dun & bradstreet

2025 Benefits

Health and Well-being

Eligibility

Eligibility

Full- and part-time employees, regularly scheduled to work 20 or more hours a week are eligible to participate in health and well-being.

YOUR DEPENDENTS' ELIGIBILITY

If you're eligible, your dependents may be too. Eligible dependents generally include:

- Your legal spouse (not including your divorced spouse) or domestic partner
  - To cover your domestic partner, you and your partner must:
    - 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
- Your dependent children until the end of the year in which they turn 26
  - Eligible children may include:
    - Biological children
    - Adopted children
    - Stepchildren
    - Foster children
    - Children placed in your care by court order/legal guardianship

For details about each plans' eligibility, review the Summary Plan Descriptions.

Dependent Verification

Dependent Verification

We conduct dependent eligibility verifications each year (in February and July) through our contracted partner, HMS (formerly Gainwell). This ensures that any newly added dependents for medical, dental and vision coverage meet plan requirements and helps our plans remain compliant.

If you enroll a dependent in a Dun & Bradstreet medical, dental or vision plan, you'll receive a letter in the mail from HMS, asking you to submit documents (such as birth or marriage certificates) for each enrolled dependent. Please ensure you submit verification by the deadline, so your dependents maintain coverage. If you don't submit documentation within the time frame, your dependents will be removed from coverage on the first of the month following the deadline.

Click here to learn more about the dependent eligibility verification process. If you have questions regarding the verification of your dependents, please call HMS at 1-877-362-8953 (select Health & Insurance, Dependent Verification) Monday through Friday, 8A.M. to 8P.M. ET.

Life Event Changes

Life Event Changes

You may make changes during the year to your medical, dental, vision, Health Care and/or Dependent Care Flexible Spending Account (FSA) elections only if you have a qualified life event, including:

- Marriage or divorce
- Birth, adoption or placement for adoption
- Turning 26
- Death of a dependent
- Change in spouse's employment
- Termination of other employer's coverage

Refer to the Summary Plan Descriptions for details on allowable changes under each plan.

To make changes to your coverage, you must complete changes within 31 days of your qualified event.

- Log on to Fidelity NetBenefits at netbenefits.com/dnb
- Click on "Menu" (upper left), and select "Life Events"
- Select your life event (i.e. New Child, Marriage, Domestic Partner, etc) and follow the prompts

Please be sure to print your final confirmation statement, check that your dependent is listed under each plan you want to add/remove and keep the print out for your records as proof of enrollment.

If you need assistance, please contact Dun & Bradstreet's Benefits Center at 1-877-362-8953.

Domestic Partner Imputed Income

Domestic Partner Imputed Income

When enrolling a domestic partner (DP) and/or your partner's child(ren) in medical and/or dental coverage, the IRS considers the Company's contribution toward the cost of coverage provided to your domestic partner or your partner's child(ren) a taxable benefit. This amount is reported as imputed income on your paycheck. Additionally, the portion of premium that you pay to cover your domestic partner and/or your partner's child(ren) is deducted post-tax.

However, if your domestic partner (or his/her children) qualifies as your tax dependent under Section 105(b) of the Internal Revenue Code, please request to complete the Certification of Domestic Partner Tax Dependents form by contacting Dun & Bradstreet's Benefits Center at Fidelity. This form must be submitted during Open Enrollment (for coverage effective January 1) or within 31 days of enrolling your dependent when you are newly eligible or if tax status of your dependent has changed for health care purposes.

Medical

Medical

Dun & Bradstreet's medical plans provide comprehensive coverage, including doctor visits, hospital services, prescription drugs and behavioral health services. Preventive care, such as physical exams and immunizations, are free of charge in all plans. There are no exclusions for pre-existing conditions. The chart on page 13 provides a comparison of the plans.

FILING MEDICAL CLAIMS

When you go to an in-network medical provider, your provider should submit your expenses to Aetna. The provider should not request payment upfront (except where a co-payment applies). Aetna will then apply the appropriate in-network discounts and inform your provider of the amount you owe toward the deductible or co-insurance. Your provider should then bill you for the amount you owe. This should match the medical Explanation of Benefits (EOB) you receive from Aetna.

When you go to an out-of-network provider under the PPO *Select* or CDHP plans, you may have to pay the provider in full at the time of service and submit a medical claim form to Aetna for reimbursement.

Prescription drug claims are automatically processed for network discounts at the time of purchase when you show your ID card at a participating in-network pharmacy.

Explanation of Benefits (EOB)

After every visit to your provider, Aetna generates an Explanation of Benefits (EOB) for your records. This statement shows charges, payments and any balances you owe. You may view your EOBs online on Aetna member website. To obtain information on your prescription drug claims, please visit the CVS Caremark website.

WORKING SPOUSE OR DOMESTIC PARTNER (DP) SURCHARGE

The surcharge applies only to medical coverage. You will need to re-certify each year. Certification is completed online through Fidelity NetBenefits. If certification is not completed, the surcharge will automatically be applied to your monthly premium.

Should the availability of medical coverage change for your spouse/domestic partner at any time during the year, you MUST report this change within 31 days to Fidelity NetBenefits, and the surcharge will be added or removed as appropriate. The spouse surcharge may be terminated on the first of the month following timely notification. For additional information, please review these FAQs.

PRESCRIPTION PLAN

Prescription drug benefits are provided by CVS Caremark as part of all the medical plan options. Prescription drugs may be obtained either through mail order or at an in-network retail pharmacy. To fill a prescription at a local pharmacy, simply hand in your prescription and show your CVS Caremark prescription drug card. You will be required to pay the applicable co-payment based on the category of drugs you receive.

Categories of Prescription Drugs

There are three categories of covered drugs: generic drugs, preferred brand-name drugs and non-preferred brand-name drugs.

Generic

Generics are equivalent to their brand-name counterparts and are ensured by the Food and Drug Administration to be as safe and effective. Generics cost less than brand-name drugs.

Preferred Brand

These are medications that have been clinically reviewed and approved to be on CVS Caremark's formulary list. These drugs may cost more than generics but less than non-preferred brands.

Non-preferred Brand

Generally, these are high-cost medications that have recently come on the market. In most cases, an alternative preferred medication is available.

Generic Drug Substitution

The PPO *Select* plan requires the use of generic drugs, when available. If you choose to receive the brand-name drug when a generic is available, you will pay the brand-name co-insurance plus the full cost difference between the brand-name and its generic equivalent. The following example shows the difference in costs to you, for a 30-day supply under the PPO plan:

	If generic used	If generic available but preferred brand used
Co-payment	$5	$28
Cost difference between generic and preferred brand	N/A	$50
Your Total cost	**$5**	**$78**

Maintenance Choice® Program

This program applies to drugs taken regularly (e.g., three months or more) for chronic conditions or long-term therapy. After a third fill, you'll be required to receive additional refills of your maintenance medication in one of two ways—through the CVS Caremark mail-order pharmacy or at a CVS retail pharmacy.

For more details, please review the online Summary Plan Description.

Preventive Therapy Drugs

The CDHP gives you affordable access to prescriptions for chronic conditions (such as high cholesterol, diabetes and hypertension) for just the co-insurance, without having to first meet your deductible. Click here for a list of eligible medicines.

COVERAGE AND COSTS

This table provides an overview of in-network costs for each of the two plans (CDHP and PPO *Select*). Click here to view both in- and out-of-network costs.

In-network Comparison of Coverage and Costs

	CDHP[1]	PPO *Select*
Provider Network	**Aetna Choice® POS II** (Open Access)	**Aetna Choice® POS II** (Open Access)
Semi-monthly Payroll Contributions Effective January 1, 2025[2]		
You Only	$48.50	$104.50
You + Spouse/DP	$100.50	$217.00
You + Child(ren)	$91.00	$195.00
You + Family	$144.00	$309.50
Annual Deductible		
Single	$2,500	$2,000
Family	$5,000	$4,000
Annual Out-of-pocket Maximum (Includes deductible, co-insurance, co-pays and prescription drug expenses)		
Single	$5,500	$5,500
Family	$11,000	$11,000
Individual in Family	$9,200	$5,500
Medical Services		
Preventive Care Services	No cost	No cost
Primary Care Office Visits	20% co-insurance after deductible	$35 co-pay
Specialist Office Visits	20% co-insurance after deductible	$60 co-pay
Teladoc (General Health, Mental Health Care, Dermatology, and Caregiver Services)	Click here for pricing	Click here for pricing

[1] *When more than one person is covered, the entire family deductible must be met before co-insurance applies for all covered participants.*

[2] *When covering more than one person, the individual in-network out of pocket maximum is capped at $9,200 before the plan pays eligible claims at 100% for the individual who reaches this cap. Once the entire family out-of-pocket maximum is met by the remaining members, the plan begins to pay 100% of the allowed amount for covered services for all other members.*

(Continued on next page)

In-network Comparison of Coverage and Costs (continued)

	CDHP	PPO *Select*
Provider Network	**Aetna Choice® POS II** (Open Access)	**Aetna Choice® POS II** (Open Access)
Medical Services (continued)		
Inpatient Hospital	20% co-insurance after deductible	20% co-insurance after deductible
Outpatient Surgery	20% co-insurance after deductible	20% co-insurance after deductible
Lab/X-ray/Scans	20% co-insurance after deductible	20% co-insurance after deductible
Emergency Room	20% co-insurance after deductible	$250 co-pay
Prescription Drugs (CVS Caremark)[3]		
Retail (30-day supply)		
Generic	20% co-insurance after deductible[4]	$5 co-pay
Preferred Brand	20% co-insurance	20% co-insurance ($25 min; $70 max co-pay)
Non-preferred Brand	20% co-insurance	35% co-insurance ($40 min; $90 max co-pay)
Specialty	20% co-insurance	30% co-insurance or $0 through PrudentRx Co-pay program[5]

[3]*Deductible does not apply to medications on the CVS Caremark Preventive Therapy Drug List (as applicable).*

[4]*Specialty medications on the plan's formulary and exclusively dispensed by CVS Specialty will be subject to a 30% co-insurance. However, members enrolled in the PrudentRx Co-pay program (if applicable) will have a $0 out-of-pocket*

[5]*The PPO Select plan does not have a deductible for the pharmacy benefits, and covered pharmacy expenses apply only to OOP max only.*

Click here to view both in- and out-of-network costs.

UNDERSTANDING YOUR MEDICAL COSTS

It's important to understand the key health insurance costs and how they work together. This chart will help explain key terms and how they impact what you pay:

	CDHP	PPO *Select*
Premium	The amount you pay through payroll deductions.	
Co-pay	N/A	A fixed-dollar amount you pay per service or prescription.
Annual Deductible	The amount you pay each calendar year for covered services before the plan begins to pay its share, other than preventive care services or services where a co-pay applies. Your deductible amount varies by plan and resets each calendar year.	
	How it works If you cover dependents, your entire family deductible must be met by one or all of your covered members before your co-insurance benefits apply. You can meet your deductible with medical and prescription drug claims.*	How it works If you cover dependents, a family deductible will apply. When one member meets the single deductible, the plan will start paying co-insurance for that member. Once the entire family deductible is met (by one or a combination of the other remaining members), the plan will start paying co-insurance for all members. Co-payments and prescription drug costs do not apply toward your annual deductible.
Co-insurance	Your share of the costs of a covered service, calculated as a percentage, once your deductible is met.	
Annual Out-of-pocket Maximum	The most you have to pay each calendar year for your covered services. This includes deductible, co-insurance, co-pays and prescription drug expenses. Once you reach the annual out-of-pocket maximum the plan begins to pay 100% of the allowed amount for covered services for the remainder of the calendar year. Your annual out-of-pocket maximum varies by plan and resets each calendar year.	
	How it works If you cover dependents, the family out-of-pocket maximum will apply. When one member meets an out-of-pocket maximum of $9,200 (for 2025), the plan begins to pay 100% of the allowed amount for covered services for that member for the remainder of the calendar year. Once the entire family out-of-pocket maximum is met by the remaining member(s), the plan begins to pay 100% of the allowed amount for covered services for all other members for the remainder of the calendar year.	How it works If you cover dependents, the family out-of-pocket maximum will apply. When one member meets the single out-of-pocket maximum, the plan begins to pay 100% of the allowed amount for covered services for that member for the remainder of the calendar year. Once the entire family out-of-pocket maximum is met by the remaining member(s), the plan begins to pay 100% of the allowed amount for covered services for all other members for the remainder of the calendar year.
Preventive Care	As part of the Affordable Care Act (ACA), certain preventive care services are provided at no cost to you. This means you don't have to pay a co-pay or co-insurance, even if you haven't met your deductible. Click here to view a list of all preventive medical services for all plans.	

**Deductible does not apply to medications on the CVS Caremark Preventive Therapy Drug List (as applicable).*

RESOURCES AND TOOLS

Identification Cards

If you lose an ID card or need additional cards:

- **Aetna (Medical):** Print replacement or additional cards from Aetna member website.
- **CVS Caremark (Prescription Drug):** Call CVS Caremark at 1-877-321-2649 if you need an ID card.

You also have convenient access to your ID card right from your mobile device:

- Aetna (Medical)
- CVS Caremark (Prescription drug)

Finding an In-Network Provider

To locate a doctor in the PPO *Select* or CDHP plans, visit aetna.com/providersearch. Enter the name of your doctor or facility, or enter the type of health care professional you need. Then, enter your zip code and select the "Aetna Choice® POS II (Open Access)" network.

To search for participating CVS Caremark pharmacies near you, visit and log on to the CVS Caremark website.

Teladoc®

Teladoc provides you with 24/7 access to a national network of U.S. board-certified doctors by phone or video when enrolled in one of our medical plans. You can contact a physician from anywhere—home, work or on the road. Teladoc doctors diagnose non-emergency medical problems, recommend treatment and can even call in any necessary prescription(s) to your pharmacy.

To use Teladoc

1. Set up an account via Teladoc.com/Aetna.
2. Complete your medical history.
3. Request a consultation and a U.S. board-certified physician will call you back within one hour.
4. Pay online.

Personal Health Advocate Service

One-on-one support for better total health

They're your very own nurse who can help you and your family achieve better overall health and well-being. Just answer their call to get confidential help with health care needs, like:

- Understanding your health plan
- Finding a doctor or medical specialist
- Managing chronic conditions
- Coordinating details of a hospital stay

This service is part of your health benefits, so you don't pay for this personalized support. Call your Personal Health Advocate anytime, toll-free, at 1-855-346-4014 (TTY: 711).

Informed Health Line

When you have a health question or need a quick opinion, don't Google it, instead call Aetna's Informed Health Line and talk with a professional. Registered nurses are available 24/7 and can:

- Answer health-related questions
- Provide clarity for medical tests and procedures
- Help prepare you for an upcoming doctor's visit

The Informed Health Line is available to you and your eligible dependents at no cost. Call 1-800-556-1555.

In-network Labs

Avoid extra costs and save on testing and other lab services by using Quest Diagnostics® or LabCorp, Aetna's preferred in-network lab. To find a lab near you, log on to Aetna member website and click on "Find a Provider" or call the Member Services number on your ID card.

Aetna Discount Program

Everyone likes to save and every penny counts. Save on what matters most to you (including family care, electronics and travel costs) with Aetna's Discount Program. To take advantage of this program, log on to Aetna member website and click on "Discounts" under "Stay Healthy."

Please note: This benefit is available only to those enrolled in the Dun & Bradstreet medical and dental plans.

Dental Plan

Dental Plan

With the Dental PPO, you have access to a nationwide network of dentists. Review the table below to see a summary of coverage and costs.

IDENTIFICATION CARDS

If you lose an ID card or need additional cards, you can print replacement or additional cards from the Delta Dental website. You also have convenient access to your ID card right from your mobile device:

- Delta Dental (Dental)

Summary of Coverage and Costs

Semi-monthly Payroll Contributions Effective January 1, 2025		
You Only	$14.00	
You + Spouse/DP	$25.50	
You + Child(ren)	$27.50	
You + Family	$40.50	
	Delta Dental PPO Dentists	**Delta Dental Premier & Non-participating Dentists[1]**
Annual Deductible	None	Single $50/Family $150
Preventive and Diagnostic **Routine Exams, Cleanings**	The plan pays 100% of negotiated fees, no deductible.	Once you meet the annual deductible, the plan pays 100% of eligible charges.
Basic Care **Fillings, Root Canals**	The plan pays 80% of negotiated fees, no deductible.	Once you meet the annual deductible, the plan pays 80% of eligible charges.
Major Care **Crowns, Bridgework**	The plan pays 60% of negotiated fees, no deductible.	Once you meet the annual deductible, the plan pays 50% of eligible charges.
Orthodontia (Comprehensive treatment for adults and children. Adult orthodontia covered in only PPO and Premier networks.)	The plan pays 50% of negotiated fees up to a separate $2,000 lifetime maximum, no deductible.	Once you meet the annual deductible, the plan pays 50% of eligible charges up to a separate $1,000 lifetime maximum.
Annual Maximum Benefit (Excludes preventive care and orthodontia lifetime maximum.)	$2,000 per covered family member	$1,500 per covered family member

[1]*Subject to reasonable and customary charges.*

Find an In-network Dentist
Visit deltadentalnj.com, click on "Find a Dentist" under "Online Tools" and select the Delta Dental PPO Plus Premier network.

Vision Plan

Vision Plan

The EyeMed Vision Plan covers routine eye exams, paired with discounts on prescription eyeglasses and contact lenses. Coverage for medical-related vision services, such as treatment for pink eye, glaucoma, etc., are covered under the medical plans.

Summary of Coverage and Costs

Semi-monthly Payroll Contributions	
You Only	$4.38
You + Spouse/DP	$8.25
You + Child(ren)	$8.68
You + Family	$12.76
	In-network
Routine Eye Exam	$0 co-pay
Frames	$150 allowance; 20% off balance over $150
Standard Plastic Lenses	$10 co-pay
Standard Progressive Lenses	$35 co-pay
Contact Lenses	
– Conventional	$150 allowance, 15% off balance over $150
– Disposable	$150 allowance, plus balance over $150
– Medically Necessary	$0 co-pay; paid-in-full
Additional Pairs Benefit	40% discount off complete pair of eyeglass purchases and 15% discount off conventional contact lenses once the funded benefit has been used

Click here to review a full list of covered services both in- and out-of-network.

USING YOUR VISION BENEFIT

When using a network provider:

1. Locate a provider that services your plan by using our Enhanced Provider Search
2. Call the eyewear provider to confirm he or she accepts your plan
3. Schedule an appointment
4. Show your EyeMed Member ID card at the time of service
   – Don't have your ID card? No worries! You don't need one to receive services. Simply show your driver's license or pull up your digital card on the EyeMed Members App.

Lookin' Good
Visit the EyeMed website or download the app to find a provider and review your benefits.

IDENTIFICATION CARDS

If you lost your card, a new card will not be issued. You can print a replacement or additional ID cards for the Vision program online at EyeMed.com.

You can also access your EyeMed member card from your mobile device by downloading the EyeMed app.

SUBMITTING A CLAIM

When you visit an in-network provider, they take care of all of the paperwork - there is nothing you need to do on your part. You pay for any copays indicated, as well as any applicable amounts over the allowances. Your provider will supply you with these amounts.

However, if you see an out-of-network provider, you'll need to pay the full amount at the time of service and submit a claim form online for reimbursement. You will need to upload an itemized paid receipt with your name included. Please visit the EyeMed website to obtain a claim form.

HEARING DISCOUNTS

Together, EyeMed and Amplifon give you access to the world's largest hearing-aid distributor, along with the following benefits:

- Discounts on hearing exams and hearing aids
- A 60-day hearing-aid trial
- Free hearing-aid batteries for two years with purchase

Learn more about all the benefits Amplifon offers.

Health Care Accounts

Health Care Accounts

When you enroll in a health care account, the money you contribute is taken out of your paycheck on a before-tax basis. Both accounts are administered by WEX.

HEALTH SAVINGS ACCOUNTS (HSAs)

The table below provides an overview of the important information you need to know about your HSA:

HSA	
Availability	CDHP members only
Dun & Bradstreet Contribution (2024)	• $500* for You Only • $1,000* for You + Dependents
Contribution Limit	• $4,300 for You Only • $8,550 for You + Dependents
Changing Contributions	Change or stop your contribution at any time
Carryover	Unused funds carry over to the following year
Investment	Earn interest on deposited funds or invest in mutual funds.
Portability	You can keep the account if you leave Dun & Bradstreet
IRS Restrictions	Cannot: • Be covered by any other non-HSA-eligible health plan • Be enrolled in Medicare • Be claimed as a dependent on someone else's tax return • Have a spouse contribute to a Health Care FSA

**Employer contribution is reduced for those newly enrolling on or after April 1. Percentage of contribution is based on the quarter you join the plan: Q2 75% ($300/$600); Q3 50% ($200/$400); Q4 25% ($100/$200)*

Accessing Your Funds

Funds must be in the account in order to use them. Expenses incurred before you open your account are not eligible for HSA reimbursement. You may use your WEX debit card to pay with funds directly from your health care account. You can manage your account online through the WEX website.

Qualified medical expenses are defined by the IRS (Publication 502). Keep in mind that the qualified medical expenses can change from time to time. HSA dollars used for non-qualified expenses are subject to tax and penalties—so be very careful about ensuring your HSA is used for allowable expenses only. Also, it is very important that you maintain receipts for ALL expenses you apply to your account. In the event of a tax audit—you will be required to show proof of qualified medical expenses.

Tax Forms

Each tax year, WEX will send you an IRS Form 1099-SA showing your distributions (sent by January 31 of the following year). If you did not have distributions during the tax year, you will not receive this form and can use your last account statement.

You will also receive Form 5498-SA showing all of the contributions made to your HSA in a tax year (sent the end of May of the following year). You can find information about your total contributions before tax day by logging on to your online account.

Debit Card Replacements

Contact WEX at 1-866-451-3399 to request a replacement if your debit card is lost or stolen.

HEALTH CARE FLEXIBLE SPENDING ACCOUNTS (HCFSAS)

The table below provides an overview of important considerations when you have a HCFSA:

HCFSA	
Availability	PPO *Select* or not enrolled in medical members only
Dun & Bradstreet Contribution (2025)	None
Contribution Limit	$3,300
Changing Contributions	Make changes during Open Enrollment or with a qualified life status change
Carryover	Unused funds are lost
Investment	You cannot invest or earn interest
Portability	Not portable
IRS Restrictions	You should not contribute to a HCFSA if you're enrolled in the CDHP and your spouse is contributing to an HSA

Availability of Funds

Your full annual contribution amount is available to pay for qualified expenses beginning on the date you started your account. You can use your WEX debit card or file a reimbursement claim online through the WEX website.

Reimbursement Deadline

For the 2025 account, health care services must be obtained between January 1, 2025 (or the date account is first opened, whichever is later) through December 31, 2025 (or the date your coverage terminates, whichever is earlier). You must file for reimbursement by March 31, 2026. Any funds remaining in your account after March 31, 2026 will be forfeited and cannot be returned to you.

Debit Card Replacements

Contact WEX at 1-866-451-3399 to request a replacement if your debit card is lost or stolen.

Debit Card Substantiation

The IRS has guidelines that require all FSA transactions—even those made using a health care debit card—to be substantiated (verified that the purchase was an eligible health care expense).

If documentation is required for a debit card transaction, you will receive an email notification from WEX. Documentation can be uploaded by logging on to your account at WEXinc.com or by using the mobile app feature.

If you do not provide timely documentation, your debit card will be deactivated, which will prevent you from using the card for future purchases. Your card will be reactivated and available for use once you submit the necessary documentation for the purchases in question.

Any FSA expenses not substantiated by March 31, 2026, will be refunded back to the plan through a deduction from your 2026 paycheck.

Please refer to the FAQs for more information.