The Dun &Bradstreet
Health Care and Dependent Care
Flexible Spending Accounts
Summary Plan Description

Table of Contents

The Dun & Bradstreet Corporation Welfare Benefit Plan provides health care, life, accident, disability, employee assistance and flexible spending account benefits to eligible active employees of Dun & Bradstreet and its related companies who participate in the plan, and their dependents. The Dun & Bradstreet Health Care and Dependent Care Flexible Spending Accounts are part of The Dun & Bradstreet Corporation Welfare Benefit Plan. This document summarizes Dun & Bradstreet's Health Care and Dependent Care Flexible Spending Accounts, 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 Health Care and/or Dependent Care Flexible Spending Accounts. If you have any questions about your benefits, please contact the Dun & Bradstreet Benefits Center. See the section "How to Reach Your Health Care and Dependent Care Flexible Spending Account Service Providers" at the beginning of this SPD for contact information.

The legal plan document provides additional information about the administration of the Health Care and Dependent Care Flexible Spending Accounts. 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 Health Care and Dependent Care Flexible Spending Accounts.

The coverage provided under the Health Care and Dependent Care Flexible Spending Accounts is self-insured by Dun & Bradstreet, and Dun & Bradstreet has contracted with a third party (the "Claims Administrator") to perform certain spending account claims services.

Day-to-day operations of the Health Care and Dependent Care Flexible Spending Accounts 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 Health Care and Dependent Care Flexible Spending Account Service Providers" at the beginning of this SPD for contact information.

HOW TO REACH YOUR HEALTH CARE AND DEPENDENT CARE FLEXIBLE SPENDING ACCOUNT SERVICE PROVIDERS

Here is how you can reach your Health Care and Dependent Care Flexible Spending Accounts service providers:

Provider	Contact Information
Administrative Services: ■ Dun & Bradstreet's Benefits Center at Fidelity	■ 1-877-362-8953 (or 1-888-343-0860 for the hearing impaired) ■ http://netbenefits.fidelity.com
Claims Administrator: ***Health Care and Dependent Care Flexible Spending Account*** ■ Wex	For Questions: ■ 1-866-451-3399 ■ www.wexinc.com ■

ABOUT YOUR PARTICIPATION

This section contains important information about your participation in the Dun & Bradstreet Health Care and Dependent Care Flexible Spending Accounts (FSA), including eligibility information, when participation begins, contributing to a spending account and when participation ends.

Who Is Eligible

You are eligible to contribute to the Health Care and/or Dependent Care Flexible Spending Account (FSA) if you meet all of the following conditions:

- You are an active full-time or part-time employee employed by Dun & Bradstreet or a related company that participates in the Health Care and Dependent Care Flexible Spending Accounts 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 Health Care and Dependent Care Flexible Spending Accounts.

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 Health Care and Dependent Care Flexible Spending Accounts only prospectively and not retroactively to the date on which you are found to have first become an employee, assuming all other eligibility requirements are met.

When Participation Begins

You must enroll in the Health Care and Dependent Care Flexible Spending Accounts within 31 days of your date of hire 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 to participate.

If you do not choose to participate in the Health Care and Dependent Care Flexible Spending Accounts when you first become eligible, you must wait until the next annual enrollment, unless you have an eligible family status change, or another event that permits a mid-year change in elections, in accordance with IRS rules. See the section, "Making Changes During the Year" in this SPD for information on changing coverage during the year.

There is no enrollment for dependents under the Health Care and Dependent Care Flexible Spending Accounts, but your dependents must meet certain IRS-defined criteria in order for their health care or dependent care expenses to be eligible for reimbursement. See the section, "Expenses Eligible for Reimbursement from Your Health Care and Dependent Care Flexible Spending Accounts" in this SPD for more information.

Contributing to a Spending Account

When you enroll in a Health Care and/or Dependent Care Flexible Spending Account, you decide how much to contribute to your account through payroll deduction. Your elected contributions will be deducted from your paycheck on a before-tax basis throughout the year.

- **Health Care Flexible Spending Account:** You may elect to contribute up to a maximum of $3,400 per year to your Health Care Flexible Spending Account. This amount may change from year to year. You will be informed of any changes during annual enrollment.

- **Dependent Care Flexible Spending Account:** You may elect to contribute between $500 and $5,000 if you are single or married and filing a joint income tax return ($2,500 if married, filing separately) to your dependent care FSA.

  If you are married, special limits may apply as follows:

If this is your situation…	The maximum annual contribution is…
You or your spouse earns less than $5,000 annually	The amount the lower-paid spouse earns

If this is your situation…	The maximum annual contribution is…
Your spouse also participates in a dependent care flexible spending account	$5,000 combined for both your and your spouse's accounts
You file separate federal income tax returns	$2,500 each

Your spouse is treated as working during any month he or she is a full-time student or is physically or mentally unable to care for himself or herself. During such a month, your spouse is deemed to have earned income of $250 (if you have one qualifying dependent) or $500 (if you have two or more qualifying dependents). To qualify as a full-time student, your spouse must be enrolled at and attend school on a full-time basis for five calendar months during the year.

Important Note for the Dependent Care Flexible Spending Account: In addition to the above, certain other limits are also applied by the IRS with regards to the Dependent Care Flexible Spending Account:

- Your annual contributions cannot exceed your earned income, or
- If you are married, the earned income of the lower-paid spouse.

For purposes of the Dependent Care Flexible Spending Account, "earned income" generally means wages, salaries, tips and other employment compensation.

Limit for Highly Compensated Employees: Tax laws provide that the Dependent Care Flexible Spending Account (FSA) may not discriminate in favor of highly compensated employees (HCEs). For 2026, the IRS generally defines a highly compensated employee as someone whose compensation in 2025 was $160,000 or more.

To prevent the Dependent Care FSA from being characterized by the IRS as discriminatory, and therefore no longer eligible for favorable tax treatment, several nondiscrimination tests must be satisfied annually. One of these tests requires that the average benefits provided to the HCEs not exceed 55% of the average benefit provided to the employees who are not HCEs. If these limits are not satisfied, the dependent care assistance benefits provided to HCEs will be taxable. To satisfy this test, the Dependent

Care FSA may require that contribution amounts elected by HCEs for the year be reduced until these limits are satisfied. If you are affected, you will be notified generally within the third quarter of the calendar year. In that notice, we will explain how much your contributions to your Dependent Care FSA must be reduced for the year.

When Participation Ends

Participation in the Health Care and Dependent Care Flexible Spending Accounts will end if you actively choose not to enroll for the next calendar year in one or both accounts during annual enrollment. Participation under the Health Care and Dependent Care Flexible Spending Accounts will also end for you when any one of the following occurs:

- You terminate employment for any reason,
- Dun & Bradstreet terminates the Health Care and/or Dependent Care Flexible Spending Accounts,
- You are no longer eligible for participation,
- You fail to make the required contributions on a timely basis, or
- You die.

In general, participation will end on the date the event occurs unless your participation terminates on account of your termination of employment. In that situation, your coverage will terminate at the end of the month in which your termination occurs. You or your eligible dependents may be able to continue participating in the Health Care Flexible Spending Account for a limited time period through the Consolidated Omnibus Budget Reconciliation Act (COBRA).

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 Health Care and Dependent Care Flexible Spending Accounts include:

- A change in your legal marital status (such as marriage, divorce, death of spouse, legal separation and annulment),
- A change in the number of your dependents (such as through birth, death, adoption and placement for adoption),
- A change in your (or your spouse's or dependent's) employment status that affects benefits eligibility (such as termination or commencement of employment; a commencement of or return from an unpaid leave of absence; switching from salaried to hourly-paid or full-time to part-time (or vice versa); and
- Your dependent's meeting (or failing to meet) the Health Care and Dependent Care Flexible Spending Accounts' dependent eligibility rules.

Important: You may be able to reimburse eligible expenses incurred on behalf of your domestic partner and/or your domestic partner's child(ren) provided they qualify as dependents based on IRS guidelines. If this situation applies to you, you should consult with your own personal tax adviser.

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 or your dependent's gaining or losing eligibility to participate in the Health Care or Dependent Care Flexible Spending Accounts or the

health care or dependent Care Flexible Spending account plan of your spouse'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 begin participating in a Health Care and/or the Dependent Care Flexible Spending Account, but you would not be able to decrease your contributions 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 Health Care and Dependent Care Flexible Spending Account participation. 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 Health Care and Dependent Care Service Providers" at the beginning of this SPD for contact information.

Other Permissible Mid-Year Election Changes

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

- Changes 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 begin participating in the Health Care Flexible Spending Account. If the order directs someone other than you to cover the child, you may stop participation, and

- If the cost of your dependent care provider (who is not your relative) increases or decreases significantly, your dependent care provider changes, or your dependent care services are significantly curtailed, you can make corresponding changes to your dependent care FSA election. For example, if mid-year, your mother will begin taking care of your child at no cost and you no longer need your current dependent care provider, you can revoke your dependent care FSA election due to a significant change in coverage. However, if your mother wants a raise mid-year, you cannot increase your contributions to your dependent care FSA to a change in cost because she is your relative.

- Changes due to entitlement (or loss of entitlement) to Medicare or Medicaid. If you, your spouse or a covered dependent becomes entitled to Medicare or Medicaid

(becomes enrolled), you may stop participating in the Health Care Flexible Spending Account. If you, your spouse or a dependent loses entitlement to Medicare or Medicaid, you may begin participating in the Health Care Flexible Spending Account.

- Changes consistent with taking leave under the Family and Medical Leave Act (FMLA). If you take a leave under the FMLA, you may revoke your participation in the Health Care Flexible Spending Account 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 Health Care and Dependent Care Flexible Spending Accounts During the Year

The following table provides some examples of the types of changes you may be able to make to your Health Care and Dependent Care Flexible Spending Accounts if you experience a qualified change in your family status. In each situation, the change that is made must be consistent with the event under IRS rules. 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 Health Care and Dependent Care Flexible Spending Accounts. See the section "How to Reach Your Health Care and Dependent Care Flexible Spending Account Service Provider" at the beginning of this SPD for contact information.

Marriage	■ You may increase or decrease your contributions within 31 days of marriage, or you can adjust your contributions during the next annual enrollment. Your new election may not be less than your year-to-date contributions.
Divorce	■ You may increase or decrease your contributions within 31 days of divorce, or you can adjust your contributions during the next annual enrollment. Your new election may not be less than your year-to-date contributions.

Birth, adoption or change in custody of a dependent child	■ You may begin or increase your contributions within 31 days of the date of birth or adoption, or you can adjust your contributions during the next annual enrollment.
Death of a spouse or dependent	■ You may decrease your contributions within 31 days of the death, or you can adjust your contributions during the next annual enrollment. Your new election must not be less than your year-to-date contributions.
The issuance of a Qualified Medical Child Support Order (QMCSO) for a dependent child	■ You may begin or increase your contributions to your Health Care Flexible Spending Account within 31 days of the QMCSO issuance, or you can adjust your contributions to your Health Care Flexible Spending Account during the next annual enrollment.
Your spouse takes an approved unpaid leave of absence	■ You may terminate your dependent care FSA during your spouse's unpaid leave of absence. Your account may be reinstated upon his/her return. ■ You may begin or increase your contributions to your Health Care Flexible Spending Account within 45 days of the date your spouse loses eligibility under his or her health care FSA
Your spouse obtains coverage because his or her employment begins	■ You may decrease your contributions within 31 days of your spouse's date of hire, or you can adjust your contributions during the next annual enrollment. Your new election must not be less than your year-to-date contributions ■ You may begin or increase your contributions to your Dependent Care Flexible Spending Account within 31 days of the date your spouse's employment begins
Loss of your spouse's health coverage because his or her employment ends or changes	■ You may begin or increase your contributions within 31days of the event, or you can adjust your coverage contributions during the next annual enrollment.

WHEN YOUR EMPLOYMENT ENDS

In most cases, your coverage will terminate at end of the month in which your employment ends. The following chart describes what happens when your coverage terminates on account of your termination of employment, retirement or death.

Terminate employment or Retire	Your contributions to your Health Care and Dependent Care Flexible Spending Accounts will stop if you terminate employment. You may continue to file claims against your Health Care Flexible Spending Account for expenses incurred up to your termination of employment and Dependent Care Flexible Spending Account for expenses incurred up to your termination of employment until the balance in your account is exhausted or the end of the run-out period. You may continue to make after-tax contributions to your Health Care Flexible Spending Account if you qualify for and elect COBRA. See the section "COBRA Continuation" in this SPD for more information.
Die	■ Your contributions to your Health Care and Dependent Care Flexible Spending Accounts will stop when you die. Your eligible dependents may continue to file claims against your Health Care Flexible Spending Account for expenses incurred up to the date of your death and Dependent Care Flexible Spending Account for expenses incurred up to the date of your death until the balance in the account is exhausted or the end of the run-out period. Your eligible dependents may continue to make after-tax contributions to your Health Care Flexible Spending Account if they qualify for and elect COBRA. See the section "COBRA Continuation" in this SPD for more information.

HOW THE HEALTH CARE AND DEPENDENT CARE FLEXIBLE SPENDING ACCOUNTS WORK

Here is how the spending accounts work:

- Carefully consider what your eligible, out-of-pocket health care and dependent care expenses will be for the year.
- Elect how much you want to contribute to your accounts to cover these eligible expenses.
- Your contributions are deducted from your pay before federal — and, in most cases, state — income and FICA taxes are withheld. That means there is less income for the federal government to tax (compared to paying with after-tax dollars), so you reduce your current taxes.
- You will then be reimbursed with tax-free dollars for the full amount of your claim as follows:
  - Under the Health Care Flexible Spending Account, the annual benefit amount is available to you throughout the year. For example, if you elect to contribute $100 per month ($1,200 for the year) and file a $750 claim in April, you will receive the full $750 reimbursement although you had only contributed $300 to your account to date. All contributions you make after your initial claim would be used to offset amounts paid out to date.
    - Your FSA funds cannot be used for domestic partner expenses unless he/she qualifies as your tax dependent. See “Requesting Reimbursement From Your Flexible Spending Account (FSA)” section for more details.
  - Under the Dependent Care Flexible Spending Account, you will only be reimbursed up to the amount contributed to your account to date. If you submit a claim for an amount in excess of the balance in your account, you will receive automatic reimbursements for the amount claimed in excess of your balance only as you make additional contributions. For example, if you elect to contribute $3,600 for the year, you contributed $1,275 to date and you file a $2,000 claim in

April, you would only receive a $1,275 reimbursement. Provided you continue have payroll contributions, you would continue to receive reimbursements as the funds are deposited to your account until the $2,000 claim was fully reimbursed.

How You Save on Taxes

Your spending account contributions are not subject to federal income or most state and local taxes. So, they will not be included in your taxable gross income. That means that you save money by reducing your taxable income and, in turn, your taxes. Contributions are never taxed either when they go into your account or when you withdraw them to reimburse yourself for eligible expenses. In addition, your contributions are not subject to FICA taxes, which may reduce your Social Security benefit slightly at retirement, but this reduction rarely outweighs the financial advantages of using a spending account. If you have any questions about the tax benefits of a spending account, you should consult with your personal tax adviser

Use it or Lose it

Be sure to calculate your contributions carefully. If you do not use your entire account balance for that calendar year's expenses, **you will forfeit any amounts remaining in your account**. *This is an IRS rule.*

Because your bills may arrive after services occur, you have until March 31 of the following calendar year to submit claims for eligible expenses you incurred in the previous year. Also note that expenses are incurred on the date of service, not the date you are billed or make payment for the service. Expenses must be incurred during the spending account plan year to be eligible for reimbursement from that year's spending account balance.

REIMBURSEMENT FROM THE HEALTH CARE AND DEPENDENT CARE FLEXIBLE SPENDING ACCOUNTS

Health Care Flexible Spending Account

The Health Flexible Spending Account enables you to use your funds to pay for eligible health care expenses allowed under Sections 105 and 213(d) of the Internal Revenue Code which are not covered by your medical, dental or vision plan, such as deductibles and co-payments. A list of covered expenses is available from the Administrator.

For a complete list of health care expenses (subject to the restrictions listed below), please refer to IRS Publication 502, *Medical and Dental Expenses*, which is available from the IRS by calling 1-800-829-3676. Or, you can download copies of the publication from the IRS web site at www.irs.gov. Please note, however, that regardless of the language found in IRS Publication 502, the following rules apply to the Health Care Flexible Spending Account:

- Expenses are deemed to be incurred on the date the participant receives the medical care, not on the date he or she is billed or charged for it or pays for it.
- Some expenses listed in IRS Publication 502 may not be reimbursed through the Health Care Flexible Spending Account, including premiums and contributions for other health coverage.

Eligible Dependents

You can use the Health Care Flexible Spending Account for eligible expenses incurred by:

- You,
- Your spouse or domestic partner (provided your domestic partner qualifies as a dependent based on IRS guidelines; if this situation applies to you, you should consult with your own personal tax adviser), and
- Any others who qualify for reimbursement based on IRS guidelines.

Health Care Tax Deduction

If you use money from your Health Care Flexible Spending Account for a health care expense, you cannot claim that expense as a deduction on your income tax return. In determining whether a tax deduction or reimbursement through your Health Care Flexible Spending Account is better for you, keep in mind that in most circumstances according to the IRS, only medical expenses that exceed 10% of your adjusted gross income can be deducted from your income taxes. Many people do not have expenses high enough to qualify for this deduction at all. And, with the Health Care Flexible Spending Account, you can reimburse yourself with *tax-free* dollars for your eligible health care expenses. If you have any questions about the tax benefits of a spending account, you should consult with your personal tax adviser.

Dependent Care Flexible Spending Account

The Dependent Care Flexible Spending Account reimburses you for dependent care expenses that are necessary for:

- You and your spouse to work or look for work.
- You to work and your spouse to attend school full-time for at least five months during the year.
- You to work while your spouse is mentally or physically disabled and is in need of care or is unable to provide care for a dependent.

Your and your spouse's work can be done for others or in your own business. It can be either full-time or part-time. However, it doesn't include volunteer work.

Important: You may be eligible to receive reimbursement for expenses incurred on behalf of your domestic partner and/or your domestic partner's child(ren) based on IRS guidelines. If this situation applies to you, you should consult with your own personal tax adviser.

For a complete list of dependent care expenses which may be eligible for reimbursement, please refer to IRS Publication 503, *Dependent Care Expenses*, which is available from the

IRS by calling 1-800-829-3676. Or, you can download a copy of the publication from the IRS Web site at www.irs.gov.

Please note: Dun & Bradstreet's spending account plan's definition of when an expense is "incurred" will control, not the definition in IRS Publication 503. *For purposes of this plan, expenses are deemed to be incurred on the date the dependent care is received, not on the date you are billed, charged or pay for services.*

Eligible Dependents

You may request reimbursement from your Dependent Care Flexible Spending Account for dependent care expenses you pay for your eligible dependents. Generally, eligible dependents include:

- Child(ren) under the age of 13 who meets all of the following requirements:
  - — Is either your child (including step, adopted and foster child) or grandchild, or your brother, sister, stepbrother, stepsister, or a descendent of any such relative (e.g., niece or nephew),
  - — Lives with you for more than one-half of the calendar year, and
  - — Does not provide over one-half of his or her own support for the calendar year.

  Special rules apply if the child can be claimed as a "qualifying child" by more than one person under IRS rules.
- Your spouse or any other qualified dependent (as defined by IRS guidelines) of any age who meets all of the following requirements:
  - — Is physically or mentally unable to care for himself or herself,
  - — Lives with you for more than one-half of the calendar year, and
  - — Is dependent on you for more than 50% of his or her financial support

Dependent Care Flexible Spending Account vs. Federal Income Tax Credit

Under current tax law, you can be reimbursed for eligible dependent care expenses with pre-tax dollars through the Dependent Care Flexible Spending Account, or you can claim a tax credit for dependent care expenses when you file your federal income tax return.

The federal dependent care tax credit applies to up to $3,000 in expenses for one qualifying dependent or up to $6,000 in expenses for two or more qualifying dependents. The credit is calculated by multiplying your eligible dependent care expenses, up to the $3,000 or $6,000 maximum by a percentage (from 35% to 20%, based on your adjusted gross income). You may be able to use both approaches, but you cannot take a deduction for the same expenses twice. In addition, the amount of expenses that will qualify for a tax credit will be reduced, dollar for dollar, by any amount you receive from a Dependent Care Flexible Spending Account.

For specific advice about your situation, you should consult a tax advisor

ADDITIONAL RULES THAT APPLY TO THE HEALTH CARE AND DEPENDENT CARE FLEXIBLE SPENDING ACCOUNTS

The following rules apply to both the Health Care and Dependent Care Flexible Spending Accounts, unless indicated otherwise.

Qualified Medical Child Support Order (QMCSO) — For Health Care Flexible Spending Accounts Only

The Health Care Flexible Spending Account will comply with all the terms of a qualified medical child support order (QMCSO). A QMCSO is an order or judgment from a court or administrative body that directs the plan to cover a child of a participant under the health plan. Federal law provides that a medical child support order must meet certain form and content requirements in order to be a qualified medical child support order. When an order is received, each affected participant and each child (or the child's representative) covered by the order will be given notice of the receipt of the order and a copy of the Dun & Bradstreet Medical Plan's procedure for determining if the order is valid. Coverage under the Health Care Flexible Spending Account 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 Health Care and Dependent Care Service Provider" at the beginning of this SPD for contact information.

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

Under certain circumstances, plan benefits may be denied or reduced from those described in this SPD. For instance, your claim will be denied or reduced if:

- You claim reimbursement for expenses that are not approved according to IRS guidelines.

- You fail to file your claim timely according to plan provisions, i.e., by March 31 of the year following the year for which you made contributions.
- You file a claim for expenses incurred after your participation in the plan ends.

REQUESTING REIMBURSEMENT FROM YOUR FLEXIBLE SPENDING ACCOUNT (FSA)

Health Care FSA Reimbursements

To be eligible for Health Care FSA reimbursement, you must incur expenses while you are actively contributing to the account. Because your bills may arrive after services occur, you have until March 31 of the year following the year for which you made contributions to submit claims for the prior calendar year.

In order to be reimbursed for a health care expense, you must submit to the Administrator an itemized bill from the service provider. Claims are processed on a daily basis and any reimbursements will be mailed to you or deposited to a designated account if you elected direct deposit. You can be reimbursed for eligible expenses up to the amount of your elected annual contribution even if you have not contributed the full amount at the time you submit your claim.

If expenses will be coordinated under two health care plans, you must submit the claim to each plan before filing a Health Care FSA claim. You will need to include the EOB from both plans with your claim form. Any eligible amount that was not reimbursed by the other plan will be considered for reimbursement from your Dun & Bradstreet Health Care FSA.

Expenses are not eligible if reimbursed under any other plan. You must certify on the Health Care FSA claim form that the expenses submitted are not eligible for reimbursement from another plan.

Health Care FSA Debit Card

The Administrator will also provide you with a debit card to use for paying health care expenses. The health care FSA debit card is a payment convenience, allowing you to use your FSA funds to pay healthcare providers at the point of sale instead of paying for the expense out-of-pocket and then requesting reimbursement of the expense**. Use of your debit card does not eliminate the requirement that you validate the expense by submitting supporting documentation proving that a qualifying expense was incurred**.

There are a few circumstances where healthcare expenses purchased with a debit card will be substantiated automatically. In that situation, you will not be required to submit documentation substantiating the expense after you use your debit card. In most cases, the following expenses are automatically substantiated although you should always keep your receipts even if you do not think you will be required to submit them to the plan:

- Purchases at Inventory Information Approval System (IIAS) Merchants. IIAS compliant stores have a point-of-sale system designed to identify eligible healthcare products when the customer is paying with an FSA debit card (typically pharmacy purchases);
- Payments to a healthcare provider that match the medical plan copay amount; and
- Recurring expenses paid to a healthcare provider, e.g.; orthodontic payments, allergy injections, etc. You must validate the first of these transactions each year and should not have to support future payments to the same provider for the same amount during that remainder of the plan year.

For all other transactions, you must validate your expense (such as transactions for deductibles, co-insurance, etc.) after you use your debit card. As a result, it is important that you keep all documentation necessary to support any transactions made with your debit card (such as an itemized bill or an Explanation of Benefits (EOB) form) even if you think your expense will not require substantiation.

Wex will inform you of any debit card transactions that you must validate via email or mail. You may also log into your Wex account to review any claims that require documentation.

If you do not respond or you submit insufficient documentation, or the expense is denied, your debit card will be deactivated according to IRS regulations. You will not be able to use your debit card until your expense is properly validated or repaid. You will be required to reimburse the Plan for any denied or unsupported amounts. Reimbursement of denied or unsupported amounts may occur as follows:

1. Wex automatically applies any future claims that are submitted and approved against the denied/unsupported amount.

2. You may submit a check to Wex as a repayment of the denied/unsupported amount.

You have until March 31 of the year following the plan year in which the expense was incurred to take corrective action. **If you have not validated your outstanding debit card transaction(s) by this time, Dun & Bradstreet will withhold the unsupported amount(s) from your paycheck on an after-tax basis**. If a paycheck is no longer available, the unsubstantiated amount(s) will be reported as taxable income on your Form W-2.

Dependent Care FSA Reimbursements

You will need to complete and submit a Flexible Spending Account Claim for Reimbursement form along with proper documentation to the Claims Administrator to receive reimbursement. The bill (including the provider's name and address, the start and end dates of service and the provider's Social Security tax identification number) must be attached to your claim form.

You will be reimbursed up to the amount in your account. If you have enough money in your account when the claim is submitted, you will receive full reimbursement at that time. Otherwise, you'll receive an initial reimbursement equal to the amount in your account. As additional contributions to your account are made, you will receive additional payments until expenses are reimbursed or your annual limit is reached. Also, any claim expenses incurred and paid prior to the date of service will not be reimbursed until the date services are rendered.

To be eligible for Dependent Care Flexible Spending Account reimbursement from contributions you have made during the year, you must incur the expense while you are participating in the plan and on or prior to the last day of the Plan Year. Because your bills may arrive after services occur, you have until March 31 of the year following the year for which you made contributions to submit claims for the prior calendar year.

PLAN ADMINISTRATION

This information about the administration of the Health Care and Dependent Care Flexible Spending Accounts is provided in compliance with the Employee Retirement Income Security Act (ERISA) of 1974, as amended. (The Dependent Care Flexible Spending Account is not subject to ERISA.) While you should not need these details on a regular basis, the information may be useful if you have specific questions about your Spending Accounts.

Plan Name

The name of the plan is The Dun & Bradstreet Corporation Welfare Benefit Plan. The Health Care and Dependent Care Flexible Spending Accounts are 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 Health Care and Dependent Care Flexible Spending Accounts are 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

Participating Employers

As of January 1, 2026, 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 Health Care and Dependent Care Flexible Spending Accounts will be under the supervision of the Plan Administrator. To the fullest extent permitted by law, the Plan Administrator will have the exclusive right to determine all matters relating to eligibility, coverage determination, interpretation and operation of the Health Care and Dependent Care Flexible Spending Accounts.

Claims Administrator

The coverage provided under the Health Care and Dependent Care Flexible Spending Accounts is self-insured by Dun & Bradstreet, and Dun & Bradstreet has contracted with a third party administrator (the "Claims Administrator") to perform certain claims administration and other administrative services.

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

Wex
P.O. Box 2926
Fargo, ND 58108-2926
866.451.3399

Claim submission and receipt upload at:
www.wexinc.com

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
Florham Park, NJ 07932
1-973-921-5500

Identification Numbers

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

Plan Year

The plan year for the Health Care and Dependent Care Flexible Spending Accounts is January 1 through December 31.

Organization Providing Administrative Services

Day-to-day operations of the Health Care and Dependent Care Flexible Spending Accounts 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
www.netbenefits.com/dnb

Sources of Contributions

The Health Care and Dependent Care Flexible Spending Accounts are funded by participant contributions. These contributions are intended to be made before-tax to the extent permitted by law. The benefits provided under the Flexible Spending Accounts are

paid by Dun & Bradstreet out of its general assets, and are neither pre-funded or insured. The Flexible Spending Accounts are administered by Wex, a third party administrator.

Plan Document

This SPD is intended to help you understand the main features of the Health Care and Dependent Care Flexible Spending Accounts. The legal plan document provides additional information about the administration of the Health Care and Dependent Care Flexible Spending Accounts. 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.

Limitation on Assignment

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

CONTINUATION OF COVERAGE

COBRA Continuation — Applies to the Health Care Flexible Spending Account Only

This section contains important information about your right to COBRA continuation coverage, which is a temporary extension of participation under the Health Care Flexible Spending Account. **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 your participation in the Health Care Flexible Spending Account ends. It may also become available to your spouse and dependent children.

What is COBRA Continuation Coverage

COBRA continuation coverage is a continuation of Health Care Flexible Spending Account coverage when Health Care Flexible Spending Account participation would otherwise end 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 participating in the Health Care Flexible Spending Account at the time of a qualifying event, and such participation ends 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 Health Care Flexible Spending Account, qualified beneficiaries must pay for 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 your participation in the Health Care Flexible Spending Account ends 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 your participation in the Health Care Flexible Spending Account ends 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; ***or***
- You become divorced or legally separated from your spouse.

Your dependent children will become qualified beneficiaries if their participation in the Health Care Flexible Spending Account ends 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 parents become divorced or legally separated; or
- The child stops being eligible for coverage under the Health Care Flexible Spending Account as a "dependent child."

Giving Notice that a COBRA Qualifying Event has Occurred

The Health Care Flexible Spending Account 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 Health Care and Dependent Care Flexible Spending Account 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, the employer will notify the Dun & Bradstreet Benefits Center (on behalf of the Plan Administrator) of the qualifying event by contacting the Dun & Bradstreet Benefits Center. See the section "How to Reach Your Health Care and Dependent Care Flexible Spending Account Service Provider" at the beginning of this SPD for contact information.

Important Note: For the other qualifying events (divorce or legal separation 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
- The date the qualified beneficiary participation ends (or would end) under the Health Care Flexible Spending Account as a result of the qualifying event. You must notify the Plan Administrator by calling the Dun & Bradstreet Benefits Center. See the section "How to Reach Your Health Care and Dependent Care Flexible Spending Account Service Providers" 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 Health Care Flexible Spending Account is changed for active employees, the same changes will be provided to individuals receiving COBRA continuation coverage. Qualified beneficiaries also may change their coverage elections if a change in status occurs, or at other times under the Health Care Flexible Spending Account to the same extent that similarly-situated non-COBRA employees may do so.

Duration of COBRA Continuation Coverage

COBRA continuation coverage is a temporary continuation of Health Care Flexible Spending Account participation. You may continue participation in, and contributions to, your Health Care Flexible Spending Account under COBRA on an after-tax basis for the **remainder of the year in which your qualifying event occurs**. **In no event will you be able to elect Health Care Flexible Spending Account participation for the year following the year in which a qualifying event occurs,** even if your COBRA continuation period is still in effect for your other health care coverage(s).

Electing COBRA Continuation Coverage

You and/or your covered spouse and dependent children must choose to continue Health Care Flexible Spending Account participation within 60 days after the later of the following dates:

- The date you and/or your covered spouse's and dependent children's participation ends under the Health Care Flexible Spending Account 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 amount you elected to contribute to your Health Care Flexible Spending Account.

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 Health Care Flexible Spending Account. **Payment is considered made on the date it is sent to the Dun & Bradstreet Benefits Center (on behalf of the Health Care Flexible Spending Account).**

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 Health Care Flexible Spending Account, and such participation 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 end of the plan year in which the qualifying event occurred;
- 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;
- 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; or
- Dun & Bradstreet terminates participation for all employees (and retirees).

COBRA continuation coverage may also be terminated for any reason the Health Care Flexible Spending Account would terminate coverage of a participant or beneficiary not receiving COBRA continuation coverage (such as fraud).

If You Have Questions

Questions concerning your Health Care Flexible Spending Account 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, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit the EBSA website at www.dol.gov/ebsa. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.)

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 Health Care and Dependent Care Flexible Spending Account Service Provider" at the beginning of this SPD for contact information.

Continuation of Benefits 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 paid qualifying military leave of absence, your participation in the Health Care and Dependent Care Flexible Spending Accounts will continue subject to timely payment of the required contributions. Your required contribution will be deducted from your pay. If you take an unpaid qualifying military leave of absence, your participation in the Health Care Flexible Spending Account will continue (subject to timely payment of the required contribution), but your participation in the Dependent Care Flexible Spending Account will terminate. You will be billed for the cost of continued participation in the Health Care Flexible Spending Account.

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 contribution 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 participation in the Health Care Flexible Spending Account while on military leave, you are generally entitled to reinstate your participation 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 Benefits 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 health care benefits including participation in the Health Care Flexible Spending Account during this time. However, dependent care expenses you incur during an FMLA leave in many cases will not be reimbursable under the Dependent Care Flexible Spending Account.

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 U.S. 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 U.S. Armed Forces or a veteran and who is being treated for or recovering from a serious injury or illness incurred of 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 unpaid leave available to you for family and medical reasons may vary based on state law requirements.

If you take a paid FMLA leave of absence, your participation in the Health Care and Dependent Care Flexible Spending Accounts will continue subject to timely payment of the required contributions. Your required contribution will be deducted from your pay. Keep in mind that your leave of absence may impact your ability to submit reimbursements for qualifying dependent care expenses incurred while you are on leave. You may also be entitled to make an election change with respect to your Dependent Care Flexible Spending Account on account of your leave. For additional information, see "Making Changes During the Year" earlier in this SPD.

If you take an approved unpaid FMLA leave of absence, you may continue your participation in the Health Care Flexible Spending Account during the leave. You will be billed monthly for contributions by the Dun & Bradstreet Benefits Center. Participation will continue as long as you pay the required contributions on a timely basis. You may continue to file claims against your account.

Alternatively, you may elect to discontinue your participation in the Health Care Flexible Spending Account during your FMLA leave of absence. If you return from leave during the same plan year, you may (1) reinstate your coverage at the same level that was in effect before the leave and make up the missed salary contributions; or (2) reinstate your coverage at a level which is prorated to reflect the missed salary contributions during your leave and resume your salary contributions at the original level. If you return to work during a different plan year, you will be allowed to make a new election.

Your participation in the Dependent Care Flexible Spending Account will terminate during your unpaid FMLA leave of absence. If you return to work during the same plan year, your account will be reinstated upon your return. If you return to work during a different plan year, you will be allowed to make a new election.

If you elect not to continue Health Care Flexible Spending Account participation during an FMLA leave, upon return from the leave during the same plan year and reinstatement in the plan, you have the choice of either:

- Resuming participation at your prior annual election amount and making up the missed contributions, or
- Resuming your prior payroll contribution amount and not making up contributions missed during the leave (thereby effectively reducing your prior annual election).

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

If you take an approved leave of absence (whether paid or unpaid), your health care FSA account will continue during your approved leave of absence subject to timely payment of your contributions, 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 health care FSA coverage will be deducted from your pay. If your leave of absence is unpaid, you will be responsible for submitting payments for your health care FSA contributions on a timely basis, otherwise

your account will be terminated. The Dun & Bradstreet Benefits Center at Fidelity will bill you on a monthly basis starting the first of the month following the start of your approved unpaid leave.

Your dependent care FSA account will continue during an approved paid leave of absence and deductions will be taken from your pay. However, if you take an approved unpaid leave of absence, your dependent care FSA account will be suspended during your unpaid leave. Your leave of absence may impact your ability to submit reimbursements for qualifying dependent care expenses incurred while you are on leave. You may also be entitled to make an election change with respect to your Dependent Care Flexible Spending Account on account of your leave. For additional information, see "Making Changes During the Year" earlier in this SPD.

Payroll deductions for both health care and dependent care FSA accounts 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 Participation Ends" occur, including your failure to pay the required contributions for coverage on a timely basis.

CLAIMS AND APPEALS PROCESS

You have the right to file a claim for benefits under the Health Care and Dependent Care Flexible Spending Accounts, ask if you have the right to any benefits under the Accounts, or appeal the denial of a claim for benefits under the Accounts. All claims must be submitted in writing. For purposes of the claims and appeals discussion, the term "you" includes any participant or beneficiary making a claim, inquiry or appeal and the authorized representative of such person. Generally, an "Authorized Representative" is a person you authorize, in writing, to act on your behalf. You must follow the Plan's procedures for appointing an authorized representative. The Plan will also recognize a court order giving a person authority to submit claims on your behalf.

Wex is responsible for determining all initial claims for benefits under the Health Care and Dependent Care Flexible Spending Accounts, and the Plan Administrator will decide all appeals of denied claims. The procedures used to decide initial claims and appeals are described below. Also, 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 (described below), but you must submit the claim to the Plan Administrator, not to Wex. All appeals of such claims must be filed with the Plan Administrator within 180 days of the denial for health care FSA claims and 90 days for dependent care FSA claims. The Plan Administrator will respond to all such appeals within the time frames and in the manner described below.

Time Frame for Initial Claim Determination

The Claims Administrator will notify you of an adverse benefit determination within a reasonable period of time but not later than 30 days after receipt of a health care FSA claim and 90 days after receipt of a dependent care FSA claim. An adverse benefit determination is any denial, reduction or termination of a benefit, or a failure to provide or make a payment, in whole or in part, for a benefit.

An extension of 15 days for health care FSA claims and 90 days for dependent care FSA claims may be allowed to make a determination. For health care FSA claims, the Claims Administrator must determine that the extension is necessary due to matters beyond its

control. If such an extension is necessary, the Claims Administrator must notify you before the end of the first 30-day or 90-day period, as applicable, of the reasons(s) requiring the extension and the date it expects to provide a decision on your claim. For health care FSA claim, if such an extension is necessary due to your failure to submit the information necessary to decide the claim, the notice of extension must *also* specifically describe the required information. The notice regarding the need for an extension will describe the period during which you must provide the information needed to process your claim. If your claim is a health care FSA claim, this period must be at least 45 days.

If an extension is necessary due to your failure to submit necessary information, the Health Care and Dependent Care Flexible Spending Accounts' 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 the required period, your claim will be considered without such additional information and the resulting claim determination by the Claims Administrator will be final.

If You Receive an Adverse Benefit Determination

The Claims Administrator will provide you with a notification of any adverse benefit determination, which will include all information required by law, including:

- The specific reason(s) for the adverse benefit determination.
- References to the specific Health Care and Dependent Care Flexible Spending Accounts' provisions on which the benefit determination is based.
- A description of any additional material or information needed to process the claim and an explanation of why that material or information is necessary.
- A description of the Health Care and Dependent Care Flexible Spending Accounts' appeal procedures and the time limits applicable to those procedures, including a statement of your right to bring a civil action under ERISA after an appeal of an adverse benefit determination.

Procedures for Appealing an Adverse Benefit Determination

If you receive an adverse benefit determination, you may ask for a review. You or your authorized representative has 180 days for health care FSA claims and 60 days for dependent care FSA claims following the receipt of a notification of an adverse benefit determination within which to appeal the determination.

You have the right to:

- Submit written comments, documents, records and other information relating to the claim for benefits.
- Request, free of charge, reasonable access to and copies of all documents, records and other information relevant to your claim for benefits. For this purpose, a document, record or other information is treated as "relevant" to your claim if it:
  - Was relied upon in making the benefit determination.
  - Was submitted, considered or generated in the course of making the benefit determination, regardless of whether such document, record or other information was relied upon in making the benefit determination.
  - Demonstrates compliance with the administrative processes and safeguards required in making the benefit determination.
- 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.

For health care FSA claims, you are also entitled to:

- 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.

Ordinarily, you will be notified of the decision regarding your appeal within reasonable period of time but not later than 60 days after receipt of your request for review of your claim. For dependent care FSA claims, the Plan Administrator may request an extension of 60 days to make a determination if the Plan Administrator determines that special circumstances require the extension. If such an extension is necessary, the Plan Administrator must notify you before the end of the first 60-day period of the reasons(s) requiring the extension and the date it expects to provide a decision on your claim. If an extension is necessary due to your failure to submit necessary information and the claim is a dependent care FSA claim, the 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 Plan Administrator does not receive the requested information from you within the required period, your claim will be considered without such additional information.

The Plan Administrator's notice of an adverse benefit determination on appeal will contain all information required by law, including:

- The specific reason(s) for the adverse benefit determination,
- References to the specific Health Care and Dependent Care Flexible Spending Accounts' provisions on which the benefit determination is based,
- A statement that you are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records and other information relevant to your claim,

- A statement describing any voluntary appeal procedures offered by the Health Care and Dependent Care Flexible Spending Accounts and your right to obtain the information about such procedures, and a statement of your right to bring an action under ERISA,

Exhaustion of Administrative Remedies

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 Health Care and Dependent Care Flexible Spending Accounts' administrative claims and appeals procedure by filing an initial claim and then seeking a timely appeal of any denial before bringing suit. This relates to claims for benefits, eligibility and to any other issue, matter or dispute (including any plan interpretation or amendment issue). Any such suit must be filed within (1) two years after receiving an adverse benefit determination on appeal, or (2) if the requirement to exhaust your administrative remedies in a timely manner does not apply, within two years of the date the claim arose. Any such suit must only be brought or filed in the federal courts of Florida. Failure to follow the Health Care and Dependent Care Flexible Spending Accounts' prescribed procedures in a timely manner will also cause you to lose your right to sue regarding an adverse benefit determination. This means that any claim, action or suit filed in court or in another tribunal will generally be dismissed.

In any action or consideration of a claim in court or in another tribunal following exhaustion of the Plan's claims procedures, the subsequent action or consideration shall be limited to the maximum extent permissible to the record that was before the Plan Administrator or Claims Administrator in the claims procedure process. Upon review by any court or other tribunal, the exhaustion requirement is intended to be interpreted to require exhaustion in as many circumstances as possible.

Discretionary Authority

The Plan Administrator and the Claim Administrator (with respect to any matters delegated to the Claims Administrator) have the exclusive discretionary authority to construe and to interpret the Plan, to decide all questions of eligibility for benefits and to determine the amount of such benefits, and their decisions on such matters are final and conclusive. Any interpretation or determination made pursuant to such discretionary authority shall be given full force and effect. Benefits under the 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 — APPLIES TO THE HEALTH CARE FLEXIBLE SPENDING ACCOUNT ONLY

As a participant in the Health Care Flexible Spending Account, 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 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 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 appeal procedure as described 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 Health Care and Dependent Care Flexible Spending Accounts 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 participate in the Health Care and/or Dependent Care Flexible Spending Accounts described in this booklet is no guarantee of continued employment with Dun & Bradstreet or any Dun & Bradstreet company that participates in the Health Care and/or Dependent Care Flexible Spending accounts.

In accordance with ERISA, this booklet provides a summary plan description of the Health Care and Dependent Care Flexible Spending Accounts, parts 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.