This 2013 Annual Enrollment BenefitsMatters (and any additional items or documents referred to in this guide) is a summary of material modifications (SMM) for the Dun & Bradstreet Corporation Welfare Benefit Plan, Plan Number 501. This SMM amends the latest Summary Plan Description (SPD) that the Plan Administrator determines is applicable to you and must be read together with the SPD. The SMM describes changes and provides clarifications to the SPD regarding the rules applicable to and the benefits provided by the plans. You should keep this SMM together with the SPD. If you have any questions regarding this SMM, contact D&B’s Benefits Center at Fidelity at 1-877-362-8953.

This issue of BenefitsMatters is printed on paper containing 30 percent post-consumer recycled fiber.
Over the past few years, we’ve made changes to our health and welfare benefits program to support our *Culture of Wellness*. Our objective is to continue to reinforce a consumer-driven approach to health care, which encourages team members to take greater responsibility for their health and better understand their health care costs.

For 2013, we will continue to move forward with this strategy by:

- Making medical plan changes related to cost sharing, while keeping premiums unchanged;
- Providing team members with resources to help evaluate their options so they can choose the medical plan that best meets their and their family’s needs; and
- Rewarding team members for taking more control in managing their health.

The changes we’re making for 2013 are necessary to help us manage the increase in medical plan costs, while encouraging team members to take a more active role in improving their health and the utilization of their health care plan.

**Unlike previous years, this year’s Annual Enrollment will be passive since changes to our benefits programs for 2013 will be minimal.** That means you do not have to take any action if you want to keep your 2012 benefit elections for 2013 (this includes medical, dental, life insurance, flexible spending accounts [FSAs], health savings account [HSA], and your other benefits)—you can essentially let your current benefits elections ride for 2013!

Even though we are having a passive enrollment, we want you to become better educated about how the different options work, so you can ensure you have the coverage that is best for you.

D&B will continue to review its health plan options annually to ensure we offer affordable, competitive, and comprehensive coverage for our team members and their families.

**Health Care Reform—Supreme Court Decision**

On June 28, 2012, the Supreme Court of the United States substantially upheld the Patient Protection and Affordable Care Act (PPACA), also known as Health Care Reform. The Supreme Court decision to uphold the law means that provisions already in effect in the D&B medical plans, such as 100 percent preventive care coverage, expanded coverage for children up to age 26, and no lifetime and annual limits on some benefits, will remain in place. For 2013, there are some additional changes, outlined on page 3. D&B will continue to make the required changes to comply with the law as they come due.
Passive Enrollment. Your benefit elections for 2012 will automatically continue for 2013, unless you make a change to them during Annual Enrollment. This means that your current elections for medical, dental, FSAs, HSA, life insurance, voluntary group accident, disability, and group legal benefits will continue in 2013. (If necessary, your health care FSA election will be reduced to comply with the new cap on health care FSA benefits, discussed on page 3.) If you do not want to make any changes to the coverage that you currently have, then you do not have to take any action. You should, however, make sure your enrolled dependents are still eligible. Note: if you don’t make any changes, you will not receive an e-mail from Fidelity confirming your elections.

No Increase to Medical Premiums. Your payroll contributions for your medical and prescription drug coverage will not change for 2013, unless you elect to change your coverage.

Medical Plan Changes. Consistent with our strategy to move toward a consumer-driven approach to health care, we are making the following changes:

– PPO Select — The co-insurance percentage is changing from 85 percent (you pay 15 percent after the deductible) to 80 percent (you pay 20 percent after the deductible).

– High Deductible Health Plan (HDHP) — Deductibles and out-of-pocket maximums are increasing in the HDHP. Please review pages 6-7 for plan details.

New Maintenance Drug Program. Starting January 1, 2013, under both the PPO Select Plan and HDHP, maintenance drugs will need to be filled through the CVS Caremark Mail Service Pharmacy, or at a local CVS pharmacy. This feature applies to drugs taken regularly for chronic conditions or long-term therapy. See page 9 for more details.

Dental Plan Contribution.

There are no plan changes for 2013; however, there is a minimal increase in contributions.

New Flexible Spending Account and Health Savings Account Administrator. The administration of D&B’s FSA and HSA products will be moving to PayFlex, a subsidiary of Aetna. As a result of the move, you will experience the following changes:

– New health care FSA and HSA debit cards will be issued for 2013.

– HSA debit card blackout period from December 24, 2012 through January 3, 2013. Also, HSA investment funds will be frozen during this period.

– Any remaining 2012 FSA balances will transfer to PayFlex.

– HSA investment funds (non-money market) under JPMorgan Chase will be liquidated into a money market account in order to transfer to PayFlex.

– New deadline for submitting FSA claims; you now have until March 31 of the following year to submit claims for the prior year.

For more details on this change, please refer to page 10.
Health Care Reform Changes

Beginning January 1, 2013, we’ll be making the following changes to comply with the federal Health Care Reform legislation:

**New Health Care FSA Limit.** Annual employee contributions to the health care FSA will be limited to $2,500. If you are currently enrolled with an annual contribution of greater than $2,500, your contribution for 2013 will automatically be reduced to $2,500, unless you elect a lesser amount during Annual Enrollment. D&B employer contributions are excluded from this limit.

If you and your spouse are eligible to contribute to a health care FSA, each of you may elect to contribute up to $2,500 to your health care FSA. This applies even if both of you are employed at D&B.

**Expanded Women’s Preventive Health Coverage.** Additional preventive care services for women will be covered at 100 percent—that means you won’t have any cost sharing, including the deductible, co-insurance, or co-payments. For the most part, the D&B medical plans already cover these services at no cost to you. The primary change for 2013 is expanding preventive services to include prenatal visits; gestational diabetes screenings; breastfeeding support, supplies and counseling; and FDA-approved contraceptive methods and counseling.

**Summary of Benefits and Coverage (SBC).** The SBC is now required to be made available to you. The purpose of an SBC is to give participants information about a medical plan’s benefits and to help consumers more easily compare plans and make appropriate enrollment and coverage decisions. Fidelity will send participants an e-mail notification during Annual Enrollment with instructions on where to access the SBC on NetBenefits®. If you are unable to view this document online, you can request that a copy be mailed to you by contacting D&B’s Benefits Center at Fidelity. While the SBC provides an overview of your medical benefits, it is not intended to take the place of your Summary Plan Description (SPD) or the official plan document.

**2012 W-2 Health Care Cost Reporting Requirement.** Employers are required to report the aggregate cost of applicable employer-sponsored health care coverage on employees’ Form W-2. It is intended to help employees better understand the benefit they receive through their employers, and at the same time raise awareness of the true cost of health coverage. The amount of benefits paid on your behalf will appear on your 2012 W-2 in Box 12 using code DD. This will have no impact on your taxable income for the 2012 tax year.
Get Ready to Enroll: What You Need to Do

No Changes for 2013?
Then let it ride! That is, you can keep your current benefit elections for 2013. You don’t have to take any action.

Use Aetna’s Plan Selection Tool to Choose Your Medical Plan
The Plan Selection tool provides you with the information you need to make an informed health care enrollment decision. Use this tool to estimate how much your family’s health care needs may cost for the coming year by:

► Comparing your medical plan choices side by side;
► Comparing how much you may pay out-of-pocket next year, including how much you’ll contribute to the plan from your paycheck; and
► Understanding the value of contributing to an HSA.

Before you start, you’ll need to have the medical claims history for you and your dependent(s), including the number of physician and specialist visits per year, as well as the number of prescription drugs filled.

Access the tool by logging on to Aetna Navigator at www.aetna.com and selecting “Use the Plan Selection Cost Estimator” from the left-hand menu.

Annual Enrollment is the time for you to review your current elections and to make any adjustments in your coverage. One of the main changes to this year’s enrollment process is that if you want to keep your current benefit elections, you do not need to take any action. Your benefit elections for plan year 2012 will automatically continue into plan year 2013. However, if you want to enroll in a different plan or coverage level, or change your health care and/or dependent care FSA or HSA annual contribution, you will need to log on to NetBenefits or call D&B’s Benefits Center at Fidelity between October 24 and November 6.

Attend an Annual Enrollment Teleconference
To learn about the 2013 benefit changes and get answers to your questions about the plans, attend one of the Annual Enrollment teleconference sessions listed below:

<table>
<thead>
<tr>
<th>Date</th>
<th>Times</th>
</tr>
</thead>
<tbody>
<tr>
<td>Monday, October 22</td>
<td>12:00 p.m. ET</td>
</tr>
<tr>
<td>Wednesday, October 24</td>
<td>12:00 p.m. ET</td>
</tr>
<tr>
<td>Monday, October 29</td>
<td>2:00 p.m. ET</td>
</tr>
<tr>
<td>Wednesday, October 31</td>
<td>2:00 p.m. ET</td>
</tr>
<tr>
<td>Friday, November 2</td>
<td>2:00 p.m. ET</td>
</tr>
</tbody>
</table>

For call-in information or to access a recorded session, go to the Benefits communications page on D&BNet.

Take These Steps to Enroll
Here are the steps you can take to help you make better decisions for you and your family for 2013:

► Step 1: Compare your medical and health care account plan options. See pages 6-7 for a comparison of your medical options. Also, be sure to use Aetna’s Plan Selection tool to compare your total out-of-pocket medical costs to see which medical plan best meets your needs.

► Step 2: If you want to make changes to your 2013 coverage, log on to Fidelity NetBenefits at www.netbenefits.com/dnb and click Get Started from the “Health & Insurance Overview” page. If you’d like to let your current elections ride for 2013, you do not need to take any action. However, you can print a summary of your 2013 benefits and costs from NetBenefits to keep for your records as you will not receive a Confirmation Statement.

You will not receive any additional enrollment materials in the mail.

► Step 3: Confirm your elections. If you enroll online, carefully review the final confirmation page to ensure the appropriate plans were selected. Be sure to print a copy of the final confirmation page for your records as you will not receive a Confirmation Statement in the mail. You will receive an e-mail from D&B’s Benefits Center at Fidelity confirming you made changes, but this e-mail does not serve as a Confirmation Statement.

Get Ready to Enroll: What You Need to Do
Take advantage of the D&B Wellness Rewards Program and get rewarded for completing certain wellness activities.

Active, benefits-eligible team members are qualified to earn a Wellness Reward payable in 2013. The following two actions must be completed between January 1, 2012, and December 31, 2012:

- **Get a routine adult physical**
  - If you are enrolled in a 2012 D&B medical plan, Aetna must receive and process your claim for the action to be completed.
  - If you are not enrolled in a 2012 D&B medical plan, after you receive your physical, you must respond "yes" to this question on your Health Assessment: “Have you had a preventive health care visit within the past year?”

- **Complete the Aetna Health Assessment**, including your health screening lab values (blood pressure, cholesterol, blood sugar). To complete the questionnaire log on to Aetna Navigator® at www.aetna.com.

### What You Get

- **$500 to your HSA if you are enrolled in the HDHP for 2013.** *Note: You must be enrolled in an HSA to receive your contribution.*

- **$250 to a health care FSA* if you are enrolled in the PPO Select Plan for 2013.**

- **$250 to a health care FSA* if you are not enrolled in a D&B medical plan option for 2013.**

If all actions are shown as completed on Aetna Navigator by Tuesday, November 6, 2012, you will receive your Wellness Reward by January 15, 2013. Otherwise, your reward will be applied once Aetna has confirmed completion of the required actions.

*An FSA will be opened for you if you are not currently enrolled in one.

### Check the Status of Your Reward

- Click View Incentives from the left-hand navigation menu.
- Select Wellness Reward from the drop-down menu.
- Once you have satisfied the requirements, you will see a Details link in the “Earned” column.

Be sure to print a copy of this page showing your completed status and keep it for your records.
Both plans use the same national network of providers and hospitals (Aetna POS Choice® II —Open Access), cover the same services, and offer the same provider discounts. The difference is in the deductible, co-insurance, and annual out-of-pocket maximum.

<table>
<thead>
<tr>
<th>Feature</th>
<th>In-Network</th>
<th>HDHP</th>
</tr>
</thead>
<tbody>
<tr>
<td>Annual Deductible</td>
<td>Single: $1,800</td>
<td>Family: $3,600²</td>
</tr>
<tr>
<td>Annual Out-of-Pocket Maximum (includes deductible)</td>
<td>Single: $4,500</td>
<td>Family: $9,000</td>
</tr>
<tr>
<td>Lifetime Maximum</td>
<td>None</td>
<td></td>
</tr>
<tr>
<td>Preventive Care³</td>
<td>Plan pays 100%</td>
<td></td>
</tr>
<tr>
<td>Co-insurance for These Types of Services:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Doctor’s office visits</td>
<td>Plan pays 75% after deductible</td>
<td></td>
</tr>
<tr>
<td>Spinal manipulation (up to 30 visits per person per calendar year)</td>
<td>Plan pays 75% after deductible</td>
<td></td>
</tr>
<tr>
<td>X-ray, lab tests</td>
<td>Plan pays 75% after deductible</td>
<td></td>
</tr>
<tr>
<td>Outpatient and inpatient hospital care</td>
<td>Plan pays 75% after deductible</td>
<td></td>
</tr>
<tr>
<td>Physical therapy (up to 30 visits per person per calendar year)</td>
<td>Plan pays 75% after deductible</td>
<td></td>
</tr>
<tr>
<td>Mental Health and Substance Abuse Treatment</td>
<td>Plan pays 75% after deductible</td>
<td></td>
</tr>
<tr>
<td>Inpatient</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Outpatient</td>
<td>Plan pays 75% after deductible</td>
<td></td>
</tr>
<tr>
<td>Emergency Care</td>
<td>Plan pays 75% after deductible</td>
<td></td>
</tr>
<tr>
<td>Hearing exam — routine (one per person per calendar year)</td>
<td>Plan pays 100%</td>
<td></td>
</tr>
<tr>
<td>Vision Exam — routine (one per person per calendar year)</td>
<td>Plan pays 100%</td>
<td></td>
</tr>
<tr>
<td>Frames and lenses</td>
<td></td>
<td>Up to $100 reimbursement per</td>
</tr>
<tr>
<td>Prescription Drugs⁴ (Caremark)</td>
<td>Plan pays 75% after deductible</td>
<td></td>
</tr>
<tr>
<td>Retail (up to a 30-day supply)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Generic</td>
<td>Plan pays 75% after deductible</td>
<td></td>
</tr>
<tr>
<td>Preferred brand name</td>
<td>Plan pays 75% after deductible</td>
<td></td>
</tr>
<tr>
<td>Non-preferred brand name</td>
<td>Plan pays 75% after deductible</td>
<td></td>
</tr>
<tr>
<td>Mail Order</td>
<td>Plan pays 75% after deductible</td>
<td></td>
</tr>
<tr>
<td>Generic</td>
<td>Plan pays 75% after deductible</td>
<td></td>
</tr>
<tr>
<td>Preferred brand name</td>
<td>Plan pays 75% after deductible</td>
<td></td>
</tr>
<tr>
<td>Non-preferred brand name</td>
<td>Plan pays 75% after deductible</td>
<td></td>
</tr>
<tr>
<td>2013 Monthly Contributions</td>
<td></td>
<td></td>
</tr>
<tr>
<td>You</td>
<td>$40</td>
<td></td>
</tr>
<tr>
<td>You + One</td>
<td>$80</td>
<td></td>
</tr>
<tr>
<td>You + Two or More</td>
<td>$120</td>
<td></td>
</tr>
</tbody>
</table>

### Preventive Care

The D&B medical plans cover preventive care services at no cost to the extent required under Health Care Reform. This includes routine screenings and annual checkups. That means no co-payment, deductible, or co-insurance is required. Additional information about covered preventive services can be found in the Medical Plan SPD. These services are not preventive if you get them as part of a visit to diagnose, monitor, or treat an illness or injury. In addition, during your visit, your doctor may order additional tests, which are not considered to be preventive care. Co-payments, co-insurance, and deductibles will apply in both situations.
<table>
<thead>
<tr>
<th>Out-of-Network¹</th>
<th>In-Network</th>
<th>Out-of-Network¹</th>
</tr>
</thead>
<tbody>
<tr>
<td>Single: $3,600</td>
<td>Single: $1,000</td>
<td>Single: $2,000</td>
</tr>
<tr>
<td>Family: $7,200²</td>
<td>Family: $2,000</td>
<td>Family: $4,000</td>
</tr>
<tr>
<td>Single: $9,000</td>
<td>Single: $2,500</td>
<td>Single: $5,000</td>
</tr>
<tr>
<td>Family: $18,000</td>
<td>Family: $5,000</td>
<td>Family: $10,000</td>
</tr>
<tr>
<td>None</td>
<td>None</td>
<td>None</td>
</tr>
<tr>
<td>Plan pays 100%</td>
<td>Plan pays 100%</td>
<td>Plan pays 100%</td>
</tr>
<tr>
<td>Plan pays 55% after deductible</td>
<td>Plan pays 100% after $30 co-payment</td>
<td>Plan pays 60% after deductible</td>
</tr>
<tr>
<td>Plan pays 55% after deductible</td>
<td>Plan pays 100% after $30 co-payment</td>
<td>Plan pays 60% after deductible</td>
</tr>
<tr>
<td>Plan pays 55% after deductible</td>
<td>Plan pays 80% after deductible</td>
<td>Plan pays 60% after deductible</td>
</tr>
<tr>
<td>Plan pays 55% after deductible</td>
<td>Plan pays 80% after deductible</td>
<td>Plan pays 60% after deductible</td>
</tr>
<tr>
<td>Plan pays 55% after deductible</td>
<td>Plan pays 100% after $30 co-payment (waived if admitted)</td>
<td>Plan pays 60% after deductible</td>
</tr>
<tr>
<td>Plan pays 55% after deductible</td>
<td>Plan pays 100% after $30 co-payment</td>
<td>Plan pays 60% after deductible</td>
</tr>
<tr>
<td>Plan pays 55% after deductible</td>
<td>Plan pays 100% after $30 co-payment</td>
<td>Plan pays 60% after deductible</td>
</tr>
<tr>
<td>Plan pays 75% after deductible</td>
<td>Plan pays 100% after $60 co-payment (waived if admitted)</td>
<td>Plan pays 100% after $60 co-payment (waived if admitted)</td>
</tr>
<tr>
<td>Plan pays 100%</td>
<td>Plan pays 100%</td>
<td>Plan pays 100%</td>
</tr>
<tr>
<td>Not covered</td>
<td>Plan pays 100%</td>
<td>Not covered</td>
</tr>
</tbody>
</table>

You pay:
- $5 co-payment
- 20% co-insurance, subject to a $20 min and a $60 max
- 35% co-insurance, subject to a $35 min and an $80 max

Not covered
- 20% co-insurance, subject to a $40 min and a $120 max
- 35% co-insurance, subject to a $70 min and a $160 max

Not covered
- 20% co-insurance, subject to a $40 min and a $120 max
- 35% co-insurance, subject to a $70 min and a $160 max

- $113
- $230
- $357

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1 Eligible charges are subject to reasonable and customary guidelines.
2 If more than one person is covered, the entire family deductible must be met before the plan starts paying co-insurance for all covered participants.
3 As defined by the medical plan.
4 For benefits to be payable, you must use a participating retail pharmacy or the mail-order feature.
In addition to your medical premium, you will incur costs when using your medical benefits. Below is a list of three key terms to help you understand how they apply under each of the plans.

### Plan Provision

<table>
<thead>
<tr>
<th>Annual Deductible*</th>
<th>HDHP</th>
<th>PPO Select Plan</th>
</tr>
</thead>
<tbody>
<tr>
<td>The amount you must pay out-of-pocket in medical expenses each year before the plan begins to pay a portion of your medical expenses.</td>
<td>If you cover dependents, the entire family deductible must be met by one or multiple covered members. Single and family deductibles may be met with medical and prescription drug claims.</td>
<td>If you cover dependents, the family deductible will apply. Once one participant meets the single deductible, the plan will start paying co-insurance for that participant. After the entire family deductible is met (by one or a combination of the remaining participants), the plan will start paying co-insurance for all participants. Co-payments and prescription drug costs do not apply toward the annual deductible.</td>
</tr>
<tr>
<td>Co-insurance</td>
<td>The percentage you pay for medical expenses after the deductible has been met.</td>
<td></td>
</tr>
<tr>
<td>Annual Out-of-Pocket Maximum</td>
<td>The maximum amount you are required to pay for medical expenses annually. Deductibles and co-insurance apply toward the out-of-pocket maximum. Once you reach the out-of-pocket maximum, the plan will pay 100 percent of the cost of care for the remainder of the plan year (excludes amounts over the reasonable and customary charge and co-payments). This protects you from significant expenses by capping the total amount you spend each year.</td>
<td>If you cover dependents, the entire family out-of-pocket maximum must be met by one or multiple covered members before the plan starts paying 100 percent. All medical and prescription drug expenses apply toward your annual out-of-pocket maximum.</td>
</tr>
</tbody>
</table>

*Co-payment, deductible, or co-insurance is not required for preventive care services.*

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**A Word About Filing Medical Claims**

When using in-network providers under either medical plan, your provider will first submit your expenses to the plan—the provider should not request payment upfront (except for a co-payment). 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 will then bill you for the amount you owe. This should match the Explanation of Benefits (EOB) you receive from Aetna.

When using out-of-network providers, you’ll pay the provider in full at the time of service and submit a medical claim form to Aetna for reimbursement.
New Maintenance Drug Program

Maintenance Choice is a new feature of the D&B prescription drug plan, starting January 1, 2013 under both the PPO Select Plan and HDHP. The new Maintenance Choice feature lets you fill 90-day supplies of your long-term prescription drugs through the CVS Caremark Mail Service Pharmacy, or at a local CVS pharmacy for the applicable co-payment or co-insurance (see the chart on pages 6-7). This feature applies to drugs taken regularly for chronic conditions or long-term therapy and when dosage adjustments are either no longer required or made infrequently. A few examples include drugs for birth control, or for managing high blood pressure, asthma, diabetes, or high cholesterol.

How the Program Works

You may obtain up to three 30-day supply prescription fills of a maintenance drug at your retail pharmacy. After your third fill, you’ll be required to receive future refills through a CVS Caremark Mail Service Pharmacy or at a local CVS retail pharmacy. If you continue to fill your maintenance prescription at a non-CVS retail pharmacy, that prescription will not be covered under the D&B prescription drug plan, and you will be responsible for the full retail cost of the drug, unless you opt out of the program.

You must inform CVS Caremark Customer Care if you do not want to include certain prescriptions in this program. The opt-out process is administered per drug. While it is optional to participate in the Maintenance Choice program, D&B encourages members to use this program for savings and convenience.

Getting Started

### Mail Service Pharmacy

- Refills can be ordered online or by phone.
- Convenient delivery to your home or another location of your choice.
- Sign up for the e-refill reminder program to get convenient e-mail notices when it’s time to refill or renew a prescription.

### Local CVS Retail Pharmacy

- Pick-up your long-term drug directly from the pharmacy at a time that is convenient for you.
- Enjoy same-day prescription availability.

#### To sign up for mail service:

- **Online:** Log on to the Caremark Web site, select [Start a New Prescription](#) and then click on FastStart®.
- **By Phone:** Call FastStart toll-free at 1-800-875-0867 Monday through Friday, between 8:00 a.m. and 8:00 p.m., Eastern time. **Note:** Your doctor can call the FastStart physician number at 1-800-378-5697 to call in a 90-day prescription.

#### To register at your local CVS:

- Register or log on to [www.caremark.com](#) to select a CVS pharmacy location for pick-up.
- Visit your local CVS pharmacy and talk to the pharmacist.
- Call the toll-free number on the back of your Caremark prescription drug ID card.

**Note:** You’ll need to get a prescription for a 90-day supply from your doctor.
Effective January 1, 2013, the D&B HSA, and health care and dependent care FSAs are moving to PayFlex, a subsidiary of Aetna. PayFlex provides robust account tools, accessible through Aetna Navigator, making it easy for you to manage your accounts. Key features include real-time account balances, customizable account alerts, a mobile application and the ability to decide if, how, and when to use your account funds.

### Important Things to Know as We Transition to PayFlex

#### Flexible Spending Accounts (FSAs):
- Your 2012 health care FSA debit card will be deactivated on December 31, 2012.
- Any remaining 2012 health care and dependent care FSA balances will transfer to PayFlex and will be available on January 3, 2013. 2012 balances can be accessed through Aetna Navigator on the PayFlex system, and reimbursement must be requested by March 31, 2013.

#### Health Savings Account (HSA):
- You cannot use your 2012 HSA debit card between December 24, 2012, and January 3, 2013. Also, HSA investment funds will be frozen during this period. This means you will not be able to trade or withdraw funds from your account during this time.
- HSA investment funds (non-money market) under JPMorgan Chase will be liquidated into a money market account in order to transfer to PayFlex. JPMorgan Chase will contact participants directly on required steps. If you do not liquidate your non-money market accounts, they will be automatically liquidated for you.

Your FSA and/or HSA funds will be available on PayFlex starting January 3, 2013.

### Online Account Access on Aetna Navigator
- File a claim online.
- Check account balances, claims and transaction history.
- View listings of eligible and ineligible expenses.
- Receive e-mail notifications or Web alerts for updates regarding your account(s).

### PayFlex Mobile App
- File a claim using your phone’s camera.
- Check account balances, claims and transaction history.
- Provide requested receipts to substantiate a debit card transaction.
- View important account alerts.

### Watch for New Health Care Account Debit Card
If you are enrolled in a health care FSA or an HSA in 2013, you should receive a new PayFlex debit card by January 3, 2013.
You are eligible to participate in an Aetna health care account, which you can use to pay for eligible health care expenses on a before-tax basis (including deductibles, co-insurance, and co-payments). If you enroll in the HDHP, you are eligible for the HSA; if you enroll in the PPO Select Plan, or if you do not enroll in a D&B medical plan, you are eligible for the health care FSA.

### Health Care Account Options

<table>
<thead>
<tr>
<th></th>
<th>HSA</th>
<th>Health Care FSA</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Availability</strong></td>
<td>Available to eligible team members who enroll in the HDHP.</td>
<td>Available to eligible team members who enroll in the PPO Select or elect no medical coverage.</td>
</tr>
<tr>
<td><strong>Carryover</strong></td>
<td>Any money in your HSA at the end of the plan year carries over to the next year and can be used for future health care expenses.</td>
<td>All money in your account must be used by the end of the plan year, or you forfeit it.</td>
</tr>
<tr>
<td><strong>Portability</strong></td>
<td>Your HSA is portable and can be taken with you if you change medical plans, leave D&amp;B, or retire.</td>
<td>Your FSA is not portable.</td>
</tr>
<tr>
<td><strong>Timing</strong></td>
<td>You can open an account any time during the year and you can increase, decrease, or stop contributions at any time.</td>
<td>You decide the amount you want to contribute during Annual Enrollment. You can only change the amount if you have a qualified family status change during the year.</td>
</tr>
<tr>
<td><strong>Funding</strong></td>
<td>► <strong>Before-tax contributions.</strong> You can contribute $3,250 for You Only coverage or $6,450 for You + One, or You + Two or More coverage for 2013. This limit includes any D&amp;B contributions.</td>
<td>► <strong>Before-tax contributions.</strong> You can contribute up to $2,500 to the health care FSA for 2013.</td>
</tr>
<tr>
<td></td>
<td>► <strong>Catch-up contributions.</strong> If you will be age 55 or older in 2013 and are not enrolled in Medicare, you can make “catch-up” contributions up to a maximum of $1,000.</td>
<td></td>
</tr>
<tr>
<td><strong>Savings</strong></td>
<td>Funds in an HSA can be invested. PayFlex offers 25 investment options.</td>
<td>No investment or interest earnings available.</td>
</tr>
<tr>
<td><strong>More Information</strong></td>
<td>For a complete list of eligible expenses, refer to IRS publications 969 and 502 at <a href="http://www.irs.gov">www.irs.gov</a>.</td>
<td>For additional information about qualified expenses, refer to IRS Publication 502 at <a href="http://www.irs.gov">www.irs.gov</a>, but keep in mind that some expenses listed in IRS Publication 502 are not eligible for reimbursement from your health care FSA.</td>
</tr>
</tbody>
</table>

### Accessing Your Health Care Account Funds

You can use your PayFlex debit card, or online tools through Aetna Navigator or PayFlex Mobile app, to access your HSA or health care FSA funds.

For the health care FSA, the full amount of your annual contribution is available at the start of the plan year. For the HSA, only deposited funds in your money market account are available.
Keep Track of Your Expenses

Keep careful records of your health care expenses, including receipts for your health care FSA debit card transactions and corresponding withdrawals from your HSA.

Under IRS regulations, every transaction on a health care FSA debit card must be either validated or recouped from the participant. In many cases, Aetna automatically validates health care FSA debit card transactions for expenses covered under the D&B medical, dental, and prescription drug plans. However, if an automatic validation is not made, you will be asked to show proof of that expense.

For the HSA, PayFlex will report distributions on IRS Form 1099-SA. You are responsible for reporting eligible and ineligible withdrawals when completing your federal taxes. You are also responsible for saving all receipts as validation of expenses in the event you are audited.

If it is determined that you have an ineligible expense or you cannot substantiate an expense:

► For the health care FSA, you will have to pay the plan back. Your card will be deactivated until the amount is returned. Also, any amounts not returned will be added to your Form W-2 as taxable income.

► For the HSA, you’ll pay taxes on that distribution and an additional 20 percent penalty if you are under age 65.

Understand the IRS Regulations for an HSA and FSA

Because HSAs and FSAs offer tax advantages, they are governed by federal regulations and have some eligibility rules.

HSAs

► You cannot contribute to an HSA if you are covered by another medical plan that is not designated as a high deductible health plan (HDHP)—e.g., a spouse’s employer’s coverage.

► You cannot contribute to an HSA if you are enrolled in Medicare or receiving Social Security benefits. If you participated in an HSA before enrolling in Medicare and have available funds, you will still be able to withdraw money from your account to pay for eligible medical expenses while covered under Medicare.

FSAs

You should not open an FSA if your spouse is contributing to an HSA. Your enrollment in the D&B health care FSA would make your spouse ineligible to contribute to his/her HSA under federal law. This applies even if you do not submit medical expenses to the health care FSA. Because of this IRS regulation, you and your spouse need to determine the best option for your situation.
Your Dependent Care Flexible Spending Account (FSA)

With the dependent care FSA, you contribute money to an account on a before-tax basis to pay for eligible dependent care expenses for your child up to age 13 so you can work and, if you are married, so your spouse can work or attend school full-time. **Note: The dependent care FSA cannot be used for dependent health care expenses.**

You can elect to contribute between $250 and $5,000 ($2,500 if married, filing separately) to your dependent care FSA for 2013. Your contribution election will include the D&B match. D&B matches your payroll contributions up to a maximum of $500. For example, if you elect $1,500, you will contribute $1,000 and D&B will contribute the additional $500. Alternatively, if you elect $250, you will contribute $125 and D&B will contribute the additional $125.


Your Dental Benefits

Under the Aetna Dental plan, you have a choice of using in-network or out-of-network dentists. You do not need to enroll for medical coverage to enroll for dental coverage. Log on to Aetna Navigator to search for a dentist in the Aetna Dental PPO II network. You can also search on Aetna’s provider directory, DocFind, at [www.aetna.com/docfind](http://www.aetna.com/docfind) and select the *Dental PPO/PDN with PPO II* network.

Your Long-Term Disability (LTD) Plan

LTD coverage can provide the protection you and your family need if you become sick or injured and unable to work. If you enroll during Annual Enrollment, you will not have to provide Evidence of Insurability (EOI).

Your contributions for LTD coverage are based on your annual earnings and made on an after-tax basis. Log on to NetBenefits for your 2013 contribution rates.

Your Group Legal Plan

The Group Legal Plan, administered by ARAG, provides access to a wide-range of covered legal matters, most of which are 100 percent paid-in-full when you work with a network attorney. The contribution for participating in the Group Legal Plan is $26 per month on an after-tax basis.

If you do not enroll now, you will have to wait until the next Annual Enrollment period to enroll, unless you experience a qualified change in family status during the year. If you are already enrolled and want to continue your coverage, no action is required.

For More Detailed Plan Information

For more details on all your D&B benefit plans, please review the online Summary Plan Descriptions (SPDs) on *D&BNet* (at the homepage click on Human Resources, then click Benefits) or on the D&B Benefits Internet site at [www.dnb.com/benefits](http://www.dnb.com/benefits).
Get Health Information Online with Aetna Navigator

With Aetna Navigator, your secure member Web site, you have access to details about your health care benefit plans when you need them. On the site, you’ll also find resources that provide easy-to-understand health and cost information, so you can learn more about your choices and get the care you need.

After you register and log on to the site, you can:

► Confirm your coverage and who in your family is covered under your plan;
► Find a primary care physician, specialist, or dentist;
► Track claims and claim payments or review an Explanation of Benefits (EOB);
► Order a replacement member ID card;
► Check FSA and HSA balances and activity;
► Review costs for medical treatments, procedures, tests, and other services in your area; and
► Send a secure e-mail to Aetna Member Services for help with claim and benefits questions.

Do Not Forget These D&B Resources

► D&BNet. Visit from your work computer for more details about your benefits, including SPDs for each benefit plan. At the D&BNet homepage, click on Human Resources, then click on Benefits.

► The D&B Benefits Internet Site. You and your family members can access D&B benefits information from any computer with Internet access, 24 hours a day, 7 days a week. Visit www.dnb.com/benefits to access SPDs and BenefitsMatters.

► D&B HR Resource Center. Have an HR question and don’t know who to contact? The HR Resource Center is here to help! HR questions that cannot be answered through HR self-service tools and resources available on D&BNet can be answered by sending an e-mail to HRResourceCenter@dnb.com. The HR Resource Center is comprised of D&B team members who specialize in the areas of benefits and HR policies and procedures.
Here is how you can learn more about your D&B benefits:

<table>
<thead>
<tr>
<th>Learn More About...</th>
<th>Contact...</th>
<th>By Phone</th>
<th>Online</th>
</tr>
</thead>
<tbody>
<tr>
<td>Health and welfare benefits enrollment, 401(k) changes, beneficiary information, or reporting a death</td>
<td>D&amp;B’s Benefits Center at Fidelity</td>
<td>1-877-362-8953</td>
<td><a href="http://www.netbenefits.com/dnb">www.netbenefits.com/dnb</a></td>
</tr>
<tr>
<td>Payment of medical and dental claims or filing an appeal of a claim denial</td>
<td>Aetna</td>
<td>1-800-422-1749</td>
<td><a href="http://www.aetna.com">www.aetna.com</a></td>
</tr>
<tr>
<td>Payment of prescription claims or filing an appeal of a claim denial</td>
<td>CVS Caremark Customer Care</td>
<td>1-877-321-2649</td>
<td><a href="http://www.caremark.com">www.caremark.com</a></td>
</tr>
<tr>
<td>Health savings account</td>
<td>PayFlex</td>
<td>1-888-678-8242</td>
<td><a href="http://www.aetna.com">www.aetna.com</a></td>
</tr>
<tr>
<td>Flexible spending account (FSA) claims</td>
<td>PayFlex</td>
<td>1-888-678-8242</td>
<td><a href="http://www.aetna.com">www.aetna.com</a></td>
</tr>
<tr>
<td>Long-term care insurance, including enrollment</td>
<td>CNA</td>
<td>1-800-528-4582</td>
<td><a href="http://www.ltcbenefits.com">www.ltcbenefits.com</a> (Password: DNB)</td>
</tr>
<tr>
<td>Group Legal Plan</td>
<td>ARAG</td>
<td>1-800-247-4184</td>
<td><a href="http://www.members.aragroup.com/db">www.members.aragroup.com/db</a></td>
</tr>
</tbody>
</table>
The Medical Plan and Mastectomy-Related Benefits

The D&B medical plans provide medical and surgical benefits for mastectomies and elective breast reconstruction. If a team member or dependent covered under a D&B medical plan has a mastectomy and elects to have breast reconstruction (in a manner determined through patient consultations with the attending physician), the option will cover:

- All stages of reconstruction of the breast on which the mastectomy has been performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance;
- Prostheses; and
- Treatment of the physical complications related to all stages of the mastectomy (including lymphedemas).

These mastectomy-related benefits are subject to the same annual deductible and co-insurance rules that apply to other medical and surgical benefits provided under D&B’s medical plans.

Notice of Special Enrollment Rights under the Health Insurance Portability and Accountability Act (HIPAA)

If you are declining enrollment for yourself or your dependents (including your spouse/domestic partner) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing toward your or your dependents’ other coverage). However, you must request enrollment within 31 days after your or your dependents’ other coverage ends (or after the employer stops contributing toward the other coverage).

If you have a new dependent as a result of marriage, birth, adoption or placement for adoption, you may be able to enroll yourself and your dependents. However, you must request enrollment within 31 days after the marriage, birth, adoption, or placement for adoption.

In addition, you may be able to enroll yourself and your dependents in this plan if your or your dependent’s coverage under a Medicaid plan or a State Children’s Health Insurance Program (CHIP) plan terminates due to loss of eligibility for such coverage or if you or your dependent(s) become eligible for premium assistance under a Medicaid plan or a CHIP plan. However, you must request enrollment within 60 days after the date your or your dependents’ Medicaid or CHIP coverage terminates or the date you or your dependents are determined to be eligible for such assistance.

To request special enrollment or obtain more information, log on to Fidelity NetBenefits® at www.netbenefits.com/dnb. If you do not have Internet access, call D&B’s Benefits Center at Fidelity toll-free at 1-877-362-8953, Monday through Friday (excluding New York Stock Exchange holidays) between 8:30 a.m. and 8:00 p.m., Eastern time to speak with a benefits representative.
This guide is a summary of the benefits provided by The Dun & Bradstreet Corporation (D&B) to D&B team members in the United States. More detailed information is provided in the official Plan Documents and insurance contracts. If there is a conflict between statements in the information in this guide and the Plan Documents and insurance contracts, the Plan Documents and insurance contracts will govern and control the operation of the Plan(s). The Board of Directors of D&B (and/or its delegate) reserves the right to modify, suspend, change, or terminate the Plan(s) at any time for all or any group of participants, whether actively employed or retired. You should address questions regarding your coverage and benefits to the organizations designated in the contact information chart in this guide. Because of the many detailed provisions of the Plan(s), no one other than the Plan Administrator and its authorized Claims Administrator is authorized to advise you as to your coverage and benefits. For this reason, D&B cannot be bound by statements made by unauthorized personnel.