# RR DONNELLEY POST-65 RETIREE WELFARE BENEFITS PLAN

## SUMMARY PLAN DESCRIPTION

This Summary Plan Description (SPD) describes the Medical Benefit Program and Drug Benefit Program benefits available to an eligible former employee of RR Donnelley based on a January 1 to December 31 plan year. The SPD effective date is May 1, 2025.

RRD BENEFITS
HEALTH | WEALTH | LIFE

May 2025

# CONTENTS


**Contents** ..... ii

**Introduction** ..... 1

Claims Administrators ..... 2

**Who Is Eligible** ..... 3

Retiree Eligibility Requirements ..... 3

If You Are Involuntarily Separated ..... 3

If You Are on an Authorized Leave of Absence ..... 3

Benefits-Eligible Position ..... 4

If You Die ..... 4

Spouse Eligibility Requirements ..... 5

**Enrolling for Coverage** ..... 6

General Information ..... 6

**Program Premium Cost** ..... 7

Determining an Annual Premium for You and your Eligible Spouse ..... 7

Program Premium Cost – Determining an Annual Premium for You and Your Eligible Spouse – Total Cost of Coverage ..... 7

Annual Subsidy Cap Amount ..... 7

Continuous Service ..... 9

**Special Rules for Certain Participants** ..... 10

Who Is Eligible – Closed Eligibility Group ..... 10

Dependent Eligibility and Program Premium Cost ..... 13

**Retiree Waive Credit Program** ..... 16

Deadline to Submit Claims ..... 17

**Retiree Health Care Account** ..... 18

*If You Retired From Moore Prior to July 1, 1997* ..... 18

*If You Retired From Moore on or After July 1, 1997* ..... 18

*Your Medical Allowance(s)* ..... 18

*Using Your RHCA to Reimburse the Cost of Coverage* ..... 19

*If you are rehired following retirement* ..... 20

*If you die before you start receiving Medical Allowance* ..... 20

*If you die after you start receiving your Medical Allowance* ..... 20

*Filing for Reimbursement Under the RHCA Plan* ..... 20

*Deadline to Submit Claims* ..... 21

*Special Disqualification Rule Regarding Competition* ..... 21

**Medical Benefit Program Summary** ..... **22**
Banta Subsidized Retiree Group ..... 23
Esselte Subsidized Retiree Group ..... 23
Meredith Burda Subsidized Retiree Group ..... 23
Making Required Premium Payments ..... 23
**Your Rights and Responsibilities** ..... **25**
General Information ..... 25
Your Rights ..... 25
Your Responsibilities ..... 26
**How the Medical Benefit Program Works** ..... **28**
General Information ..... 28
Plan Design Charts ..... 29
AETNA MEDICARE PLAN (PPO) ESA 400 PLAN DESIGN SUMMARY ..... 30
AETNA MEDICARE PLAN (PPO) ESA 200 PLAN DESIGN SUMMARY ..... 32
Available to Moore Pre-1979 Retirees Only ..... 32
AETNA MEDICARE PLAN (PPO) ESA 275 PLAN DESIGN SUMMARY ..... 33
Available to Moore 1979 – 1986 Retirees Only ..... 33
BCBSIL SELF-FUNDED PLAN OPTION PLAN DESIGN SUMMARY Available to Esselte Corporation, Boorum & Pease Division Retirees from Brooklyn Only ..... 34
BCBSIL SELF-FUNDED PLAN OPTION PLAN DESIGN SUMMARY Available to Esselte Corporation, Boorum & Pease Division Retirees from Syracuse Only ..... 36
WELLMARK BCBS OF IA POST-65 RETIREE MEDICARE ..... 39
Available to Meredith Burda Post-65 Retirees by 12/31/1991 Only ..... 39
Medicare Part A Hospital Services (Per Benefit Period) ..... 39
Medicare Part B Medical Services (Per Calendar Year) ..... 41
Prescription Drug Coverage ..... 42
Other Benefits Not Covered By Medicare ..... 42
Additional Plan Details ..... 43
**Your Legal Right to Continuation Coverage** ..... **44**
General Information ..... 44
Notification ..... 45
Election Procedure ..... 45
Payment ..... 45
When Continuation Coverage Ends ..... 46
ACA 1557 Grievance Procedures ..... 46
Procedure ..... 47
**Situations Affecting Your Benefits** ..... **48**
General Information ..... 48

If the Plan Is Modified or Ended ..... 48
If the Plan Is Discriminatory ..... 49
Plan Rebates ..... 49
**Administrative and Contact Information ..... 50**
General Information ..... 50
Eligibility Administration ..... 51
Claims Administrator and Network Manager ..... 52
Claims Administrator for Eligibility Claims ..... 53
COBRA Administrator for Continuation Coverage ..... 53
Allocation and Delegation of Fiduciary Responsibilities by the Benefits Committee ..... 53
Trust and Insurance ..... 54
Funding ..... 54
Participating Employers ..... 54
**Your ERISA Rights ..... 55**
General Information ..... 55
Receive Information About Your Plan and Benefits ..... 55
Continue Group Health Plan Coverage ..... 55
Prudent Actions by Plan Fiduciaries ..... 56
Enforce Your Rights ..... 56
Assistance With Your Questions ..... 56
**Appendix A – Member Certificates and Booklets ..... 57**
**Appendix B – Discrimination is Against the Law ..... 58**

# INTRODUCTION

Effective May 1, 2025, the Post-65 medical and prescription drug components of the R.R. Donnelley & Sons Company Retiree Welfare Benefits Plan, as well as the Retiree Waive Credit Program and the Retiree Healthcare Account were spun off from that plan and moved to a new plan named the RR Donnelley Post-65 Retiree Welfare Benefits Plan (the "Post-65 Plan" or "Plan").

The Plan provides benefits to eligible Retirees through four programs, the:

- "Medical Benefit Program";
- "Drug Benefit Program";
- Retiree Waive Credit Program ("RWCP"); and
- Retiree Healthcare Account ("RHCA").

This Summary Plan Description ("SPD") describes the Medical Benefit Program and Drug Benefit Program (collectively called the "Group Health Program") benefits available to an eligible former employee of R.R. Donnelley & Sons Company ("RR Donnelley") and its subsidiaries who retired prior to October 1, 2016 (a "Retiree"), and who is age 65 or older, as well as eligible dependent(s) of Retirees who are age 65 or older who participate in the Plan. The SPD also describes the RWCP and RHCA benefits available to a Retiree and his or her covered dependents irrespective of age.

When the term "Program" is used in this SPD, it refers collectively to the Medical Benefit Program, the Drug Benefit Program, the RWCP, and the RHCA.

This SPD explains who is eligible for coverage, when coverage begins and ends, and which expenses are and are not covered under the Post-65 Plan. It also describes how to file a claim and your rights under the Plan. Please read this information to familiarize yourself with the Plan.

# Claims Administrators

The Post-65 Plan has contracted with a number of third parties to render services necessary for the operation and administration of the Plan and the Programs as the claims administrator and network manager. Some of these services involve authority and discretion over the Plan.

The following insurers and/or claims administrators administer the Programs:

| Program | Administrator |
|---|---|
| **Medical Benefit Program** | Aetna |
| **Drug Benefit Program** | Aetna |
| **Esselte (Medical Benefit Program)**<br>**Esselte (Drug Benefit Program)** | Blue Cross and Blue Shield of Illinois<br>Prime Therapeutics |
| **Meredith Burda Post-65 (Retired by 12/31/1991) (Medical Benefit Program)** | Wellmark Blue Cross and Blue Shield of Iowa |
| **RWCP** | HealthEquity |
| **RHCA** | HealthEquity |

*See the "Administrative and Contact Information" section for additional information.

This SPD and any supplemental information incorporated by reference are intended to be a complete, accurate, and up-to-date description of your coverage under the Plan. However, since treatments, protocols, and practice patterns continually change, this document cannot adequately define every potentially covered service or exclusion. In all cases, the applicable claims administrator will have the authority and discretion to make the determination of covered services. If there is any discrepancy between this SPD and the Plan, the Plan always governs.

In addition, nothing in this SPD should be interpreted as a guarantee of continued coverage. This summary merely describes the coverages and benefits offered to eligible Retirees and their dependent(s) who retired from a Participating Employer prior to October 1, 2016. RR Donnelley reserves the right to change or terminate the Plan or Program, in whole or in part, at any time.

The Plan also provides similar Retiree coverage for certain grandfathered Retirees of acquired companies and their subsidiaries. (See the "Special Rules for Certain Participants" section for additional information.)

This content contains a summary in English of your rights and benefits under the Program. If you have difficulty understanding any part of this content, call the RR Donnelley Benefits Center at 1-877-RRD-4BEN (1-877-773-4236). Benefits Center Representatives are available from 7 a.m. to 7 p.m. CT, Monday through Friday, except holidays.

# WHO IS ELIGIBLE

## Retiree Eligibility Requirements

The following eligibility requirements apply only to employees of a Participating Employer as defined in the "Administrative and Contact Information" section of this SPD. See the "Special Rules for Certain Participants" section for additional information for Participating Employer (Acquisition Group – Grandfathered).

You are eligible for coverage as a Retiree under the Program if you meet all of the following requirements:

- Your employment with a Participating Employer terminated prior to October 1, 2016; and
- Your employment with a Participating Employer terminated on or after your 55th birthday; and
- You completed 10 or more years of service with a Participating Employer in a benefits-eligible position, and this period of service must end after attaining age 55.

## If You Are Involuntarily Separated

If you were involuntarily separated from employment pursuant to a workforce reduction within 12 months of the date you otherwise would have satisfied the eligibility criteria for the Plan, you would have been treated, but only for purposes of the Plan, as if your employment did not terminate until you would have become eligible for coverage under the Plan. You became eligible for coverage effective on the date you would have become eligible for coverage if your involuntary separation had not occurred, provided you were alive on that date.

**An age example*:*** If you were age 54 and have completed 10 years of service at the time you are involuntarily separated, you are eligible for coverage on the date you attain age 55. You must still take the necessary steps to enroll and make the required payments of your premiums to the Plan in a timely manner.

**A service example:** If you were age 60 with nine years of service at the time you are involuntarily separated, you are eligible for coverage on the date in which your 10-year anniversary of employment would have occurred. You must enroll and make required payments of your premiums to the Plan in a timely manner.

## If You Are on an Authorized Leave of Absence

If you were an employee on an authorized leave of absence as determined under the provisions of your employer's policies, you would have been eligible for coverage under the Plan if you met the eligibility requirements for the Plan as outlined above. For this purpose, service earned while on an authorized leave of absence from a benefits-eligible position counted toward satisfying the requirement that you serve two or more years of continuous service in a benefits-eligible position.

**Retiree Eligibility Requirements**

Notwithstanding anything to the contrary in this SPD or any other document describing eligibility for coverage under the Plan, any right to coverage under the Plan immediately terminated effective October 1, 2016, if you had not met the eligibility requirements above. In order to qualify as an eligible Retiree, you must have terminated/retired from RR Donnelley and all of its subsidiaries and affiliates (including but not limited to LSC Communications and Donnelley Financial Services) on or before September 30, 2016. If you retire(d) from a Participating Employer on or after October 1, 2016, you will not be eligible to enroll in the Medical Benefit Program or Drug Benefit Program.

In addition, and notwithstanding any other provision of this SPD to the contrary, if you met the above requirements and you were a union employee covered by a collective bargaining agreement, you were eligible for coverage only to the extent the collective bargaining agreement provided for your and perhaps your eligible spouse's eligibility to participate.

You are not eligible for coverage under the Plan if you are currently working as an active employee (e.g., if you are rehired by RR Donnelley and return to active employment following retirement). However, when you later cease working as an active employee of RR Donnelley, you will automatically rejoin Group Health Program if you were enrolled in the Plan immediately prior to returning to active employment.

You are not eligible for coverage under the Plan if you are currently covered as a spouse or dependent of an active employee under the Active Group Health Program ("Active Program"). If you want to enroll in the Pre-65 Group Health Program or the Post-65 Plan (collectively "Retiree Plans"), you must drop your Active Program coverage and enroll in the Retiree Plans no later than the date you attain Medicare eligibility or age 65. Otherwise, coverage under the Retiree Plans will no longer be available to you (or your spouse, if eligible), and you will not be permitted to join the Retiree Plans in the future.

# Benefits-Eligible Position

You are/were in a benefits-eligible position if you are/were an employee of a Participating Employer and you are/were eligible to participate in the Active Program.

**Note:** You are not eligible to participate in this program if your employment with a Participating Employer terminates on or after October 1, 2016.

**Important:** Being eligible for the Program does not mean you or your eligible spouse can enroll in the Program. See the section titled "Enrolling for Coverage" for additional rules and limitations.

# If You Die

If you are eligible for coverage under the Plan when you die, your surviving spouse may commence or continue coverage, regardless of whether he or she remarries or becomes eligible for coverage under another employer's plan.

However, if you have not enrolled in the Plan prior to your death, your surviving spouse must enroll if he or she wants coverage.

# Spouse Eligibility Requirements

A “spouse” means an individual to whom a Retiree is legally married, or a Retiree’s common-law spouse, in states that recognize common-law marriages.

A Retiree’s spouse is eligible for coverage under the Plan only if the Retiree, and if applicable, the Retiree’s spouse, meet all of these requirements at all times:

- If the Retiree is alive, the Retiree must be enrolled for coverage under a Retiree Plan. The Retiree’s spouse cannot elect coverage under the Plan on his or her own. However, if the Retiree’s spouse is also a Retiree and has met the eligibility requirements for coverage under the Plan, he or she may elect his or her own coverage as a Retiree.
- The Retiree must be married to the Retiree’s spouse on the date the Retiree terminates employment with, or dies while employed by, a Participating Employer. No coverage will be provided for a spouse Retiree marries after the date the Retiree’s employment terminates (except that if a Retiree marries or remarries (i) on or after May 1, 2025, and (ii) while the Retiree is participating in the Pre-65 Group Health Program, then the Retiree may enroll a new spouse who is under age 65 in the Pre-65 Group Health Program, and that spouse may later enroll in this Plan once turning age 65).
- The Retiree’s spouse may not be legally separated or divorced from the Retiree.
- The Retiree’s spouse may not be covered as an active employee under the Active Program or under the Plan as a Retiree.

Except as where otherwise noted for Retirees of Moore or Wallace, domestic partners are not eligible for coverage and references to a “spouse” throughout this SPD do not include references to a Retiree’s domestic partner.

A Retiree’s spouse who continues coverage as a surviving spouse who later remarries cannot enroll his or her new spouse in the Plan.

Dependent children of a Retiree or a Retiree’s spouse are not eligible for coverage under the Plan.

# ENROLLING FOR COVERAGE

## General Information

If you are enrolled or eligible to enroll in the Plan each year you will receive Annual Enrollment materials. Here is a brief look at how enrolling for coverage works.

If you want to enroll, you can:

- Log on to **rrd.bswift.com**.
- Call the Benefits Center at 1-877-RRD-4BEN (1-877-773-4236).

You will receive a confirmation of your enrollment or disenrollment based on your method of enrollment. If you enroll via the website, print a confirmation page (a paper statement will not be mailed to you). If you enroll by phone, you will receive a written confirmation in the mail.

**If, on December 31, 2013, a former employee was under age 65 (and not enrolled in the Plan)**: The Retiree must enroll the earlier of attaining Medicare eligibility or age 65. Otherwise, coverage under the Plan will no longer be available to the Retiree or his or her spouse, if eligible. **This means the former employee's last chance to opt in to the Program is when he or she becomes Medicare-eligible.** In addition, once enrolled in the Plan, even if prior to age 65 or Medicare-attainment, if a former employee decides to opt out of coverage, such individual and his or her eligible spouse cannot opt back in.

**Note:** Medicare is effective the first of the month in which you turn 65, but it can take 60 days for coverage under the Plan to take effect, since your election must first be accepted by the Centers for Medicare and Medicaid Services (CMS). Thus, if you want coverage to take effect at the same time as Medicare, you will need to contact the Benefits Center 60 days prior to that date. Otherwise, you may have a lapse in coverage and may need to pay a penalty. Visit **medicare.gov** for more information about enrollment and potential penalties.

**The rules above apply based on your (the Retiree's) Medicare eligibility.** For example, if the Retiree is under age 65, but the Retiree's spouse is over 65, you have until the Retiree's Medicare attainment age to enroll both the Retiree and spouse in coverage.

**If, on December 31, 2013, a former employee regardless of age continued enrollment in the Retiree Plans:** The former employee will continue his or her coverage under the Retiree Plans. However, if a former employee later decides to opt out of Retiree Plan coverage after December 31, 2013, such individual and his or her eligible spouse cannot opt back in.

**Note:** If you enroll in coverage under the Plan and later decide to opt out, you cannot reenroll yourself or your eligible spouse.

# PROGRAM PREMIUM COST

## Determining an Annual Premium for You and your Eligible Spouse

### Program Premium Cost – Determining an Annual Premium for You and Your Eligible Spouse – Total Cost of Coverage

Each calendar year, the Plan's actuaries determine the projected total cost of coverage for the Group Health Program based on each Group Health Program option available to a Retiree and his or her spouse. The "total cost of coverage" includes all Group Health Program claims incurred by the Plan and operating expenses.

How much you and your eligible spouse must pay to the Plan to be enrolled for coverage (called your "premium") will depend upon:

- Which Group Health Program you are enrolled in;
- Whether you cover an eligible spouse; and
- The amount of the subsidy, as described below, from your former employer.

You will know the premium for the next calendar year when you receive your Annual Enrollment materials.

If you are a grandfathered Retiree of an acquired company, you may be eligible for a subsidy as outlined in your grandfathered coverage. (See the "Special Rules for Certain Participants" section for additional information.)

### Annual Subsidy Cap Amount

On January 1, 1997, RR Donnelley implemented a cap (the "annual subsidy cap amount") on how much a Participating Employer will pay, on and after January 1, 1997, to the Plan for coverage of a Retiree and his or her spouse in the Plan, based on the Group Health Program in which the Retiree and his or her spouse are enrolled, if the Retiree satisfies an age and continuous service requirement. When the total cost of coverage (e.g., without a subsidy) exceeds the annual subsidy cap amount, the Retiree and his or her spouse, if eligible for the annual subsidy cap amount, are responsible for the total cost of coverage in excess of their annual subsidy cap amount. As a result, if you and your spouse are eligible for an annual subsidy cap amount, the premiums you and your spouse are charged for participating in the Plan will be equal to the total cost of coverage you and your spouse would otherwise have to pay, based on the Group Health Program in which you and your spouse are enrolled (without the subsidy), minus the annual subsidy cap amount for you and your spouse for that Group Health Program.

You and your spouse are eligible, on and after January 1, 1997, for an annual subsidy cap amount only if all of the following criteria are met:

- You have 10 years of “continuous service”;
- Your employment with a Participating Employer terminated:
  - on or after your 55th birthday, and
  - on or before September 30, 2016; and
- Your 10 years of continuous service must end on or after you attain age 55 while you are employed in a benefits-eligible position.

On and after January 1, 2002:

- RR Donnelley eliminated any subsidy amount if you were hired on or after January 1, 2002, by a Participating Employer, or
- You were hired prior to January 1, 2002, but did not work prior to January 1, 2002, for a Participating Employer in a benefits-eligible position.

On and after January 1, 2005:

- RR Donnelley froze the group of Retirees and their spouses who were, or could have become, eligible for the annual subsidy cap amount.
- To be eligible, or to become eligible, for the annual subsidy cap amount, you must satisfy the eligibility criteria created effective on and after January 1, 1997, and January 1, 2002, plus you either (1) must have terminated employment from a Participating Employer or died while employed by a Participating Employer, prior to January 1, 2005, or (2) must have a combination of your age and continuous service as of December 31, 2004, equal to at least 65.
- If you could have become eligible for the annual subsidy cap amount but your combined age and continuous service, on December 31, 2004, was less than 65, you and your spouse will become eligible for a reduced annual subsidy cap amount when you satisfy the eligibility criteria created effective January 1, 1997, and January 1, 2002.

If you and your spouse are eligible for an annual subsidy cap, the following charts outline the current amount of an annual subsidy cap based on the Group Health Program in which you and your spouse are enrolled.

| You satisfy the eligibility criteria created effective on and after January 1, 1997, and January 1, 2002, and you: | Annual subsidy cap amount per individual if you or your spouse is age 65 or older and is enrolled in the Post-65* |
|---|---|
| • Terminate employment or die before January 1, 2005. | $1,458 |
| • Terminate employment or die on or after January 1, 2005, and your age and continuous service, when combined, equal at least 65 as of December 31, 2004. | $1,458 |
| • Terminate employment or die on or after January 1, 2005, and your age and continuous service, when combined, is less than 65 as of December 31, 2004. | $500 |

*Does not apply to Esselte and Meredith Burda Retirees.

## Continuous Service

Continuous service, for eligibility purposes, means that you were continuously employed in a benefits-eligible position, or if you terminated employment, you were reemployed in a benefits-eligible position within 30 days of your termination date.

# SPECIAL RULES FOR CERTAIN PARTICIPANTS

For purposes of the Program, some Retirees currently have grandfathered rights under the Program. This most likely occurred when RR Donnelley acquired a business, sold a business or when there was a significant workforce reduction.

## Who Is Eligible – Closed Eligibility Group

If you are in a Retiree group described below ("Retiree Group"), your eligibility and benefits are subject to the additional rules described below for your group.

### *Moore Pre-1979 Retiree Group*

Coverage under the Program is available if you:

- Are a former employee of a participating division of Moore North America, Inc. (formerly Moore U.S.A. Inc.);
- Meet the requirements of an early, normal, deferred, or certain disability retirement under the Moore Retirement Income Plan; and
- Retired prior to January 1, 1979.

Participating divisions include all U.S. Moore divisions as of December 31, 1978, except for collective bargaining units of the Minneapolis plant of Moore Data Management Services.

### *Moore 1979 – 1986 Retiree Group*

Coverage under the Program is available if you:

- Are a former employee of a participating division of Moore North America, Inc. (formerly Moore U.S.A. Inc.);
- Meet the requirements of an early, normal, deferred, or certain disability retirement under the Moore Retirement Income Plan; and
- Retired between January 1, 1979, and June 30, 1986.

Participating divisions include all U.S. Moore divisions as of June 30, 1986, except for collective bargaining units of the Minneapolis plant of Moore Data Management Services.

## *Moore 1986 – 1994 Retiree Group*

Coverage under the Program is available if you:

- Are a former employee of a participating division of Moore North America, Inc. (formerly Moore U.S.A. Inc.);
- Meet the requirements of an early, normal, deferred, or certain disability retirement under the Moore Retirement Income Plan; and
- Retired between July 1, 1986, and March 31, 1994.

Participating divisions include all U.S. Moore divisions as of March 31, 1994, except for collective bargaining units of the Minneapolis plant of Moore Data Management Services.

## *Moore Post-4/1/1994 Retiree Group*

Coverage under the Program is available if you:

- Are a former employee of a participating division of Moore North America, Inc. (formerly Moore U.S.A. Inc.);
- Meet the requirements of an early, normal, deferred, or certain disability retirement under the Moore Retirement Income Plan; and
- Retired between April 1, 1994, and June 30, 1997; or
- Retired on or after July 1, 1997, and were "grandfathered."

You are considered "grandfathered" if you fall into one of the following categories:

- As of June 30, 1997, you were age 65 or older; or
- As of June 30, 1997, you were age 50 or older with 10 or more years of service; or
- As of June 30, 1997, you were age 45 with 20 or more years of service and you were employed by Moore on December 31, 1997.

## *General Rules Applicable to Moore Retiree Groups*

Generally, all divisions and units of Moore are eligible for the Moore Retirement Income Plan, except collective bargaining units of the Data Management Services Division or any divisions, units, or subsidiaries formed, reorganized, or acquired after January 1, 1992 – unless Moore designates it in writing as a participating division or unit. In addition, most expatriate employees are ineligible.

## *Wallace Subsidized Retiree Group*

Coverage under the Program is available if you:

- Retired before 1997 and were age 55 or older with five or more years of service at retirement; or
- Were a Retiree covered by the Program as of January 1, 1994; or
- Were an employee at least age 55 and had 20 or more years of service by December 31, 1993; or
- Were an employee between ages 50 and 54 who had 20 years of service by December 31, 1993, and elected on or prior to December 31, 1998, to elect early retirement and was 55 years of age or older at the time of the special election; or
- Were an employee who was at least 60 years of age with less than 20 years of service by December 31, 1993, who elected to take early retirement by the end of 1993.

## *Wallace, Litho, Nielsen Unsubsidized Retiree Group*

Coverage under the Program is available if you:

- Were actively at work on December 31, 2003;
- Were age 55 or older with 10 or more years of service at retirement; and
- Had 75 points (age and service) as of December 31, 2003.

## *Wallace, Litho, Nielsen Unsubsidized Retiree Group (retired on or after January 1, 2004)*

Coverage under the Program is available if you:

- Were a former employee of Wallace Computers, Litho Industries, or The Nielsen Company; and
- Were age 55 or older with 10 or more years of service at retirement.

# Dependent Eligibility and Program Premium Cost

In addition to spouses, Retirees of Moore and Wallace may cover a domestic partner as further described below.

See the table below for information on the premium for you and your spouse/domestic partner for the Program. Refer to the "Who Is Eligible" section for a detailed description of who qualifies for each of the Retiree Groups.

| Retiree Group | Retiree Medical Coverage Cost |
|---|---|
| Moore Pre-1979 Retirees | The company pays the entire cost of your coverage. |
| Moore 1979 – 1986 Retirees | The company subsidizes a portion of your coverage. |
| Moore 1986 – 1994 Retirees | The company subsidizes a portion of your coverage. |
| Moore Post-4/1/1994 Retirees | You are responsible for the full cost of your coverage. |
| Wallace Subsidized Retirees | The company subsidizes a portion of your coverage. |
| Wallace, Litho, Nielsen Unsubsidized Retirees | You are responsible for the full cost of your coverage. |
| Wallace, Litho, Nielsen Retirees Who Retired on or After 1/1/2004 | You are responsible for the full cost of your coverage. |

Thus, all eligible Retirees and their spouses/domestic partners, except Moore pre-1979 Retirees, must pay premiums to be covered under the Program.

"Domestic partner" means the person of the same or opposite sex with whom the eligible Retiree had a domestic partner relationship as of their retirement date, which is registered with a state or local governmental entity or which satisfies the criteria described in the last paragraph of this definition. A domestic partner is generally eligible for all eligible spouse coverage offered under the Program. If the eligible Retiree's domestic partnership is not registered with a state or local governmental entity, it must satisfy the following criteria for the eligible Retiree's domestic partner to be eligible for coverage:

- Neither the eligible Retiree nor his or her domestic partner are legally married to or are the legal domestic partner of anyone else;
- The eligible Retiree and his or her domestic partner intend to remain each other's sole domestic partner indefinitely;
- The eligible Retiree and his or her domestic partner are committed to each other and share joint responsibilities for their common welfare and financial obligations; and

- The eligible Retiree and his or her domestic partner are not related by blood, closer than would prohibit marriage in the state in which they live.

A Retiree's domestic partner is eligible for coverage under the Plan only if the Retiree, and if applicable, the Retiree's spouse, meet all of these requirements at all times:

- If the Retiree is alive, the Retiree must be enrolled for coverage under a Retiree Plan. The Retiree's domestic partner cannot elect coverage under the Plan on his or her own. However, if the Retiree's domestic partner is also a Retiree and has met the eligibility requirements for coverage under the Plan, he or she may elect his or her own coverage as a Retiree.
- The Retiree must have been in a domestic partner relationship with the Retiree's domestic partner on the date the Retiree terminates employment with, or dies while employed by, a Participating Employer. No coverage will be provided for a domestic partner a Retiree enters into a domestic partner relationship with after the date the Retiree's employment.
- The Retiree's domestic partnership may not have ended subsequent to the retirement.
- The Retiree's domestic partner may not be covered as an active employee under the Active Program or under the Plan as a Retiree.

## Cap on Company Subsidies

On January 1, 2005, RR Donnelley implemented a subsidy cap on future Moore Wallace Retiree and spouse/domestic partner health care costs. When future Program costs exceed the subsidy cap amount, participating Retirees and their spouses/domestic partners are responsible for all additional costs. As a result, the contributions you and your spouse/domestic partner are charged for participating in the Program reflect the excess costs.

The cap on the Retiree medical subsidy applies to members of the Moore 1986 – 1994 Retiree Group and the Wallace Subsidized Retiree Group.

The following chart summarizes the amount of the subsidy cap.

| Retiree Group | Annual subsidy cap amount per individual if you or your spouse/domestic partner are under age 65 and you or your spouse/domestic partner are enrolled in the Program |
|---|---|
| **If You Are Under Age 65** | |
| Moore Pre-1979 Retirees | No cap |
| Moore 1979 – 1986 Retirees | No cap |
| Moore 1986 – 1994 Retirees | $5,000 |
| Moore Post-4/1/1994 Retirees | Not applicable (subsidy based on Retiree Medical Allowance if you retired before July 1, 1997; if not, you are not subsidized) |
| Wallace Subsidized Retirees | $5,000 |
| Wallace, Litho, Nielsen Unsubsidized Retirees | Not subsidized |
| Wallace, Litho, Nielsen Retirees Who Retired on or After 1/1/2004 | Not subsidized |
| **Retiree Group** | **Annual subsidy cap amount per individual if you or your spouse/dependent partner are age 65 or older and you or your spouse/dependent partner are enrolled in the Program** |
| **If You Are Age 65 and Over** | |
| Moore Pre-1979 Retirees | No cap |
| Moore 1979 – 1986 Retirees | No cap |
| Moore 1986 – 1994 Retirees | $2,000 |
| Moore Post-4/1/1994 Retirees | Not applicable (subsidy based on Retiree Medical Allowance if you retired before July 1, 1997; if not, you are not subsidized) |
| Wallace Subsidized Retirees | $2,000 |
| Wallace, Litho, Nielsen Unsubsidized Retirees | Not subsidized |
| Wallace, Litho, Nielsen Retirees Unsubsidized Who Retired on or After 1/1/2004 | Not subsidized |

# RETIREE WAIVE CREDIT PROGRAM

The Retiree Waive Credit Program (RWCP) is available to eligible Retirees and their spouses/domestic partners who seek medical coverage through another source.

You're eligible for the RWCP if you are a:

- Moore North America Retiree who retired between January 1, 1979, and March 31, 1994; or
- Wallace Subsidized Retiree who retired before 1997, at age 55 or older with five or more years of service at retirement.

If you and/or your spouse/domestic partner choose to opt out of coverage under the Group Health Program, each of you who elect to opt out will be eligible to receive up to a $1,200 reimbursement. This is to cover medical premiums you pay for an alternative plan during this period, on an after-tax basis. You must first incur a premium cost for coverage outside of this program; then you can submit the claim for premium reimbursement.

If you choose to participate in the RWCP, you will need to choose "No Coverage" under this Group Health Program. For your spouse/domestic partner to receive the RWCP reimbursement, you must ensure that your spouse/domestic partner is listed as an eligible dependent in the RRD Benefits Center system. If the RWCP coverage is for the Retiree and the spouse/domestic partner, then the spouse/domestic partner will be eligible to continue a $1,200 opt-out reimbursement after the Retiree's death. The surviving spouse/domestic partner will also be eligible to continue the RWCP as long as the Retiree selected two $1,200 opt-out reimbursements at the time of your initial participation in the RWCP. If the Retiree selected only one reimbursement, then the benefit stops with the Retiree's death (i.e., the spouse will no longer receive a reimbursement).

**Note:** If you are dropped from RR Donnelley coverage during the coverage period due to non-payment, you are not treated as having elected an opt-out and are not eligible to receive the RWCP reimbursement for the remainder of the year. The RWCP is only offered during the benefits enrollment period, unless you have a qualifying status change.

HealthEquity will handle all administrative and customer service issues for reimbursements related to premiums paid. Once you incur a premium charge, you will be able to submit your claim electronically by logging into your account at **healthequity.com** and navigate to the "Claims & Payments" tab. For assistance, please contact HealthEquity Member Services at 1-877-472-8632.

To file a claim via mail, please call HealthEquity at 1-877-472-8632 to obtain a reimbursement form. Please mail the completed form, along with receipts or copies of receipts to the following address:

*HealthEquity*
Attn: Member Services
PO Box 14374
Lexington, KY 40512
1-877-472-8632

# Deadline to Submit Claims

You must submit your request for reimbursement no later than three months after the end of the plan year in which you incurred the coverage cost.

# RETIREE HEALTH CARE ACCOUNT

Here is some important information regarding the Retiree Health Care Account (RHCA) Plan, including eligibility requirements and how the RHCA Plan operates. Additional details about the RHCA plan are available in the Moore Business Forms, Inc. Retiree Health Care Account Plan document.

## *If You Retired From Moore Prior to July 1, 1997*

During your active employment, the Company allocated a certain amount on your behalf to the Retiree Health Care Account (RHCA) for each year of service with Moore. When you retired, your Retiree Medical Allowance was determined, based on the value of your account and your age, and whether or not you chose a separate medical allowance for your spouse/domestic partner, and if so, your spouse's/domestic partner's age.

## *If You Retired From Moore on or After July 1, 1997*

If you were an active regular full-time employee of Moore as of June 30, 1997, your RHCA balance was frozen as of that date, provided you were (as of June 30, 1997):

- Age 65 or older; or
- Age 50 or older with 10 or more years of service; or
- Age 45 with 20 or more years of service and employed with Moore as of December 31, 1997.

Following that date, contributions were no longer made to your account. However, your account may have continued to earn interest until you retired.

**Note:** Interest adjustments ended after January 1, 2004.

If you retired after June 30, 1997, and did not meet the criteria above, you are not eligible for the RHCA. Moore Wallace does not subsidize the cost of your medical coverage.

## *Your Medical Allowance(s)*

Upon retirement, your account will be converted to a Medical Allowance, which can be applied toward the cost of health insurance premiums. If you are single at the time of retirement, the value of your account will be converted to a single Medical Allowance. If you are married at the time of retirement, you must elect whether to have the value of your account converted to a single Medical Allowance, or to two allowances – one for you and one for your spouse. Additional details are available in the Moore Business Forms, Inc. Retiree Health Care Account Plan document.

# *Using Your RHCA to Reimburse the Cost of Coverage*

Throughout retirement, you can use your Retiree Medical Allowance to reimburse premiums you pay for medical, vision, or Medicare insurance. You cannot use your Medical Allowance to reimburse services received under these or other benefit programs. If you or your spouse/domestic partner is under age 65 (and not Medicare-eligible), your Medical Allowance can be used to purchase coverage through this Program or through an individual policy of your choice. Once Medicare becomes the primary payer of benefits for you or your spouse/domestic partner, that person can no longer be covered by the Pre-65 Group Health Program. However, your RHCA will still be available to you.

Once you reach age 65, your plan year Medical Allowance is adjusted to approximately one-third of the Medical Allowance in effect immediately prior to your 65th birthday. This adjustment is made because Medicare will be your primary coverage. You can use your Medical Allowance to pay your Medicare Part B premiums, premiums for supplemental Medigap insurance, and premiums for Medicare Part D.

Medical Allowances will increase 7% each July 1 after retirement until the retiree reaches age 65. The retiree will receive a prorated adjustment if he or she is retired for less than one year prior to the July 1 adjustment, and in the first year after the retiree reaches age 65. If the retiree elects two Medical Allowances, the same type of adjustment schedule will apply to his or her spouse's Medical Allowance based on when the spouse reaches age 65.

RRD may change allocations into the RHCA at any time in its sole discretion.

To receive a calculation of your estimated benefits under the RHCA Program, call the RR Donnelley Benefits Center at 1-877-RRD-4BEN (1-877-773-4236). You will receive your estimate within 10 business days from the date of your request.

If you purchase medical coverage for yourself or your spouse/domestic partner during retirement, you will be reimbursed each plan year – up to the amount of your plan year Medical Allowance – for the cost of that coverage.

Your Medical Allowance reimburses you for premiums only. You do not receive cash reimbursements for actual medical services received under the coverage you elect.

Your Medical Allowance may not cover the entire cost of your medical coverage during retirement. For example:

- If the cost of your medical coverage is greater than your Medical Allowance for any plan year, you will be responsible for the difference.
- If the cost of your coverage is less than your Medical Allowance, the amount of your unused Medical Allowance will be carried forward and added to your next plan year's Medical Allowance.

## If you are rehired following retirement

If you are rehired following retirement, special rules apply regarding your eligibility and the calculation of your Medical Allowance. See the Moore Business Forms, Inc. Retiree Health Care Account Plan document for more information.

## If you die before you start receiving Medical Allowance

If you are an eligible employee and you die BEFORE you retire, your spouse/domestic partner will be given a Medical Allowance as if you had elected the spousal Medical Allowance on the day before you die. Your spouse/domestic partner's Medical Allowance will become available after the expiration of continued coverage under the active medical plan.

## If you die after you start receiving your Medical Allowance

If you die after you begin receiving your allowance and you have a spouse who is also receiving an allowance, the remaining balance of your allowance for the year in which you die is allocated to your spouse. As of the first of the next plan year, your spouse only receives their own allowance and your allowance has ended. If however you elected a single Medical Allowance, then your spouse will lose eligibility to participate in the RHCA upon your death.

## Filing for Reimbursement Under the RHCA Plan

HealthEquity is the claims administrator for the RHCA Plan.

You must submit proof of coverage, a premium reimbursement form, and proof of payment with each request to HealthEquity. You can use your Medical Allowance to reimburse premiums paid for medical, vision, and Medicare. In general, a copy of a premium statement or bill, or a notice of enrollment from the insurer, which indicates the person(s) covered and the premium costs, can be used as proof of coverage. A reimbursement form is available by calling HealthEquity at 1-877-472-8632.

*HealthEquity*
Attn: Member Services
PO Box 14374
Lexington, KY 40512
1-877-472-8632

You cannot use your Medical Allowance to pay COBRA premiums, for extended coverage during a severance period, or for before-tax contributions for coverage under another employer's medical plan.

## Deadline to Submit Claims

You must submit your request for reimbursement no later than three months after the end of the plan year in which you incurred the coverage cost

## Special Disqualification Rule Regarding Competition

If you are a sales manager or sales representative of Moore Wallace or any of its participating subsidiaries and/or a Participating Employer who is included in the grandfathered group otherwise eligible for the RHCA and you engage in competition with Moore Wallace or any of its participating subsidiaries and/or participating affiliates, you will cease to be eligible as a grandfathered participant for the RHCA.

# MEDICAL BENEFIT PROGRAM SUMMARY

This section summarizes Medical Benefit Program options available to the different Retiree Groups. Not every Retiree Group is eligible for every option. Certain options are available only for those grandfathered Retiree Groups who were covered by a specific labor agreement and/or acquisition agreement, as follows:

| Retiree Group | Coverage Option |
|---|---|
| Moore Pre-1979 Retirees | Aetna Medicare Plan (PPO) ESA - $200 Deductible |
| Moore 1979 – 1986 Retirees | Aetna Medicare Plan (PPO) ESA - $275 Deductible |
| Moore 1986 – 1994 Retirees | Aetna Medicare Plan (PPO) ESA - $400 Deductible |
| Moore Post-4/1/1994 Retirees | Aetna Medicare Plan (PPO) ESA - $400 Deductible |
| Wallace Subsidized Retirees | Aetna Medicare Plan (PPO) ESA - $400 Deductible |
| Wallace, Litho, Nielsen Unsubsidized Retirees | Aetna Medicare Plan (PPO) ESA - $400 Deductible |
| Wallace, Litho, Nielsen Retirees Who Retired on or After 1/1/2004 | Aetna Medicare Plan (PPO) ESA - $400 Deductible |
| Meredith Burda Post-65 Retired by 12/31/1991 | Wellmark BCBS of IA Plan |
| Esselte Boorum & Pease – enrolled in the Esselte Retiree medical plan as of 3/25/2014 | BCBSIL Retiree Hospital Brooklyn & Syracuse PPO Plan |

You receive information regarding the coverage option available to you when you are first eligible for Retiree coverage and during each Annual Enrollment period thereafter.

In addition to the Medical Benefit Program, you have prescription drug coverage through the Drug Benefit Program. The Aetna Medicare Plan covers both medical and prescription drug coverage.

**Note:** Esselte retirees have prescription coverage through Prime Therapeutics. Meredith Burda retirees do not have prescription drug coverage through the Plan but may obtain Medicare Part D prescription coverage through **Medicare.gov** or by calling 1-800-633-4227. Coverage is available when an individual first becomes eligible for Medicare and each year from October 15 to December 7.

# Banta Subsidized Retiree Group

If you are a Retiree of Banta as of April 1, 2007, or its subsidiaries, and you currently receive a subsidy because you met the age and service requirements on the day you retired, you continue to receive a subsidy for Retiree coverage. Effective April 1, 2007, you will receive a flat 20% employer subsidy.

If you were an active nonunion employee of Banta as of April 1, 2007, you are eligible for a subsidy if your employment with a Participating Employer terminated on or before September 30, 2016, and:

- You were employed by Banta on December 31, 2002, and you were age 60 or older with at least 15 continuous years of service on the day you retired; or
- As of December 31, 2007, you were age 57 or older and you had at least 10 continuous years of service, or you were age 65 or older and you had at least five continuous years of service; or
- You became totally and permanently disabled at age 57 or older and you had at least 10 continuous years of service on the date of disability leave.

# Esselte Subsidized Retiree Group

If you were enrolled in the Esselte Corporation, Boorum & Pease Division, retiree medical plan as of March 25, 2014, the acquisition by R.R. Donnelley & Sons Company, you are eligible to receive a subsidy.

# Meredith Burda Subsidized Retiree Group

If you are a Post-65 Retiree who was retired from Meredith Burda by December 31, 1991, from one of the following Divisions, you are eligible for Retiree-only subsidized coverage:

- Des Moines
- Lynchburg
- Newton
- Casa Grande

# Making Required Premium Payments

How you pay premiums to the Plan depends on whether or not you receive a monthly pension from the Pension Plan maintained by a Participating Employer and, if you do, your monthly pension amount. If you receive a pension from another employer's plan, premiums are not deducted from the other pension. Premiums can be paid in the following manner:

- If at the time you enrolled for coverage, your monthly pension benefit from your Participating Employer's Pension Plan (after taxes are withheld) is more than the monthly premiums for

coverage under the Program, premiums for coverage automatically are deducted from your pension each month.

- If you do not want monthly premiums for coverage under this Program automatically deducted from your pension each month, you may at any time elect to receive a monthly invoice. You may pay the monthly invoice for coverage with a personal check, or you may elect to have the required premium deducted from a bank account of your choice. Contact the RRD Benefits Center if you want to arrange this payment option.
- If your monthly pension benefit from your Participating Employer's Pension Plan is less than the monthly premiums for coverage under the Plan, or if you are not receiving a pension payment, you will receive an invoice by mail each month.
- The first payment for coverage is due on or before the effective date of coverage, which is the first of the month. If payment is not received within 30 days of the effective date of coverage, your coverage will be terminated.
- For ongoing premium payments, payment for you and your spouse is due the first of the month, and you have a 30-day grace period for payment. If you are more than 30 days late with your payment, coverage will be terminated.

# YOUR RIGHTS AND RESPONSIBILITIES

## General Information

If you are enrolled in the Program, you assume certain rights and responsibilities. It is important that you fully understand both.

## Your Rights

You have the right:

- To be treated in a manner that respects your privacy and dignity as a person.
- To receive assistance in a prompt, courteous, and responsive manner.
- To be provided with information about your benefits, any exclusions and limitations associated with the Program, and any charges for which you will be responsible.
- To be provided with guidance and recommendations for continuation of coverage.
- To the confidential handling of all communications and medical information maintained by the claims administrator, as provided by law and professional ethics.
- To be informed by your treating provider of your diagnosis, prognosis, and plan of treatment in terms you understand. You are encouraged to ask questions of your provider until you fully understand the care you are receiving.
- To receive prompt, courteous, and appropriate treatment.
- To be informed by your treating provider about any treatment you may receive. Your provider will request your consent for all treatment, unless there is an emergency and your life and health are in serious danger. If written consent is required for special procedures, such as surgery, be sure you understand the procedure and why it is advised.
- To refuse treatment and be advised of the probable consequences of your decision by your treating provider. You are encouraged to discuss your objections with your provider. He or she will advise you and discuss alternative treatment plans with you, but the final decision as to how to proceed is yours.
- To be provided automatically, without charge, a list of participating providers and participating pharmacies in your area.
- To change your provider through your coverage option under the Medical Benefit Program as applicable.

- To express a complaint to the claims administrator about the care you have received or will not receive, and to receive a response in a timely manner.
- To initiate the grievance procedure if you are not satisfied with the decision regarding your complaint about care.
- To file a claim (pre-service or post-service) for a benefit with the claims administrator and to have any denial of a claim for benefit reviewed by the claims administrator under ERISA's claim procedure rules. See the "ERISA Claims and Appeals Procedures" section for details.

## Statement of Rights Under the Newborns' and Mothers' Health Protection Act

Under federal law, the Program generally may not restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a delivery by cesarean section. However, federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable).

In any case, the Program may not, under federal law, require that a provider obtain authorization from the Program for prescribing a length of stay not in excess of 48 hours (or 96 hours). However, to use certain providers or facilities, or to reduce your out-of- pocket costs, you may be required to obtain certification. For information on certification, contact the claims administrator.

# Your Responsibilities

All covered individuals are responsible for learning how the Program works by carefully studying and referring to the SPD.

You have a responsibility:

- To fully understand the benefit communication materials you receive.
- To present your ID card before receiving services.
- To know how to properly use the Program and its benefits.
- To select a provider or primary care physician (if applicable).
- To keep scheduled appointments and notify the provider's office promptly if you will be delayed or unable to keep the appointment.
- To follow the advice of your provider or primary care physician (if applicable) and consider the likely consequences when you refuse to comply with his or her advice.
- To make the lifestyle changes recommended by your physician (if applicable).
- To provide honest and complete information to your provider or primary care physician.

- To know what medications you and your eligible spouse take, why you are taking them, and the proper way to take them.
- To express your opinions, concerns, or complaints in a constructive manner to the appropriate people.
- To pay all applicable fees at the time service is rendered (if applicable), plus any additional payments due, in a timely manner.
- To remove individuals from coverage within 30 days of when they cease to be an eligible dependent.
- To initiate the certification of a disabled dependent with your claims administrator within 30 days and each year thereafter when requested.
- To comply with any documentation requests made by the eligibility administrator or claims administrator to substantiate your claim for coverage or benefits.
- To comply with any documentation requests made by the dependent audit to substantiate your dependents under the Program.

# HOW THE MEDICAL BENEFIT PROGRAM WORKS

## General Information

The Medical Program offers the following Medical Benefit Program options through Aetna (collectively the "Aetna Retiree Medicare Advantage Plans"):

- The **Aetna Medicare Plan (PPO) with Extended Service Area (ESA) - $400 Deductible** option covers you and your spouse who are age 65 or older or who are otherwise eligible for Medicare due to disability.*
- The **Aetna Medicare Plan (PPO) with Extended Service Area (ESA) - $275 Deductible** option covers you and your spouse who are age 65 or older or who are otherwise eligible for Medicare due to disability.*
- The **Aetna Medicare Plan (PPO) with Extended Service Area (ESA) - $200 Deductible** option covers you and your spouse who are age 65 or older or who are otherwise eligible for Medicare due to disability.*

If either you or your spouse is age 65 or older (or otherwise Medicare-eligible due to disability) and the other is under age 65 (and not Medicare-eligible), you may be covered by different plans. In this case, the not Medicare-eligible individual generally will be eligible for coverage under the Pre-65 Group Health Program. The individual who is age 65 (or otherwise Medicare-eligible due to disability) is eligible only for the Post-65 Plan. (Special rules may apply for certain grandfathered Retirees of acquired companies and their subsidiaries, such as those participating in the RWCP and RHCA.)

You receive information regarding the Medical Program coverage options available to you and your eligible spouse when you are first eligible for coverage under the Program and during each Annual Enrollment period thereafter.

Once you and your eligible spouse are enrolled in a Medical Program, you and your spouse automatically are enrolled in the Prescription Drug Program.

The Medical Program covers most charges for illness and injury (up to the maximum reimbursable charge), provided the claims administrator considers the expense to be a covered expense.

The amount the Medical Program pays is based on the plan design.

**Note:** The Aetna Medicare Plans are fully insured options and you must refer to the insurance certificate provided by Aetna for all terms and coverages. You will receive an Annual Notice of Change each with any Plan updates.

# Plan Design Charts

The Medical Program offers several plan designs, which may vary depending on whether the Retiree is a member of a closed Retiree Group. The plan design charts that follow provide a high-level summary of the coverage for each Medical Program option. Where the option is fully insured, additional details can be found in the insurance certificate booklet, which is provided to you separately.

Additional information about the Prescription Drug Program administered by Aetna can be found in the mailings you receive from Aetna, including the:

- Annual Notice of Change
- Evidence of Coverage
- Pharmacy Directory
- Abridged Formulary (list of preferred drugs)

You can also visit **AetnaRetireePlans.com**.

# AETNA MEDICARE PLAN (PPO) ESA 400 PLAN DESIGN SUMMARY

(Formerly known as the 400 POST-65 RETIREE MEDICARE OPTION PLAN)

This chart provides only highlights of the benefit plan(s).The complete list of services can be found in the Aetna **Evidence of Coverage**. You may also request a copy of the EOC by contacting Member Services at 1-888-267-2637.

| PROGRAM/BENEFIT | THIS IS WHAT YOU PAY FOR NETWORK & OUT-OF-NETWORK PROVIDERS |
|---|---|
| **Medical** | **Aetna**<br>**1-800-307-4830 (TTY: 711)**<br>**AetnaRetireePlans.com** |
| **Annual Deductible** | $400 |
| **Annual Out-of-Pocket Maximum** | $2,000/individual |
| **Lifetime Maximum** | N/A |
| **Preventive Care** | $0 copay |
| **Physician Office Visits** | PCP: $10 copay; Specialist: $20 copay |
| **Inpatient Hospital Services** | $150 copay |
| **Outpatient Services & Surgery** | 90% covered after deductible |
| **Outpatient Lab/X-ray** | 80% covered after deductible |
| **Emergency Room/Urgent Care Facility** | Emergency Room: $65 copay;<br>Urgent Care Facility: $35 copay |
| **Outpatient Rehabilitation Services**<br>*Limited to a maximum of 90 visits per year combined with Physical, Occupational, Pulmonary, Cognitive and Speech Therapies* | PT/OT/ST: 90% covered after deductible<br>Cardiac/Pulmonary: 90% covered after deductible<br>Chiropractic: $20 copay |
| **Mental Health and Substance Abuse** | Inpatient: $150 copay<br>Outpatient: $20 copay |

| PROGRAM/BENEFIT | | | POST-65 RETIREE MEDICARE | | |
|---|---|---|---|---|---|
| **Prescription Drug** | | | **Aetna**<br>**1-800-307-4830 (TTY: 711)**<br>**AetnaRetireePlans.com** | | |
| **Calendar-Year Deductible for Prescription Drugs** | | | $0 | | |
| **Annual Prescription Out-of-Pocket Maximum** | | | $2,000/individual | | |
| **Prescription Drug Coverage at Network Pharmacies** | | | | | |
| **4 Tier Plan** | **30-day Supply through Retail** | | **90-day Supply through Retail or Mail** | | |
| | **Preferred** | **Standard** | **Preferred Retail** | **Preferred Mail** | **Standard Retail or Mail** |
| **Tier 1 – Generic**<br>Generic Drugs | Greater of $7 or 15% coinsurance | Greater of $10 or 20% coinsurance | Greater of $21 or 15% coinsurance | Greater of $21 or 15% coinsurance | Greater of $30 or 20% coinsurance |
| **Tier 2 - Preferred Brand**<br>Preferred Brand Drugs | Greater of $10 or 25% coinsurance | Greater of $10 or 25% coinsurance | Greater of $30 or 25% coinsurance | Greater of $30 or 25% coinsurance | Greater of $30 or 25% coinsurance |
| **Tier 3 - Non-Preferred Brand**<br>Non-Preferred Brand Drugs | Greater of $10 or 50% coinsurance | Greater of $10 or 50% coinsurance | Greater of $30 or 50% coinsurance | Greater of $30 or 50% coinsurance | Greater of $30 or 50% coinsurance |
| **Tier 4 - Specialty**<br>Includes high-cost/unique generic and brand drugs | Greater of $10 or 33% coinsurance | Greater of $10 or 33% coinsurance | Limited to one-month supply | Limited to one-month supply | Limited to one-month supply |

# AETNA MEDICARE PLAN (PPO) ESA 200 PLAN DESIGN SUMMARY

(Formerly known as the 200 POST-65 RETIREE MEDICARE OPTION PLAN)

## Available to Moore Pre-1979 Retirees Only

This chart provides only highlights of the benefit plan(s).The complete list of services can be found in the Aetna **Evidence of Coverage**. You may also request a copy of the EOC by contacting Member Services at 1-888-267-2637.

| PROGRAM/BENEFIT | COVERAGE |
|---|---|
| **Annual Deductible** | $200 |
| **Annual Out-of-Pocket Maximum** | $6,700/individual |
| **Coinsurance Percentage** | 80% or 90%, varies by service (see certificate) |
| **Preventive Care** | $0 copay |
| **Physician Office Visits** | • PCP: $5 copay<br>• Specialist: $15 copay |
| **Inpatient Hospital Services** | $0 copay |
| **Inpatient/Outpatient Professional Services** | 80% covered after deductible |
| **Outpatient Lab/X-ray** | 80% covered after deductible |
| **Outpatient Surgery** | 80% covered after deductible |
| **Urgent Care Facility** | $35 copay |
| **Emergency Room** | $65 copay |
| **Outpatient Rehabilitation Services** Limited to a maximum of 90 visits per year combined with Physical, Occupational, Pulmonary, Cognitive and Speech Therapies | • PT/OT/ST: 90% covered after deductible<br>• Cardiac/Pulmonary: 80% covered after deductible<br>• Chiropractic: $20 copay |
| **Mental Health and Substance Abuse** | • Inpatient: $0 copay<br>• Outpatient: $15 copay |
| **Prescription Drug** | **Aetna 1-800-307-4830 (TTY: 711)**<br>**AetnaRetireePlans.com** |
| If you are currently enrolled, you will receive these materials from SilverScript prior to Annual Enrollment, which further describe the terms of the Plan: | • Annual Notice of Change<br>• Evidence of Coverage<br>• Pharmacy Directory<br>• Abridged Formulary (list of preferred drugs) |

**Charges above usual and customary (U&C) limits are member's responsibility.** Amounts above U&C do not count toward the annual deductible or the out-of-pocket maximum.

# AETNA MEDICARE PLAN (PPO) ESA 275 PLAN DESIGN SUMMARY

(Formerly known as the 275 POST-65 RETIREE MEDICARE OPTION PLAN)

## Available to Moore 1979 – 1986 Retirees Only

This chart provides only highlights of the benefit plan(s).The complete list of services can be found in the Aetna **Evidence of Coverage**. You may also request a copy of the EOC by contacting Member Services at 1-888-267-2637.

| PROGRAM/BENEFIT | COVERAGE |
|---|---|
| **Annual Deductible** | $275 |
| **Annual Out-of-Pocket Maximum** | $6,700/individual |
| **Coinsurance Percentage** | 80% or 90%, varies by service (see certificate) |
| **Preventive Care** | $0 copay |
| **Physician Office Visits** | • PCP: $5 copay<br>• Specialist: $15 copay |
| **Inpatient Hospital Services** | $0 copay |
| **Inpatient/Outpatient Professional Services** | 80% covered after deductible |
| **Outpatient Lab/X-ray** | 80% covered after deductible |
| **Outpatient Surgery** | 80% covered after deductible |
| **Urgent Care Facility** | $35 copay |
| **Emergency Room** | $65 copay |
| **Outpatient Rehabilitation Services** Limited to a maximum of 90 visits per year combined with Physical, Occupational, Pulmonary, Cognitive and Speech Therapies | • PT/OT/ST: 90% covered after deductible<br>• Cardiac/Pulmonary: 80% covered after deductible<br>• Chiropractic: $20 copay |
| **Mental Health and Substance Abuse** | • Inpatient: $0 copay<br>• Outpatient: $15 copay |
| **Prescription Drug** | **Aetna 1-800-307-4830 (TTY: 711)**<br>**AetnaRetireePlans.com** |
| If you are currently enrolled, you will receive these materials from SilverScript prior to Annual Enrollment, which further describe the terms of the Plan: | • Annual Notice of Change<br>• Evidence of Coverage<br>• Pharmacy Directory<br>• Abridged Formulary (list of preferred drugs) |

**Charges above usual and customary (U&C) limits are member's responsibility.** Amounts above U&C do not count toward the annual deductible or the out-of-pocket maximum.

# BCBSIL SELF-FUNDED PLAN OPTION PLAN DESIGN SUMMARY

## Available to Esselte Corporation, Boorum & Pease Division Retirees from Brooklyn Only

| PROGRAM/BENEFIT | COVERAGE |
|---|---|
| **Lifetime Comprehensive Major Medical Coverage** | Unlimited |
| **Deductible**<br>**Out-of-Pocket Expense Limit** | Not applicable<br>Not applicable |
| **Hospital Services** | ***maxes are per calendar year** |
| **Inpatient Hospital Services**<br>Coverage includes services received in a hospital, skilled nursing facility and hospice, including mental health and substance abuse services. Room allowances based on the hospital's most common semi-private room rates. | 100%<br>365 day max<br>• Hospice, 210 day max<br>• Skilled Nursing, 210 day max |
| **Hospital Ambulatory Surgical Facility Services** | 100% |
| **Ambulance** | 100% |
| **Inpatient Mental Health and Substance Abuse** | Inpatient Services - 100%, 30 day max<br>Outpatient Services – 80%, $30 max per visit, up to $1,500 per calendar year |
| **Outpatient Surgery and Diagnostic Tests**<br>Including X-rays, blood tests, CAT scans, MRIs, annual routine mammograms and PSA tests performed at a hospital. | 100% - Facility Services<br>80% - Professional Services |
| **Outpatient Hospital Services** | 100% - Facility Services only |
| Including Radiation, Chemotherapy and Renal Dialysis. | |
| **Hospital Emergency Medical/Accident Care**<br>Initial treatment in hospital of accidental injuries or sudden and unexpected medical conditions with severe acute symptoms. If an inpatient admission occurs, MSA must be contacted within two business days. | 100% - Facility Services<br>100% - Professional Services |
| **Professional Services** | |
| **Outpatient Physician Services** | 80% |
| **Preventive Care**<br>Routine annual physicals, well-baby exam, immunizations, and other preventive health services as determined by the USPSTF. | Not Covered |
| **Additional Services** | ***maxes are per calendar year** |

| PROGRAM/BENEFIT | | | COVERAGE |
|---|---|---|---|
| Coordinated Home Health | | | 100%, 200 visit max |
| Private Duty Nursing | | | 100%, 120 visit max |
| Medical Supplies, Durable Medical Equipment and Appliances | | | 100%, only if billed by a Hospital or Surgicenter |
| Kidney and Cornea Transplant Services | | | 100% |
| Muscle Manipulation Services | | | 80% |
| Outpatient Therapy Services – Speech, Occupational and Physical | | | 100% - Facility Services<br>80% - Professional Services |
| **Prescription Drug** | | | ***specific maxes listed below** |
| **Annual and Lifetime Maximums** | | | 100%, up to $10,000 max per calendar year and up to an overall $25,000 lifetime max |
| **Plan** | **What You Will Pay** | | **Limitations, Exceptions, & Other Important Information** |
| | **In-Network Provider** | **Out-of-Network Provider** | |
| Generic Drugs | No Charge, deductible does not apply | Not Covered | 34-day supply at Retail<br>90-day supply at Mail Order<br><br>Certain women's preventive services will be covered with no cost to the member. For a full list of these prescriptions and/or services, please contact Customer Service.<br><br>Coverage limited to $10,000 per person per Annual Max.<br>Coverage limited to $25,000 per person per Lifetime Max. |
| Preferred Brand Drugs | No Charge, deductible does not apply | Not Covered | |
| Non-Preferred Brand Drugs | No Charge, deductible does not apply | Not Covered | |
| Includes high-cost/unique generic and brand drugs | No Charge, deductible does not apply | Not Covered | Specialty benefit through all in Network Pharmacies.<br>Specialty drug coverage based on group policy.<br>Preauthorization may be required.<br>Specialty retail limited to a 30-day supply. |

**Schedule of Maximum Allowances (SMA):** The Schedule of Maximum Allowances (SMA) is not the same as a Usual and Customary fee (U&C). Blue Cross and Blue Shield of Illinois' SMA is the maximum allowable charge for professional services, including but not limited to those listed under Medical/Surgical and Other Covered Services above. The SMA is the amount that professional PPO providers have agreed to accept as payment in full. When members use PPO providers, they avoid any balance billing other than applicable deductible, coinsurance and/or copayment.

# BCBSIL SELF-FUNDED PLAN OPTION PLAN DESIGN SUMMARY

## Available to Esselte Corporation, Boorum & Pease Division Retirees from Syracuse Only

| PROGRAM/BENEFIT | COVERAGE |
|---|---|
| **Lifetime Comprehensive Major Medical Coverage** | $1,000,000 |
| **Deductible (per calendar year)**<br>Program deductible does not apply to services that have a copayment. | Individual: $150<br>Family: $450 (aggregate) |
| **Out-of-Pocket Expense Limit**<br>The amount of money that any individual will have to pay toward covered health care expenses during any one calendar year. The following items will not be applied to the out-of-pocket expense limit:<br>• Reductions in benefits due to non-compliance with utilization management program requirements<br>• Charges that exceed the eligible charge or the Schedule of Maximum Allowances (SMA)<br>• Transplant expenses | Individual: $2,000<br>Family: Not Applicable |
| **Hospital Services** | ***maxes are per calendar year** |
| **Inpatient Hospital Services**<br>Coverage includes services received in a hospital, skilled nursing facility and hospice, including mental health and substance abuse services. Room allowances based on the hospital's most common semi-private room rates | 100%, 365 day max<br>• Hospice, 210 day max<br>• Skilled Nursing, 120 day max |
| **Hospital Ambulatory Surgical Facility Services** | 80%, after deductible |
| **Ambulance** | 80%, after deductible |
| **Inpatient Mental Health and Substance Abuse** | Inpatient Services – 100%, 30 day max<br>Outpatient Services – 80%, $30 max per visit, up to $1,500 max per calendar year |
| **Outpatient Surgery and Diagnostic Tests** | 80%, after deductible - Facility Services |
| Including X-rays, blood tests, CAT scans, MRIs, annual routine and diagnostic mammograms and PSA tests performed at a hospital. | 80%, after deductible - Professional Services |
| **Outpatient Hospital Services** | 80%, after deductible |
| Including Radiation, Chemotherapy and Renal Dialysis. | |
| **Hospital Emergency Medical/Accident Care** | 80%, after deductible – Facility Services<br>80%, after deductible – Professional Services |

| PROGRAM/BENEFIT | | | COVERAGE |
|---|---|---|---|
| Initial treatment in hospital of accidental injuries or sudden and unexpected medical conditions with severe acute symptoms. If an inpatient admission occurs, MSA must be contacted within two business days. | | | |
| **Professional Services** | | | |
| Outpatient Physician Services | | | 80%, after deductible |
| **Preventive Care**<br>Routine annual physicals, well-baby exam, immunizations, and other preventive health services as determined by the USPSTF. | | | Not Covered |
| **Additional Services** | | | *maxes are per calendar year |
| Coordinated Home Health | | | 80%, after deductible - 200 visit max |
| Private Duty Nursing | | | 80%, after deductible -120 visit max |
| Medical Supplies, Durable Medical Equipment and Appliances | | | 100%, only if billed by a Hospital or Surgicenter |
| Muscle Manipulation Services | | | 80%, after deductible |
| Outpatient Therapy Services – Speech, Occupational and Physical | | | 80%, after deductible - Facility Services<br>80%, after deductible - Professional Services |
| **Prescription Drug** | | | ***specific maxes listed below** |
| Annual and Lifetime Maximums | | | 100%, up to 10,000 max per calendar year and up to an overall $25,000 lifetime max |
| **Plan** | **What You Will Pay** | | **Limitations, Exceptions, & Other Important Information** |
| | **In-Network Provider** | **Out-of-Network Provider** | |
| Generic Drugs | No Charge, deductible does not apply | Not Covered | 34-day supply at Retail<br>90-day supply at Mail Order<br><br>Certain women's preventive services will be covered with no cost to the member. For a full list of these prescriptions and/or services, please contact Customer Service.<br><br>Coverage limited to $10,000 per person per Annual Max.<br>Coverage limited to $25,000 per person per Lifetime Max. |
| Preferred Brand Drugs | No Charge, deductible does not apply | Not Covered | |
| Non-Preferred Brand Drugs | No Charge, deductible does not apply | Not Covered | |
| Specialty Drugs | No Charge, deductible does not apply | Not Covered | Specialty benefit thru all in Network Pharmacies.<br>Specialty drug coverage based on group policy.<br>Preauthorization may be required.<br>Specialty retail limited to a 30-day supply. |

**Schedule of Maximum Allowances (SMA):** The Schedule of Maximum Allowances (SMA) is not the same as a Usual and Customary fee (U&C). Blue Cross and Blue Shield of Illinois' SMA is the maximum allowable charge for professional services, including but not limited to those listed under Medical/Surgical and Other Covered Services above. The SMA is the amount that professional PPO providers have agreed to accept as payment in full. When members use PPO providers, they avoid any balance billing other than applicable deductible, coinsurance and/or copayment.

# WELLMARK BCBS OF IA POST-65 RETIREE MEDICARE

## Available to Meredith Burda Post-65 Retirees by 12/31/1991 Only

This chart provides only highlights of the benefit plan(s). After enrollment, members will receive an insurance certificate booklet that more fully describes the terms of coverage.

# Medicare Part A Hospital Services (Per Benefit Period)

| PROGRAM/BENEFIT | COVERAGE | | |
|---|---|---|---|
| **Services** | **Medicare Pays** | **Wellmark Pays** | **You Pay** |
| **Hospitalization**[1]<br>Semi-private room and board, general nursing and miscellaneous services and supplies | | | |
| First 60 days | All but $1,288 | $1,288 (Part A deductible) | $0 |
| 61st thru 90th day | All but $322 a day | $322 a day | $0 |
| 91st day and after: | | | |
| - While using 60 lifetime reserve days | All but $644 a day | $644 a day | $0 |
| - Once lifetime reserve days are used: | | | |
| Additional 365 days | $0 | 100% of Medicare eligible expenses | $0 [2] |
| Beyond the additional 365 days | $0 | $0 | All costs |
| **Skilled Nursing Facility Care**[1]<br>You must meet Medicare's requirements, including having been in a hospital for at least three days and entered a Medicare- approved facility within 30 days after leaving the hospital | | | |
| First 20 days | All approved amounts | $0 | $0 |
| 21st thru 100th day | All but $161 a day | Up to $161 a day | $0 |
| 101st thru 130th day | $0 | All approved amounts | $0 |
| 131st day and after | $0 | $0 | All costs |
| **Blood** | | | |
| First 3 pints | $0 | 3 pints | $0 |
| Additional amounts | 100% | $0 | $0 |
| **Hospice Care**<br>Available as long as your doctor certifies you are terminally ill and you elect to receive these services | All but very limited coinsurance for outpatient drugs and inpatient respite care | $0 | Balance |

**1** A benefit period begins on the first day you receive services as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

**2** NOTICE: When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Basic Benefits."

**Note:** Medicare benefits are subject to change and are typically adjusted annually. The numbers in this chart reflect the Medicare benefits in effect in 2016. For complete details of Medicare benefits and exclusions, you may obtain a copy of Medicare & You from the Social Security Administration, or visit **medicare.gov**.

# Medicare Part B Medical Services (Per Calendar Year)

| PROGRAM/BENEFIT | COVERAGE | | |
|---|---|---|---|
| **Services** | **Medicare Pays** | **Wellmark Pays** | **You Pay** |
| **Medical Expenses**<br>IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment | | | |
| First $166 of Medicare-Approved Amounts[3] | $0 | $166 (Part B deductible) | $0 |
| Remainder of Medicare-Approved Amounts | Generally 80% | Generally 20% | $0 |
| **Part B Excess Charges**<br>(Above Medicare-Approved Amounts) | $0 | $0 | All Part B excess charges |
| **Blood** | | | |
| First 3 pints | $0 | All costs | $0 |
| Next $166 of Medicare-Approved Amounts[3] | $0 | $166 (Part B deductible) | $0 |
| Remainder of Medicare-Approved Amounts | 80% | 20% | $0 |
| **Clinical Laboratory Services**<br>BLOOD TESTS FOR DIAGNOSTIC SERVICES | 100% | $0 | $0 |
| **Home Health Care**<br>MEDICARE-APPROVED SERVICES | | | |
| Medically necessary skilled care services and medical supplies | 100% | $0 | $0 |
| Durable Medical Equipment: | | | |
| • First $166 of Medicare-Approved Amounts[3] | $0 | $166 (Part B deductible) | $0 |
| • Remainder of Medicare-Approved Amounts | 80% | 20% | $0 |

**3** Once you have been billed $166 of Medicare-approved amounts for covered services, your Part B deductible will have been met for the calendar year. $166 is the Part B deductible for 2016. It is adjusted by Medicare each year.

# Prescription Drug Coverage

| PROGRAM/BENEFIT | COVERAGE | | |
|---|---|---|---|
| **Services** | **Medicare Pays** | **Wellmark Pays** | **You Pay** |
| **Prescription Drug** NOT COVERED* | N/A | N/A | N/A |

*Although the Plan does not cover prescription drugs, coverage is available through Medicare Part D. Visit **Medicare.gov** or call 1-800-633-4227.

# Other Benefits Not Covered By Medicare

| PROGRAM/BENEFIT | COVERAGE | | |
|---|---|---|---|
| **Services** | **Medicare Pays** | **Wellmark Pays** | **You Pay** |
| **Foreign Travel Emergency Care** NOT COVERED BY MEDICARE<br>Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA<br>Charges | $0 | 75% of approved charges | 25% of approved charges |
| **Preventive Medical Care Benefit** [4] NOT COVERED BY MEDICARE<br>Some annual physical and preventive tests and services administered or ordered by your doctor when not covered by Medicare<br>Routine mammography screening per calendar year | After $135 (Part B deductible), 80% of Medicare-approved amount for one screening every year for women 65 and older | One mammography screening per year for women 65 or older up to maximum allowable fee amount, less any amount paid by Medicare | $0 |

# Additional Plan Details

For the Aetna Medicare Advantage Plans, see the Aetna Evidence of Coverage for plan details regarding:

- Glossary of Key Terms
- Covered Expenses
- Other Services Available
- Excluded Expenses
- Preadmission Certification
- Drug Benefit Program
- Coordination of Benefits
- Claims & Appeals Procedures
- The Plan's Right of Recovery and Reimbursement

For the Wellmark BCBS of IA, see the Wellmark Benefits Certificate for information on the plan terms listed above.

For Esselte BCBSIL, see Appendix C (which will be provided to Esselte participants only.)

# YOUR LEGAL RIGHT TO CONTINUATION COVERAGE

In some cases, you or your spouse may continue coverage under COBRA if his or her coverage under this Program ends.

## General Information

A federal law called the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended (COBRA), requires that most employers, including a Participating Employer, that sponsor medical benefit plans (including HMOs) offer employees and certain members of their families the opportunity to extend coverage temporarily at group rates after coverage under the medical benefits plan would otherwise end due to specific events. The extension of coverage to employees and their eligible spouses is called "continuation coverage."

In general, the coverage that may be continued is the same as the coverage in which you and your spouse were enrolled under the Program on the day before the qualifying event (as listed below). For example, if you are enrolled in the Program with Retiree and spouse coverage, you and your spouse can continue this same coverage under COBRA. In addition, if you elected the "No Coverage" option as a retired employee, you would not be eligible for any continuation coverage.

To be eligible for continuation coverage, a qualifying event must take place. After the qualifying event, continuation coverage must be offered to each person who is a continuation coverage beneficiary. You and your spouse could become continuation coverage beneficiaries if coverage under the Program is lost because of a qualifying event. The following are qualifying events:

| Who Can Continue Coverage | In What Situations | For How Long |
|---|---|---|
| **Retiree and spouse** | Loss of coverage or increases in cost due to, or significant reduction in coverage within one year before or after, the commencement of bankruptcy proceedings under Title 11 of the United States Code with respect to RR Donnelley or its subsidiaries from whose employment you retired | Until death; however, in the case of the covered surviving spouse, no later than 36 months after the death of the covered former employee |
| **Retiree's spouse** | Divorce or legal separation or death of Retiree | 36 months |

If you or your spouse becomes eligible to participate in Medicare but does not elect to participate therein, you or your spouse may become entitled to certain COBRA rights. You should contact the COBRA administrator within 60 days of not electing Medicare to receive more information.

# Notification

In the case of a proceeding in bankruptcy under Title 11 of the United States Code with respect to RR Donnelley or its subsidiary from whose employment you retired, you or your spouse who is a continuation coverage beneficiary will automatically be advised of the right to continuation coverage within 14 days of the date the COBRA administrator is notified by the employer of the event. The employer has 30 days after the date of the qualifying event to notify the COBRA administrator.

Under the law, the former employee or spouse who is a continuation coverage beneficiary has the responsibility to inform the COBRA administrator of the Retiree's death, a divorce or legal separation, within 60 days after the qualifying event occurs. Upon such notification, coverage will be terminated retroactive to the date of the qualifying event. Failure to provide this notification results in the loss of continuation coverage rights. When the COBRA administrator is notified that one of these qualifying events has happened, you and your spouse will in turn be notified within 14 days of the right to choose continuation coverage.

# Election Procedure

Under the law, to continue coverage, you and your spouse have 60 days from the later of the:

- Date you and your spouse ordinarily would have lost coverage because of one of the qualifying events described above; or
- Date the notice of the right to elect continuation coverage for you and your spouse is sent by the COBRA administrator.

If you and your spouse do not choose continuation coverage within this 60-day period, your and your spouse's coverage under the Program will end.

You and your spouse do not have to show that you and your spouse is insurable to choose continuation coverage. However, continuation coverage under the law is provided subject to your eligibility for coverage under the Program. The Program reserves the right to terminate your continuation coverage retroactively if you or your spouse is determined to be ineligible. Once your continuation coverage ends for any reason, it cannot be reinstated.

# Payment

Generally, you and your spouse must pay a premium to the Program of 102% of the applicable unsubsidized premium during the 36-month (or, in the case of bankruptcy, longer) period of continuation coverage. The initial continuation coverage premium is due by the 45th day after coverage is elected. All other payments are due on the first day of the month for which you and your spouse are buying coverage, subject to a 30-day grace period. If you and your spouse do not make payment on or before the first day of the month, claims by you and your spouse will not be paid by the Program until payment is received within the 30-day grace period.

# When Continuation Coverage Ends

Continuation coverage of a continuation coverage beneficiary continues until the earliest of:

- The end of the 36-month continuation period or in the case of bankruptcy, the time periods indicated in the chart above;
- The date RR Donnelley and its subsidiaries no longer provide coverage to any of their employees;
- The date you and your spouse fail to pay the required premium by the specified deadline; or
- The date you and your spouse first become covered after the date of his or her continuation coverage election under another group health care program that does not contain a pre-existing exclusion that affects his or her benefits. If continuation coverage is rejected in favor of an alternate coverage under the Program, continuation coverage will not be offered at the end of that period.

Remember to notify the COBRA administrator of any address or telephone number changes.

# ACA 1557 Grievance Procedures

It is the policy of the Plan not to discriminate on the basis of race, color, national origin, sex, age or disability. The Plan has adopted an internal grievance procedure providing for prompt and equitable resolution of complaints alleging any action prohibited by Section 1557 of the Affordable Care Act (42 U.S.C. 18116) and its implementing regulations at 45 CFR part 92, issued by the U.S. Department of Health and Human Services.

Section 1557 prohibits discrimination on the basis of race, color, national origin, sex, age or disability in certain health programs and activities. Section 1557 and its implementing regulations may be examined in the office of the Section 1557 Coordinator:

RR Donnelley Post-65 Retiree Welfare Benefits Plan
c/o Vice President, Benefits
4101 Winfield Road
Warrenville, IL 60555
312-326-8000
Email: **corporatehealthwelfare@rrd.com**

The Section 1557 Coordinator has been designated to coordinate the efforts of the Plan to comply with Section 1557. Any person who believes someone has been subjected to discrimination on the basis of race, color, national origin, sex, age or disability may file a grievance under this procedure. It is against the law for the Plan to retaliate against anyone who opposes discrimination, files a grievance, or participates in the investigation of a grievance.

# Procedure

- Grievances must be submitted to the Section 1557 Coordinator within (60 days) of the date the person filing the grievance becomes aware of the alleged discriminatory action.
- A complaint must be in writing, containing the name and address of the person filing it. The complaint must state the problem or action alleged to be discriminatory and the remedy or relief sought.
- The Section 1557 Coordinator (or her/his designee) shall conduct an investigation of the complaint. This investigation may be informal, but it will be thorough, affording all interested persons an opportunity to submit evidence relevant to the complaint.
- The Section 1557 Coordinator will maintain the files and records relating to such grievances. To the extent possible, and in accordance with applicable law, the Section 1557 Coordinator will take appropriate steps to preserve the confidentiality of files and records relating to grievances and will share them only with those who have a need to know.
- The Section 1557 Coordinator will issue a written decision on the grievance, based on a preponderance of the evidence, no later than 30 days after its filing, including a notice to the complainant of their right to pursue further administrative or legal remedies.
- The person filing the grievance may appeal the decision of the Nondiscrimination Grievance Coordinator by writing to the Benefits Committee within 15 days of receiving the Section 1557 Coordinator's decision. The Benefits Committee shall issue a written decision in response to the appeal no later than 30 days after its filing. The availability and use of this grievance procedure does not prevent a person from pursuing other legal or administrative remedies, including filing a complaint of discrimination on the basis of race, color, national origin, sex, age or disability in court or with the U.S. Department of Health and Human Services, Office for Civil Rights.
- A person can file a complaint of discrimination electronically through the Office for Civil Rights Complaint Portal, which is available at:
  - **https://ocrportal.hhs.gov/ocr/portal/lobby.jsf**, or
  - By mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue SW., Room 509F, HHH Building, Washington, DC 20201.
  - Complaint forms are available at: **http://www.hhs.gov/ocr/office/file/index.html**.

Such complaints must be filed within 180 days of the date of the alleged discrimination. Section 1557 Coordinator will make appropriate arrangements to ensure that individuals with disabilities and individuals with limited English proficiency are provided auxiliary aids and services or language assistance services, respectively, if needed to participate in this grievance process. Such arrangements may include, but are not limited to, providing qualified interpreters, providing taped cassettes of material for individuals with low vision, or assuring a barrier-free location for the proceedings. The Section 1557 Coordinator will be responsible for such arrangements.

# SITUATIONS AFFECTING YOUR BENEFITS

## General Information

The Program is designed to help you pay the cost of medical care services for you and your spouse. However, some situations could cause the delay, loss, or reduction of your benefits under this Program. A few of these situations are highlighted below. The Program:

- Pays benefits only for covered expenses – those listed in this SPD, applicable Aetna Evidence of Coverage or Wellmark Benefits Certificate, or the Plan document – approved by the claims administrator.
- Pays benefits up to the contracted amount for in-network covered expenses and the maximum reimbursable charge for out-of-network covered expenses, but only to the extent that the covered expense is medically necessary as determined by the claims administrator.
- May reduce benefits if you or your spouse does not follow the approval procedures before admission to a hospital or other treatment facility. If amended, any change in benefit levels applies as of the date the amendment occurs.
- Pays no benefit for you or your spouse if you or your spouse is enrolled in Medicare Part D (this pertains to the Drug Benefit Program).
- Pays no benefit for you or your spouse if you or your spouse is enrolled in Medicare Part C (this pertains to the Medical Benefit Program).

## If the Plan Is Modified or Ended

RR Donnelley reserves the right to amend or terminate the Plan or the Program at any time, in whole or in part. Benefits do not vest. If the Plan or the Program is ever terminated, suspended, or modified, benefits for any service you or your spouse receives before the change are paid under the Program's former conditions. The Program does not pay any benefits for services received after such action (unless specific provisions are adopted).

RR Donnelley can amend or replace the group insurance contracts through which benefit claims are paid under the Plan. If the Plan or its programs are terminated, the rights of a participant covered under the plan or its Programs are limited to the payment of eligible losses that occur prior to the termination.

# If the Plan Is Discriminatory

RR Donnelley reserves the right to modify or tax benefits to the extent required to ensure that the Plan does not discriminate in favor of highly compensated individuals as defined in the Internal Revenue Code.

# Plan Rebates

The Plan may receive rebates or other proceeds, such as a settlement in litigation or rebates and other discounts in connection with the Drug Benefit Program. The amount you are required to pay under the Drug Benefit Program is based on the price of the prescription before the application of any rebate or other discount. The rebates or other proceeds will be held in the RR Donnelley Medical Benefit Trust and used to pay Plan claims and expenses.

# ADMINISTRATIVE AND CONTACT INFORMATION

## General Information

This section provides you with information about how the Plan is administered.

### *Type of Plan*

The Plan is a welfare benefit plan. Its objective is to reimburse non-occupational medical expenses of eligible retired employees and their eligible dependents in accordance with the terms of the Plan.

### *Plan Sponsor*

R.R. Donnelley & Sons Company
4101 Winfield Road
Warrenville, IL 60555
630-322-6000

### *Employer Identification Number of Plan Sponsor*

36-1004130

### *Plan Name and Number*

RR Donnelley Post-65 Retiree Welfare Benefits Plan – 513

### *Plan Year End*

December 31

### *Agent for Service of Legal Process*

Corporate Secretary
R.R. Donnelley & Sons Company
4101 Winfield Road
Warrenville, IL 60555

Legal process also may be served on the Benefits Committee and/or the trustee. Trustee's address is:

The Northern Trust Company
50 S. LaSalle Street
Chicago, IL 60675
312-630-6000

## *Benefits Committee and Plan Administrator*

Benefits Committee
c/o Vice President, Benefits
R.R. Donnelley & Sons Company
4101 Winfield Road
Warrenville, IL 60555

An appeal of your COBRA benefit denial is processed by the Benefits Committee.

# Eligibility Administration

The eligibility administration is performed by bswift, at the following address and phone number:

RRD Benefits Center
PO Box 804057
Chicago, IL 60680
1-877-RRD-4BEN (1-877-773-4236)

Benefits Center Representatives are available from 7 a.m. to 7 p.m. CT, Monday through Friday, except holidays.

Website: **rrd.bswift.com**

Contact the Benefits Center to:

- Verify benefit eligibility;
- Report that you have, or your spouse/domestic partner has, become eligible for Medicare;
- Remove a spouse/domestic partner from coverage;
- Ask general benefit questions; and
- Report an address change.

If you want to enroll yourself or your spouse in the Program, you must follow the enrollment procedures described in this SPD.

# Claims Administrator and Network Manager

If you or your spouse has questions about a specific benefit, contact the appropriate claims administrator as shown in the chart below.

| Coverage Options | Claims Administrator |
|---|---|
| **Group Health Program Medical Benefit Program Options** | |
| Post-65: Aetna Medicare Plan (PPO) | Aetna Medicare<br>PO Box 7082<br>London, KY 40742<br>1-866-474-4040<br>**AetnaRetireePlans.com** |
| Esselte: Blue Cross and Blue Shield of Illinois | Blue Cross and Blue Shield of Illinois<br>PO Box 660603<br>Dallas, TX 75266<br>1-800-537-9765<br>**BCBSIL.com** |
| Meredith Burda: Wellmark Blue Cross and Blue Shield of Iowa | Wellmark Blue Cross and Blue Shield<br>Mail Station 1E238<br>PO Box 9291<br>Des Moines, IA 50306-9291<br>1-800-524-9242 |
| **The Drug Benefit Program** | |
| Post-65: Aetna Prescription Drug Plan | Aetna Medicare<br>PO Box 7082<br>London, KY 40742<br>1-866-474-4040<br>**AetnaRetireePlans.com** |
| Esselte: Blue Cross and Blue Shield of Illinois | Prime Therapeutics<br>2900 Ames Crossing Rd.<br>Eagan, MN 55121<br>1-800-617-5997 |
| Meredith Burda: Wellmark Blue Cross and Blue Shield of Iowa | Not Covered. Although the Plan does not cover prescription drugs, coverage is available through Medicare Part D. See **Medicare.gov** or call 1-800-633-4227 |
| **Appeals** | |
| Post-65: Aetna Medicare Plan (PPO) Appeals | Aetna Medicare Part C Appeals<br>PO Box 14067<br>Lexington, KY 40512<br>1-888-267-2637<br>**AetnaRetireePlans.com** |
| Post-65: Aetna Prescription Drug Plan Appeals | Aetna Medicare Part D Appeals<br>PO Box 7082<br>London, KY 40742<br>1-724-741-4954<br>**AetnaRetireePlans.com** |

| | |
|---|---|
| Esselte: Blue Cross and Blue Shield of Illinois – Medical Coverage Appeals | Blue Cross Community Health Plans<br>Attn: Grievance and Appeals Unit<br>PO Box 660717<br>Dallas, TX 75266-0717<br>Fax: 1-866-643-7069 |
| Esselte: Blue Cross and Blue Shield of Illinois – Prescription Coverage Appeals | Blue Cross Community Health Plans<br>Attn: Prime Therapeutics Appeals Department<br>2900 Ames Crossing Road<br>Eagan, MN 55121<br>Fax: 1-855-212-8110 |
| Meredith Burda: Wellmark Blue Cross and Blue Shield of Iowa – Medical Coverage Appeals | Wellmark Blue Cross and Blue Shield<br>Special Inquiries, Station 5W189<br>PO Box 9232<br>Des Moines, IA 50306-9232<br>Fax: 515-376-9073 |
| Meredith Burda: Medicare Part D - Prescription Coverage Appeals | Not applicable under the Plan. Please see the Medicare.gov website for details and instructions if you have enrolled in Medicare Part D. |

Each of the claims administrators is also a network manager over the health care providers it makes available through its provider network.

# Claims Administrator for Eligibility Claims

The Benefits Committee is the claims administrator for claims related to eligibility and appeals of denied claims related to eligibility.

# COBRA Administrator for Continuation Coverage

The COBRA administrator is bswift. If you or your spouse has questions about your continuation coverage rights, contact the COBRA administrator at the following address and phone number:

RRD Benefits Center
PO Box 804057
Chicago, IL 60680
1-877-RRD-4BEN (1-877-773-4236)
Website: **rrd.bswift.com**

# Allocation and Delegation of Fiduciary Responsibilities by the Benefits Committee

The Plan provides a procedure for the Benefits Committee, acting as named fiduciary, to allocate or delegate fiduciary responsibilities to its members or to other persons. Where the Benefits Committee has allocated to an applicable investment-named fiduciary some authority to control or manage assets held in the RR Donnelley Medical Benefit Trust ("Trust"), or to an applicable

administrative-named fiduciary some authority and control over the operation and administration of the Plan, references in this SPD to the Benefits Committee are intended to refer to any such applicable investment-named fiduciary or applicable administrative-named fiduciary. The Plan also provides a procedure for the Benefits Committee, acting as the Plan's sponsor, to identify persons, such as the claims administrator, to be a named fiduciary. Typically, the Benefits Committee has identified each third-party administrator as a named fiduciary with respect to the authority and control or discretion it possesses or has exercised in connection with the Plan or Trust.

# Trust and Insurance

RR Donnelley sponsors the RR Donnelley Medical Benefit Trust to be used for funding benefits, holding insurance contracts, and contracting with claims administrators. The trustee is:

The Northern Trust Company
50 S. LaSalle Street
Chicago, IL 60675
312-630-6000

# Funding

Wellmark and Aetna Medicare Advantage Program are provided through contracts of insurance and benefits are paid by the carriers. All other options are self-funded.

All of the benefits under the Program are funded by the Trust. The Trust is maintained by RR Donnelley, and its assets are managed by investment managers selected by the Benefits Committee or The Prudential Insurance Company of America. The benefits funded solely by the Trust are not guaranteed by the claims administrators or network managers. The claims administrators' role is to provide services to the Program.

The Trust is the policyholder for the funding of the insurance policies. These policies are contracts of insurance which are guaranteed by the issuer and not the Plan or the Trust. The Prudential Insurance Company of America has issued a contract of insurance to the Trust. Under the terms of the insurance contract, The Prudential Insurance Company of America is the named fiduciary over the control and management of the Trust's assets held under that contract.

# Participating Employers

The Program described in this document applies to retired employees of Participating Employers to whom benefits have been extended. The Plan Administrator and eligibility administrator maintain records regarding Participating Employers. If you have questions concerning your eligibility to participate in this Program, call the RRD Benefits Center, which is the Program's eligibility administrator.

You or your spouse may receive from the eligibility administrator, upon written request, information as to whether a particular employer is a Participating Employer and, if the employer is a Participating Employer, the Participating Employer's address.

# YOUR ERISA RIGHTS

## General Information

As a participant in the Plan, you and your covered spouse are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974, as amended ("ERISA"). ERISA provides that you are entitled to the following.

## Receive Information About Your Plan and Benefits

- Examine, without charge, at the Plan Administrator's office and at other specified locations, such as work sites and union halls, all documents governing the Plan, including insurance contracts and collective bargaining agreements, 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 collective bargaining agreements, copies of the latest annual report (Form 5500 Series), and an updated SPD. The Plan Administrator may make a reasonable charge for the copies.
- Receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of this Summary Annual Report.

## Continue Group Health Plan Coverage

- Continue health care coverage for you or your covered spouse if there is a loss of coverage under the Program as a result of a qualifying event. You or your covered spouse may have to pay for such coverage. Review this SPD and the documents governing the Plan on the rules governing your COBRA continuation coverage rights.
- Reduce or eliminate exclusionary periods of coverage for pre-existing conditions under your Program, if you have creditable coverage from another plan. You should be provided a certificate of creditable coverage, free of charge, from your Program or health insurance issuer when you lose coverage under the Program, when you become entitled to elect COBRA continuation coverage, when your COBRA continuation coverage ceases, if you request it before losing coverage, or if you request it up to 24 months after losing coverage. Without evidence of creditable coverage, you may be subject to a pre-existing condition exclusion for 12 months (18 months for late enrollees) after your enrollment date in your coverage. **Note:** These provisions were eliminated by the Affordable Care Act effective in 2015.

# 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 benefits 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, your union, or any other person – may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare 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 a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of Plan documents or the latest annual report from the Plan and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator.

If you have a claim for benefits that is finally denied or ignored, in whole or in part, you may file suit in a state or federal court. In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a domestic relations order, you may file suit in 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 Benefits Center or the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, of if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of the Employee Benefits Security Administration, 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, D.C. 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.

# APPENDIX A – MEMBER CERTIFICATES AND BOOKLETS

For additional details see the following:

| Program | Administrator |
|---|---|
| Medical Benefit Program | **Aetna Evidence of Coverage** |
| Drug Benefit Program | **Aetna Evidence of Coverage** |
| Meredith Burda Post-65 Retired by 12/31/1991 | **Wellmark Blue Cross and Blue Shield of Iowa Benefits Certificate**<br>**Wellmark Overview of Coverage**<br>**Wellmark Health Insurance Brochure** |
| Esselte | Blue Cross and Blue Shield of Illinois Addendum (Appendix C will be provided to Esselte participants only.) |

# APPENDIX B – DISCRIMINATION IS AGAINST THE LAW

RR Donnelley Post-65 Retiree Welfare Benefits Plan complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex.
RR Donnelley Post-65 Retiree Welfare Benefits Plan does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

RR Donnelley Post-65 Retiree Welfare Benefits Plan:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, contact the RRD Benefits Center at 1-877-RRD- 4BEN (1-877-773-4236) or online at **rrd.bswift.com**.

If you believe that RR Donnelley Post-65 Retiree Welfare Benefits Plan has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with: Vice President, Benefits, 4101 Winfield Road, Warrenville, IL 60555, 630-963-9494. You can file a grievance in person or by mail, or email. If you need help filing a grievance, Vice President, Benefits, is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at **https://ocrportal.hhs.gov/ocr/portal/lobby.jsf**, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
1-800-368-1019, 1-800-537-7697 (TDD)

Complaint forms are available at **http://www.hhs.gov/ocr/office/file/index.html**.

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-877-773-4236.

注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-877-773-4236.

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-877-773-4236.

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-877-773-4236 번으로 전화해 주십시오.

PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-877-773-4236.

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-877-773-4236.

ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 4236-773-877-1

ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele 1-877-773-4236.

ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-877-773-4236.

UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1-877-773-4236.

ATENÇÃO: Se fala português, encontram-se disponíveis serviços linguísticos, grátis. Ligue para 1-877-773-4236.

ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 1-877-773-4236.

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-877-773-4236.

注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。1-877-773-4236 まで、お電話にてご連絡ください。

توجه: اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می باشد. با 4236-773-877-1 تماس بگیرید.