RRD BENEFITS
HEALTH | WEALTH | LIFE

WITH YOU ON LIFE'S JOURNEY

2026 Annual Enrollment Highlights Guide

October 29 – November 12, 2025

RRD BENEFITS
HEALTH | WEALTH | LIFE

WITH YOU ON LIFE'S JOURNEY

Choose Your 2026 Benefits
October 29 – November 12, 2025

Your RRD benefits support your physical, mental and financial well-being, so you can live your best life. During Annual Enrollment, review and choose the benefits that are right for you and your family for the year ahead.

Stay Connected to Your RRD Benefits

When it comes to your benefits, RRD makes it easy for you to stay connected and informed. Plug in so you don't miss out on important announcements and information.

Get text alerts

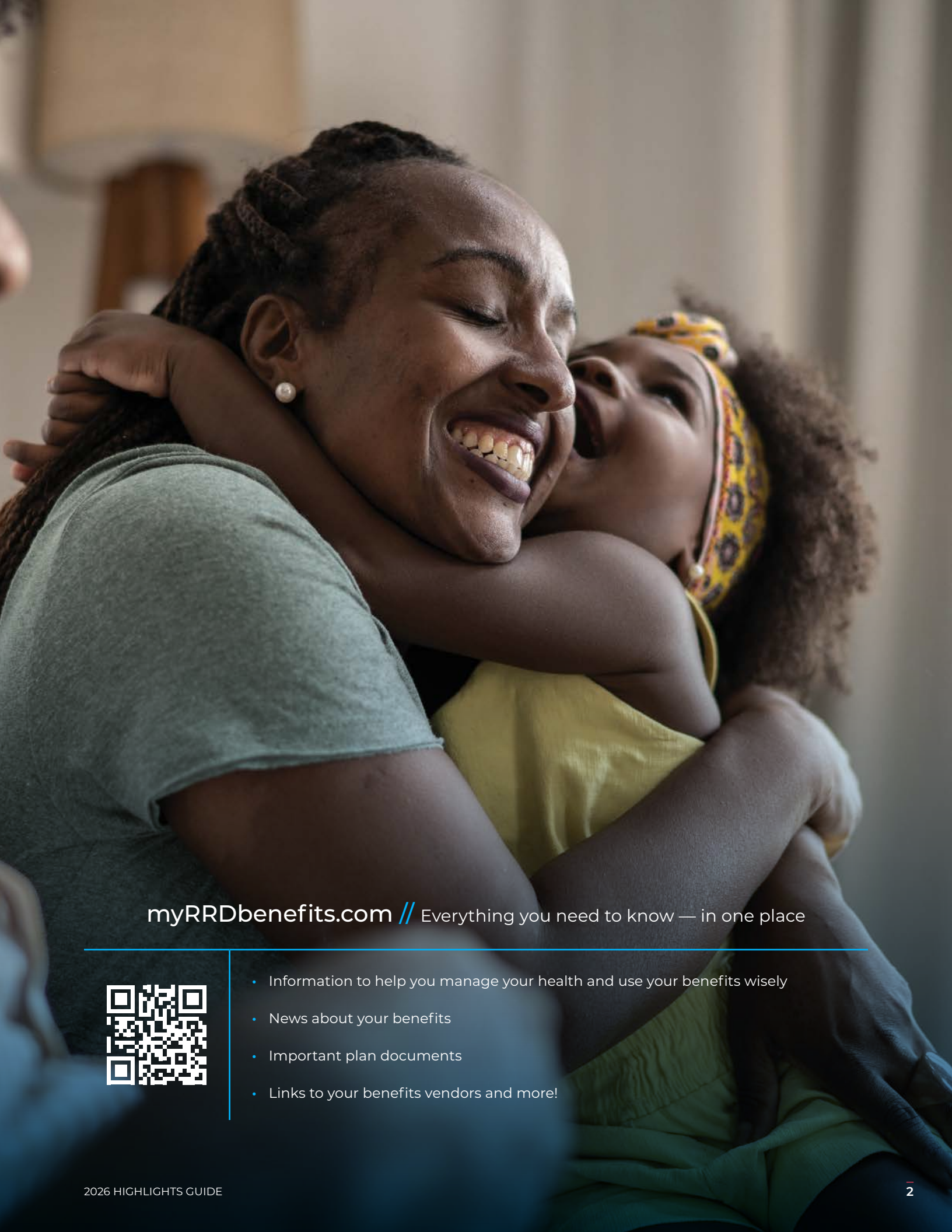
Enroll in text alerts for important reminders.

Go paperless

Sign up to receive emails instead of paper.

Get easy access

Download the bswift app to access coverage information, enroll for benefits, upload required documents, and more.



myRRDbenefits.com // Everything you need to know — in one place

- Information to help you manage your health and use your benefits wisely
- News about your benefits
- Important plan documents
- Links to your benefits vendors and more!

WHAT'S NEW FOR 2026

Here's an overview of what's new and different about your RRD benefits effective January 1, 2026. Additional information about your 2026 benefits will be available mid-October at **myRRDbenefits.com**.

Lower deductibles for HSA Advantage, HSA Value and Copay Advantage — again!

A lower deductible means your medical option starts covering costs sooner. This is especially helpful if you visit doctors frequently, take regular prescriptions, have a chronic condition or expect medical procedures.

HSA ADVANTAGE AND HSA VALUE

Deductibles will decrease by $100 for Employee Only coverage and $200 for other coverage levels.

COPAY ADVANTAGE

Deductibles will decrease by $400 for Employee Only coverage and $800 for all other coverage levels.

Small premium increase for the National Medical Program options

The amount you pay for your coverage will increase by $5 per month for Employee Only coverage and $10 per month for all other coverage levels.

Out-of-pocket maximum increase for the National Medical Program options (except BCBS Coupe PPO)

HSA Advantage, HSA Value and Copay Advantage out-of-pocket maximums (the most you have to pay for covered health care services in a plan year) will increase by $400 for Employee Only coverage and $800 for other coverage levels.

New Paytient Financing Card for BCBS Coupe PPO Participants

Health care financing under the BCBS Coupe PPO option is changing. Instead of having the option to receive a consolidated billing statement each month, BCBS Coupe PPO participants now have the option to receive a health care financing card from Paytient. This new card option is exclusively for BCBS Coupe PPO participants and will have a $3,000 revolving credit limit — just swipe and pay your copay expenses directly to your providers at the time of service.*

To receive this new Paytient card, answer "yes" to the question in the enrollment website asking whether you would like health care financing when you select BCBS Coupe PPO as your medical program option, and additional information will be sent to you. Once you create your Paytient account, you'll have instant access to your virtual card, and you'll receive a physical card by mail shortly thereafter. Paytient pays your BCBS Coupe PPO providers upfront, while you can create your preferred payment plan on the back end. Payments are processed automatically via payroll deduction or the payment method of your choice. You pay $0 in interest and fees.

* This new payment feature allows for a maximum revolving credit line of $3,000. If you already have a Paytient card and elect the BCBS Coupe PPO medical option, your Paytient line of credit will be increased upon satisfactory completion of the ability-to-repay form.

Higher HSA contribution limits

Contributing to an HSA lets you save and pay for eligible health care costs tax-free. For 2026, if you enroll in the HSA Advantage or HSA Value National Medical Program options and don't have other disqualifying coverage, you can contribute $4,400 if you have Employee Only coverage and $8,750 for other coverage levels. If you'll be 55 or older by the end of 2026, you can contribute up to $1,000 more in catch-up contributions. Money in your HSA is always yours to keep and use when you need it — now and in the future. Special HSA contribution limit rules apply if you are married or are covering another adult on your medical plan. See the ***Ways to Save & Pay for Care Guide*** for more information.

Higher Dependent Day Care FSA contribution limit*

The Dependent Day Care FSA allows you to pay for eligible out-of-pocket dependent day care expenses with before-tax dollars. Subject to the terms of the RR Donnelley Flexible Benefits Plan, you may contribute $200 – $7,500 (or $200 – $3,750 if your federal income tax filing status is married filing separately) to reimburse yourself for expenses such as day care for your qualifying child, elderly parent or disabled spouse. This is the first time the limit has been increased since Dependent Day Care FSAs were created.

ACTION REQUIRED!

To participate in the **FSA programs** in 2026, you must enroll during Annual Enrollment. Your current elections **won't** carry over.

Summaries of Benefits & Coverage (SBCs) provide detailed information about each of the medical program options. To view the SBCs, go to **myRRDbenefits.com**. You can also request a paper copy free of charge by calling the RRD Benefits Center at **1-877-RRD-4BEN (1-877-773-4236)**. If you enroll online, copies are also available through the enrollment website.

Higher Health Care Flexible Spending Account (FSA) contribution limit*

You can pay for eligible out-of-pocket health care expenses tax-free when you enroll in a Health Care FSA. For 2026, you may contribute $200 – $3,300 to a Health Care FSA. The full amount you elect to contribute to a Health Care FSA for the year is immediately available for eligible expenses, even if it exceeds the amount of your payroll contribution that has been deducted from your pay and deposited into your account at the time you submit a claim. If you are enrolled in the Copay Advantage or BCBS Coupe PPO medical option, you may contribute to a Full-Use Health Care FSA. With the Full-Use Health Care FSA, you can receive tax-free reimbursement for qualifying medical, prescription drug, dental and vision expenses at any time throughout the year. If you are enrolled in the HSA Advantage or HSA Value medical option, you can contribute to a Limited-Use Health Care FSA. With the Limited-Use Health Care FSA, you can receive reimbursement for qualifying dental and vision expenses at any time throughout the year, but you are only eligible for reimbursement of qualifying medical and prescription drug expenses after you've met a legally required minimum portion of your Medical Program deductible in 2026 ($1,700 for Employee Only coverage and $3,400 for Employee + Spouse, Employee + Child(ren), and Family).

NOTE: You can't be reimbursed by both an FSA and an HSA for the same expense.

No changes to vision plan premiums

The amount you pay for 2026 vision coverage will not change.

Small increase to dental plan premiums

The amount you pay for your 2026 dental coverage will increase by a small amount. View your premiums on the enrollment website.

Enhanced Critical Illness Insurance

Critical Illness Insurance pays a lump-sum benefit if you or a covered family member is diagnosed with a covered health condition. Starting in 2026, you and your covered family members can each receive a $50 cash benefit when you/they get a screening for one of the covered medical conditions.

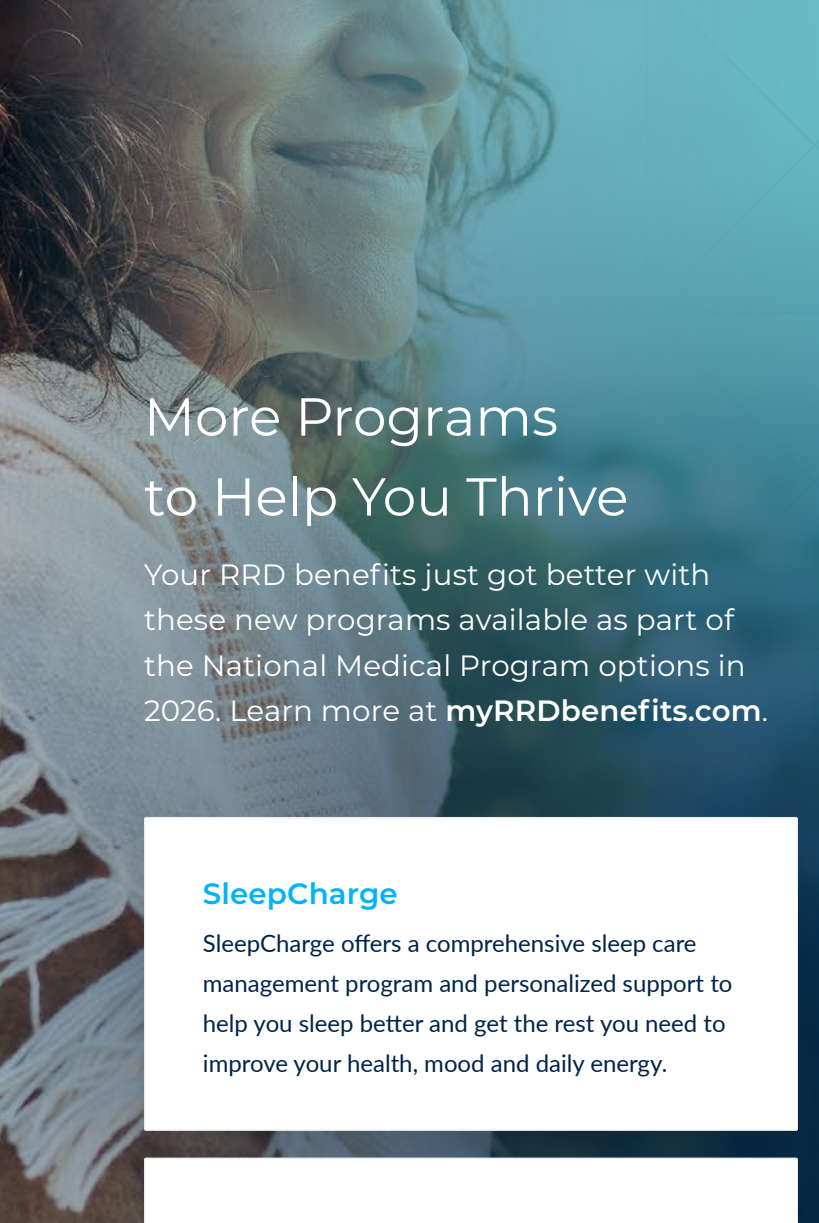
Disability and absence management administration moving to Lincoln Financial

Short- and long-term disability (STD and LTD respectively) and leave of absence management will switch from The Hartford to Lincoln Financial. This change will take effect January 1, 2026. Additional information will be sent to those with an active leave or disability claim at the time of the transition. To file a new claim with a disability or leave start date on or after January 1, 2026, please contact Lincoln Financial. Claims can be initiated by calling **1-800-331-4914** or going to **lincolnfinancial.com** (Company Code: RRDONNELLEY). If your disability was incurred prior to January 1, 2026, your disability benefits will be paid by The Hartford but your concurrent Family and Medical Leave Act (FMLA) leave will be administered by Lincoln Financial.

STD Only	STD with FMLA	FMLA Only	LTD
Date of Disability or Leave Start Date — Prior to January 1, 2026			
STD will remain with The Hartford	STD will remain with The Hartford, FMLA will transition to Lincoln	FMLA will transition to Lincoln	LTD will remain with The Hartford
Date of Disability or Leave Start Date — On or after January 1, 2026			
STD will transition to Lincoln	STD and FMLA will transition to Lincoln	FMLA will transition to Lincoln	LTD will transition to Lincoln

NEW! Fidelity Medicare Services

If you are becoming eligible for Medicare, Fidelity Medicare Services can help you navigate your Medicare options with confidence. They'll help you compare plans and choose coverage that fits your needs and budget. This service will replace Allsup Benefits Coordination as of January 1, 2026.



More Programs to Help You Thrive

Your RRD benefits just got better with these new programs available as part of the National Medical Program options in 2026. Learn more at **myRRDbenefits.com**.

SleepCharge

SleepCharge offers a comprehensive sleep care management program and personalized support to help you sleep better and get the rest you need to improve your health, mood and daily energy.

OneImaging MANDATORY

Makes it easy and convenient to get medical imaging — like MRIs, CT scans, X-rays and mammograms — without the wait times and high costs often found elsewhere. OneImaging is the new exclusive network provider under the National Medical Program options for non-emergency/non-urgent MRIs and CT scans. You must contact OneImaging and use one of their recommended providers for non-emergency/non-urgent MRIs and CT scans. The Plan provides no coverage for MRIs or CT scans provided by other providers (except in the case of urgent care or emergency).

Maven Clinic from BCBSIL

Designed to raise the standard of women's and family health care by providing support for fertility and family building, maternity and postpartum care, parenting and pediatrics, and menopause and ongoing care. (Not available with BCBS Coupe PPO.)

WellTheory

Provides expert guidance and personalized support for people with autoimmune and inflammatory conditions. With WellTheory, you get two visits per month and unlimited messaging with coaches who specialize in autoimmunity. Their care team works with you to manage symptoms, reduce inflammation and improve your overall well-being.

CVS Drug Savings Review

Works with your providers to find lower-cost options for your medications. (This program will replace Rx Savings Solutions.)

WHAT YOU NEED TO DO

1 Join the Benefits Bootcamp.

Boost your benefits knowledge for Annual Enrollment and beyond. Benefits Bootcamp starts October 14. View the schedule at **myRRDbenefits.com**.

2 Review your benefits.

Visit **myRRDbenefits.com** to access your ***2026 Benefits Enrollment Guide*** (available mid-October) and other guides, Summary Plan Descriptions (SPDs), Summaries of Benefits and Coverage (SBCs), and any Summaries of Material Modifications (SMMs).

3 Ask Emma for help to make informed decisions.

On the enrollment website (accessible from **myRRDbenefits.com**), use the "Ask Emma" virtual assistant to view costs, compare options, and help you choose the benefits that are right for your situation.

* You (and/or each of your enrolled dependents) who indicate "Yes" for Tobacco User status may avoid the premium surcharge by participating in the tobacco cessation program and completing five coaching sessions during the Plan year. So long as the individual completes five coaching sessions by December 31, 2026, you will be refunded the tobacco medical plan surcharge for that individual. If you are enrolled in the Optional Life plans, those premium rates will be adjusted prospectively to reflect the non-tobacco premium discount effective on the first of the month following completion of five coaching sessions. Contact UBreathe at **1-888-882-5462** to participate in the program. (Alternate cessation recommendations by your physician will be accommodated.)

4 Choose your 2026 benefits October 29 – November 12, 2025.

Go to **myRRDbenefits.com** to link to the enrollment website.

- The enrollment website will be available 24/7 during Annual Enrollment. You may go back to the enrollment website to make changes as often as needed before the deadline. You can also download the bswift app (**myrrdbenefits.com/mobile-apps**) for easy enrollment via your smartphone.
- If you don't have online access, you can enroll by phone starting October 29 at **1-877-RRD-4BEN (1-877-773-4236)**, Mon. – Fri., 7 a.m. – 7 p.m. CT.
- DON'T DELAY! Phone enrollment ends November 12, 2025, at 6:59 p.m. CT. You could experience long wait times if you try to enroll by phone during the last four days of Annual Enrollment.

If you don't enroll or update your benefits by the deadline, your current elections will carry over to 2026 **except for FSA contributions.**

5 Review/update your dependents on the enrollment website.

Review/update your dependents on the enrollment website. Review and confirm whether your dependent spouse/domestic partner's eligibility has already been verified. If it has not, and you want to cover them for the 2026 plan year, you must complete the verification process. Check now to avoid problems later on if you are found to have enrolled an ineligible dependent.

6 Certify your tobacco status on the enrollment website.

Your current tobacco status will carry over, so update it if it has changed. Tobacco users will pay an annual medical premium surcharge of $500 per adult and $250 per child.*

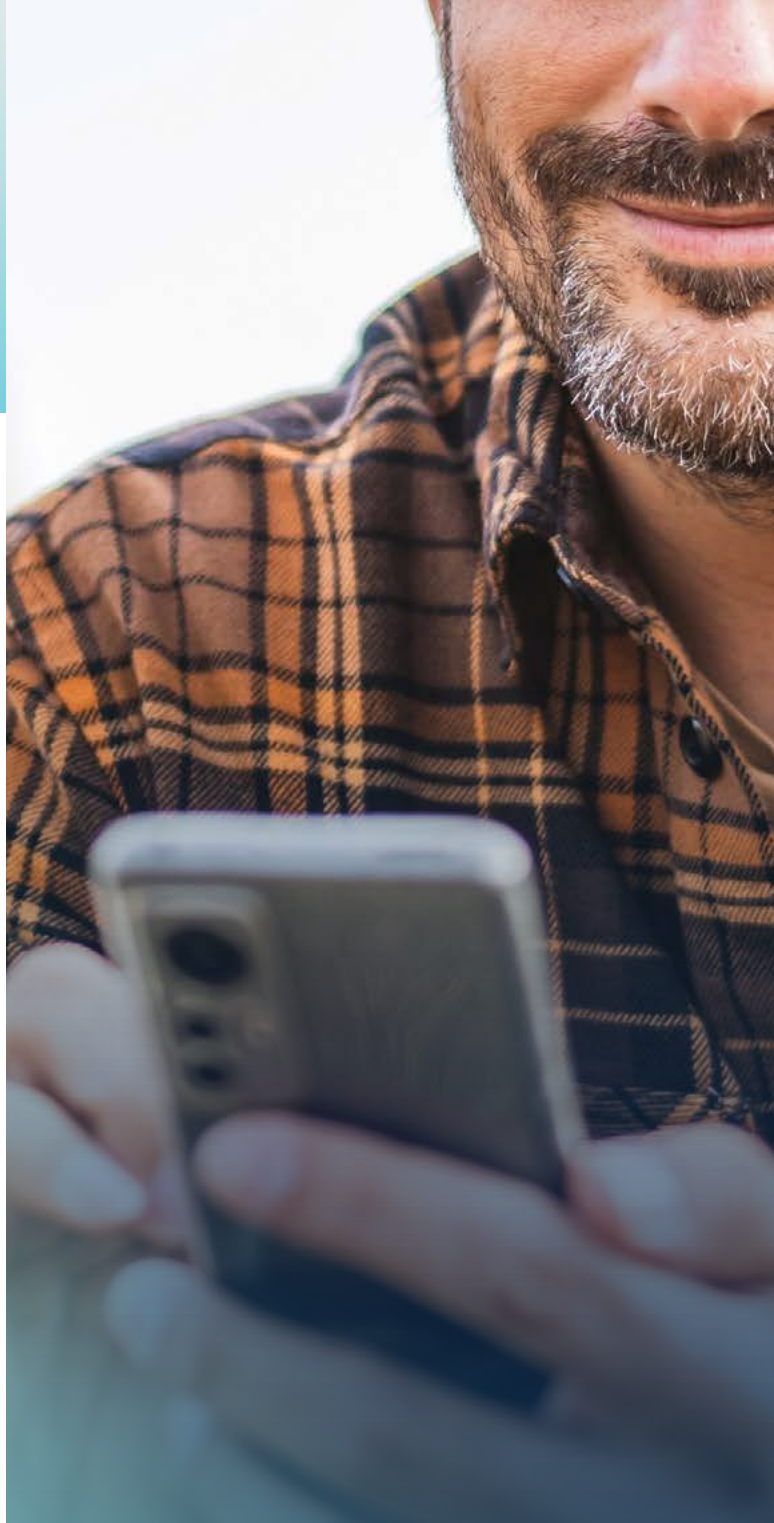
7 Review/update your beneficiary designations.

Protect your family and your money by designating your beneficiaries for your:

- Life insurance and supplemental health care coverage on the enrollment website (**rrd.bswift.com**)
- RRD 401(k) Savings Plan (**NetBenefits.com**)
- HSA (**HealthEquity.com**)

8 Confirm your elections.

Print and keep a copy of your elections for your records. You may make changes or corrections until November 12, 2025, on the enrollment website or by calling the RRD Benefits Center at **1-877-RRD-4BEN (1-877-773-4236)**. You will receive in the mail an official confirmation statement. Upon receipt, review your confirmation statement to verify your elections, covered dependents and per-pay-period costs are correct. If you discover any errors, you need to contact the RRD Benefits Center on or before December 31, 2025.



Your benefit elections will be in effect January 1 – December 31, 2026.

You cannot make changes during the year unless you experience a Qualified Status Change (e.g., marriage, divorce, birth of a child). For more information, read the Special Enrollment Period for Group Health Coverage notice on **page 9** or the Administration Information Booklet at **myRRDbenefits.com**.

IMPORTANT NOTICES & DISCLOSURES

Changing Your Elections During the Year

If you do not enroll by the deadline or would like to change your elections, the only way you may be able to enroll or change an election during the calendar year is if you experience a Qualified Status Change. (See the Special Enrollment Period for Group Health Coverage notice below or the Plan Administration Information Booklet for more information). Keep in mind, new dependents are not automatically covered by the Plan; you must enroll them for coverage. For dependents who are no longer eligible for coverage under the Plan, you are required to call the RRD Benefits Center at **1-877-RRD-4BEN (1-877-773-4236)** or go online to **rrd.bswift.com** to remove them from coverage under the Plan.

NOTE: This rule does not apply to life insurance or HSAs. You may make changes to the optional supplemental life insurance, spouse life insurance, child life insurance and/or optional accident insurance coverages during the calendar year and at Annual Enrollment each year. You may be subject to satisfactory Evidence of Insurability (EOI) for such coverage changes to become effective. Please review the Life and Accident Insurance Program's Member Certificates for details regarding increases or decreases to your coverage amounts.

Special Enrollment Period for Group Health Coverage

If you decline Medical Program coverage for yourself or your dependents because you/your dependents have other coverage and you/your dependents later lose that other coverage (or if the employer stops contributing toward your or your dependent's other coverage), you may qualify for special enrollment in health coverage under the Plan. Your loss of other health coverage qualifies for special enrollment treatment only if both of the following apply:

- You/your dependents were covered under another group health care plan or health insurance coverage at the time you were offered coverage under the RR Donnelley Group Benefits Plan.
- You/your dependents lost the other coverage because you/they exhausted your/their right to COBRA continuation coverage, you/they were no longer eligible under that plan or an employer's contributions for coverage terminated.

You must enroll within 30 days after your/your dependents' other coverage ends (or after the employer stops contributing toward the other coverage). You may also be able to enroll if you/your dependents lose eligibility for coverage under Medicaid or a state Children's Health Insurance Plan (CHIP) and enroll within 60 days of losing Medicaid or CHIP. Also, you may be able to enroll if you/your dependents become eligible for premium assistance from Medicaid or CHIP toward the cost of the group health plan, and enroll within 60 days of eligibility for state premium assistance.

If you have a new dependent as a result of marriage, birth, adoption or placement for adoption, you may be able to enroll yourself and your dependents for coverage under the Plan. Generally, you must enroll within 30 days after such event.

NOTE: The Plan provides a more generous time frame to enroll than required by law for the addition of new children under certain circumstances described in this paragraph. If you are adding a newborn child, a newly adopted child, or a child newly placed with you for adoption, you generally have up to 60 days to report such event to the eligibility administrator under the Plan's more generous policy. However, if you are already enrolled in one of the self-funded national Medical Program options at the Employee + Child(ren) or Family levels, you will have up to 90 days to report such event to the eligibility administrator to add your new child to coverage, since this election does not require any change in your premiums or approval of any insurance company. Many of the Regional Medical Options Program also offer more generous timeframes to enroll than required by law for the addition of new children, which varies by insurance carrier. See the carrier documents for more information.

To request special enrollment or if you have questions regarding special enrollment rights, please contact the Benefits Center at **1-877-RRD-4BEN (1-877-773-4236)**.

Right to Choose a Primary Care Provider

Depending on where you live, you might be eligible for a Regional HMO Medical Program option in addition to the National Medical Program options. If you are eligible, you will receive additional information about the Regional HMO for which you are eligible, including contact information.

The Regional HMOs generally require the designation of a primary care provider (but the National Medical Program options do not). You have the right to designate any primary care provider who participates in the Regional HMO network and is available to accept you or your family members. For information on how to select a primary care provider and a list of participating primary care providers, contact the Regional HMO directly at the number or website included in your enrollment materials. For children, you may designate a pediatrician as the primary care provider.

You do not need prior authorization from the Regional HMO or from any other person (including a primary care provider) to obtain access to obstetrical or gynecological care from a health care professional in the network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, contact the Regional HMO directly at the number or website provided in the enrollment materials.

Women's Health & Cancer Rights Act

Important information about benefits that may be available to women who have had or are going to have a mastectomy: If you have had or are going to

have a mastectomy, you may be entitled to certain benefits under the Women's Health and Cancer Rights Act (WHCRA). For individuals receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending physician and the patient for:

- All stages of reconstruction of the breast on which the mastectomy was performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance;
- Prostheses; and
- Treatment of physical complications of the mastectomy, including lymphedema.

Such coverage is subject to all Plan provisions, limitations and requirements applicable to other medical and surgical benefits provided under the Medical Program, including any annual deductible and coinsurance limitations, outlined in the Summary of Benefits and Coverage (SBC), your SPD, and any related SMMs.

Your Rights and Protections Against Surprise Medical Bills

When you get emergency care or are treated by an out-of-network provider at an in-network hospital or ambulatory surgical center, you are protected from balance billing. In these cases, you shouldn't be charged more than the Plan's copayments, coinsurance and/or deductible. You can visit **www.cms.gov/nosurprises/consumers** for more information about your rights under federal law. If you think you've been wrongly billed, contact **1-800-985-3059**.

What is "balance billing" (sometimes called "surprise billing")?

When you see a doctor or other health care provider, you may owe certain out-of-pocket costs, like a copayment, coinsurance, or deductible. You may have additional costs or have to pay the entire bill if you see a provider or visit a health care facility that isn't in the Plan's network.

"Out-of-network" means providers and facilities that haven't signed a contract with the Plan (or one of the Regional Medical Program Option's insurers) to provide services. Out-of-network providers may be allowed to bill you for the difference between what the Plan pays and the full amount charged for a service. This is called "balance billing." This amount is likely more than in-network costs for the same service and might not count toward the Plan's deductible or annual out-of-pocket limit.

"Surprise billing" is an unexpected balance bill. This can happen when you can't control who is involved in your care—like when you have an emergency or when you schedule a visit at an in- network facility but are unexpectedly treated by an out-of-network provider. Surprise medical bills could cost thousands of dollars depending on the procedure or service.

You're protected from balance billing for:

- **Emergency services** — If you have an emergency medical condition and get emergency services from an out-of- network provider or facility, the most they can bill you is the Plan's in-network cost-sharing amount (such as copayments, coinsurance, and deductibles). You can't be balance billed for these emergency services. This includes services you may get after you're in stable condition, unless you give written consent and give up your protections not to be balanced billed for these post-stabilization services.
- **Certain services at an in-network hospital or ambulatory surgical center** — When you get services from an in-network hospital or ambulatory surgical center, certain providers there may be out-of-network. In these cases, the most those providers can bill you is the Plan's in-network cost-sharing amount. This applies to emergency medicine, anesthesia, pathology, radiology, laboratory, neonatology, assistant surgeon, hospitalist, or intensivist services. These providers can't balance bill you and may not ask you to give up your protections not to be balance billed.

If you get other types of services at these in-network facilities, out-of-network providers can't balance bill you, unless you give written consent and give up your protections. You're never required to give up your protections from balance billing. You also aren't required to get out-of-network care. You can choose a provider or facility in the Plan's network.

When balance billing isn't allowed, you also have these protections:

You're only responsible for paying your share of the cost (like the copayments, coinsurance, and deductible that you would pay if the provider or facility was in-network). The Plan will pay any additional costs to out-of-network providers and facilities directly.

Generally, the Plan must:

- Cover emergency services without requiring you to get approval for services in advance (also known as "prior authorization").
- Cover emergency services by out-of-network providers.
- Base what you owe the provider or facility (cost-sharing) on what it would pay an in-network provider or facility and show that amount in your explanation of benefits.
- Count any amount you pay for emergency services or out-of-network services toward your in-network deductible and out-of-pocket limit.

About This Guide

This guide describes key changes to the coverage RRD will offer for 2026 to the majority of benefits-eligible employees and constitutes a Summary of Material Modifications (SMM) under the RR Donnelley Group Benefits Plan, the RR Donnelley Group Medical Plan, and the RR Donnelley Flexible Benefits Plans (the "Plans"). Your benefits eligibility will determine the precise coverage that is offered to you, your spouse, domestic partner and/or your dependent child(ren). More details on benefits eligibility are available in the Summary Plan Descriptions (SPDs) and prior SMMs online at **myRRDbenefits.com**.

Important

The descriptions provided in this guide are based on official Plan documents. Every effort has been made to ensure the accuracy of this material. In the unlikely event there is a discrepancy between this document, the SPDs, SBCs, SMMs, any other materials summarizing the Plans and the official Plan documents, the following documents will control:

- Where this document is intended to summarize existing benefit provisions, the SPDs, SMMs, any other materials summarizing the Plans and the official Plan documents, the official Plan documents will control.
- Where this document is intended to communicate a change to the SPDs, SMMs, any other materials summarizing the Plans and the official Plan documents, this document will control.

RRD reserves the right to amend or terminate the Plans or Programs at any time for any reason.