using standard spectacle lenses.
- **Vision Improvement** for members whose vision can be corrected two lines of improvement on the visual acuity chart when compared to best corrected standard spectacle lenses

The benefit may not be expanded for other eye conditions even if you or your providers deem contact lenses necessary for other eye conditions or visual improvement.

### *Savings on Laser Vision Correction*

To activate your savings on laser vision correction, you should locate a U.S. Laser Network provider. For additional information or to locate a network provider, you should visit www.eyemedlasik.com or call 1-877-5LASER6. After you have located a U.S. Laser Network provider, you should contact the provider, identify yourself as an EyeMed member

and schedule a consultation to determine if you are a good candidate for laser vision correction. If you are a good candidate and schedule treatment, you must call the U.S. Laser Network again at 1-877-5LASER6 to activate the discount.

At the time treatment is scheduled, you will be responsible for an initial refundable deposit to the U.S. Laser Network. Upon receipt of the deposit, and prior to treatment, the U.S. Laser Network will issue an authorization number to your provider. Once you receive treatment, the deposit will be deducted from the total cost of the treatment. On the day of treatment, you must pay or arrange to pay the remaining balance of the fee. Should you decide against the treatment, the deposit will be refunded.

You are responsible for scheduling any required follow-up visits with the U.S. Laser network provider to ensure the best results from your laser vision correction procedure.

### *Mail Order Contact Lens Replacement Program*

A contact lens replacement website is available. To place an order go to www.contactsdirect.com. Simply complete the online transaction form and your contact lenses will be delivered directly to your home. For quality purposes, your order and prescription will be validated with your eye care provider. Please note that this service is for replacement lenses only.

### *What is not covered*

The Vision Plan does not cover certain services or materials, including:

- Orthoptics or vision training, subnormal vision aids and any associated supplemental testing.
- Aniseikonic lenses.
- Medical and/or surgical treatment of the eye, eyes or supporting structures.
- Any eye or vision examination, or any corrective eyewear required by an employer as a condition of employment.
- Safety eyewear.

- Services provided as a result of any Workers' Compensation law, or similar legislation, or required by any governmental agency or program whether federal, state or subdivisions thereof.
- Plano (non-prescription) lenses and/or contact lenses.
- Non-prescription sunglasses.
- Two pair of glasses (frames and lenses) in lieu of bifocals.
- Services or materials provided by any other group benefit plan providing vision care.
- Services rendered after the date a participant ceases to be covered under the Vision Plan, except when vision materials ordered before coverage ended are delivered, and the services rendered to the participant are within 31 days from the date of such order.
- Lost or broken lenses, frames, glasses, or contact lenses will not be replaced except in the next plan year when vision materials would next become available.
- Benefit allowances provide no remaining balance for future use within the same plan year.
- Benefits may not be combined with any discount, promotional offering, or other group benefit plan providing vision care.
- Certain brand name vision materials in which the manufacturer imposes a no-discount practice.
- Experimental vision services, treatments and materials.
- Cosmetic services and materials.

Please contact EyeMed to confirm whether or not your service will be covered. See the section "How to Reach Your Vision Plan Service Provider" at the beginning of this SPD for contact information.

## Filing a Claim

If you use an EyeMed network provider for care, the provider should file the claim for you.

For out-of-network benefits, you must pay the provider for the services and supplies that you receive at the time of your visit and file a claim for reimbursement. You must complete and sign an out-of-network claim form, attach proper documentation of your claim, including the provider's name, the date services were received any bills or receipts, and send to EyeMed. You can download a claim form from EyeMed's web site or request one by calling EyeMed directly. See the section "How to Reach Your Vision Plan Service Provider" at the beginning of this SPD for contact information.

**Out-of-network claim forms** can be obtained online and must be sent to First American Administrators, Inc. ("FAA"), a wholly-owned subsidiary of EyeMed at the following address:

FAA/EyeMed Vision Care, LLC
Attn: OON Claims
P.O. Box 8504
Mason, OH 45040-7111

Online out-of-network claim form: click here

### *Claims Filing Deadline*

You must file all claims for vision expenses within 15 months of when you incurred the expense. If you do not file claims on a timely basis, your claim 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 billing. In addition, the service must be completed to be considered a covered expense.

# ADDITIONAL RULES THAT APPLY TO THE VISION PLAN

The following rules apply to the Vision Plan.

## Qualified Medical Child Support Order (QMCSO)

The Vision 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 a 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 Vision Plan's procedure for determining if the order is valid. Coverage under the Vision 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 Vision Plan Service Provider" at the beginning of this SPD for contact information.

## Recovery of Overpayment

If a benefit payment is made by Claims Administrator, to or on behalf of any person, which exceeds the benefit amount such person is entitled to receive in accordance with the terms of the group contract, this plan has the right to:

- Require the return of the overpayment on request; or
- Reduce by the amount of the overpayment, any future benefit payment made to or on behalf of that person or another person in his or her family.

Such right does not affect any other right of recovery this plan may have with respect to such overpayment.

# PLAN ADMINISTRATION

This information about the administration of the 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 plan.

## Plan Name

The name of the plan is The Dun & Bradstreet Corporation Welfare Benefit Plan. The Vision 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 Vision 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 vision 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 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 Vision 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 Vision Plan.

## Insurance Provider

The vision coverage provided under the Vision Plan is insured through Combined Insurance Company of America. Dun & Bradstreet has contracted with a third party administrator (the "Claims Administrator") to perform claims processing and other administrative services with respect to the Vision Plan.

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

*EyeMed Vision Care*

*Submit out-of-network claims to:*

FAA/EyeMed Vision Care, LLC
Attn: OON Claims
P.O. Box 8504
Mason, OH 45040-7111
Phone: 1-866-804-0982

*Submit appeals for denied claims to:*

FAA/EyeMed Vision Care, LLC
Attn: Quality Assurance Dept.
4000 Luxottica Place
Mason, OH 45040
Phone: 1-866-804-0982

The Plan Administrator has delegated to the Claims Administrator full discretion to determine all matters relating to vision 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 of The Dun & Bradstreet Corporation Welfare Benefit Plan is 501.

## Plan Year

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

## Organizations Providing Administrative Services

Day-to-day operations of the Vision 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 Vision Plan is fully insured, which means the Insurance Provider assumes full responsibility for payment of benefits. Participants pay 100% of the cost of coverage under the Vision Plan.

## Plan Document

This SPD is intended to help you understand the main features of the Vision Plan. The legal plan document provides additional information about the administration of the Vision 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 Payment

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 Vision 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 Vision Plan. It may also become available to your spouse and dependent children who are covered under the Vision 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 Vision 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 Vision 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 Vision 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 Vision 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 Vision 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 Vision 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 Vision 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 Vision 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 of the qualifying event. See the section "How to Reach Your Vision 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 Vision Plan as a result of the qualifying event (or second qualifying event). You must notify the Dun & Bradstreet Benefits Center. See the section "How to Reach Your Vision 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 employees 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 Vision 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 Vision 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 Vision 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 Vision 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 Vision 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 Vision 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 Vision Plan. See the section "How to Reach Your Vision 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 Vision Plan as a dependent child, but only if the event would have caused the spouse or dependent child to lose coverage under the Vision 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 Vision 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 Vision 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 Vision 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 employee and employer 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 of 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 Dun & Bradstreet 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 Vision Plan. **Payment is considered made on the date it is sent to the Dun & Bradstreet Benefits Center (on behalf of the Vision 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 Vision 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;
- 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 (and retirees).

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

### *If You Have Questions*

Questions concerning your Vision 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 Vision 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 vision 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 vision coverage while on military leave, you are generally entitled to reinstate your vision 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 vision 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 Vision 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 Vision 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 Vision 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 Vision Plan will continue during your approved leave of absence subject to timely payment of the required premiums, 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 Vision Plan. See the beginning of this section "Plan Administration" for the name and address of the Claims Administrator.

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

## Filing Vision 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. 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 below.

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. Additional information is provided below.

The Claims Administrator is responsible for determining all claims for vision benefits under the Vision 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 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 Vision 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 Vision 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 a Claims Administrator or the Plan Administrator) does not waive the Plan's anti-assignment provisions.

## Time Frame for Claim Determinations

You will be notified of the decision within a reasonable period of time not later than 30 days after receipt of the claim.

This 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. 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).

If an extension is necessary due to your failure to submit necessary information, the Vision 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.

## Filing an Appeal of an Adverse Benefit Determination for a Vision Claim

As a participant in the Vision 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 vision care services
- Claim payment
- Plan interpretation
- Benefit determination
- Eligibility

Appeals must be filed in writing with the Claims Administrator at the address provided at the beginning of this "Plan Administration" section. Your request should include:

- The applicable claim number or a copy of the written denial or a copy of the EOB, if applicable;
- The item of your vision coverage that you believe was misinterpreted or inaccurately applied; and

- Any additional information that you believe will assist the Claims Administrator in completing its review of your appeal, including documents, records, questions, comments 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 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.

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.

## 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 Vision 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 this Vision 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.

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 Vision 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 Vision 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 Vision 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 Vision 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 Vision Plan described in this booklet is no guarantee of continued employment with Dun & Bradstreet or any Dun & Bradstreet company that participates in the Vision Plan.

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