FLEXIBLE SPENDING ACCOUNT PROGRAM BOOKLET

This Flexible Spending Account Program Booklet describes the Health Care Spending Program, Dependent Care Spending Program, Health Savings Account Program, and Premium Payment Program as of January 1, 2021. The Health Care Spending Program, Dependent Care Spending Program, Health Savings Account Program, and Premium Payment Program are part of the RR Donnelley Flexible Benefits Plan.

September 2021

RRD BENEFITS
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INTRODUCTION

The Flexible Benefits Plan (the "Plan"), offered by R. R. Donnelley & Sons Company and its participating subsidiaries (or "Participating Employers," referred to herein collectively as "RRD"), provides a before-tax opportunity to help you save on certain eligible health and dependent care-related expenses by contributing to the following programs:

- **Health Care Spending Program**, which offers two types of Health Care Flexible Spending Accounts (Health Care FSAs):
  - A Regular-Use Health Care FSA, for all medical expenses that would be eligible for Health Care FSA reimbursements in accordance with applicable law; and
  - A Limited-Use Health Care FSA, for dental, vision and post-deductible medical expenses that would be eligible for Health Care FSA reimbursements in accordance with applicable law (i.e., until the employee has met the deductible under the HSA Value, HSA Advantage or Kaiser HSA medical options);
- **Dependent Care Spending Program** (Dependent Day Care Flexible Spending Account or "Dependent Day Care FSA");
- **Health Savings Account Program** ("HSA Program"); and
- **Participant Premium Program** to pay for your share of the premiums for the following options under the Group Benefits Plan on a before-tax basis:
  - Group Health Program (including the Medical Program, Prescription Drug Program and Regional Medical Program);
  - Dental Program;
  - Vision Care Program.

Collectively, the Health Care FSAs and the Dependent Day Care FSA may be referred to as the FSAs.

Together, this Flexible Spending Account Program Booklet, as well as any Summaries of Material Modifications (SMMs), the Annual Enrollment materials, and other plan summaries, make up the complete Summary Plan Description (SPD) for the Plan. The complete SPD for the Plan includes this Flexible Spending Account Program Booklet, as well as any SMMs, the Annual Enrollment materials, and other plan summaries.

This Flexible Spending Account Program Booklet describes the FSA, HSA, and Participant Premium Program options under the Plan as of January 1, 2021.

This Flexible Spending Account Program Booklet and any supplemental information are intended to be a complete, accurate, and up-to-date description of the Plan. However, since laws and regulations change periodically, this document cannot adequately define every potentially reimbursable expense or exclusion or the frequently-changing contribution limits. In each case, the claims administrator will have the authority or discretion to make the determination of whether a contribution is permitted, or an expense incurred is a reimbursable expense in accordance with applicable law. If there is any discrepancy between the SPD and the Plan document, the Plan document always governs.

The Plan has contracted with third parties to render services necessary to the operation and administration of the FSAs. bswift is the eligibility administrator and HealthEquity is the claims administrator for the FSAs.

Flexible Benefits Plan Summary Plan Description

Together, this Flexible Spending Program Booklet, any SMMs, the Annual Enrollment materials, and other plan summaries make up the complete SPD for the Flexible Benefits Plan. Please read this information to familiarize yourself with your coverage. If changes to the Flexible Benefits Plan occur, you will be notified through a SMM or the Annual Enrollment materials.

Union employees covered by a collective bargaining agreement need to refer to such agreement for any differences from the options offered as described in this Flexible Spending Program Booklet. If there are differences between the rules contained in the SPD and the rules contained in your applicable collective bargaining agreement, your collective bargaining agreement will control.

Nothing in this Flexible Spending Program Booklet should be interpreted as an employment contract. This Flexible Spending Program Booklet merely describes the spending account benefits offered to eligible employees as of January 1, 2021. RRD reserves the right to amend, change or terminate the Flexible Benefits Plan or Flexible Spending Program, in whole or in part, at any time.

This Flexible Spending Program Booklet contains a summary in English of the benefits available under the Flexible Spending Program. If you have difficulty understanding any part of this Flexible Spending Program Booklet or the SPD, or to request language assistance call the RRD Benefits Center at **1-877-RRD-4BEN (1-877-773-4236)** or go to **rrd.bswift.com**. Benefits Center Representatives are available to assist you from 7 a.m. to 7 p.m. CT, Monday through Friday.

BENEFITS-AT-A-GLANCE

A summary of the FSAs is shown below:

FSA Feature	Health Care FSAs	Dependent Day Care FSA
Before-tax Contributions	**Regular-Use Health Care FSA:** You can set aside money from your paycheck before it is taxed to be used to pay for or reimburse eligible health care expenses not covered by another medical, prescription drug, dental, or vision program. **Limited-Use Health Care FSA:** If you participate in the RRD Group Health Program and elect an HSA eligible Medical Program option, you can use the Limited-Use Health Care FSA for the following expenses that are not covered by another medical, prescription drug, dental, or vision program: • eligible medical and prescription drug expenses after you have met your Medical Program option's deductible requirement, and • eligible dental and vision expenses at any time, even before your Medical Program option's deductible has been met.	You can set aside money from your paycheck before it is taxed to be used to reimburse eligible dependent day care expenses for your children under age 13* or adult disabled dependents.
Contribution Limits	You decide to contribute between $200 and the communicated maximum ($2,750 for 2021).	You decide to contribute between $200 and $5,000 annually.
Paying Expenses	You will: • Pay an eligible expense and submit a claim for reimbursement, or • Use a debit card to pay an eligible health care expense.	You will pay an eligible expense and submit a claim for reimbursement.
Use It or Lose It	Because you do not have to pay taxes on the money you set aside, the Internal Revenue Service (IRS) requires that you forfeit any money that you do not use for the year in which you participate (use it or lose it). Keep this in mind when you decide how much to contribute.**	

* For the Plan Years ending in 2020 and 2021 only, expenses maybe reimbursed for children who are under age 14, under certain circumstances. See the **COVID-19 Temporary Changes under IRS Notice 2020-29 and the Consolidated Appropriations Act SMM** for more information.

** For the Plan Years ending in 2020 and 2021 only, any amounts remaining in your account on the last day of the Plan Year may carry forward to the following Plan Year. See the **COVID-19 Temporary Changes under IRS Notice 2020-29 and the Consolidated Appropriations Act SMM** for more information.

WHO IS ELIGIBLE

You are eligible to participate in the Plan if you are classified as a:

- Full-time benefits-eligible employee of a Participating Employer regularly scheduled to work 30 or more hours per week,
- Part-time "A" employee of a Participating Employer working at least 1,040 hours during the 12-month period preceding the date on which benefits eligibility is determined, or
- Union employee of a Participating Employer who is covered by a collective bargaining agreement and such agreement provides for your FSA participation.

In addition, you must:

- For the Health Care FSA, be eligible for the RRD Group Health Program.
- For the Dependent Day Care FSA, have an eligible dependent that is a qualifying individual as described in **How the Dependent Day Care FSA Works**.

You are not eligible to participate in the Plan if you are:

- An employee of a non-Participating Employer,
- A part-time "B" employee,
- Hired for seasonal or vacation relief work (and not classified as Part-Time "A"),
- In any classification other than a full-time benefits-eligible or part-time "A" employee, or
- A union employee represented by a collective bargaining agreement, except if such agreement allows for participation in the FSAs.

Once you become a participant, your participation may be terminated, suspended, or otherwise affected under certain circumstances.

If You Are Reemployed

If you terminate employment with a Participating Employer and are reemployed by a Participating Employer within 30 days of your termination date as a full-time benefits-eligible or part-time "A" employee of a Participating Employer, you are not treated as a new hire. Your prior period of employment will be recognized, and your previous benefit elections and annual contribution election will automatically resume. In order to still meet your annual contribution amount, your per pay period contribution will be recalculated based on the remaining pay periods. Your participation will be subject to any Annual Enrollment changes that became effective during your absence.

If you are reemployed by a Participating Employer more than 30 days after your termination date, you will be considered a new hire and will have a new opportunity to enroll for Plan coverage. Generally, you will need to meet the applicable eligibility requirements, including the applicable eligibility waiting period, unless the Participating Employer's look-back measurement and stability periods policy under the Patient Protection and Affordable Care Act requires that you be reinstated to benefit plan coverage at an earlier date. Any additional amounts you elect to contribute must be within the IRS limits.

ENROLLING TO PARTICIPATE

If you meet the eligibility requirements, you can enroll in Plan benefits. When you enroll in a Plan benefit, your contributions are deducted from your pay before-tax. As a new benefits-eligible employee, you receive enrollment information that details the coverages for which you are eligible. This information also includes specific instructions on how to enroll. You must enroll yourself by the enrollment deadline set forth in your enrollment materials. For purposes of determining whether you have satisfied this waiting period, all periods of your employment with a Participating Employer before a period of more than 30 consecutive days during which you are not employed with a Participating Employer are disregarded. For certain programs, including the Health Care FSAs, the Dependent Day Care FSA, and the HSA, you must enroll each year to participate in the Plan for that year. For the Participant Premium Program, your elections will be modified each year to match the applicable premiums for the medical, dental and/or vision coverage in which you enroll; those coverage elections may be carried over from year-to-year, as described in the Annual Enrollment materials for those benefits.

If you and your spouse are both RRD employees eligible to participate, each of you may elect to contribute to the Health Care FSA, the Dependent Day Care FSA, and/or an HSA (if eligible). However, maximum contribution limits apply, and the elections that each spouse makes may affect the elections the other can make, as further described throughout this booklet.

When you enroll in medical, dental and/or vision benefits under the RRD Group Benefits Plan, you are automatically enrolling in the Participant Premium Program to make your premium payments before-tax, if available, under the IRS rules.

Your Contributions

When you enroll in the Health Care and/or Dependent Day Care FSAs, the HSA Program, or medical, dental or vision benefits under the Group Benefits Plan, you authorize the deduction of the required employee contributions from your paycheck on a before-tax basis.

“Before-tax” means that your contribution is taken from your paycheck before federal and Social Security/Medicare (FICA) taxes (and, in most cases, state and local taxes) are deducted. This reduces your taxable income (your gross pay minus contributions), so you pay less in taxes.

The IRS limits the instances when you are permitted to change your contributions to the FSAs or the Participant Premium Program. Your elections for the FSAs and Participant Premium Program (including your elections for the medical, dental and vision insurance under the Group Benefits Plan) are generally binding for the entire calendar year for which the elections were made, unless a Qualified Status Change occurs during the calendar year. See the section titled **Qualified Status Changes** for more information.

Your elections are also subject to changes in the provisions of the FSAs and compliance with applicable state and federal laws. Provisions of the FSAs or the Participant Premium Program limiting your election to one calendar year will not apply if RRD has advanced contributions for you which are unpaid at the end of the calendar year.

If you experience a Qualified Status Change, you may not reduce your contribution election below an amount that will result in your total contributions for the calendar year being less than the total amount of premiums paid and FSA reimbursements you will receive for claims incurred in the same calendar year prior to the date of the change. And, if you experience a Qualified Status Change and timely elect to increase your contribution election, the increased contribution amount can only be used to reimburse eligible expenses incurred on or after the date of the Qualified Status Change.

HSA Program elections are not subject to the rules for Qualified Status Changes. You may change your HSA Program election throughout the year without a Qualified Status Change.

When Participation Begins

As a new benefits-eligible employee, you will receive enrollment information that details Group Benefits Plan options, the FSAs, and the HSA Program. This information also includes specific instructions on how to enroll. You must enroll by the enrollment deadline set forth in your enrollment materials. As long as you enroll by the deadline, you begin participating on the first day of the calendar month after your one-month anniversary of employment (with the exception of employees hired in October electing FSA coverage, as further described below). If you have a period of more than 30 consecutive days during which you are not employed with a Participating Employer, then all prior periods of employment with a Participating Employer are disregarded for purposes of determining whether you have satisfied this waiting period.

As stated above, you are automatically enrolled in the Participant Premium Program when you enroll in medical, dental and/or vision benefits.

The chart below shows when participation begins based on different start dates throughout the calendar year.

If You Start During the Month of:	Your Coverage Begins:
January	March 1
February	April 1
March	May 1
April	June 1
May	July 1
June	August 1
July	September 1
August	October 1
September	November 1
October	HSA, medical, dental, and vision coverage: December 1 FSA coverage: January 1 (even though your coverage for other benefits begins on December 1)
November	January 1
December	February 1

If you are not eligible for coverage when you are first hired with a Participating Employer, you become eligible on the date you transfer from benefits-ineligible to benefits-eligible status with that Participating Employer (provided you have at least one full calendar month of employment, as determined above, from your original hire date).

If you become a new benefits-eligible employee because you have transferred your employment from a non-Participating Employer who is an affiliate of RRD, the following special rules will apply:

- Your coverage under the Health Care Spending Program and/or Dependent Day Care Spending Program begins on the first day of the month following the month in which you transfer if:
  - You transfer from a U.S. affiliate and you had not satisfied the waiting period for, and therefore were not covered by, a Health Care Spending Program and/or Dependent Day Care Spending Program on the date of the transfer; and
  - You have at least one full calendar month of employment with that U.S. affiliate.

- If you do not have a least one full calendar month of employment, these special rules do not apply and you are treated as a newly hired benefits-eligible employee on your date of transfer.
- If you transfer from a U.S. affiliate and you were either covered by or elected not to be covered by a Health Care FSA and/or Dependent Day Care FSA on the date of the transfer, your election for these program will continue until the end of the calendar year in which you transfer. As a result, your coverage under the Health Care Spending Program and/or Dependent Day Care Spending Program begins on the following January 1.
- If you transfer from a non-U.S. affiliate, your coverage under the Health Care Spending Program and/or Dependent Day Care Spending Program begins on the date you transfer.

If You Are Not Actively at Work

If you are not actively at work (due to an approved leave) on the day participation is scheduled to begin, your participation still takes effect on that day. You do not need to return to active work for your participation to take effect.

If You Do Not Enroll by the Deadline

If you do not enroll by the deadline set forth in your enrollment materials, either as a new hire or during the Annual Enrollment period, you will not be able to do so until the next Annual Enrollment period. The only exception is if you contribute to the HSA Program, of if you report a Qualified Status Change within the required time frame.

Annual Enrollment

Every fall during the Annual Enrollment period, you receive information about the medical, dental, vision, FSAs and HSA Program options for which you are eligible. You also receive instructions on how to make your medical, dental, vision, FSA and HSA contribution elections for the upcoming calendar year. You then have the opportunity to enroll, change your contribution amounts, or choose not to participate. IRS regulations require that FSA elections must be made for each Plan Year; they do not automatically renew from year to year. The Plan also requires that you make new HSA Program elections each Plan Year.

The choices you make during the Annual Enrollment period take effect the following January 1 and remain in effect throughout the entire calendar year, unless you report a Qualified Status Change permitting you to make a mid-year election change.

Your Benefit Elections May Not Exceed Your Net Income

You are not permitted to elect benefit options that would result in your share of the employee contributions exceeding your monthly net income. If you make such an election at the time of enrollment, or should you later become unable to pay the required contribution for the option(s) you elected due to an insufficient amount of earnings for two or more consecutive pay periods (e.g., resulting from reasons such as garnishments, child support orders, reduction in work hours, or other governmentally required withholdings), then the Plan Administrator may take steps necessary to correct the situation, including but not limited to the following:

- Reducing your elections under the Health Care FSA, Dependent Day Care FSA and/or a HSA to levels that would not result in an overspent account;
- Terminating your coverage in Group Benefits Plan elections other than the Medical Program; and/or
- If there is a Medical Program option available to you under the Group Benefits Plan that would comply with this rule, making you ineligible to elect any Medical Program option that is in violation of this rule. If you become ineligible for an option under the Group Benefits Plan under this rule, coverage will be terminated retroactively to the first date of the month in which the non-payment of premiums began. If you become ineligible for a Medical Program option under the Group Benefits Plan under this rule, this ineligibility will create a special enrollment right for you and your dependents and a notification will be mailed to you outlining your rights to elect alternate coverage. Within 35 days of the date of such notification, you may elect an option for which you can pay the applicable premiums for you (and your dependents, if applicable). Should you take no action during this time, you will be defaulted to the lowest cost option available under the Medical Program. Should you elect alternate coverage or be defaulted to the lowest cost Medical Program option, you will be responsible for paying the premiums from the effective date of the new coverage, which will be the first date of the month in which the non-payment of premiums for your prior election began. In the event you continue to fail to pay the premium for the lowest cost option, your coverage will be terminated retroactively as stated above and you will be defaulted to no coverage.

Qualified Status Changes

In most cases, because of IRS rules, the benefits you elect each year must remain in effect until the beginning of the next calendar year. However, when a significant change in your life or employment occurs, you may be able to adjust your benefits program choices to meet your changing needs.

You are allowed to make adjustments to your benefits program choices between Annual Enrollment periods only in response to specific situations called “Qualified Status Changes.” If

you experience a Qualified Status Change, you can make limited changes to the following benefits program choices:

- Health Care Spending Program:
  - Regular-Use Health Care FSA
  - Limited-Use Health Care FSA
- Dependent Day Care Spending Program
- Participant Premium Program (this is the portion of the Flexible Benefits Plan that allows you to have your paycheck deductions used to pay premiums for the Group Benefits Plan on a before-tax basis):
  - Group Health Program (including the Medical Program and Prescription Drug Program)
  - Regional Medical Options Program
  - Dental Benefit Program
  - Vision Care Program

The ability to change your elections in response to a Qualified Status Change may vary depending whether it is a change under the Health Care Spending Program, Dependent Day Care Spending Program, and may even vary within the Participant Premium Program (i.e., permitted election changes may be different for the Group Health Program than for the Dental Benefit Program or Vision Care Program).

Key Terms

See Key Terms in the Eligibility section for most definitions. Additional definitions include:

Contributions – means the amounts you are contributing to the FSAs, HSA and/or Participant Premium Program on a before-tax basis.

Premiums – means the amount you pay for coverage in which you have enrolled under the Group Benefits Plan. Sometimes the term "employee contribution" is used to refer to your share of premiums.

Sole Legal Guardian – as used with respect to an individual, it means that such individual has been appointed by a court as "sole legal guardian," or equivalent designation, and that parental rights have been severed or have been terminated due to death.

Benefits Changes You May Be Able to Make

The following chart highlights Qualified Status Changes that may allow you to change certain coverages under the Plans. However, to make any Qualified Status Change under the Plans, you generally must report the event which gives rise to the Qualified Status Change to the **eligibility**

administrator within 30 days following such event (with the exception of certain events that permit 60 days or more to make an election change, as further described below).

In general, if your Qualified Status Change is approved by the eligibility administrator, your change in coverage under the Group Benefits Plan will take effect as of the date of the event. Except as noted below, any change in before-tax contributions for the cost of coverage under the Group Benefits Plan takes effect as soon as administratively possible after you report the Qualified Status Change to the eligibility administrator. Any payroll deductions for coverage retroactive to the date of the Qualified Status Change will be deducted from your pay after-tax.

If you are adding a newborn child, you have up to 60 days to report such event to the eligibility administrator. However, depending on your insurance carrier and if you were already covered by Employee + Child(ren) or Family coverage, you may have up to 90 days (or for Regional Plans from 30 days to as long as a year) to enroll that dependent. If the election change is reported within 30 days of birth or adoption, then all payroll deductions (including those retroactive to the date of birth or adoption) will be paid on a before-tax basis. If the Qualified Status Change is reported more than 30 days following birth or adoption, then any change in before-tax contributions for the cost of coverage under the Group Benefits Plan takes effect as soon as administratively possible after you report the change to the eligibility administrator. In that case, any payroll deductions retroactive to the date of the change will be paid after-tax.

For the Health Care Spending Program and Dependent Day Care Spending Program, if you provide proper notice to the eligibility administrator and request your election change within 30 days of your qualifying event, then your Qualified Status Change will take effect once the claims administrator processes your program election. The processing will take place as soon as administratively possible. You will not be permitted to submit claims for expenses incurred prior to the date your Qualified Status Change is processed.

If you fail to report an event giving rise to a Qualified Status Change within the applicable timeframes described above, you must wait until the next Annual Enrollment period to make a coverage change.

The following chart provides a summary of your options associated with Qualified Status Changes. This list may from time-to-time in accordance with new IRS guidance. If you have any questions about whether an event is a Qualified Status Change, contact the RRD Benefits Center.

Eligibility Administrator

The rules governing when you or your eligible dependents may change coverage are governed by the terms of the Plan, the Internal Revenue Code (Code), the Employee Retirement Income Security Act of 1974, as amended (ERISA), and other applicable laws and regulations. The Plan's eligibility administrator has the discretionary authority to interpret these terms and apply them to your situation as appropriate.

Summary of Qualified Status Changes and Your Options

Event	Benefit Type	Changes You May Be Able to Make
Marriage/Special Enrollment Rights May Also Apply Marriage is considered to be a legal marriage and includes common-law marriages only in states where common-law marriages are legally recognized.	Medical/Dental/Vision	You may enroll your new eligible dependents or increase your election on account of your new eligible dependents; coverage option change maybe made; can revoke or decrease coverage for you or your existing eligible dependents only when such coverage becomes effective or is increased under your spouse's health plan.
	Health Care FSA	You may enroll your new eligible dependents or increase your election on account of new eligible dependents; or revoke or decrease your election for you or your existing eligible dependents if you or your existing eligible dependents become eligible under your spouse's health plan.
	Dependent Day Care FSA	You may enroll your new eligible dependents or increase your election on account of new eligible dependents; or decrease or cease coverage if spouse is not employed or increase/decrease coverage if spouse makes a Dependent Day Care FSA coverage election under his or her own health plan.
Gain Domestic Partner	Medical/Dental/Vision	You may add domestic partner and add domestic partner's eligible dependents. Drop coverage if this event includes a gain of plan eligibility under the domestic partner's plan.
	Health Care FSA	No changes allowed.
	Dependent Day Care FSA	You may enroll your new eligible dependents or increase your election on account of new eligible dependents; or decrease or cease coverage if your domestic partner is not employed or increase/decrease coverage if domestic partner makes a Dependent Day Care FSA coverage election under his or her own health plan.

Event	Benefit Type	Changes You May Be Able to Make
Birth/Adoption (or placement for adoption)/Special Enrollment Rights May Also Apply	Medical/Dental/Vision	You may enroll your new eligible dependents or increase your election on account of eligible dependents; coverage option change may be made; can revoke or decrease coverage for you or your existing eligible dependents if you or your existing eligible dependent become eligible under a spouse's health plan.
	Health Care FSA	You may enroll your new eligible dependents or increase your election on account of your new eligible dependents; coverage option change maybe made; can revoke or decrease coverage for you or your existing eligible dependents if you or your existing eligible dependents become eligible under a spouse's health plan.
	Dependent Day Care FSA	You may enroll your new eligible dependents or increase coverage to accommodate newly eligible dependents and any other existing eligible dependents who were not previously covered.
Loss of Eligible Dependent Status/Special Enrollment Rights May Also Apply This event applies in the following circumstances: • Loss of a legal guardianship arrangement • Loss of a legal foster child arrangement • Eligible dependent reaches age 26	Medical/Dental/Vision	You may drop coverage only for the eligible dependent who loses eligibility; coverage option change may be made.
	Health Care FSA	You may decrease (or cease) your election for and on account of an eligible dependent who loses eligibility.
	Dependent Day Care FSA	You may decrease (or cease) your election for and on account of an eligible dependent who loses eligibility.

Event	Benefit Type	Changes You May Be Able to Make
Gain of Eligible Dependent/ Special Enrollment Rules May Also Apply This event applies in the following circumstances: • Gain of an eligible dependent due to a legal guardianship arrangement • Gain of a foster child	Medical/Dental/Vision	You may enroll your new eligible dependents or increase your election on account of new eligible dependents; other eligible dependents also may be enrolled if not covered previously under the "tag along rule"; coverage option change maybe made; can revoke or decrease coverage for you or your existing eligible dependents if you or your existing eligible dependent become eligible under a spouse's health plan.
	Health Care FSA	You may enroll your new eligible dependents or increase your election on account of new eligible dependents or for other eligible dependents newly enrolled in medical under the tag along rule; coverage option change maybe made; can revoke or decrease coverage for you or your existing eligible dependents if you or your existing eligible dependents become eligible under a spouse's health plan.
	Dependent Day Care FSA	You may enroll your new eligible dependents or increase coverage to accommodate newly eligible dependents and any other existing eligible dependent who was not previously covered.

Event	Benefit Type	Changes You May Be Able to Make
Divorce/Legal Separation/ Annulment/Special Enrollment Rights May Also Apply	Medical/Dental/Vision	You may revoke your election only for a former spouse; coverage option change can be made. You may elect coverage for yourself or other eligible dependents (excluding your former spouse) who lose eligibility under your former spouse's plan if such individual loses eligibility as a result of the divorce, legal separation, annulment. In addition, under the tag-along rule, any dependents may be enrolled so long as at least one dependent has lost coverage under spouse's plan.
	Health Care FSA	You may decrease your election to reflect the loss of spouse's eligibility. You may enroll or increase your election where coverage is lost under former spouse's health plan.
	Dependent Day Care FSA	You may enroll or increase contributions to accommodate newly eligible dependents or cease your coverage if eligibility is lost.
Death of Spouse/Eligible Dependent	Medical/Dental/Vision	You may revoke your election only for deceased eligible dependent; coverage option change can be made. You may elect coverage for yourself or other eligible dependents who lose eligibility under your deceased spouse's plan if such individual loses eligibility as a result of the death. In addition, under the tag-along rule, any dependents may be enrolled so long as at least one dependent has lost coverage under spouse's plan.
	Health Care FSA	You may decrease your election to reflect the loss of eligible dependent's eligibility. You may enroll or increase election where coverage is lost under a deceased spouse's health plan.
	Dependent Day Care FSA	You may enroll or increase your contributions to accommodate newly eligible dependents or cease coverage if eligibility is lost.

Event	Benefit Type	Changes You May Be Able to Make
Loss of a Domestic Partner	Medical/Dental/Vision	You may drop a domestic partner or drop affected eligible dependents. You may enroll for coverage or add eligible dependents if this event includes a loss of plan eligibility under the domestic partner's plan. In addition, under the tag-along rule, any dependents may be enrolled so long as at least one dependent has lost coverage under your domestic partner's plan.
	Health Care FSA	No changes are allowed.
	Dependent Day Care FSA	You may enroll or increase your contributions to accommodate newly eligible dependents or cease coverage if eligibility is lost.
Begin Approved Unpaid Leave of Absence (employees only) **Note:** RRD will advance premiums while you are on a leave of absence, provided you agree to repay the advance when you return from the leave of absence (does not apply for the Dependent Day Care FSA).	Medical/Dental/Vision	You may revoke your election for leaves under FMLA or USERRA only, unless your leave of absence results in a loss of eligibility under the Plan.
	Health Care FSA	You may decrease or stop your election for leaves under FMLA or USERRA only, unless your leave of absence results in a loss of eligibility under the Plan.
	Dependent Day Care FSA	You may decrease or stop your election.
Return from Approved Unpaid Leave of Absence (employees only) This event applies only **more than 30 days** from the date the leave began.	Medical/Dental/Vision	You may add or change your coverage option to reinstate coverage upon return to work if your leave was taken under FMLA or USERRA or resulted in a loss of eligibility under the Plan.
	Health Care FSA	You may increase or re-start your contributions if your leave was taken under FMLA or USERRA or resulted in a loss of eligibility under the Plan. You may reinstate either your prior total annual election, or your prior per-pay-period amount.
	Dependent Day Care FSA	You may increase or re-start your contributions.

Event	Benefit Type	Changes You May Be Able to Make
Change from Non-Benefits-Eligible to Benefits-Eligible Employment (employees only) Must result in gain of Plan eligibility	Medical/Dental/Vision	You may add coverage for yourself and your eligible dependents.
	Health Care FSA	You may add coverage for yourself and your eligible dependents.
	Dependent Day Care FSA	You may add coverage for yourself and your eligible dependents.
Employee's or Spouse's/Dependent's Change from Non-Benefits-Eligible to Benefits-Eligible at His or Her Employer This event must result in the **gain of other plan eligibility** and applies in the following circumstances: • Your spouse or eligible dependent begins employment (including becoming an RRD benefits-eligible employee) • Your spouse or eligible dependent experiences a work-site transfer • Your spouse or eligible dependent experiences a change in status from part-time to full-time, or from hourly to salaried employment • Your spouse or eligible dependent returns from an unpaid leave of absence • Your spouse or eligible dependent returns from a strike or lockout at his/or her workplace	Medical/Dental/Vision	You may revoke or decrease your election or your spouse's, or other eligible dependent's election under the Plans if you, your spouse, or your other eligible dependent (as applicable) are added to your spouse's or other eligible dependent's plan and a coverage option change may be made.
	Health Care FSA	You may revoke or decrease your election or your spouse's, or other eligible dependent's election under the Plans if you, your spouse or your other eligible dependent (as applicable) are added to your spouse's or other eligible dependent's plan and a coverage option change may be made.
	Dependent Day Care FSA	You may revoke or decrease your election or your spouse's or other eligible dependent's election under the Plans if you, your spouse or your other eligible dependent (as applicable) are added to your spouse's or other eligible dependent's plan and a coverage option change may be made. In addition, you may make or increase your election to reflect new eligibility (e.g., if your spouse previously did not work).

Event	Benefit Type	Changes You May Be Able to Make
Spouse's/Dependent's Change from Benefits-Eligible to Non-Benefits-Eligible at His or Her Employer This event must result in the **loss of other plan eligibility** and applies in the following circumstances: • Your spouse or eligible dependent ends employment • Your spouse or eligible dependent experiences a work-site transfer • Your spouse or eligible dependent experiences a change in status from full-time to part-time, or from salaried to hourly employment • Your spouse or eligible dependent begins an unpaid leave of absence • Your spouse or eligible dependent experiences a strike or lockout at his/or her workplace	Medical/Dental/Vision	You may enroll or increase the election of benefits for you or your eligible dependent who loses eligibility under the other eligible dependent's plan. Also, a coverage option change may be made.
	Health Care FSA	You may enroll or increase your election to reflect loss of eligibility for health coverage.
	Dependent Day Care FSA (applies only to spouse)	You may enroll or increase your election if your spouse loses eligibility for the program sponsored by your spouse's employer (e.g., your spouse's contributions to a dependent day care FSA are stopped midyear following nondiscrimination testing). You may decrease or cease your election to reflect loss of eligibility for coverage.
Spouse's/Dependent's Annual Enrollment or Plan Year That Does Not Correspond with the Employee's Annual Enrollment	Medical/Dental/Vision	You may enroll for coverage, add affected spouse, add affected eligible dependents, or drop coverage if this is consistent with the change made by your spouse or dependent at his or her employer's plan.
	Health Care FSA	You may start, increase, decrease, or stop your contributions.
	Dependent Day Care FSA (applies only to spouse)	You may start, increase, decrease, or stop your contributions.

Event	Benefit Type	Changes You May Be Able to Make
Special Enrollment Rights This event applies in the following circumstances: • Marriage • Birth or adoption • A loss of Medicaid or CHIP coverage • Gaining a Medicaid or CHIP premium subsidy • Loss of eligibility for other coverage for employee, spouse, or eligible dependents when the employee had waived RRD benefits at the time of RRD enrollment because the employee, spouse or dependents had other coverage, including COBRA (e.g., loss of eligibility for coverage as a result of legal separation, divorce, cessation of dependent status such as attaining the maximum age to be eligible as a dependent child under the plan, death of an employee, termination of employment, reduction in the number of hours of employment, or relocation to a different service area) • Termination of employer contributions to other coverage (e.g., through spouse's employer)	Medical	You may enroll for coverage, add affected spouse, add affected eligible dependents, or change your medical coverage option.
	Dental/Vision	No changes are allowed.
	Health Care FSA	No changes are allowed.
	Dependent Day Care FSA	No changes are allowed.
Marketplace Coverage This event applies when a participant enrolls in Marketplace coverage during the Annual Enrollment period and wants to drop their RRD coverage as a result of their Marketplace enrollment	Medical	You may drop coverage for yourself, your affected spouse, and affected dependents.
	Dental/Vision	No changes are allowed.
	Health Care FSA	No changes are allowed.
	Dependent Day Care FSA	No changes are allowed.

Event	Benefit Type	Changes You May Be Able to Make
Qualified Medical Child Support Order (QMCSO) This event applies in the following circumstances: • QMCSO requires employee to provide health coverage for dependents • QMCSO requires spouse to provide health coverage for dependents and coverage is actually provided	Medical/Dental/Vision	You may add coverage, add newly eligible dependents, drop affected dependents, or change medical coverage option.
	Health Care FSA	You may start, increase, decrease, or stop your contributions.
	Dependent Day Care FSA	No changes are allowed.
Judicial Order Affecting Employee's Responsibility for Custody or Child Care	Medical/Dental/Vision	You may add coverage, add newly eligible dependents, drop affected dependents, or change medical coverage option.
	Health Care FSA	You may start, increase, decrease, or stop your contributions.
	Dependent Day Care FSA	You may increase or decrease an election amount only if the eligible dependent switches residence/primary custody between parents. The change in election must be consistent with a change in the cost of day care and only the expenses of the custodial parent qualify.
Significant Cost Changes Changes include significant increases or decreases in premium.	Medical/Dental/Vision	*If there is a Cost Increase:* You may increase your before-tax election correspondingly or may revoke your election and elect coverage under another benefit package option providing similar coverage. If no option providing similar coverage is available, you may revoke your election. *If there is a Cost Decrease:* You may decrease your before-tax election correspondingly or may elect coverage (even if you had not participated before) with decreased cost and your drop election for a similar coverage option.
	Health Care FSA	No changes are allowed.
	Dependent Day Care FSA	You may increase or decrease an election amount unless the cost change is imposed by a day care provider who is your relative.

Event	Benefit Type	Changes You May Be Able to Make
Significant Coverage Changes Changes include significant curtailment of coverage that may or may not result in a loss of coverage, or the addition or significant improvement of benefit package option.	Medical/Dental/Vision	*Curtailment Without a Loss of Coverage: You may revoke your election for the curtailed coverage and make a new prospective election for coverage under another benefit package option that provides similar coverage.* *Curtailment With a Loss of Coverage:* You may revoke your election for the curtailed coverage and make a new prospective election for coverage under another benefit package option that provides similar coverage, or drop coverage if no similar benefit package option is available. *Addition or Significant Improvement:* You may revoke your existing election and make a new prospective election for the newly added (or newly improved) option.
	Health Care FSA	No changes are allowed.
	Dependent Day Care FSA	You may increase or decrease an election amount if you change day care providers or if there is a change in the hours of day care.
Residence Changes – Resulting in a Gain of Eligibility • This event applies to employees, spouse, or eligible dependents and must result in **gain** of plan eligibility • Includes a spouse or eligible dependents that move to the U.S. for the first time	Medical/Dental/Vision	You may add coverage, add a spouse, add eligible dependents, or change your medical coverage option.
	Health Care FSA	No changes are allowed.
	Dependent Day Care FSA	No changes are allowed.

Event	Benefit Type	Changes You May Be Able to Make
Residence Changes– Resulting in a Loss of Eligibility • This event applies to employees, spouse, or eligible dependents and must result in **loss** of plan eligibility • Includes a spouse or eligible dependents that move outside the U.S.	Medical/Dental/Vision	You may drop your coverage or change your coverage option.
	Health Care FSA	No changes are allowed.
	Dependent Day Care FSA	No changes are allowed.
Qualify for Medicaid/Medicare This event applies to employees	Medical/Dental/Vision	You may revoke your coverage or (relative to Medicare) change your coverage option.
	Health Care FSA	You may start, increase, decrease, or stop your contributions.
	Dependent Day Care FSA	No changes are allowed.
Loss of Medicaid/Medicare The event applies to employees	Medical/Dental/Vision	You may add coverage for yourself, add coverage for eligible dependents, or change your medical coverage option.
	Health Care FSA	You may start, increase, decrease, or stop your contributions.
	Dependent Day Care FSA	No changes are allowed.
Qualify for Medicaid/Medicare Applies to Spouse or Eligible Dependents	Medical/Dental/Vision	You may revoke your coverage, or (relative to Medicare) change coverage option for an affected spouse or affected dependents.
	Health Care FSA	You may start, increase, decrease, or stop your contributions.
	Dependent Day Care FSA	No changes are allowed.
Loss of Medicaid/Medicare Applies to Spouse or Eligible Dependents	Medical/Dental/Vision	You may add coverage for affected spouse, add affected dependents, and/or change your medical coverage option.
	Health Care FSA	You may start, increase, decrease, or stop your contributions.
	Dependent Day Care FSA	No changes are allowed.

Event	Benefit Type	Changes You May Be Able to Make
Reduction in Hours A change from full-time to part-time employment status (if you were expected to average at least 30 hours of service per week, but are now expected to average less than 30 hours of service per week).	Medical	You may revoke coverage for you or your existing eligible dependents (even if reduction of hours does not result in immediate loss of eligibility), if you and your eligible dependents intend to enroll in another plan providing minimum essential coverage, with coverage effective no later than first day of second month following the month in which coverage under the Plan is revoked.
	Dental/Vision	No changes are allowed.
	Health Care FSA	No changes are allowed.
	Dependent Day Care FSA	You may decrease or revoke your election if you do not need as much day care on account of your reduction in hours.

A Note About Health Care and Dependent Day Care FSA Changes

Your elections for the FSAs are binding for the remainder of the calendar year for which the elections were made, unless a Qualified Status Change occurs during the calendar year.

If you experience a Qualified Status Change, you may not reduce your annual election below an amount that will result in your total contributions for the calendar year being less than the total amount of reimbursements you already received for claims incurred in the same calendar year prior to the date of the election change. And, if you experience a Qualified Status Change and increase your contribution election, the increased contribution amount can only be used to reimburse eligible expenses incurred on or after the effective date of the Qualified Status Change.

As described in the chart above, not all Qualified Status Change events permit you to make a change to your election for the Health Care or Dependent Care FSA. See the chart above for more information.

Reporting a Qualified Status Change

If you do not change your coverage within 30 days after the date of the event that permits the change, you must wait until the next Annual Enrollment period to make the change (within 60 days if the event is a loss of Medicaid or CHIP coverage, gaining a Medicaid or CHIP premium subsidy, or adding a newborn or adopted child, unless a longer period is permitted by a Regional Medical Options Program option).

Action Steps – Reporting a Qualified Status Change

You cannot request changes before the event takes place (for example, you cannot request your spouse be added before you get married). If you miss the deadline, you will not be able to change your benefits until the next Annual Enrollment period (unless you experience another Qualified Status Change).

Notification

Within 30 days after the date of the event itself or earlier, if the 30th day falls on a weekend or a holiday (within 60 days if the event is a loss of Medicaid or CHIP coverage, gaining a Medicaid or CHIP premium subsidy, or adding a newborn or adopted child, unless a longer period is permitted by a Regional Medical Program option):

- Log on to **rrd.bswift.com** then go to the Life Events panel and follow the prompts, or
- Call the eligibility administrator at **1-877-RRD-4BEN (1-877-773-4236)**. You must call to make an election change if it is after the first 30 days but before the deadline (for those events that have a 60-day or longer deadline).

Note: Newly added eligible dependents will be subject to the **dependent verification audit**.

Check Your Confirmation Statement

If you report your change via **rrd.bswift.com**, you can print or send yourself an email with your confirmation statement. If you call the eligibility administrator, you will receive a confirmation statement in the U.S. mail. Keep the confirmation statement for your records. **If something is incorrect,** report the inaccuracies by the deadline specified on the statement to complete the benefit change process.

Any change in before-tax contributions for the cost of coverage under an applicable Plan takes effect as soon as administratively possible after you report the change to the eligibility administrator. Except in the case of a birth or adoption that is reported within 30 days of the Qualified Status Change, payroll deductions for coverage that is retroactive to the date of the change will be deducted from your pay on an after-tax basis.

Responsibility for Reporting Ineligible Dependents

You are responsible for reporting your eligible dependent's loss of eligibility within 30 days after the date your eligible dependent is no longer eligible for coverage. Your eligible dependent loses coverage when he or she is no longer an eligible dependent, even if you fail to report the status change within the 30-day period, unless your eligible dependent has elected COBRA continuation coverage.

In addition, any claims for services or expenses incurred beyond the date your eligible dependent ceases to be an eligible dependent will not be paid, unless your eligible dependent has elected COBRA continuation coverage. RRD reserves the right to request, at any time, documentation necessary to substantiate an eligible dependent's eligibility for coverage.

However, after that 30-day period, your eligible dependent will be dropped without any COBRA continuation coverage offered (unless the event occurred within the last 60 days). **If you do not report the qualifying event within 60 days, COBRA continuation coverage will not be offered.**

In addition, the premium amount (employer and employee share) during the period of time for which you maintained an ineligible dependent on coverage will now become taxable income to you and will be reported as additional wages on your IRS Form W-2. Please see the Administrative Information Booklet for more information.

Qualified Status Changes

An election change generally **must be due to, and consistent with,** the following Qualified Status Changes. As a result, you may change your coverage and premiums during the Plan Year only if:

- The Qualified Status Change causes you or your eligible dependents to lose or gain eligibility for coverage under the Group Benefits Plan or Health Care Spending Program (or under a spouse's or dependent's plan), and
- Your election change reflects the gain or loss of coverage.

The Qualified Status Changes that must be due to, and consistent with, the qualifying event include the following:

- Legal marital status: Events that change your legal marital status, including:
  - Marriage
  - Death of a spouse
  - Divorce
  - Legal separation
  - Annulment
- Domestic partner status: Beginning or ending of your domestic partner relationship

- Number of dependents: Events that change your number of eligible dependents, including:
  - Birth
  - Death
  - Adoption
  - Placement for adoption
- Employment status: Any of the following events that change the employment status of you or your eligible dependents, including:
  - A termination or commencement of employment
  - A strike or lockout
  - A commencement of or return from an unpaid leave of absence
  - A change in worksite
  - In addition, if there is a change in employment status with the consequence that you or your eligible dependents become (or cease to be) eligible under the Plans or a plan of the eligible dependent's employer, then that change constitutes a change in employment, including:
    - Taking or returning from an unpaid leave of absence
    - Switching from full-time to part-time employment (or vice versa)
    - Becoming or ceasing to be benefits-eligible
    - Being involved in a strike or lockout
- Eligible dependent satisfies or ceases to satisfy eligibility requirements: Events that cause your eligible dependent to satisfy or cease to satisfy eligibility requirements for coverage on account of attainment of age or any other similar circumstance
- Residence: A change in the place of residence of you or your eligible dependents
- Adoption: The commencement or termination of an adoption proceeding

For example, if the change in status is due to the death of your eligible dependent, or your eligible dependent ceasing to satisfy the eligibility requirements for coverage, your election to cancel coverage for any individual other than the deceased eligible dependent, or the eligible dependent that ceased to satisfy the eligibility requirements for coverage, respectively, fails to correspond with that change in status. If the change in status is due to your divorce, annulment, or legal separation from your spouse, your election to cancel coverage for any individual other than the spouse involved in the divorce, annulment, or legal separation fails to correspond with that change in status – unless your spouse enrolled that individual on your spouse's employer health plan in connection with the change in marital status.

Judicial Order

You may make an election change required by a judicial order from a divorce, legal separation, annulment, change in legal custody, or Qualified Medical Child Support Order (QMCSO) that:

- Requires you to provide health coverage for your child; or
- Permits you to cancel health coverage for your child because the order requires someone else (for example, a former spouse) to provide coverage, and that coverage in fact is provided.

Note: A judicial order that requires you to provide coverage for an ineligible dependent, such as a former spouse, does not permit you to leave that person on the applicable Program. Ineligible dependents must be removed from such Program.

Entitlement to Medicare

You may make an election change to:

- Cancel or reduce health coverage for yourself or your eligible dependent if you or your eligible dependent becomes enrolled in for Medicare coverage,or
- Start or increase health coverage for yourself or your eligible dependent if you or your eligible dependent loses eligibility for Medicare coverage.

Change in Coverage Under Another Employer Plan

You may make a prospective election change that is on account of and corresponds with a change made under another employer's plan if:

- The other plan permits participants to make an election change that would be permitted under the Plan; or
- The other employer plan has a different period of coverage (i.e., Plan Year) than RRD's plan, or has a different open enrollment period if it has the same Plan Year (so long as your election changes are made prior to the start of the new Plan Year).

Significant Cost or Coverage Changes

Rules for election changes as a result of changes in cost or coverage include (but do not apply to an election change with respect to a Health Care Spending Program):

- Cost changes include:
  - Automatic changes: If the premium increases or decreases during a period of coverage a prospective increase or decrease in your election will be made automatically if the cost change is not significant.
  - Significant cost changes: If your premium significantly increases or significantly decreases, you may make a corresponding election change. Changes may include electing lower cost coverage, or, in the case of an increase in cost, revoking an election for that coverage and, in lieu thereof, either receiving on a prospective basis other similar coverage, or dropping coverage if no other similar coverage is available.
- Coverage changes include:
  - Significant curtailment without loss of coverage: If you or your eligible dependent has a significant curtailment of coverage under the Plan that is not a loss of coverage, you may revoke your election for coverage and, in lieu thereof, elect to receive on a prospective basis another option providing similar coverage.
  - Significant curtailment with loss of coverage: If you or your eligible dependent has a significant curtailment that is a loss of coverage under the Plan, you may elect either to:
    - Receive on a prospective basis other similar coverage, or
    - Drop coverage if no similar benefit package is available.
  - Addition or Significant Improvement of a benefit package option: If a new benefit program or other coverage option becomes available under the Plan, or if coverage under an existing option or other coverage option under the Plan is significantly improved, you may revoke your election. In lieu thereof, you may make an election on a prospective basis for coverage under the new or improved benefit program or coverage option.

Enrollment in Marketplace Coverage

You may elect to drop your Group Health Program or Regional Medical Options Program coverage under the Plans due to enrollment in Marketplace (Exchange) coverage if you are eligible for a Special Enrollment Period to enroll in a Qualified Health Plan through a Marketplace pursuant to guidance issued by the United States Department of Health and Human Services and any other applicable guidance, or you seek to enroll in a Qualified Health Plan through a Marketplace during such Marketplace's annual open enrollment period; and the revocation of your election of coverage under the Plans corresponds to the intended enrollment of you and your eligible dependents who cease coverage due to the revocation in a Qualified Health Plan through a Marketplace for new coverage that is effective beginning no later than the day immediately following the last day of the original coverage that is revoked.

Special Enrollment Rights

Marriage, birth, adoption, or placement for adoption are Qualified Status Changes that carry special enrollment rights under the:

- Group Health Program, Regional Medical Options Program, and
- Participant Premium Program (premiums payable for these programs).

These are special enrollment rights because you or your eligible dependents can change coverage without regard to the consistency of your election with the event giving rise to such right.

You also have special enrollment rights when either you or your eligible dependent:

- Loses eligibility for coverage under:
  - Medicaid or Child Health Insurance Program (CHIP) coverage;
  - Eligibility or coverage under another group health plan (including COBRA) or other health insurance coverage, when you had waived RRD benefits at the time of annual enrollment because the employee, spouse or dependents had such other coverage (e.g., this commonly occurs due to loss of eligibility for coverage as a result of legal separation, divorce, cessation of dependent status such as attaining the maximum age to be eligible as a dependent child under the plan, death of an employee, termination of employment, reduction in the number of hours of employment, or relocation to a different service area)
- Loses an employer subsidy / contribution to the cost of group health plan coverage (e.g., through spouse's employer); or
- Gains a Medicaid or CHIP premium subsidy.

A FEW WORDS ABOUT TAXES

By contributing to an FSA or HSA, you authorize a certain amount from your pay to be set aside before taxes are withheld. This reduces your federal income taxes, most state and local income taxes, and your Social Security and Medicare (FICA) taxes (if you earn less than the Social Security wage base).

An Example of the Before-Tax Advantage

To illustrate how contributing to an FSA could affect you, assume that you earn contribute $1,500 to your Health Care FSA. Here is how you may save annually on taxes by contributing.

If you are in the following tax bracket…	Federal Tax Savings…
22%	$330
24%	$360
32%	$480
35%	$525
37%	$555

As you can see, an employee using the Health Care FSA instead of paying out-of-pocket for medical expenses saves in federal income taxes, not including any applicable state income taxes. Remember, these are only examples. Your tax savings will depend on current laws and your own personal financial and medical situation. You should consult a tax adviser for tax advice.

Keep in mind that any contributions you make to the Health Care FSA or Dependent Day Care FSA and do not use by year-end are forfeited.* You lose these contributions because they may not be used to reimburse you for eligible expenses incurred after that calendar year. The forfeited contributions are used only to pay the administrative costs of the FSAs.

* For the Plan Years ending in 2020 and 2021 only, any amounts remaining in your account on the last day of the Plan Year may carry forward to the following Plan Year. See the **COVID-19 Temporary Changes under IRS Notice 2020-29 and the Consolidated Appropriations Act SMM** for more information.

HOW THE HEALTH CARE FSA WORKS

Contribution Limits

Each Plan Year, you decide how much, if any, you want to contribute. You make all of your contributions on a tax-free basis. Your projected total annual contribution is divided by the number of times you are expected to be paid during the year, and that amount is deducted each pay period. For instance, if you want to contribute $360 for the year and you are paid twice a month, $15 is deducted from each of your paychecks ($360 ÷ 24 pay periods = $15 per pay period). If you elect to participate in the Health Care FSA, your total annual contribution must be at least $200 but cannot be more than the communicated maximum ($2,750 for the 2021 Plan Year).

When you decide how much to contribute to your Health Care FSA, keep in mind that any of your contributions that remain at the end of the Plan Year will be forfeited.* Forfeited amounts are then used to pay the administrative expenses of operating the FSA. You should carefully consider how much you want to contribute to your Health Care FSA.

* For the Plan Years ending in 2020 and 2021 only, any amounts remaining in your account on the last day of the Plan Year may carry forward to the following Plan Year. See the **COVID-19 Temporary Changes under IRS Notice 2020-29 and the Consolidated Appropriations Act SMM** for more information.

Eligible Expenses

In general, you may use the amounts you contribute to reimburse eligible expenses incurred by you or your eligible dependents not paid for by the Group Benefits Plan or other benefit programs outside of the Group Benefits Plan. This also includes any eligible expenses that your spouse's medical, dental, vision, or prescription drug plan does not cover. You may use the debit card option or file a claim for reimbursement of an eligible expense you have paid. You may be asked to provide additional documentation related to your claimed expense to prove that it was an eligible expense.

If you participate in the Group Health Program and select an HSA-eligible Medical Program option, you can enroll in the Limited-Use Health Care FSA. You can use the Limited-Use Health Care FSA to reimburse eligible dental and vision expenses at any time, but you can use it to reimburse eligible medical and prescription drug expenses only after you have met your Medical Program option's deductible requirement. This is because these options offer you an HSA, and under IRS regulations you cannot be reimbursed by the Health Care FSA for medical expenses until after you satisfy a minimum medical plan deductible. You cannot use the Health Care FSA to reimburse contributions you or your spouse/domestic partner makes to pay for coverage under a medical, dental, or vision plan.

Only certain expenses are eligible for reimbursement from the Health Care FSA. For a complete listing of eligible expenses, see Publication 502 on **irs.gov**. Please note that the listing is subject to change at any time.

Ineligible Expenses

Certain expenses are not reimbursable through the Health Care FSA, including expenses incurred before the effective date of your Health Care FSA, or by an ineligible dependent, such as a Domestic Partner or child(ren) of a Domestic Partner who are not your tax dependents (see "Domestic Partner Tax Affidavits" for more information).

Health Care FSAs cannot be used to pay for health plan premiums, nor can they be used for long term care expenses, cosmetic services, or items that promote general health versus a medical condition (e.g., vitamins, nutritional supplements and weight loss programs generally are not eligible, unless prescribed to treat a specific medical condition).

Domestic Partner Tax Affidavits

In most cases, Domestic Partners and their children do not qualify as the employee's tax dependent(s). If your Domestic Partner (or his or her child) does not meet the IRS definition of a tax dependent, then you cannot submit their claims for reimbursement from your Health Care FSA.

However, the IRS definition of a tax dependent for health insurance and Health Care FSA purposes is broader than the definition of who is claimed as a dependent on your income tax return or for HSA purposes, and in some cases these individuals will qualify as your tax dependent for health insurance or the Health Care FSA even if they are not an eligible dependent for other tax purposes. For example, the income limits that normally apply to determine whether an individual is your tax dependent ($4,300 for 2020, indexed for inflation annually) are disregarded, and children can be considered your dependent to age 26 for health insurance and Health Care FSA purposes.

You should consult with a tax advisor to determine if your Domestic Partner or his/her child(ren) qualify as your tax dependent for health insurance and Health Care FSA purposes. You will be required to provide the Plan with a signed affidavit attesting to the dependent's tax qualified status in order to avoid imputed income with respect to such individual's participation in the Medical Program, Dental Program or Vision Care Program, and the same affidavit may be used to establish their eligibility for Health Care FSA reimbursements.

In general, the requirements for a Domestic Partner (or your partner's child) to be your tax dependent for purposes of health insurance and the Health Care FSA are:

- the individual lives with you for the entire calendar year (and the relationship must not violate local law),
- during the calendar year, you must provide more than half of the total support (as described below) for the individual,
- the individual cannot be claimed as a qualifying child on anyone else's federal tax return, and
- the individual must be a U.S. citizen, a U.S. national, or a resident of the U.S.

To determine whether you provide more than half of the total support for your Domestic Partner or his/her child, you must compare the amount of support you provide with the amount of support your Domestic Partner (or your partner's child) receives from all sources, including Social Security, welfare payments, the support you provide, alimony and child support from the other parent, and the support the Domestic Partner (or the child) provides from his or her own funds. Support includes food, shelter, clothing, medical and dental care, education, and similar expenses. If you believe you might provide more than half of the support for your Domestic Partner (or child), you should complete the support worksheet in IRS Publication 501 (Exemptions, Standard Deduction, and Filing Information).

If you submit a signed affidavit certifying that your Domestic Partner or partner's child is your tax dependent, and it is later determined that the value of those benefits should have been taxable to you, then you will be required to reimburse RRD for any liability it may incur for failure to withhold federal, state, or local income taxes, Social Security taxes, or other taxes related to such benefits.

Using Your Health Care FSA Debit Card

When you're enrolled in the Health Care Spending Account, you have the opportunity to pay for eligible health care expenses with the FSA debit card. The FSA debit card allows you to avoid paying for eligible expenses out of pocket and having to file for reimbursement. When you use your FSA debit card, your eligible expenses are deducted automatically from your account. You cannot request claim reimbursement for any expenses purchased with your FSA debit card.

- As you make payments with your FSA debit card, the balance of your Health Care FSA will be reduced to reflect the payment. Reimbursement for eligible items and services will be made up to the annual amount you have allocated to your Health Care FSA at the time you submit the claim. The total contribution amount elected for the Plan Year will be available in your Health Care FSA for claim reimbursement at all times, reduced by any amount that has already been used for reimbursement. Only current Plan Year funds will be available for card transactions.
- If you do not have sufficient funds left in your Health Care FSA to cover the entire expense at the time of sale, then your attempt to use the FSA debit card will be declined. Please note that the attempted use of the FSA debit card to pay a provider is not considered submission of a claim under the Plan, and the claims administrator's determination that an expense for which a card swipe is made is not an eligible expense

does not constitute a claim denial under the Plan. To initiate the Plan's claims and appeals procedure, you must submit a claim in accordance with the Plan's claims procedures.

- IRS rules state that FSA debit cards cannot be used at locations unless the retailer uses a certain type of medical coding. If your pharmacy or provider does not have these merchant category codes, your debit card may be declined. However, you can still submit a reimbursement request if purchasing a qualified item or service.
- Understand that all FSA debit card transactions must be validated. As part of the validation process, HealthEquity will notify you if itemized receipts are needed to validate your FSA debit card purchases. Although many transactions can be validated automatically, it's important that you save all itemized receipts for your FSA debit card transactions in case supporting documentation is requested. Frequently substantiation can take place automatically, such as if your card swipe was at a qualifying provider and matches your Medical Program copay amount, where a recurring claim amount has previously been substantiated, or if the vendor where you made your card purchase utilizes an IIAS inventory system. Other times, the claims administrator will require that you submit additional documentation to substantiate that you made an eligible purchase.
- If the FSA debit card is used to pay an expense that is not electronically substantiated at the point of sale, then you will be notified and will be required to submit acceptable documentation of the transaction, such as an Explanation of Benefits (EOB), itemized bills or receipts, or other information requested by the claims administrator to substantiate that the amount charged was an eligible expense. When you use the FSA debit card, you should save all receipts and supporting documentation in the event you need to submit them to the claims administrator.
- If you fail to provide information to satisfy the claims administrator that amounts paid with the card are eligible expenses, then the claims administrator, Plan Administrator and/or RRD may take whatever action they deem appropriate to require you to repay the unsubstantiated amount, including:
  - Requesting that you reimburse the Plan for the unsubstantiated amount;
  - Suspending your FSA debit card and requiring you to submit forms to obtain future reimbursements of eligible expenses;
  - Offsetting future Health Care FSA reimbursement claims by the unsubstantiated amount paid with the FSA debit card;
  - Suspending your eligibility to participate in the Plan;
  - To the extent permitted by law, having RRD deduct from your taxable wages the amount of the unsubstantiated expense paid with the FSA debit card; and
  - Where recovery is not made by the end of the taxable year, reporting the amount of the ineligible expense as taxable income to the Internal Revenue Service (IRS) on Form W-2 and taking appropriate withholdings from other pay.
- If the Plan's correction efforts prove unsuccessful, you still owe the Plan the amount of the unsubstantiated payment. In that event, and consistent with its business practices, RRD may treat the unsubstantiated amount as it would any other business debt.

- You can use the FSA debit card to pay for eligible items or services at health care providers (medical, dental or vision, as appropriate) and retail merchants with an IRS-approved inventory system that sell eligible over-the-counter items and prescriptions (called “IIAS merchants”). You can also use your FSA debit card for prescription amounts that are not covered under the Prescription Drug Program at merchants where 90% of the store’s gross receipts for the last tax year consisted of items that qualify as medical expenses under IRS guidelines (called “90% merchants”). If you try to use your FSA debit card at any other retail merchant, the card will be declined and you must pay the provider by another means and request reimbursement using the claim form process described above.
- Do not use the FSA debit card for ineligible items or services. The card cannot be used to purchase certain items and services that require additional documentation. Such items are only reimbursable if you submit a claim form with appropriate documentation, receipts, doctor’s prescription or documentation of medical necessity.
- You can only use your FSA debit card to purchase eligible health care items or services—dependent day care expenses are not eligible for payment with your card. Always separate eligible health care items (e.g., prescriptions, reading glasses, contact lenses) from ineligible items (e.g., magazines, cosmetics) before using your FSA debit card. Ineligible items must be purchased with another form of payment
- Choose “credit” when you swipe your card. The FSA debit card is a signature-based debit card. This means you’ll be required to provide your signature, similar to when you use a credit card. If you choose the “debit” option, your transaction will not be processed. Each time you sign, you are affirming that the medical expense has not been reimbursed from any other source, and that you will not seek reimbursement from any other source.
- Most providers will also accept the card over the phone, online or written-in on the statement for payment. You can also use the HealthEquity member portal to setup a direct payment, using the online payment tool. HealthEquity will send the payment directly to the provider and include all of the information necessary to apply the payment to your bill.
- If the expense is determined to be ineligible, your FSA debit card may be suspended from further use until the overpayment is repaid. To the extent the overpayment is not repaid or recaptured, it will be included as wages and reported on IRS Form W-2.
- If your FSA debit card is suspended, you won’t be able to use the card, but you will be able to submit claims via the website or through postal mail. You’ll always have access to your account, regardless of the status of your FSA debit card. Once the overpayment is corrected, you’ll receive notification (via email or postal mail, based on whether we have an email address on file) that your FSA debit card was reinstated.
- The claims administrator has adopted other rules to ensure that the FSA debit card is used only for eligible expenses, such as canceling the card upon termination of employment, and establishing transaction limits. Please be sure to read the separate communication explaining the special rules and requirements that apply to your card.

Filing a Claim

Generally, you can file a claim whenever you incur an eligible expense while you are a participant and after the service has been rendered, but no later than March 31 of the following calendar year.* To file a claim, complete a claim form and submit it electronically. Or, complete a claim form and return it with the required documentation to the claims administrator at the address on the form. You must attach documentation to your claim form for it to be processed.

* The deadlines discussed in this section have been temporarily extended due to the COVID-19 National Emergency. See the **2020 COVID-19 Suspension of Deadlines SMM** and the **COVID-19 Temporary Changes under IRS Notice 2020-29 and the Consolidated Appropriations Act SMM** for more information.

This documentation may include:

- An Explanation of Benefits (EOB) from the health, dental, or vision program (if you, your spouse, or your dependent is covered under multiple plans or programs, submit an EOB from each plan or program, as applicable);
- An itemized bill with the patient's name and address, the date of service, the description of service, total fees charged for services, and the name and address of the provider;
- The itemized receipt that includes the provider's name and address, the date of service, total charges, insurance payment (or denial), and the patient's copayment amount (if any);
- A receipt from your provider for payment; or
- The receipt you receive from the pharmacist that indicates the date of service, the patient's name, the drug purchased, and the out-of-pocket cost.

Action Steps – Using the HealthEquity online member portal to file claims

Using the HealthEquity online member portal, you can check your balance, review transactions, pay providers and submit for reimbursement.

Member Portal Login Page

Logging into your member portal is easy. Simply follow the steps below to access your HealthEquity FSA.

Logging in to your portal the first time:

1. Go to **www.myHealthEquity.com**, click 'Begin Now.'
2. Enter the information requested on the 'Find your account' screen.
3. Enter the information asked for on the 'Verify your identity' screen.
4. On the 'Set up your login' screen:
   - Pick a user/login name of at least six characters with numbers and letters on the 'Set up your login' screen.
   - Choose a password of at least eight characters with an uppercase letter, a lowercase letter and a number.
   - Follow password creation recommendations as listed in the log in screen.
5. On the 'Your email settings' screen, enter your email address.
6. Click the box to agree to the terms of the website and save the agreement.

Logging in to your portal after your first login:

1. Go to **www.myHealthEquity.com**.
2. Use the same username & password you created the first time you logged in.

Request Reimbursement

Reimburse yourself from your FSA for payments you made out-of-pocket:

1. From the 'Claims & Payments' tab, select 'Request Reimbursement.'
2. Select to have the funds come out of your FSA and then select 'Enter claim record and send payment' before clicking 'Next.'
3. Select 'Reimburse Me.'
4. Choose to enter new expense or select an existing expense if HealthEquity has received claim information from your insurance.
   - Clicking 'New' will allow you to enter specific claim details such as the provider originally paid, patient, and date(s) of service.
5. The Payment Detail page will allow you to enter the amount of the expense, as well as how you would like to be reimbursed.
6. If you have not done so already, you can add your banking information (for EFTs) directly on the member portal by clicking 'Add Account.'
   - Clicking 'Next' will take you to a review page to confirm the payment before it is sent. If you would like to schedule reimbursements, instead of completing the 'Amount' section, select the button for 'Scheduled Payments.' You will be able to specify the number of reimbursements you would like, the amount of each reimbursement, and the date you would like them to be paid out.

After your claim is processed, you will be reimbursed by a check mailed to your home address or via direct deposit, depending on your preference. Special situations apply to submitting claims for the following two medical services:

- LASIK: You cannot submit a claim for the deposit that you make for LASIK before you have the procedure. However, once the LASIK procedure is performed, you can submit a claim for the entire amount, including the deposit.
- Orthodontia: You can submit a claim for orthodontia services before the services are provided, but only to the extent that you have actually made payments in advance of the orthodontia services in order to receive the services.

If you terminate employment during the year, you can submit claims incurred only on or before your termination date, unless you elect COBRA continuation coverage as described in **Your Right to COBRA Continuation Coverage**.*

You can submit claims postmarked by March 31 of the following calendar year, as long as you received the service and you incurred the expense prior to the end of the Plan Year (and if applicable, prior to the end of your participation in the Health Care FSA).* You are reimbursed for the amount of the expense, up to the total amount of your annual contribution election. You forfeit any money that remains in your Health Care FSA at the end of the calendar year, and for which you do not submit a claim by March 31 of the year after the calendar year in which you participated.

* For the Plan Years ending in 2020 and 2021 only, any amounts remaining in your account on your termination date may be used to reimburse claims incurred on any day through the end of the Plan Year in which the termination occurred. Certain claims filing deadlines are also temporarily suspended. See the **2020 COVID-19 Suspension of Deadlines SMM** and the **COVID-19 Temporary Changes under IRS Notice 2020-29 and the Consolidated Appropriations Act SMM** for more information.

Forfeiture After Two Years

Any check issued under the Plan will be void and not reissued if it is not cashed within two years after the date the original check was issued, and the FSA benefit for which the check was issued will be forfeited.

The HEART Act and Your Health Care FSA

The HEART Act (Heroes Earnings Assistance and Relieve Tax Act of 2008) allows a Health Care FSA to offer a special distribution called a Qualified Reservist Distribution (QRD) to those who, by reason of being a member of a reserve component (as defined in the Code) are ordered or called to active duty (reservists).

As a reservist, you can receive all or a portion of your unused contributions in your Health Care FSA as a taxable distribution to avoid forfeiting the funds at year end if:

- You are called or ordered to active duty for a period of 180 days or more, or for an indefinite period; and
- The distribution is made after the order/call and before the April 1st following the Plan Year that includes the order/call.

The maximum distribution is the amount available in the Health Care FSA (i.e., contributions minus reimbursements). Reservists who would like to request a distribution may be required to complete a Qualified Reservists Distribution form. Contact HealthEquity for more information.

Statutory Benefit

Health Care FSA benefits are regulated by the Internal Revenue Code (Code). You will receive only those benefits that may be provided through a Health Care FSA under the Code. For more information on what is an eligible expense payable as a benefit and for definitions of terms used in this summary, consult your tax advisor or see Publications 502 or 969 on **irs.gov**.

HOW THE DEPENDENT DAY CARE FSA WORKS

You can use the Dependent Day Care FSA to reimburse eligible expenses to care for one or more of the following qualifying individuals (as defined in section 21(b)(1) of the Code) who has the same principal residence as you for more than half the year and who is:

- Your tax dependent child under age 13;*
- Your spouse who is mentally or physically incapable of self-care, and regularly spends at least 8 hours per day in your home; or
- Another individual (such as a parent whom you support) who is physically or mentally incapable of self-care, regularly spends at least 8 hours per day in your home, and either:
  - is your tax dependent; or
  - could have been your tax dependent except that he or she has gross income that equals or exceeds the gross income test amount, or files a joint return, or you (or your spouse, if filing jointly) could have been claimed as a dependent on another taxpayer's return.

If you are divorced or legally separated from your spouse, you may use your Dependent Day Care FSA for child care expenses only if you have custody of your child during more of the year than the child's other parent/dependent; it does not matter which parent claims the child as a dependent on their income tax return.

Contribution Limits

Each Plan Year, you decide how much, if any, you want to contribute. You must estimate how much you will need for the upcoming year to help pay for your eligible care expenses. You make all of your contributions on a before-tax basis. Your total annual contribution is divided by the number of times you are paid in a year, and that amount is deducted each pay period. For instance, if you want to contribute $360 for the year, and you are paid twice a month, $15 is deducted from each of your paychecks ($360 ÷ 24 pay periods = $15 per pay period).

When you decide how much to contribute, keep in mind that the IRS generally requires you to forfeit any money that remains in your account at the end of the Plan Year.** Forfeited amounts are then used to pay the administrative expenses of operating the FSA, or may be used to reduce the employer-funded contributions under the Flexible Benefits Plan. You should carefully consider how much you want to contribute to your Dependent Day Care FSA.

* For the Plan Years ending in 2020 and 2021 only, expenses maybe reimbursed for children who are under age 14, under certain circumstances. See the **COVID-19 Temporary Changes under IRS Notice 2020-29 and the Consolidated Appropriations Act SMM** for more information.

** For the Plan Years ending in 2020 and 2021 only, any amounts remaining in your account on the last day of the Plan Year may carry forward to the following Plan Year. See the **COVID-19 Temporary Changes under IRS Notice 2020-29 and the Consolidated Appropriations Act SMM** for more information.

If you choose to participate, your minimum contribution amount is $200 each year. Your annual contributions to the Dependent Day Care FSA are limited to:

- $5,000 if your tax filing status is single, head of household, or married filing jointly;
- $2,500 if your tax filing status is married filing separately; or
- $5,000 total, including your spouse's contributions, if your spouse's employer offers a similar program.

In addition:

- If you are not married at the end of the calendar year, your annual contributions can never be more than your earnings.
- If you are married at the end of the calendar year, your annual contributions can never be more than the lesser of:
  - Your earnings; or
  - Your spouse's earnings.

Special rules apply if you are a "highly compensated" employee as defined by the Code. If you meet the definition, your contributions may be limited. You will be notified if you are affected by these rules.

Eligible Expenses

Eligible expenses are for services provided while you are a participant during the calendar year in which the service is rendered and the expense is incurred. You can use the Dependent Day Care FSA to reimburse payments you make to institutions or individuals, including a:

- Child care center or nursery school that provides care for six or more children;
- Family day care provider;
- Baby-sitter;
- Neighbor;
- Day camp;
- Live-in helper;
- Nanny; or
- Member of your family – other than your spouse or a dependent.

A child care provider is eligible if he or she meets state and local requirements where they apply.

To be reimbursed for an eligible expense, you must be working during the time you incur eligible expenses for the qualifying individual who meets the criteria. If you are married when you incur the eligible expenses, your spouse must be:

- Working or seeking work;
- A full-time student; or
- Mentally or physically disabled and unable to care for himself/herself.

You are still considered to be working during any period you are unemployed but actively looking for work, on active military duty, or on a short-term leave of absence (generally for less than two weeks).

Ineligible Expenses

Certain expenses are not considered eligible expenses and therefore you cannot use the Dependent Day Care FSA to reimburse them. For a complete listing of expenses that are excluded from reimbursement, visit the HealthEquity website. Please note that the listing is subject to change at any time.

How to Receive Reimbursement from Your Dependent Day Care FSA

You can file a claim provided the service is an eligible expense. As long as your claim satisfies the requirement for reimbursement and the funds are available in your Dependent Day Care FSA, you are reimbursed for the eligible expense.

You can submit claims as long as they are postmarked by March 31* of the following calendar year. You will be reimbursed up to the lesser of:

- The total amount of the eligible expense; and
- The amount that is in your Dependent Day Care FSA at the time you submit the claim.

To file a claim, complete a claim form and submit it electronically. Or, complete a claim form and return it with the required documentation (i.e., receipt from the provider) to the claims administrator at the address on the form. Remember, in any calendar year, you can be reimbursed only for completely rendered services and for eligible expenses you incurred for a qualified individual while you and your spouse worked, even though you may submit the expense after the year is over. You forfeit any money that remains in your Dependent Day Care FSA at the end of the calendar year, and for which you do not submit a claim by March 31 of the year following the calendar year in which you participated.

After your claim is processed, you will be reimbursed by a check mailed to your home address or via direct deposit, depending on your preference.

* The deadlines discussed in this section have been temporarily extended due to the COVID-19 National Emergency. See the **2020 COVID-19 Suspension of Deadlines SMM** and the **COVID-19 Temporary Changes under IRS Notice 2020-29 and the Consolidated Appropriations Act SMM** for more information.

Statutory Benefit

Dependent Day Care FSA benefits are regulated by the Code. You will receive only those benefits which may be provided through a Dependent Day Care FSA under the Code. For more information on what is an eligible expense payable as a benefit and for definitions of terms used in this summary, consult your tax advisor or see Publication 503 on **www.irs.gov**.

HOW THE HSA PROGRAM WORKS

If you elect to participate in the HSA Value, HSA Advantage or Kaiser HSA option, you may also elect to make before-tax contributions to an HSA, established and maintained outside the Plan by a trustee/custodian, to which RRD can forward employer contributions and contributions deducted from your pay on a before-tax basis.

HSA benefits cannot be elected with a Regular Use Health Care FSA. Employees enrolled in the HSA Value, HSA Advantage or Kaiser HSA option will only be permitted to enroll for HSA contributions and/or contributions to the Limited-Use Health Care FSA. (See above for additional discussion regarding the interaction of the Health Care FSA and HSA).

Contribution Limits

RRD may contribute a lump-sum contribution to your HSA based on your medical coverage level under the HSA Value, HSA Advantage, or Kaiser HSA options. The amount of the RRD contribution, if any, will be communicated each year in the New Hire Benefits Guide and/or the Enrollment Highlights.

You can make contributions to your account too, up to IRS limits. The IRS limits are adjusted annually. RRD contributions count towards the IRS limit.

The IRS limits are $3,600 for single and $7,200 for higher coverage levels in 2021. The maximum annual contribution is prorated for the number of months in which you are an HSA-eligible individual.

If you are or will be age 55 or older in 2021 and are not Medicare-eligible, you can also make a $1,000 catch-up contribution to your HSA.

Visit **myRRDbenefits.com** to learn how you can use an HSA to save and pay for eligible health care expenses tax-free.

Eligibility

You can contribute to an HSA if you enroll in RRD's HSA Value or HSA Advantage medical option and you don't have any disqualifying medical coverage.

Disqualifying Medical Coverage

You cannot contribute to an HSA if you have other medical coverage, including Medicare (Parts A, B, C and/or D), TRICARE, or a full-use Health Care Flexible Spending Account (FSA) or Health Reimbursement Account (HRA) (including a spouse's FSA or HRA). Having access to certain telemedicine programs that provide medical care with no charge per use before your Medical Program deductible is met, or to another employer's onsite medical clinic that provides significant medical care, may also disqualify you from HSA eligibility. Limited-Use FSAs and HRAs (for dental, vision and post-deductible medical expenses) will not disqualify you from contributing to an HSA. Receipt of Veterans Administration (VA) benefits or Indian Health

Services (IHS) benefits may also disqualify you from making HSA contributions for the next three months, except where the benefits are preventive in nature, are for dental or vision care, or (in the case of VA benefits) are received for a service-connected disability. If you are making HSA contributions through payroll, you must notify the RRD Benefits Center if you acquire any disqualifying coverage during the year, so your HSA contributions may be stopped.

Medicare and Your HSA

Once you enroll in Medicare (generally at age 65), you can no longer contribute to your HSA.* However, you may continue to use the existing balance in your HSA to pay for eligible out-of-pocket health care expenses, tax-free. This includes premiums, deductibles, copays and coinsurance under Medicare. This does not include MediGap premiums.

* This occurs even if just the automatic Medicare Part A coverage goes into effect when you start collecting Social Security retirement benefits. So unless you delay receiving Social Security retirement benefits and Medicare, you need to stop any HSA contributions you may be making to avoid any tax consequences. Please contact the RRD Benefits Center at 1-877-RRD-4BEN (1-877-773-4236) for questions or assistance.

Eligible Dependents

Eligible dependents for the HSA are different than for the Medical Program or FSA. Under the HSA, you generally can submit claims only for a child who is a tax dependent on your federal income tax return, which means a child under age 19 (or age 24 if a full-time student), except that:

- Children of divorced parents are considered a child of both parents for the HSA, and
- Restrictions on a child's income that may prevent you from claiming the child as a dependent on your income tax return don't apply to the HSA.

Likewise, your domestic partner (or your domestic partner's children) generally must be considered your federal tax dependents in order for their health care expenses to be eligible for reimbursement from your HSA. As with other non-qualified HSA expenses, if you submit a claim for an ineligible dependent, the distribution will be subject to income taxes and possibly a 20% penalty tax.

Adult children and domestic partners who are enrolled as dependents in your HSA Value or HSA Advantage option through the Medical Program, but are not your tax dependents, may be able to contribute to their own HSA up to the $7,200 maximum that applies to coverage levels other than employee only.

For More Information

For more information regarding contributions, withdrawals, investments, and other issues, see the **Guide to Your HSA** available on **myrrdbenefits.com**.

Statutory Benefit

HSA benefits are regulated by the Internal Revenue Code (Code). For more information on what is an eligible expense payable as a benefit and for definitions of terms used in this summary, consult your tax advisor or see Publications 969 on **irs.gov**.

WHEN PARTICIPATION ENDS

When Health Care FSA Benefits End

Your participation in the Health Care FSA ends when your employment ends or, if earlier, when you are no longer eligible or decline to participate.* Participation also ends on December 31 if you do not re-enroll during the Annual Enrollment period (unless you have carried over an eligible portion (i.e. not more than $500) of your Health Care FSA balance).

If you do not use the amount of your projected total annual contributions minus eligible expenses paid to you by the time your participation ends, the only way you can continue submitting receipts for expenses incurred after your participation ends is to continue coverage under the Health Care FSA for a specified period of time, as described in **Your Right to COBRA Continuation Coverage**. However, after you leave RRD, any contributions for continuation coverage are made after taxes. As a result, the before-tax advantage of the Participant Premium Program is lost.

* For the Plan Years ending in 2020 and 2021 only, any amounts remaining in your account on your termination date may be used to reimburse claims incurred on any day through the end of the Plan Year in which the termination occurred. See the **COVID-19 Temporary Changes under IRS Notice 2020-29 and the Consolidated Appropriations Act SMM** for more information.

When Dependent Day Care FSA Benefits End

Your participation in the Dependent Day Care FSA ends when your employment ends (although you may submit claims for expenses incurred through the last day of the Plan Year) or, if earlier, when you are no longer eligible or decline to participate. Participation also ends on December 31 if you do not re-enroll during the Annual Enrollment period.

If you have made more Dependent Day Care FSA contributions than eligible expenses have been paid to you at the time your participation ends, you can still receive the unspent balance by submitting claims for eligible expenses incurred prior to the end of the Plan Year in which your participation ended. You may submit these eligible expenses after you cease to participate and through the end of the calendar year in which your participation ends.

You will not be able to make new contributions to your Dependent Day Care FSA after your participation ends.

When HSA Program Benefits End

Your participation in the HSA Program does not end when you terminate employment but you will no longer receive RRD contributions. Depending what kind of coverage you have, you may not be eligible to make contributions to your HSA, but you will be able to use the account balance to reimburse eligible expenses.

Employment While on an Approved Leave

While you are on an approved leave of absence, if you continue employment with any other employer outside of RRD, or if you accept new employment, either of which can include self-employment, you will be considered to have voluntarily abandoned your job at RRD. This will be treated as a voluntary separation thus ending employment with RRD and termination of coverage under its benefit programs. For example, this termination of employment with RRD will result in a loss of all Group Benefit Plan benefits, including the Health Care and Dependent Day Care FSAs. Voluntary separation will be deemed to occur in these circumstances regardless of the amount of income generated from the new or existing employment and regardless of the length of time you intend to perform the services associated with the other job or self-employment.

If the Plan Is Modified or Ended

RRD reserves the right to amend or terminate the Plan or the FSAs at any time, in whole or in part. If the Plan or the FSAs are ever terminated, suspended, or modified, reimbursements for any eligible expense you incur before the change are paid under the Plan's former conditions, provided that a written notice of claims is timely given. The FSAs do not reimburse eligible expenses incurred after such action (unless specific provisions are adopted).

SPECIAL EXTENSIONS OF PARTICIPATION

Depending on your situation when you leave employment with your Participating Employer, you may be eligible to continue your participation in an FSA. Situations in which an extension of participation is available are described below.

During a Leave of Absence

If you are granted an unpaid leave of absence pursuant to RRD's Human Resources Core Policy 6-4, Leaves of Absence, or you are laid off pursuant to Human Resources Core Policy 6-8, Temporary Layoffs, you may have the right to discontinue coverage when your unpaid leave begins. See **Qualified Status Changes** for additional information. This includes leaves that:

- Result in a loss of Plan eligibility;
- Are unpaid and taken under the Family and Medical Leave Act of 1993 (FMLA); and
- Are unpaid and taken under the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA).

Any time you take a paid (e.g., for your own personal disability) or unpaid leave of absence in excess of two weeks, you lose eligibility for the Dependent Day Care FSA.

If you do not terminate either of your FSA contributions while you are on an unpaid leave of absence (including a military leave), your contributions will go into arrears for any deductions missed during your absence; however, you will still participate in the FSAs but only up to your account balance on the day your leave commenced. Your election to authorize RRD to reduce your future wages on a before-tax basis for your required FSA contributions includes an authorization to withhold from your pay, in the calendar year you return to work or commence to be paid, the arrears amount for your FSA contributions during the time of your leave of absence. Therefore, if RRD advances FSA contributions for you or places your deductions in arrears in the calendar year in which you are reemployed by, or commence to be paid by, a Participating Employer, you will be deemed to have elected to:

- Participate in the Plan for each calendar year to the extent required to repay contributions placed in arrears beginning with the calendar year in which your leave of absence begins and ending in the calendar year in which your leave of absence ends; and
- Repay RRD for the advanced contributions.

The FSA contributions will be recovered by taking one past deduction plus one current deduction, beginning with your first available pay upon your return to work or when you commence being paid. Deductions from your pay will continue until you repay your outstanding balance. If you separate employment from RRD with an outstanding balance due, the remaining balance will be recovered from your final pay as permitted by law.

Your Right to COBRA Continuation Coverage

A federal law called the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended (COBRA), requires that most employers, including RRD, who sponsor health care flexible spending programs offer employees the opportunity to extend participation temporarily after participation under the health care flexible spending program would otherwise end. The extension of coverage to employees is called "COBRA continuation coverage."

In general, the Health Care FSA coverage that may be continued is the same as the coverage that was in effect under the Plan on the day before the qualifying event (as listed below). However, if you elected not to participate in the Health Care FSA as an active employee, you would not be eligible for any COBRA continuation coverage.

Note: The deadlines discussed in this section have been temporarily extended due to the COVID-19 National Emergency. See the **2020 COVID-19 Suspension of Deadlines SMM** for more information.

Qualifying Event

To be eligible for COBRA continuation coverage, a qualifying event must take place and the maximum amount payable to you under the Health Care FSA during the period of COBRA continuation coverage must equal or exceed the maximum contributions made to the Health Care FSA during the period of COBRA continuation coverage.

The following are qualifying events:

Who Can Continue Coverage	In What Situations	For How Long
Employee	• A reduction in work hours that would cause employee to be classified as a benefits-ineligible employee • Termination of employee's employment (other than for gross misconduct)	From the date of the qualifying event until the end of the Plan Year in which the qualifying event occurs
Spouse or Domestic Partner	• A reduction in work hours that would cause employee to be classified as a benefits-ineligible employee • Termination of employee's employment (other than for gross misconduct) • Divorce, annulment, or legal separation, or termination of a domestic partnership • Death of the employee	From the date of the qualifying event until the end of the Plan Year in which the qualifying event occurs

Who Can Continue Coverage	In What Situations	For How Long
Dependents	• A reduction in work hours that would cause employee to be classified as a benefits-ineligible employee • Termination of employee's employment (other than for gross misconduct) • Dependent's loss of eligibility • Death of the employee	From the date of the qualifying event until the end of the Plan Year in which the qualifying event occurs

Notification

In the case of your termination of employment (other than for gross misconduct) or reduction in hours that would cause you to be classified as a benefits-ineligible employee, you will automatically be advised of the right to this continued 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.

Election Procedure

Under the law, to continue Health Care FSA coverage, you have 60 days from the later of the:

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

If you do not choose COBRA continuation coverage within this 60-day period, Health Care FSA coverage will end as of the date of the qualifying event.

COBRA continuation coverage under the law is provided subject to eligibility for coverage under the Health Care FSA. Once your COBRA continuation coverage terminates for any reason, it cannot be reinstated.

Payment

Generally, you must pay the Health Care FSA 102% of your contribution amount during the period of COBRA continuation coverage. Your initial COBRA continuation coverage payment 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 are buying coverage, subject to a 30-day grace period. If you do not make payment on or before the first day of the month, your claim(s) will not be paid by the Health Care FSA until payment is received within the 30-day grace period.

When COBRA Continuation Coverage Ends

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

- The end of the Plan Year in which the qualifying event occurs;
- The date your employer no longer provides a Health Care FSA to any of its employees;
- The date you fail to pay the required contribution by the specified deadline (or end of the applicable grace period); or
- The date you first become covered after the date of your COBRA continuation coverage election under another flexible spending account that does not contain a pre-existing exclusion that affects your benefits.

Address Information

Be sure to keep your current address information up to date with the RRD Benefits Center. Doing so is the only way to ensure that important benefit information will reach you.

Your Rights Under ERISA

For more information about your rights under ERISA, including COBRA, the Patient Protection and Affordable Care Act, and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's (DOL's) Employee Benefits Security Administration (EBSA) in your area or visit the EBSA website at **www.dol.gov**. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.) For more information about the Marketplace, visit **www.HealthCare.gov**.

For More Information

bswift and the RRD Benefits Center are providing COBRA administration services on behalf of the Plan administrator. Please address any written correspondence to:

RRD Benefits Center
PO Box 617907
Chicago, IL 60661
1-877-RRD-4BEN (1-877-773-4236)
rrd.bswift.com

CLAIMS AND APPEAL PROCEDURES

The following claim review and claim appeal procedures apply to all benefit claims and eligibility claims of any nature related to the Health Care FSA and Dependent Day Care FSA.

A benefit claim is a claim for a particular benefit under a Plan. It will typically include your initial request for benefits. An example of a benefit claim is a claim to receive reimbursement for a particular expense. If you are filing a benefit claim, you need to contact the claims administrator.

An eligibility claim is a claim to participate in an option or to change an election to participate during the year. An eligibility claim also includes any rescissions of coverage (i.e., a retroactive cancellation of coverage). An example of an eligibility claim is a claim to clarify a dependent's eligibility or to change contributions midyear. If you are filing an eligibility claim, you need to contact the RRD Benefits Center.

A disability claim is a benefit claim that also requires a determination as to whether an individual is disabled. For example, if you are filing a benefit claim on the basis that a dependent is disabled, then the additional procedures applicable to disability claims will also apply to your benefit claim.

Note: The deadlines discussed in this section have been temporarily extended due to the COVID-19 National Emergency. See the **2020 COVID-19 Suspension of Deadlines SMM** for more information.

Authorized Representatives

Claims and appeals of denied claims may be pursued by a claimant, or, if approved by the claims administrator, his or her authorized representative. See **Claims Administrator** for the appropriate claims administrator.

The claims administrator may establish standards for an individual to act as an authorized representative. For claims and appeals where the Benefits Committee acts as the claims administrator (e.g., in the case of eligibility claims), the following procedures generally apply to determine whether an individual is an authorized representative:

- Specific Written Designation. The claimant may provide in writing the name, address, and phone number of his or her authorized representative and a statement that the representative is authorized to act on his or her behalf in the claims and appeals process.
- Other Legal Representative Status. In the event a claimant is deceased or incapacitated, an individual may demonstrate that he or she is the claimant's authorized representative by submitting certified letters testamentary, letters of administration, or valid documentation of power of attorney or guardianship, as applicable.
- Employee as Authorized Representative of Dependents. An employee may act as the authorized representative of his or her covered dependents, or other individuals

asserting an eligibility claim to become his or her covered dependents, without written authorization.

- Additional Authorization Required for Claims and Appeals Involving PHI. However, if the authorized representative is requesting access to HIPAA protected health information (PHI) in conjunction with the claims and appeals process, a valid HIPAA authorization form must also be submitted before PHI will be shared with the authorized representative (except in certain cases involving minor children).

Procedure for Filing a Claim

A communication from you, your eligible dependent or your authorized representative (claimant) constitutes a valid benefit claim if it is in writing on the appropriate claim form (or in such other manner acceptable to the claims administrator) and is delivered (along with any supporting comments, documents, records, and other information) to the claims administrator by first-class postage-paid mail, to the address for the claims administrator. If a claimant fails to properly file a claim for a benefit under the Plan, he or she will be considered not to have exhausted all administrative remedies under the Plan, and this will result in his or her inability to bring a legal action for that benefit. Claims and appeals of denied benefit claims may be pursued by a claimant, or, if approved by the **claims administrator**, his or her authorized representative.

Defective Claims

If a claimant fails to follow the Plan's procedures for filing a valid benefit claim, the claims administrator will notify him or her of the failure and the proper procedures to follow in filing a benefit claim, provided that the communication received by the claims administrator from the claimant names the specific claimant and the specific treatment, service, or product for which reimbursement is requested. The notice will be provided by the claims administrator.

Initial Claim Review

The claims administrator will conduct the initial claim review and consider the applicable terms, provisions, amendments, information, evidence presented, and any other information it deems relevant.

Initial Benefit Determination

The claims administrator will notify the claimant of the approval or denial within 30 days after receipt of the claim for a benefit under the Health Care FSA and within 60 days after receipt of the claim for a benefit under the Dependent Day Care FSA. The claims administrator may extend the period for making the benefit determination by 15 days if it determines that such an extension is necessary due to matters beyond the Plan's control. The claims administrator will notify the claimant, prior to the expiration of the initial 30-day or 60-day period, of the circumstances that require the extension of time and the date by which the claims administrator expects to render a decision.

If an extension is necessary due to the claimant's failure to submit the information necessary to decide the claim, the notice of extension will describe the required information. The claimant will then have at least 45 days from receipt of the notice within which to provide the specified information. The period within which the claims administrator is required to make a decision is then suspended from the date on which the notification is sent to the claimant until the earlier of the date the claimant responds to the request for additional information, or the due date established by the claims administrator for furnishing the requested information.

Benefit Claims Requiring a Determination of Disability

In the case of a benefit claim that is filed that requires a disability determination (including, but not limited to, a claim for benefits involving a decision whether a dependent is disabled for purposes of eligibility), the claims administrator will notify the claimant of the denial within 45 days after receipt of the claim. The claims administrator may extend the period for making the benefit determination by 30 days if it determines that such extension is necessary due to matters outside the Plan's control. The claims administrator will notify the claimant, prior to the expiration of the 45-day period, of circumstances requiring the extension of time and the date by which the claims administrator expects to render a decision. The claims administrator may extend the period for making the benefit determination by an additional 30 days if it determines that such additional extension is necessary due to matters outside the Plan's control. The claims administrator will notify the claimant, prior to the expiration of the first 30-day extension period, of circumstances requiring the additional extension of time and the date by which the claims administrator expects to render a decision. All notices of extension will specifically explain the standards on which entitlement to a benefit is based, the unresolved issues that prevent a decision on the claim, and the additional information needed to resolve those issues, and you will have at least 45 days from receipt of the notice within which to provide the specified information.

If an extension is necessary due to the claimant's failure to submit the information necessary to decide the claim, the period in which the claims administrator is required to make a decision is then suspended from the date on which the notification is sent to the claimant until the earlier of the date the claimant responds to the request for additional information, or the due date established by the claims administrator for furnishing the requested information. If the claimant provides additional information in response to such a request, a decision will be rendered within 30 days of when the information is received by the Plan.

Manner and Content of Notification of Denied Claim

The claims administrator will provide the claimant with notice of any denial, in accordance with applicable U.S. Department of Labor (DOL) regulations.

The notification of a denial will include:

- The specific reason or reasons for the denial;
- Reference to the specific Plan provision(s) on which the determination is based;
- A description of any additional material or information necessary for the claimant to perfect the claim, and an explanation of why such material or information is necessary;

- In the case of a denial involving a benefit claim under the Health Care FSA, it will also include:
  - If an internal rule, guideline, protocol, or other similar criterion was relied upon in making the denial, the specific rule, guideline, protocol, or other similar criterion that was relied upon, or a statement that such rule, guideline, protocol, or similar criterion was relied upon and that a copy will be provided free of charge to the claimant upon request;
  - If the denial is based on medical necessity, experimental treatment, or a similar exclusion or limit, an explanation of the scientific or clinical judgment relied upon for the determination, applying the terms of the Plan to the claimant's medical circumstances, or a statement that such explanation will be provided free of charge upon request; and
  - Identification of any medical or vocational experts whose advice was obtained in connection with the denial, regardless of whether the advice was relied upon in making the determination;
- In the case of a denial involving a disability claim, it will also include:
  - A discussion of the decision, including an explanation of the basis for disagreeing with or not following:
    - The views presented by the claimant to the Plan of health care professionals treating the claimant and vocational professionals who evaluated the claimant;
    - The views of medical or vocational experts whose advice was obtained on behalf of the Plan in connection with a claimant's denial, without regard to whether the advice was relied upon in the claim denial; and
    - A disability determination regarding the claimant presented by the claimant to the Plan made by the Social Security Administration;
  - Either:
    - The specific internal rules, guidelines, protocols, standards, or other similar criteria of the Plan that was relied upon in the claim denial; or
    - A statement that such rules, guidelines, protocols, standards, or other similar criteria of the Plan do not exist;
  - If the denial was based on medical necessity or experimental treatment or similar exclusion or limit, the denial will provide either:
    - An explanation of the scientific or clinical judgment relied upon for the claim denial, applying the terms of the Plan to the claimant's medical circumstances; or
    - A statement that such explanation will be provided free of charge upon request;
  - A statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claimant's disability claim; and
  - Such denial will be provided in a culturally and linguistically appropriate manner, in accordance with applicable DOL regulations; and

- A description of the Plan's review procedures, the time limits applicable to such procedures, and if applicable, the claimant's right to bring a civil action under Section 502(a) of ERISA following a claim denial on review (see below).

Review of Initial Benefit Denial

Procedure for Filing an Appeal of a Denial

A claimant must bring any appeal of a denial to the claims administrator for eligibility claims within 180 days after he or she receives notice of the denial. If the claimant fails to appeal within the 180-day period, he or she will not be permitted to seek an appeal with the claims administrator and he or she will have failed to have exhausted all administrative remedies under the Plan. This failure will result in the claimant's inability to bring a legal action to recover a benefit under the Plan. The claimant's request for an appeal must be in writing utilizing the appropriate form provided by the claims administrator for eligibility claims (or in such other manner acceptable to the claims administrator for eligibility claims). A claimant's request for an appeal must be filed with the claims administrator for eligibility claims in person, by messenger as evidenced by written receipt or by first-class postage-paid mail to the address for the claims administrator.

Review Procedures for Appeals of Denials

The claims administrator will provide a full and fair review that takes into account all comments, documents, records, and other information the claimant submits, without regard to whether such information was submitted or considered in the initial benefit determination.

- The claimant will have the opportunity to submit written comments, documents, records, and other information relating to the claim.
- The claimant will have the opportunity to review the claim file, if any, created by the claims administrator during the initial claim.
- The claimant will have the opportunity to present evidence and testimony as part of the review of the claimant's initial benefit denial.
- The claimant will be provided, upon request and free of charge, reasonable access to and copies of all relevant documents.
- The review of a denial does not defer to the initial determination made by the claims administrator.
- The individual who conducts the review process is neither the individual who made the initial denial nor the subordinate of such individual.
- In deciding an appeal of any denial that is based in whole or in part on a medical judgment, including determinations as to whether a particular treatment, drug, or other item is experimental, investigational, or not medically necessary or appropriate, the individual conducting the review process will consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment. The health care professional will be neither the individual who was consulted in connection with the denial that is the subject of the review nor the subordinate of such individual.

- The claims administrator will identify any medical or vocational experts whose advice was obtained on behalf of the Plan in connection with the claimant's denial, without regard as to whether the advice was relied upon in making the benefit determination.
- In the case of disability claims, the claims administrator will provide the claimant, free of charge, with any new or additional evidence considered, relied upon, or generated by the claims administrator (or at the direction of the claims administrator) in connection with the claim and any new or additional rationale for a claim determination. Such evidence or rationale, as applicable, will be provided as soon as possible and sufficiently in advance of the date on which the notice of final internal adverse benefit determination is required to be provided to give the claimant a reasonable opportunity to respond prior to that date. If new or additional rationale is received close to the date on which the claims administrator must provide notice of the claim determination on review, the Plan may extend the time to respond where the claims administrator determines that special circumstances require an extension of time for processing the review of the claim.

Timing of Notification of Benefit Determination on Review

The claims administrator for eligibility claims will notify the claimant of the benefit determination on review within 60 days after receipt of the request for review.

Manner and Content of Notification of Benefit Determination on Review

The claims administrator will provide a written or electronic notice of the Plan's benefit determination on review, in accordance with applicable DOL regulations. If the claimant's appeal is denied, the notification will include:

- The specific reason or reasons for the denial;
- Reference to the specific Plan provision(s) on which the determination is based;
- A statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all relevant documents;
- In the case of a denial involving a benefit claim under the Health Care FSA, it will also include:
  - If an internal rule, guideline, protocol, or other similar criterion was relied upon in making the denial, the specific rule, guideline, protocol, or other similar criterion that was relied upon, or a statement that such rule, guideline, protocol, or similar criterion was relied upon and that a copy will be provided free of charge to the claimant upon request;
  - If the denial is based on medical necessity, experimental treatment, or a similar exclusion or limit, an explanation of the scientific or clinical judgment relied upon for the determination, applying the terms of the Plan to the claimant's medical circumstances, or a statement that such explanation will be provided free of charge upon request; and

- Identification of any medical or vocational experts whose advice was obtained in connection with the denial, regardless of whether the advice was relied upon in making the determination;

- In the case of a denial involving a disability claim, it will also include:
  - A discussion of the decision, including an explanation of the basis for disagreeing with or not following:
    - The views presented by the claimant to the Plan of health care professionals treating the claimant and vocational professionals who evaluated the claimant;
    - The views of medical or vocational experts whose advice was obtained on behalf of the Plan in connection with a claimant's denial, without regard to whether the advice was relied upon in the claim denial; and
    - A disability determination regarding the claimant presented by the claimant to the Plan made by the Social Security Administration;
  - Either:
    - The specific internal rules, guidelines, protocols, standards, or other similar criteria of the Plan that was relied upon in the claim denial; or
    - A statement that such rules, guidelines, protocols, standards, or other similar criteria of the Plan do not exist;
  - If the denial was based on medical necessity or experimental treatment or similar exclusion or limit, the denial will provide either:
    - An explanation of the scientific or clinical judgment relied upon for the claim denial, applying the terms of the Plan to the claimant's medical circumstances; or
    - A statement that such explanation will be provided free of charge upon request;
  - A statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claimant's disability claim; and
  - Such denial will be provided in a culturally and linguistically appropriate manner, in accordance with applicable DOL regulations; and
- A statement describing any voluntary appeal procedures offered by the Plan and the claimant's right to obtain information about such procedures, including a statement of the claimant's right to bring a civil action under Section 502(a) of ERISA following a denial on review. With respect to claims regarding disability, such statement will also include any applicable contractual limitations period that applies to the claimant's right to bring such action, including the calendar date on which the contractual limitations period expires for the claim.

The claims administrator will ensure that all disability claims are adjudicated in a manner designed to ensure the independence and impartiality of the persons involved in making the decision. Accordingly, decisions regarding hiring, compensation, termination, promotion, or other similar matters with respect to any individual (such as a claims adjudicator, vocational or medical expert, or independent review organization) will not be made based on the likelihood that such individual will support a denial of a claim for benefits or determination of disability.

Legal Action

A claimant cannot bring legal action to recover any benefit under, or for eligibility in, the Plan if he or she does not first exhaust the Plan's internal claims and appeals procedures by timely filing a valid claim and seeking timely review of all denials of that claim. In addition, no legal action may be brought:

- More than two years after the claims administrator first received the claimant's claim;
- If you received a denial on appeal of such claim, more than two years after such receipt;
- After such other date that is provided in an applicable insurance certificate; or
- If you forfeited a benefit based on the two-year forfeiture rule described in the subsection titled **Forfeiture After Two Years**.

In the case of disability claims, notwithstanding the previous paragraph, if the Plan fails to adhere to all of the requirements of the procedures set forth above for disability claims, then to the extent required by law, the claimant may bring an action in an appropriate court under state law or section 502(a) of ERISA, but only if the action is commenced no later than the earlier of (1) the applicable statute of limitations, or (2) the first anniversary of the claims administrator's decision on appeal. However, the claimant cannot bring an action in an appropriate court under state law or section 502(a) of ERISA without first exhausting the claims procedures set forth above if the violation:

1. Was *de minimis*;
2. Does not cause, and is not likely to cause, prejudice or harm to the claimant;
3. Was attributable to good cause or matters beyond the Plan's control;
4. Was in the context of an ongoing good-faith exchange of information between the claimant and the claims administrator; and
5. Was not reflective of a pattern or practice of non-compliance by the Plan.

Within 10 days of the Plan's receipt of a written request by the claimant, a claimant is entitled to an explanation of the Plan's basis for asserting that it meets the above exception that includes a specific description of its basis, if any, for asserting the violation should not cause the internal claims and appeals process to be deemed exhausted. If a court rejects the claimant's request for immediate review on the basis that the Plan met the requirements for the exception, then the Plan will provide the claimant with notice of the opportunity to resubmit and pursue the internal appeal of the claim within a reasonable time after the external reviewer or court rejected the claim for immediate review (but not to exceed 10 days). Time periods for re-filing the claim will begin to run upon claimant's receipt of such notice.

The Plan requires that any legal action involving or related to the Plan, including but not limited to any legal action to recover any benefit under the Plan, be brought in the United States District Court for the Northern District of Illinois, and no other federal or state court. In any legal action against a Plan Party (as defined below) in connection with any matter related to the Plan, the person bringing such action is not entitled to recover any legal fees or expenses from the Plan, RRD, other participating employers, the Benefits Committee, the claims administrator, any of their respective affiliates, or any of their respective designees, allocatees, officers, directors, employees or agents, or any other person with a right to indemnification from any of

the foregoing parties (each, a “Plan Party”). This includes any legal fees or expenses incurred in connection with:

- Administrative proceedings under, or legal actions involving, the Plan; and
- Actions brought under ERISA or any other law, rule, or regulation.

Such prohibition on recovery applies regardless of whether or not all or any part of legal actions are decided in favor of the claimant. Additionally, no employee, former employee, covered dependent, former covered dependent, beneficiary or other person is entitled to recover any legal fees or expenses from a Plan Party in connection with any administrative proceedings related to a claim, including if the claim is approved and no legal action is brought in connection with such claim.

PLAN ADMINISTRATION

Plan and Contact Information

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

Type of Plan

The Flexible Benefits Plan is a welfare benefits plan under ERISA and a cafeteria plan under Section 125 of the Code. It includes a Health Care FSA under Code Sections 105, 106 and 125, which is subject to ERISA, and a Dependent Day Care FSA under Code Sections 125 and 129, which is not subject to ERISA. Its objective is to reimburse eligible expenses of covered employees and their spouse and eligible dependents in accordance with the terms of the Program.

Plan Sponsor

R. R. Donnelley & Sons Company
4101 Winfield Rd
Warrenville, IL 60555
1-630-963-9494

Employer Identification Number

36-1004130

Plan Name and Number

For federal income tax purposes, the following Programs are treated as separate, written plans:

- Health Care FSA – 510
- Dependent Day Care FSA – 509

Plan Year End

December 31

Agent for Service of Legal Process

Corporate Secretary
R. R. Donnelley & Sons Company
35 W. Wacker Drive
Chicago, IL 60601
1-630-963-9494

Legal process also may be served on the Benefits Committee.

Benefits Committee and Plan Administrator

Benefits Committee
c/o Vice President, Benefits
R. R. Donnelley & Sons Company
4101 Winfield Rd
Warrenville, IL 60555
1-630-963-9494

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

Participating Employers

The Program described in this document applies to employees of Participating Employers. If you become an employee of RRD due to an acquisition, your effective date for a benefit generally is that date on which benefits are extended. That date will be announced in each affected location.

If you have questions concerning your eligibility to participate in this Program, call the **eligibility administrator**.

Eligibility Administrator

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

RRD Benefits Center
PO Box 617907
Chicago, IL 60661

1-877-RRD-4BEN (1-877-773-4236), Benefits Center Representatives are available from Monday – Friday from **7 a.m. to 7 p.m. CT.**
rrd.bswift.com

Contact the RRD Benefits Center for:

- General questions about flexible benefits;
- Questions about Qualified Status Changes;
- Questions about expenses eligible for reimbursement;
- Instructions on how to get a claim form; or
- Instructions on filing FSA claims.

If you want to participate, you must follow the enrollment procedures provided herein and included in the Annual Enrollment materials established by the Benefits Committee.

Claims Administrator

If you have questions about a specific benefit, contact HealthEquity at the following address and phone number:

HealthEquity
Attn: Reimbursement Accounts
15 W. Scenic Pointe Drive, Ste. 100
Draper, UT 84020

HealthEquity can be accessed 24 hours a day, 7 days a week at:

1-844-291-0928
Fax: 1-801-999-7829
www.healthequity.com

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. Initial eligibility claims involving a determination of disability will be made by a subset of the Benefits Committee, and appeals of those denials will be decided by a different subset of the Benefits Committee, and no one in the second subset will report to anyone in the first subset.

COBRA Administrator

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

RRD Benefits Center
PO Box 617907
Chicago, IL 60661

1-877-RRD-4BEN (1-877-773-4236)
rrd.bswift.com

Allocation and Delegation of Fiduciary Responsibilities

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 administrative named fiduciary some authority and control over the operation and administration of the Plan, references in this Flexible Spending Account Program Booklet to the Benefits Committee are intended to refer to any such 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.

Self-Funded Benefits

The benefits paid from your Health Care Spending Program or your Dependent Day Care Spending Program are from the general assets of RRD. The benefits provided by the Programs are not guaranteed by the claims administrator. The claims administrator's role is to provide services to the Programs.

Your ERISA Rights

As a participant in the Health Care FSA portion of the Plan, you 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 the Health Care FSA 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 Health Care FSA, including collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the Plan for the Health Care FSA 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 Health Care FSA, including 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 for the Health Care FSA. The Plan Administrator is required by law to furnish each Health Care FSA participant with a copy of this Summary Annual Report.

Continue Group Health Plan Coverage

Continue health care coverage for yourself if there is a loss of coverage under the Health Care FSA as a result of a qualifying event. You may have to pay for such coverage. Review this Flexible Spending Account Program Booklet and the documents governing the Health Care FSA on the rules governing your COBRA continuation coverage rights.

Prudent Actions by Plan Fiduciaries of the Health Care FSA

In addition to creating rights for participants in a Health Care FSA, ERISA imposes duties upon the people who are responsible for the operation of the Plan. The people who operate the Health Care FSA, called "fiduciaries," have a duty to do so prudently and in the interest of you and other participants and beneficiaries under the Health Care FSA. 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 benefit available under the program or exercising your rights under ERISA.

Enforce Your Rights

If your claim for a benefit under the Health Care FSA 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 example, if you request a copy of Plan documents governing the Health Care FSA 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 under the Health Care FSA 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 Health Care FSA's decision or lack thereof concerning the qualified status of a domestic relations order or medical child support 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 the Health Care FSA, you should contact the RRD Benefits Center or the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of the Employee Benefits Security Administration, 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.

COMPLETE SPD FOR THE FLEXIBLE BENEFITS PLAN

The following documents make up the complete SPD:

- This Flexible Spending Program Booklet.
- The *Administration Booklet* (with respect to the Participant Premium Program only).
- Any SMMs.
  - 2020 COVID-19 & Your RRD Benefits
  - 2020 COVID-19 Suspension of Deadlines SMM
  - 2021 COVID-19 Temporary Changes under IRS Notice 2020-29 and the Consolidated Appropriations Act
- The Annual Enrollment materials.
- Other plan summaries.

Links to All SPD Documents

Click on links below to access complete SPD information:

Summary of Material Modifications

All other RR Donnelley Group Benefits Plan Booklets