

RRD BENEFITS
HEALTH | WEALTH | LIFE

YOUR JOURNEY. YOUR BENEFITS.

2027 Benefits Enrollment Guide for New Employees

ACTION REQUIRED!

2027 BENEFITS ENROLLMENT

YOUR JOURNEY. YOUR BENEFITS.

The right benefits can help you navigate life's journeys with confidence and peace of mind.

RRD offers a variety of benefits designed to support your health, finances and wellbeing, while giving you the flexibility to choose the coverage that fits your needs and budget.

This guide provides an overview of your benefit options. Take time to review it and explore your choices before enrolling. To see what you will pay for your coverage, visit **rrd.bswift.com**, and use the "Ask Emma" tool to compare plans, coverage features and costs.

Be sure to enroll by the deadline listed in your enrollment kit. (The date shown in your enrollment kit is your benefits effective date. For example, if the date shown is February 1, you must enroll by January 31.)

This is your only opportunity to choose your 2027 benefits unless you experience a qualifying life event, such as marriage, divorce, the birth of a child, or another eligible change in life or work status specified in the Plan Administration Information Booklet, during the year.

myRRDBenefits.com

Everything you need to know — in one place.



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BENEFITS ELIGIBILITY

You are generally eligible for RRD benefits if you are a regular full-time or benefits-eligible part-time employee of RRD or any of its participating subsidiaries. Certain employees may also be eligible under the Affordable Care Act requirements if they worked a minimum number of hours during the previous year.

Eligible Dependents

Eligible dependents generally include:

- Your spouse (including your common-law spouse in states that recognize common-law marriages)
- Your domestic partner
- Your children to age 26, including:
  - Natural children
  - Legally adopted children
  - Stepchildren
  - Foster children
  - Children for whom you are the sole legal guardian
  - Your domestic partner's children
- Your dependent children age 26 and older who are incapable of earning a living because of a disability, subject to conditions defined in the SPD, any related SMM, and/or an insurance certificate

Need More Eligibility Details?

This information is a summary and does not contain all Plan provisions, conditions or definitions. For more details, please refer to the SPD, any related SMM and, in some cases, the insurance certificate for each benefit at **myRRDbenefits.com**.

Ineligible Dependents

Your parents, grandparents, adult brothers and adult sisters are not eligible for coverage. Your minor brothers and sisters or grandchildren are not eligible for coverage unless you are the sole legal guardian. You cannot cover any person who is covered as an employee or as a dependent of another employee under the Plan. The Plan does not pay benefits for ineligible dependents, even if they are enrolled.

Are Your Dependents Eligible for Coverage?

- **If your dependent(s) are no longer eligible for coverage**, you must call the Benefits Center or go online to remove them from coverage generally within 30 days of the date they become ineligible. Claims will not be paid for ineligible dependents.
- **If you newly enroll a dependent**, watch for a dependent verification letter via mail or email. If you fail to respond in a timely manner with acceptable proof of your dependent's eligibility, the dependent's coverage may be denied.

RRD conducts ongoing audits to confirm dependents enrolled under the Plan are eligible for coverage. This ensures only eligible dependents are covered, which helps us manage health care costs for both you and the company.

SUMMARY OF HEALTH & WELFARE BENEFITS

These benefits are available to you, provided you meet the eligibility and waiting period requirements. You receive some benefits automatically; others you receive only if you elect an option and coverage category and pay the applicable premiums.

	Who's Eligible	Coverage Starts On	Who Enrolls
Benefits provided by RRD (no employee contribution)			
Basic Employee Life Insurance	Regular full-time and benefits-eligible part-time employees of RRD or any of its participating subsidiaries [1]	First day of the month after one-month anniversary of employment	Automatic enrollment
Short-Term Disability			
Employee Assistance Program SupportLinc		Date of hire	
Benefits for which you and RRD contribute			
Medical & Prescription Drug	Regular full-time and benefits-eligible part-time employees of RRD or any of its participating subsidiaries [1]	First day of the month after one-month anniversary of employment	You [2]
Optional benefits paid entirely by you			
Dental & Vision	Regular full-time and benefits-eligible part-time employees of RRD or any of its participating subsidiaries [1]	First day of the month after one-month anniversary of employment	You [4]
Health Savings Account			
Flexible Spending Accounts Health Care & Dependent Day Care [3]			
Long-Term Disability			
Life Insurance Employee, Spouse/DP & Child			
AD&D Insurance			
Accident, Critical Illness & Hospitalization Insurance			

1. For definitions of regular full-time and benefits-eligible part-time status, please refer to HR Core Policy 2-1, "Employee Classifications," on "Discover" RRD/Policies & Compliance. Bargaining unit employees are eligible only if agreed on in the collective bargaining agreement.
2. The coverage options for which you are eligible are listed on **rrd.bswift.com**. If you don't take action to elect "No Coverage" or you don't enroll in a Medical Program before the deadline indicated, you will default to Employee Only coverage under the HSA Value option, and you will have no HSA contributions. Your next opportunity to enroll or change options will be the following Annual Enrollment period.
3. If you are hired in October, you become eligible for the FSAs on January 1, even though your coverage for other benefits begins on December 1.
4. The coverage options for which you are eligible are listed on **rrd.bswift.com**. If you don't take action to enroll before the deadline indicated, you'll have no coverage for the Plan year. Your next opportunity to enroll will be the following Annual Enrollment period. Optional life is subject to evidence of insurability (EOI). See **page 28** for details.

WHAT YOU NEED TO DO

1 Take action/enroll before the deadline specified in your enrollment kit

You must take action, even if you don't want coverage. Otherwise, default coverage will be assigned.

2 Read the enrollment materials

Visit **myRRDbenefits.com** for more information. Refer to **rrd.bswift.com** to see the coverage options available to you and costs.

3 Get personalized help from Emma

On the enrollment website at **rrd.bswift.com**, use Emma to view your plan rates, compare your options, and help you choose the plan that's right for you and your family.

4 Make your benefit elections

IMPORTANT! Even if you don't want coverage, you must go online or call to elect "No Coverage."

- Enroll online at **rrd.bswift.com**.
- If you don't have online access, enroll by phone at **1-877-RRD-4BEN (1-877-773-4236)**, Mon. – Fri., 7 a.m. – 7 p.m. CT.
- You may enroll eligible dependents as described on **page 2**. You must provide a Social Security number (SSN) for each dependent and enter their name exactly as it appears on their Social Security card.
- If you add a dependent, check the box on the enrollment website for each of the programs (e.g., medical, dental, vision) in which you wish to enroll the dependent. (Simply adding a dependent does NOT enroll them in coverage.)

When Your Coverage Begins

Your benefit elections — including any default coverage if you don't enroll — will generally be in effect the first day of the calendar month after your one-month anniversary of employment (regardless of the day of the month you started your employment) through December 31, 2027.

When You Start	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	December 1*
November	January 1
December	February 1

* January 1 for FSAs.

5 Certify your tobacco status

On the enrollment website, you must certify whether you and each of your covered dependents are "Tobacco Users." If you are not a Tobacco User, or if you complete five coaching sessions in 2027, you will receive a premium discount for the Medical, Optional Employee Life, and Optional Spouse/Partner Life plans.

To answer "No" to the Tobacco User question on the enrollment website, you must certify that you (or your dependents) have not used any of the following during the past 12 months: tobacco products (including cigarettes, pipe tobacco, cigars, chewing tobacco, tobacco snuff and hookah tobacco) and/or tobacco-derived or non-Food and Drug Administration (FDA)-approved nicotine-based products (like e-cigarettes, nicotine gels and dissolvables).

You may still answer "No" to the Tobacco User question if you use the following aids to quit tobacco/nicotine: over-the-counter FDA-approved nicotine replacement products (skin patches, chewing gum and lozenges) and/or prescription drugs (Chantix, Zyban or Nicotrol).

Each Tobacco User who does not complete five coaching sessions in 2027 will pay an annual medical premium surcharge of $500 per adult and $250 per child (added to your medical premium) up to the following maximums:

- **Employee Only or Spouse/Domestic Partner Only:** $500
- **Employee + Spouse/Domestic Partner:** $1,000
- **Dependent Child(ren) Only:** $250
- **Employee + Child(ren) or Spouse/Domestic Partner + Child(ren):** $750
- **Family (Employee + Spouse/Domestic Partner + Child(ren)):** $1,250

Optional Life premium rates for Tobacco Users are available at **rrd.bswift.com**.

You (and/or each of your enrolled dependents) who indicate "Yes" for Tobacco User status may qualify for the non-Tobacco User premium discounts by completing five coaching sessions during the Plan year. So long as the individual completes five coaching sessions by December 31, 2027, 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.)

6 Confirm your elections

After enrolling, review your confirmation statement and verify that your elections, covered dependents and per-pay-period costs are correct. Print and keep a copy for your records. If you need to make changes or corrections, call the RRD Benefits Center.

IF YOU DON'T TAKE ACTION

If you don't take action before the deadline indicated on your personalized New Hire Enrollment Worksheet, the following coverage categories will be assigned to you automatically:

Medical

DEFAULT COVERAGE

HSA Value for you only

Dental & Vision

NO COVERAGE

You will have no coverage for the year.

HSA & FSAs

NO CONTRIBUTION

Although your HSA contribution will be set to $0, you can still elect to contribute to your HSA during the year.

Basic Employee Life Insurance

DEFAULT COVERAGE

One times your annual base pay, up to $250,000. (See the SPD and any related SMM for Program details, including annual reductions for active employees age 65 and older.)

Short-Term Disability (STD)

DEFAULT COVERAGE

Weekly benefit of 50% of your predisability earnings for up to 26 weeks if you are an hourly employee, and 100% of your pre-disability earnings for the first three weeks and 50% for up to 23 additional weeks if you are a salaried employee. (See the SPD and any related SMM for details.)





YOUR HEALTH

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2027 NATIONAL MEDICAL PROGRAM OPTIONS

You have a choice of four National Medical Program options from Blue Cross Blue Shield of Illinois (BCBSIL): HSA Advantage, HSA Value, Copay Advantage and Copay Edge. Depending on where you live, you might be eligible for a regional medical option (Kaiser or Dean Health Plan). If any of these options are available to you, you will see them listed when you log in to the enrollment website (**rrd.bswift.com**).

Compare the National Medical Options

	HSA Advantage	HSA Value	Copay Advantage	Copay Edge
Preventive Care In-Network	✓	✓	✓	✓
Prescription Drugs Through CVS Caremark	✓	✓	✓	✓
Telemedicine Through MDLIVE	✓	✓	✓	✓
Fertility Treatment	✓	✓	✓	✓
Covers Care Received In- & Out-of-Network	✓	✓	✓	✓
Includes PrudentRx Assistance	✓	✓	✓	✓
Eligible for Paytient	✓	✓	✓	✓
Eligible for an HSA & Limited-Use Health Care FSA	✓	✓	✗	✗
Eligible for Full-Use Health Care FSA	✗	✗	✓	✓
Premiums	$$	$	$$	$
Deductible	$$	$$$	$	✗
Out-of-Pocket Maximum	$$	$$	$$	$$

Use In-Network Providers

When you enroll in a National Medical Program option, you can use any provider, but using in-network providers will save you money.

Out-of-network services have two times the deductible and out-of-pocket maximum as in-network services.

Visit **bcbsil.com/rrd/doctors-and-hospitals** to find a network provider. We recommend you also confirm your providers are in-network by calling the number on the back of your ID card prior to receiving services, or call your physician's office to verify they are participating in the network.

* A high-deductible health plan option, like the HSA Advantage or HSA Value National Medical Program option, can sometimes "financially dominate" a lower-deductible, higher-premium option by producing lower total out-of-pocket costs across levels of medical spending. In other words, it is possible that for many participants, their total costs under the HSA options — even if they meet their entire deductible and incur significant additional coinsurance expenses — might be less than if they paid the premium for a Copay option and incurred no additional expenses. You should use "Ask Emma" to evaluate whether the lower monthly premium but higher deductible under one of the HSA-eligible National Medical Program options would be financially better overall for you than the Copay National Medical Programs' higher premiums, after taking into account your projected medical spend for 2027. Of course, some participants value certainty over potential cost savings; if it is important to you to have predictable and steady monthly costs instead of the potential to save money overall but with varying monthly costs, then a Copay option might be your preferred choice even if it might cost you more.



Requirements for Cost-Effective Care

These Plan requirements are designed to help you receive high-quality care while avoiding unnecessary costs:

- **Call OneImaging for non-emergency/non-urgent MRIs and CTs.** OneImaging offers convenient medical imaging (MRIs, CT scans, X-rays, mammograms, etc.) without the wait times and high costs often found elsewhere. The Plan doesn't cover MRIs or CT scans by other providers except in the case of emergency or urgent care.
- **Use Nox Sleep Care for testing or treatment for sleep conditions** (obstructive sleep apnea, insomnia, restless leg syndrome, circadian rhythm disorders, etc.). There is no coverage for sleep conditions if you see other providers.
- **Use a "Blue Distinction Specialty Care" facility** for these five surgical specialties: bariatric, cardiac, knee and hip replacement, spine and transplant surgeries. Blue Distinction facilities are recognized for delivering higher-quality care. If you don't use a Blue Distinction Specialty Care facility, you will pay higher coinsurance: 40% for the HSA Advantage and Copay Advantage options, and 45% for the HSA Value option.

  NOTE: If you choose a provider with Carrum Health, you are not required to use a BCBSIL Blue Distinction Specialty Care facility. (See **page 17** for more information.)
- **Receive prior authorization** for hospitalizations, radiation therapy (proton treatment, radiation treatment, etc.), skilled nursing and rehabilitation, home health care, and other services listed in the SPD that require preauthorization.

For more details about these requirements and the additional costs you'll avoid by following them, contact a health advocate at **1-800-537-9765**.

How to Use Your Prescription Drug Benefits

Your prescription drug coverage through CVS Caremark gives you flexibility and opportunities to save money.

- You can fill non-maintenance medication prescriptions at any pharmacy, including pharmacies other than CVS. To find a local pharmacy in your network, register at **caremark.com** or download the CVS Caremark app to access the pharmacy search tool.
- You must use the CVS Caremark Maintenance Choice Program or Mail Order Service to fill your maintenance medication prescriptions (except as otherwise required by state law). For more information, visit **caremark.com** or call **1-866-273-8402**.
- You can access CVS Caremark prescription drug services anytime and anywhere through the CVS Caremark mobile app or **caremark.com** to:
  - Save money,
  - Fill new prescriptions and refills,
  - Find a network pharmacy,
  - Monitor your spending,
  - Set up medication reminders,
  - Understand your prescription drug benefits and more.

PrudentRx Program for Specialty Medications — $0 Copay!

If you enroll in any of the National Medical Program options, you are automatically enrolled in the PrudentRx program as part of your prescription drug coverage through CVS Caremark.

Through this **FREE** program, you pay $0 for covered specialty medications filled at CVS Specialty Pharmacy. (If you enroll in an HSA National Medical Program option, you must meet your deductible before PrudentRx benefits begin.) The PrudentRx program currently targets specialty medications in the following therapy classes: hepatitis C, autoimmune, oncology and multiple sclerosis.

To opt out of the PrudentRx program, you must call **1-800-578-4403** to disenroll. If you disenroll, you will pay 30% coinsurance for any specialty medications you take that are eligible for the program. **If you are required to pay this 30% coinsurance for a specialty medication, and if the particular medication is considered a "non-essential health benefit," then you will be required to continue paying this amount *even if you've otherwise met the Plan's out-of-pocket maximum*.**

See **pages 13–16** for more information about the applicable copay or coinsurance for specialty medications under each National Medical Program option.

CVS Helps You Save

CVS Drug Savings Review works with your providers to find lower-cost options for your medications.

COMPARE YOUR NATIONAL MEDICAL PROGRAM OPTIONS

Use the charts on the following pages to compare your options. For in-network coverage, you pay the amounts and percentages shown, and the Plan covers the rest. For out-of-network coverage, you may also have to pay amounts in excess of the Plan's allowances.

View your personalized premiums on **rrd.bswift.com**.* Visit **myRRDbenefits.com** for more details, and see the full SPD and SBC for each National Medical Program option. To request paper copies, call **1-877-RRD-4BEN (1-877-773-4236)**.

COPAY EDGE

Copay Edge makes health care easier to understand and use. With a $0 in-network deductible, predictable copays, access to the same wide network of providers as the other National Medical Program options, and personalized support, Copay Edge helps you better understand your costs before you receive care so you can make informed decisions.

Unlike traditional medical options that include deductibles and coinsurance, Copay Edge has a simple copay structure and offers guidance to help you choose high-quality care. View copay highlights on **page 13**, and visit **myRRDbenefits.com** for complete plan details.

Find Care With Confidence

Choosing the right health care provider matters. Find trusted providers to get the care you need while managing costs. Use the BCBSIL app to:

- Find high-quality doctors and facilities.
- Compare copays before you get care.
- Get personalized recommendations and care reminders.
- Find care options to fit your needs and budget.

Easy-to-Understand Costs

Knowing what you'll pay can make health care decisions easier. In-network copays are lower when you choose high-quality providers, so you get more value from your benefits. Copay Edge comes with guided digital tools to help you stay on top of your health care costs.

- View and track monthly medical balances.
- Check clinical review status and details.

Earn Rewards for Smart Health Care Decisions

Member Rewards is part of your plan. Use the Member Rewards feature in your app to earn cash rewards when you:

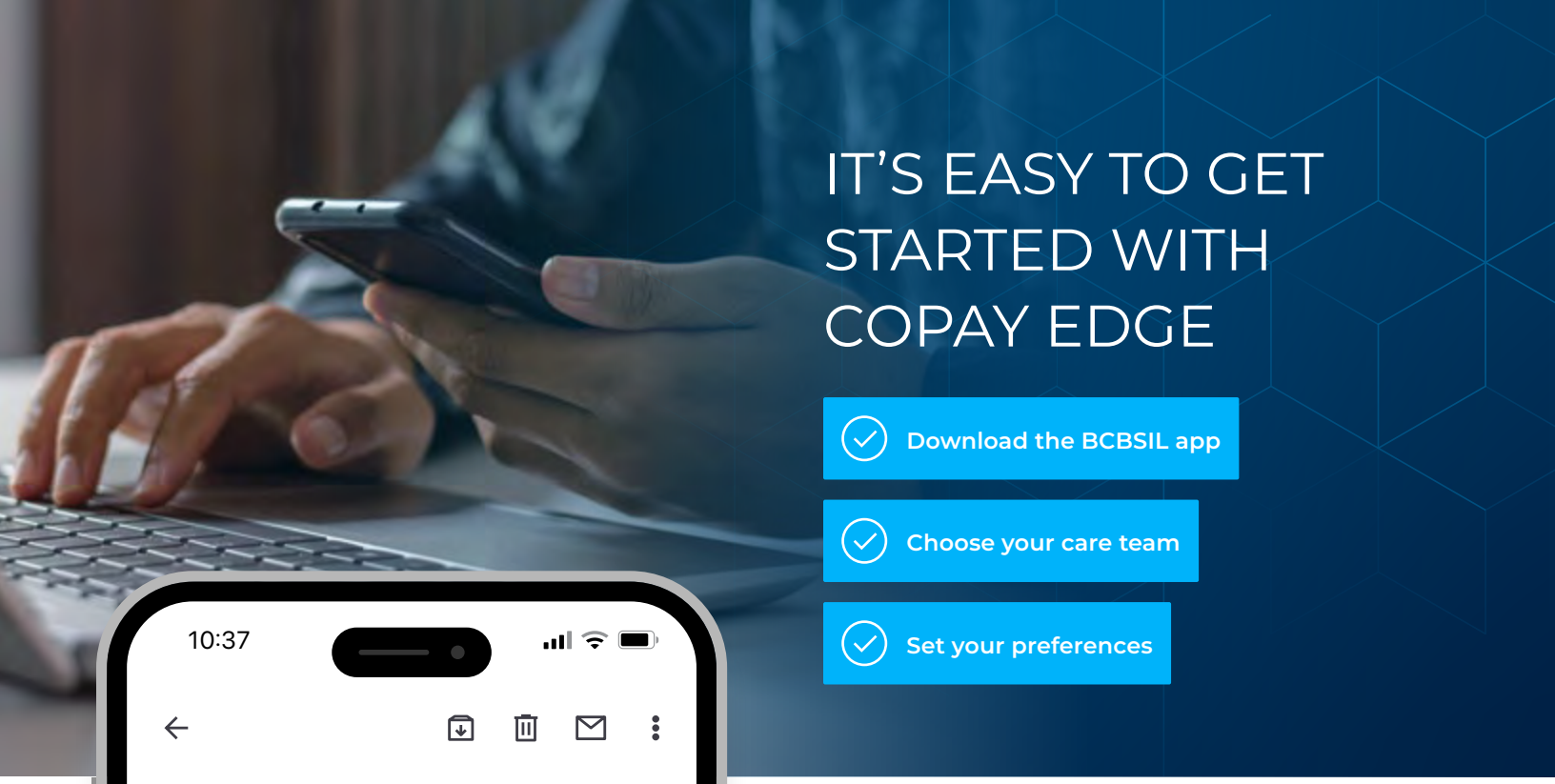
- Choose eligible facilities for certain services.
- Select top preferred providers.
- Shop for care and compare options.

Flexible Ways to Pay

Copay Edge includes the option to receive financing through Paytient — with an interest- and fee-free $3,000 line of credit — to make health care costs more manageable.

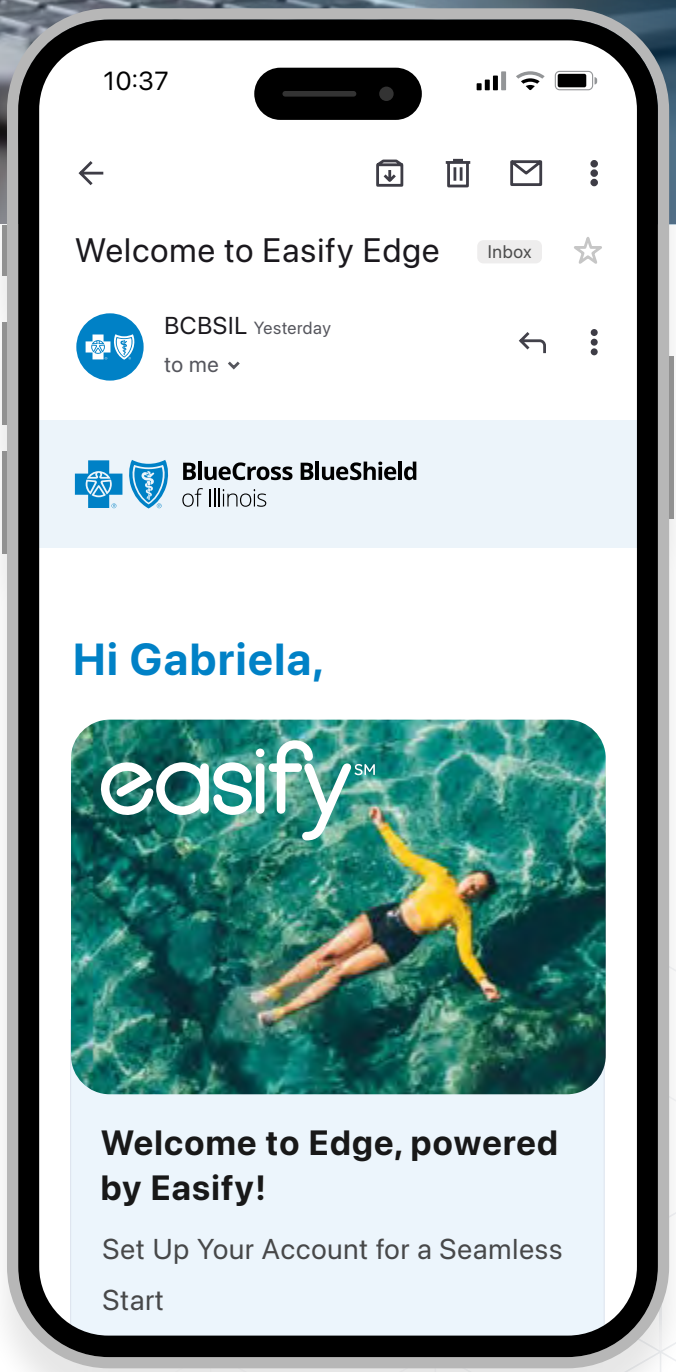
To sign up for Paytient, check the "yes" box to the financing questions on the enrollment website when you're electing your benefits. See **page 27** for additional details.

- Pay your copay at the time of service.
- Receive an easy-to-read monthly statement.
- Track payments through the app.
- Choose from convenient payment options, including payroll deduction.



IT'S EASY TO GET STARTED WITH COPAY EDGE

- Download the BCBSIL app
- Choose your care team
- Set your preferences



STAY HEALTHY

When care is simpler and costs are clearer, it's easier to:

- Get preventive care
- Address health concerns sooner
- Follow treatment plans
- Stay on track with your health goals

COPAY EDGE

MEDICAL	Top Preferred Provider	Preferred Provider	Core Provider	Out-of-Network
Annual Deductible	$0	$0	$0	$5,000 employee only; $10,000 family
Annual Out-of-Pocket Maximum	$8,000 employee only; $16,000 family	$8,000 employee only; $16,000 family	$8,000 employee only; $16,000 family	Unlimited
Common Medical Services				
Preventive Care [1]	$0	$0	$0	30%
Office Visit Primary / Specialty	$30/$75	$65/$150	$125/$325	30%
Mental Health & Chemical Dependency	$30	$30	$30	30%
Emergency Room [2]	$1,200; waived if admitted	$1,200; waived if admitted	$1,200; waived if admitted	$1,200; waived if admitted
Urgent Care	$150	$150	$150	30%

You are required to use OneImaging for non-emergency/non-urgent MRIs and CTs.

PRESCRIPTION DRUG [3]	Retail	Mail Order
Generic Tier 1	25% ($10 min/$45 max)	25% ($25 min/$115 max)
Brand Formulary Tier 2	40% ($40 min/$100 max)	40% ($100 min/$250 max)
Brand Non-Formulary Tier 3	50% ($75 min/$150 max)	50% ($185 min/$375 max)
Specialty Tier 4	N/A	**If not covered by PrudentRx:** $210 **If covered by PrudentRx:** $0 [4]

Endnotes (page 35)

HSA ADVANTAGE

MEDICAL	Employee Only		Family	
	In-Network	Out-of-Network [5]	In-Network	Out-of-Network [5]
Annual Deductible	$2,100	$4,200	$4,200	$8,400
Annual Out-of-Pocket Maximum [6]	$8,700	$17,400	$17,400; Individual cap of $8,700	$34,800; Individual cap of $17,400
Office Visit	20% after deductible	40% after deductible	20% after deductible	40% after deductible
Preventive Care	0%	40% after deductible	0%	40% after deductible
Emergency Room	20% after deductible	20% if true emergency; otherwise 40% after deductible	20% after deductible	20% if true emergency; otherwise 40% after deductible

You are required to use OneImaging for non-emergency/non-urgent MRIs and CTs.

PRESCRIPTION DRUG [3]	Retail	Mail Order
Generic	20% after deductible	
Brand Formulary	30% after deductible	
Brand Non-Formulary	40% after deductible	
Specialty	**If not covered by PrudentRx:** 30% after deductible **If covered by PrudentRx:** 0% after deductible [7]	

Endnotes (page 35)

HSA VALUE

MEDICAL	Employee Only		Family	
	In-Network	Out-of-Network[5]	In-Network	Out-of-Network[5]
Annual Deductible	$3,000	$6,000	$6,000	$12,000
Annual Out-of-Pocket Maximum[6]	$8,700	$17,400	$17,400; Individual cap of $8,700	$34,800; Individual cap of $17,400
Office Visit	25% after deductible	50% after deductible	25% after deductible	50% after deductible
Preventive Care	0%	50% after deductible	0%	50% after deductible
Emergency Room	25% after deductible	25% if true emergency; otherwise 50% after deductible	25% after deductible	25% if true emergency; otherwise 50% after deductible

You are required to use OneImaging for non-emergency/non-urgent MRIs and CTs.

PRESCRIPTION DRUG[3]	Retail	Mail Order
Generic	25% after deductible	
Brand Formulary	40% after deductible	
Brand Non-Formulary	50% after deductible	
Specialty	**If not covered by PrudentRx:** 30% after deductible **If covered by PrudentRx:** 0% after deductible[7]	

Endnotes (page 35)

COPAY ADVANTAGE

MEDICAL	Employee Only		Family	
	In-Network	Out-of-Network[5]	In-Network	Out-of-Network[5]
Annual Deductible	$1,700	$3,400	$3,400	$6,800
Annual Out-of-Pocket Maximum[6]	$8,700	$17,400	$17,400; Individual cap of $8,700	$34,800; Individual cap of $17,400
Office Visit	$25 PCP or Mental Health; $40 Specialist	40% after deductible	$25 PCP or Mental Health; $40 Specialist	40% after deductible
Preventive Care	0%	40% after deductible	0%	40% after deductible
Emergency Room	$500 copay + 20% of remaining balance after deductible	$500 copay + 20% of remaining balance if true emergency; otherwise 50% of remaining balance after deductible[8]	$500 copay + 20% of remaining balance after deductible	$500 copay + 20% of remaining balance if true emergency; otherwise 50% of remaining balance after deductible[8]

You are required to use OneImaging for non-emergency/non-urgent MRIs and CTs.

PRESCRIPTION DRUG[3]	Retail	Mail Order
Generic	20% ($10 min/$40 max); no deductible	20% ($25 min/$100 max); no deductible
Brand Formulary	30% ($40 min/$75 max); no deductible	30% ($100 min/$185 max); no deductible
Brand Non-Formulary	40% ($55 min/$125 max); no deductible	40% ($140 min/$315 max); no deductible
Specialty	**If not covered by PrudentRx:** $150; no deductible **If covered by PrudentRx:** $0; no deductible[4]	More than 30-day supply not allowed

Endnotes (page 35)

HEALTH RESOURCES FOR EVERY STEP OF YOUR JOURNEY

Your RRD benefits connect you to specialized resources and personalized support for every stage of your health journey. You and your covered family members can take advantage of these programs, which are included as part of the RRD National Medical Program options. Learn more about these programs at **myRRDbenefits.com**.

Carrum Health

Carrum Health helps you get expert care for serious health conditions by connecting you with top-quality providers, guiding you through the process, and lowering your health care costs.

- High-quality health care doesn't have to cost you thousands of dollars. RRD covers most, if not all, of the medical costs related to your surgery when you use Carrum. If you are enrolled in Copay Advantage or Copay Edge and you use Carrum Health, you'll pay $0. If you are enrolled in HSA Value or HSA Advantage, you'll pay up to the statutory deductible ($1,750 for Employee Only coverage and $3,500 for Employee + Spouse, Employee + Child(ren), and Family coverage) before the Plan will pay toward your surgery.
- When facing a major health condition or surgery, finding the right care can be overwhelming. Carrum Health makes it easier by helping you find trusted providers, understand your options, coordinate treatment, and potentially save money along the way.
- Dedicated care navigators help coordinate appointments, answer questions, explain your options, and guide you through the treatment process from start to finish.

NOTE: If you choose to use Carrum Health to connect to a provider, you are not required to use a BCBSIL Blue Distinction Specialty Care facility. (See **page 9** for more information.)

Maven Clinic

Get 24/7 virtual health support for fertility, family building, maternity and newborn care, parenting, pediatrics, menopause and midlife health.

Nox Sleep Care

Nox Sleep Care is RRD's exclusive network provider for sleep conditions such as obstructive sleep apnea, insomnia, restless leg syndrome, and circadian rhythm disorders. There is no coverage if you use other providers.

WellTheory

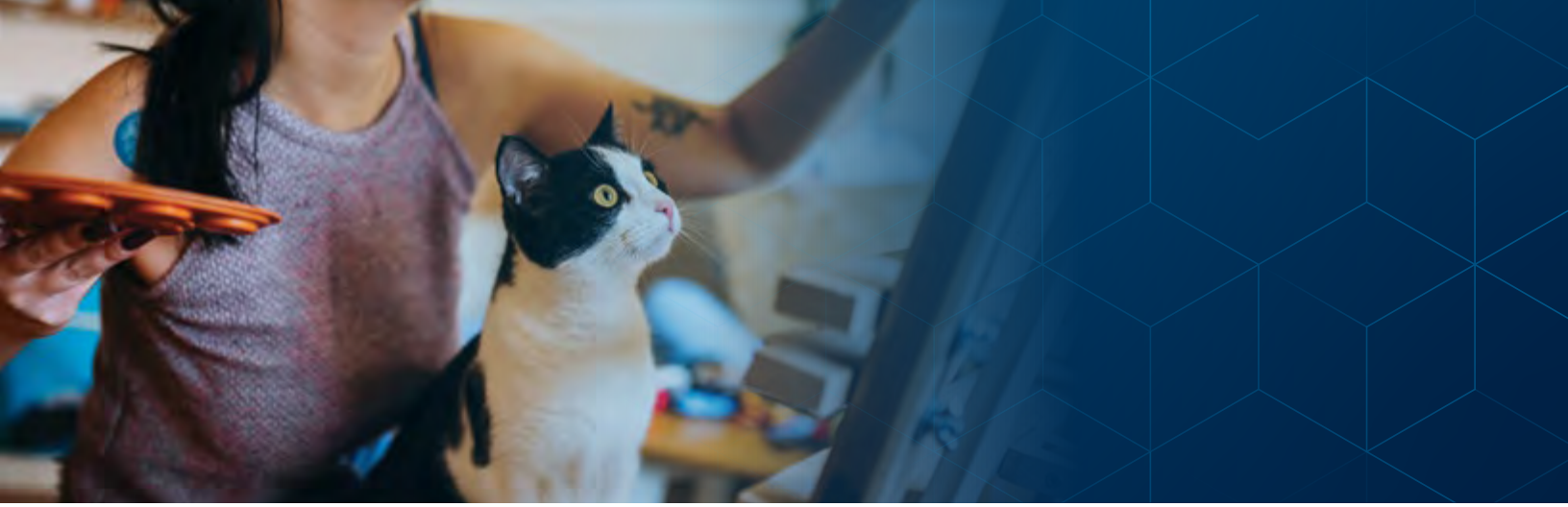
WellTheory provides expert guidance and personalized support for people with autoimmune and inflammatory conditions. Their care team will work with you to manage symptoms, reduce inflammation and improve your overall well-being.

Teladoc Health for Hypertension Management

Living with high blood pressure is easier with help from Hypertension Management by Teladoc Health. When you sign up, you get an advanced blood pressure monitor, support from coaches who can answer your questions and help you make lifestyle changes to improve your blood pressure and lower your risk for complications, and an easy-to-use app and dashboard.

Hinge Health

Hinge Health offers virtual support for back, knee, hip, neck, shoulder, women's pelvic health, and other musculoskeletal concerns. You can access personalized exercise therapy, education and care team support from the comfort of home. Participate when and where it's convenient for you.



Diabetes Care

FROM TWIN HEALTH & CVS HEALTH

If you or a covered family member has or is at risk of developing diabetes, you can choose between two programs to help you live a healthier life: Twin Health or Transform Diabetes Care from CVS Health.

- **Twin Health** uses digital technology to deliver precise, individualized guidance and heal your underlying cause of type 2 diabetes and prediabetes.
- **Transform Diabetes Care** can help you control your type 1 or type 2 diabetes and stay on track with your prescribed treatment plan.

Weight Loss Support

FROM TWIN HEALTH & WONDR

You have two unique programs designed to help you lose weight and live a healthier life: Twin Health and Wondr Health.

- **Twin Health** combines a mobile app, technology and the support of a medical team to help you understand how your body works and what it needs to achieve sustainable weight loss.
- **Wondr** is a digital well-being program that teaches clinically proven, healthy habits that lead to less stress, better sleep, weight loss and more.

Private Health Management

Private Health Management (PHM) helps you and your family navigate serious or complex health conditions. Working alongside your doctors, PHM provides expert guidance and support to help you get the best possible care.

Member Rewards from BCBSIL

Shop and earn cash rewards when you select quality, reward-eligible providers for procedures and services like scans, colonoscopies, surgeries and more. Member Rewards is available with all four National Medical Program options, including Copay Edge.

Additional Health Resources

NOT AVAILABLE WITH COPAY EDGE

AccessHope

If you or a covered family member is diagnosed with cancer, AccessHope connects you and your treating oncologist with cancer specialists from leading academic cancer centers, providing expert insights to help inform treatment decisions and care plans.

Health Advocacy Solutions

Your RRD medical coverage through BCBSIL includes support from a health advocate who can help you get the most from your benefits.

SUPPLEMENTAL HEALTH CARE BENEFITS

Supplemental health care benefits can complement your RRD medical coverage by providing cash benefits if you or a covered family member gets sick or injured.

You may elect additional insurance protection from MetLife during Annual Enrollment. These benefits are entirely optional and are 100% employee paid. You pay for them through payroll deductions on an after-tax basis.

Accident Insurance

You receive a lump-sum payment when you or a covered family member suffers a covered injury or undergoes covered testing, medical services or treatment. This benefit includes coverage for on- and off-the-job accidents. There are more than 150 covered conditions associated with an accident that could trigger benefits, including various injuries, hospitalization, nursing care, medical services and treatments. Payments are made directly to you and can be used any way you see fit.

For more information:

Visit **myRRDbenefits.com**, review the *Supplemental & Voluntary Benefits Guide* and watch your mail for additional details from MetLife. View your personalized premiums on **rrd.bswift.com**.

For plan questions:

Visit **metlife.com/mybenefits** or call **1-800-GETMET8 (1-800-438-6388)**.

For general information and questions about eligibility:

Call the RRD Benefits Center at **1-877-RRD-4BEN (1-877-773-4236)**.

Critical Illness Insurance

You receive a lump-sum payment of $10,000, $20,000 or $30,000 if you or a covered family member is diagnosed with a serious illness such as cancer, heart attack, stroke, benign brain tumor, coma, paralysis of two or more limbs, ALS, multiple sclerosis, muscular dystrophy, advanced Parkinson's disease, childhood cerebral palsy, cystic fibrosis, type 1 diabetes and skin cancer. The maximum amount you can receive through your Critical Illness Insurance plan is called the Total Benefit Amount and is five times your Benefit Amount. This means you can receive multiple benefit payments until you reach the maximum of $50,000, $100,000 or $150,000.

You can also get $50 per calendar year from MetLife when you get a specified screening* for one of the covered medical conditions.

Hospital Indemnity Insurance

If you or a covered family member is hospitalized due to a covered event, you receive a flat amount when you are admitted and a per-day amount for up to a 30-day hospital stay for each covered event. Payment can be used to help pay out-of-pocket costs, such as health insurance deductibles and copays, or any way you see fit.

* Covered screenings include: biopsies for cancer, blood chemistry panel, blood test to determine total cholesterol, blood test to determine triglycerides, bone marrow testing, breast MRI, breast ultrasound, breast sonogram, cancer antigen 15-3 blood test for breast cancer (CA 15-3), cancer antigen 125 blood test for ovarian cancer (CA 125), carcinoembryonic antigen blood test for colon cancer (CEA), carotid doppler, chest x-rays, clinical testicular exam, colonoscopy, complete blood count (CBC), fasting blood glucose test, fasting plasma glucose test, flexible sigmoidoscopy, hearing test, hemoccult stool specimen, hemoglobin A1C, human papillomavirus (HPV) vaccination, lipid panel, mammogram, oral cancer screening, pap smears or thin prep pap test, prostate-specific antigen (PSA) test, serum cholesterol test to determine LDL and HDL levels, serum protein electrophoresis, skin cancer biopsy, skin cancer screening and skin exam.

DENTAL BENEFITS

You have three RRD dental options from Cigna: **Dental PPO**, **Dental PPO Plus**, and **Dental HMO** (in-network coverage only). Use this chart to compare your options. View your personalized premiums on **rrd.bswift.com**.

Find an In-Network Dentist

Cigna Members: Register and log in at **mycigna.com**.

- **Cigna Dental PPO network:** Select *DPPO/EPO* > *Total Cigna DPPO*.
- **Cigna Dental HMO network:** Select *CIGNA DENTAL CARE DHMO* > *Cigna Dental Care Access Plus*.

Not yet a Cigna member?

Visit **cigna.com** > *Find a Doctor* > *Employer or School*. Then enter your ZIP code or search for a dentist by name.

	Cigna Dental PPO		Cigna Dental PPO Plus		Cigna Dental HMO
	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network Only
Annual Deductible	$50	$150	$50	$150	$0
Annual Maximum Non-orthodontia	$1,500 per individual		$2,000 per individual		No annual maximum
Lifetime Orthodontia Maximum	N/A		$2,000 per individual		Limited to one treatment per person, per lifetime; contact Cigna (see **page 33**) for details
Preventive Care Type A	100%		100%		100%
Basic Care Type B	70%		80%		100%
Major Care Type C	50%		50%		60%
Orthodontia Type D	N/A		50%		50%

VISION BENEFITS

You have two vision options: **EyeMed Essential** and **EyeMed Enhanced**. Both provide comprehensive coverage for exams, lenses, frames and contact lenses, as well as discounts on laser vision correction.

Find an Eyemed Provider

Visit **eyemed.com** and click *Find an Eye Doctor*. Choose *Insight Network* from the drop down, and then click *Use My Location* or search by ZIP code.

PLUS Providers

For extra coverage to help you save more money, look for PLUS providers. Prospective members can also call **1-866-299-1358** for assistance.

	EyeMed Essential		EyeMed Enhanced	
	In-Network	Out-of-Network	In-Network	Out-of-Network
Frequency of Service				
Exam	Every 12 months		Every 12 months	
Frames	Every 24 months		Every 12 months	
Lenses	Every 12 months		Every 12 months	
Exams				
Routine Vision Exam	$10 copay ($0 at PLUS providers)	Up to $35 allowance	$0 copay	Up to $35 allowance
Frames				
Standard Frame	$0 copay, 20% off balance over $150 allowance ($200 allowance at PLUS providers)	Up to $75 allowance	$0 copay, 20% off balance over $180 allowance ($230 allowance at PLUS providers)	Up to $90 allowance
Smart Frame	$0 copay; 20% off balance over $200 allowance ($250 allowance at PLUS providers)	Up to $100 allowance	$0 copay; 20% off balance over $230 allowance ($280 allowance at PLUS providers)	Up to $115 allowance
Hearing Frame	$0 copay; 20% off balance over $350 allowance ($400 allowance at PLUS providers)	Up to $175 allowance	$0 copay; 20% off balance over $350 allowance ($400 allowance at PLUS providers)	Up to $175 allowance

	EyeMed Essential		EyeMed Enhanced	
	In-Network	Out-of-Network	In-Network	Out-of-Network
Lenses*				
Single Vision	$20 copay	Up to $25 allowance	$10 copay	Up to $25 allowance
Bifocal		Up to $40 allowance		Up to $40 allowance
Trifocal		Up to $55 allowance		Up to $55 allowance
Lenticular		Up to $55 allowance		Up to $55 allowance
Progressive Standard	$85 copay	Up to $40 allowance		Up to $55 allowance
Progressive Premium Tier I, II, III or IV	**Tier I:** $105 copay	Up to $40 allowance	**Tier I:** $30 copay	Up to $55 allowance
	Tier II: $115 copay		**Tier II:** $40 copay	
	Tier III: $130 copay		**Tier III:** $55 copay	
	Tier IV: $195 copay		**Tier IV:** $185 copay	
Lens Options Anti-Reflective Coating	**Standard:** $45 copay	Up to $5 allowance	**Standard:** $0 copay	Up to $5 allowance
	Tier I: $57 copay		**Tier I:** $12 copay	
	Tier II: $68 copay		**Tier II:** $23 copay	
	Tier III: $85 copay		**Tier III:** $85 copay	
Contacts*				
Disposable	$0 copay, 100% of balance over $150 allowance ($200 allowance at PLUS providers)	Up to $150 allowance	$0 copay, 100% of balance over $170 allowance ($220 allowance at PLUS providers)	Up to $150 allowance
Conventional	$0 copay, 15% off balance over $150 allowance ($200 allowance at PLUS providers)		$0 copay, 15% off balance over $170 allowance ($220 allowance at PLUS providers)	

* Benefit coverage is for either contact lenses or frame lenses, but not both. Visit **eyemed.com** for details.

Eye360

Your coverage also includes Eye360, an enhanced benefit package for members who visit a select group of EyeMed's in-network providers called PLUS providers. Eye360 benefits include $0 eye exams, additional allowances for frames and contact lenses, 40% off additional pairs of glasses, discounts on LASIK surgery and more. Use this chart to compare your options. View premiums on **rrd.bswift.com**.



YOUR WEALTH

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RRD 401(k) SAVINGS PLAN

The RRD 401(k) Savings Plan (also known as the RR Donnelley Savings Plan) helps you save money for your retirement on a tax-advantaged basis. RRD will make a matching contribution to help you grow your retirement account even more.

Enrollment

If you're eligible, you will be automatically enrolled in the Plan when you join RRD, and 5% of your eligible pay will be deducted from your pay on a pre-tax basis. Your contribution will be invested entirely in the target date fund that is most closely aligned with your target retirement date, which assumes you plan to retire at age 65. You may change your investment election at any time at **NetBenefits.com**.

If you make an affirmative election that you don't want to participate in the Plan within 30 days after the date your first automatic contribution was made, you may withdraw all your automatic contributions that were made to the Plan.

Employee Contributions

You may contribute from 1% to 85% of your pay as pre-tax, Roth 401(k) and/or after-tax contributions, all through payroll deductions taken each pay period. The total of your pre-tax, Roth 401(k) and after-tax contributions cannot exceed 85% (or annual IRS limits).

If you're age 50 or older by the end of a given calendar year, you can make additional pre-tax and/or Roth 401(k) catch-up contributions for that year, up to annual IRS limits.

RRD Contributions

If you are eligible, RRD will make matching contributions each payroll period equal to $0.25 for every dollar you contribute to your 401(k), on up to 5% of your pay, as a pre-tax, Roth 401(k) or catch-up contribution. See the Savings Plan Summary Sheet — 401(k) Matching Contributions for details.

Learn more about the RRD 401(k) Savings Plan at **myRRDbenefits.com**, and watch your mail for enrollment information from Fidelity.

Managing Your 401(k) is Easy

Your 401(k) is managed through Fidelity (**NetBenefits.com**), which offers online planning tools, videos and workshops to help you make decisions for your financial future. You also get a lineup of investment options, including target date funds and a self-directed brokerage option. And help from Fidelity's experienced representatives is only a phone call away.



HEALTH SAVINGS ACCOUNT (HSA)

An HSA is a tax-free account that lets you save money to pay for eligible health care expenses now and in the future. You are eligible for an HSA if you enroll in the HSA Value or HSA Advantage medical option (and you don't have any disqualifying medical coverage).

1 Enroll

Your HSA will be automatically opened for you with Fidelity (the HSA custodian) when you elect to contribute to an HSA.

2 Pay for Eligible Expenses Tax Free

You can use your HSA to help pay for eligible health care expenses (including your deductible and coinsurance) now and/or in the future.

3 Contribute Tax Free

You can make tax-free contributions to your HSA, up to IRS limits.

Employee Only:

$4,500

Other Coverage Categories:

$9,000*

Catch-Up Contribution:

$1,000 (If you'll be age 55 or older by the end of 2027 and not enrolled in Medicare)

Get More Details

For more information about eligibility, disqualifying coverage, and opening and using an HSA or Limited Use Health Care FSA, review *Ways to Save & Pay for Care* or **IRS publication 969.**



Invest in Your Future

Your account is in your name and is yours to keep — even if you change Medical Program options, change jobs or retire. Any money left in your HSA at the end of the year carries over for future use, and your money grows tax-free while it's in your account. Plus, you may invest your account balance in a choice of investment options.

* Special HSA contribution limit rules apply if you are married or are covering another adult on your medical plan.
  - Married couples are generally limited to a combined contribution maximum of $9,000 (unless they each have Employee Only coverage).
  - If you are enrolled in Employee plus Domestic Partner coverage and neither of you is considered a tax dependent of the other, you and your Domestic Partner can both contribute up to the family maximum to your own HSAs. That means both of you could contribute up to $9,000 for the 2027 tax year. However, you are not allowed to pay for your Domestic Partner's eligible medical expenses with your HSA. If one partner is a tax dependent of the other partner, and both are covered by a family health plan, then only the partner who is not the tax dependent of the other can open an HSA and only that HSA can be funded. The partners could contribute the family annual maximum to that one HSA, currently $9,000, and the account holder could pay for the tax-dependent Domestic Partner's eligible medical expenses with it, but the tax-dependent partner could not contribute to his or her own separate HSA.
  - Rules similar to the Domestic Partner rules apply to adult children.

FLEXIBLE SPENDING ACCOUNTS (FSAs)

Save money on eligible health care and dependent day care expenses. RRD's FSAs are administered by HealthEquity. To learn more, go to **myRRDbenefits.com** and **irs.gov**, or review *Ways to Save & Pay for Care*.

	Full-Use Health Care FSA[1]	Limited-Use Health Care FSA[2]	Dependent Day Care FSA
How much can I contribute in 2027?	$200 – $3,400	$200 – $3,400	$200 – $7,500 (depending on your federal income tax filing status)[3]
Can I change my contributions during the year?	You cannot change or stop your contributions during the year unless you have a Qualified Status Change event.		
What expenses can I use it for?	Eligible medical, prescription drug, dental and vision expenses	Eligible dental and vision expenses **at any time**, and eligible medical and prescription drug expenses **after** you've met a legally required minimum portion of your Medical Program deductible in 2027 ($1,750 for Employee Only coverage and $3,500 for Employee + Spouse, Employee + Child(ren), and Family coverage). **NOTE:** You can't be reimbursed by both an FSA and an HSA for the same expense.	Eligible dependent day care-related expenses such as day care for your child under age 13, elderly parent or disabled spouse
When are the funds available for use?	The full amount you elect to contribute for the year is immediately available.		Your contributions will be deducted from your paycheck in equal installments on a before-tax basis during the Plan year. You can use funds once they are deposited into your account.
What happens to unused funds at the end of the year?	You lose any money remaining in your FSA at the end of the Plan year. You have until March 31 of the following year to submit claims for services incurred during the current Plan year.		

1. Available if enrolled in Copay Advantage or Copay Edge or waived medical coverage
2. Available if enrolled in HSA Value or HSA Advantage
3. Lower maximums may apply, for example if your tax filing status is Married Filing Separately (in which case it is capped at $3,750), or if your or your spouse's earned income is less than $7,500 (in which case it is capped at your or your spouse's earned income). See the *Ways to Save & Pay for Care* guide on **myRRDbenefits.com** for more information.

PAYTIENT HEALTH PAYMENT ACCOUNT

How It Works with HSA Advantage, HSA Value & Copay Advantage

If you're eligible for RRD benefits, you have Paytient, a no-fee, no-interest health care card you can use to pay out-of-pocket health care expenses, including dental, vision and even veterinary care for your pet. No credit check required.

Your Paytient health care card has a $1,200 limit. When you use Paytient, the doctor's office, hospital or pharmacy gets paid in full at that time. You can pay back money you borrow through payroll deduction or your HSA, FSA or bank account. It's an easy way to pay for care over time. (Note that if you use your card for veterinary expenses, you cannot use your HSA without incurring a penalty or your FSA to pay back money you borrow for such expenses.) You can sign up at any time.

Learn more at **myRRDbenefits.com/paytient**.

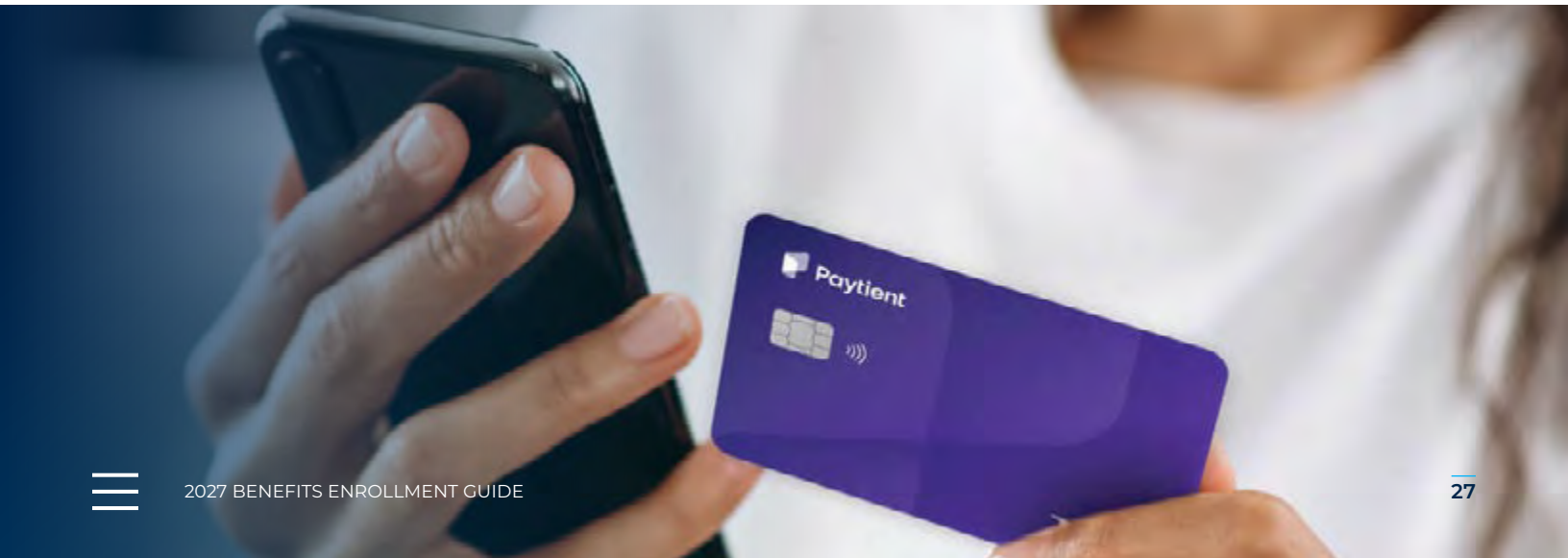
How It Works with Copay Edge

If you enroll in Copay Edge, you'll have the option to receive a health care financing card from Paytient with a $3,000 revolving credit limit ($1,800 higher than the standard Paytient credit limit). Just swipe and pay your copay expenses directly to your health care providers at the time of service.

Paytient pays your Copay Edge providers upfront, while you can create your preferred payment plan on the back end. Payments are processed automatically via payroll deduction or payment method of your choice. You pay $0 in interest and fees.

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.

To receive a Paytient card, answer "yes" to the question on the enrollment website asking whether you would like health care financing when you enroll in Copay Edge as your medical program option. Additional information on how to open your account will be sent to your email address on file. You will also be asked to answer a few questions about your ability to repay funds. You will not be able to elect the special/higher $3,000 financing until the next Annual Enrollment period.



LIFE & ACCIDENT INSURANCE

Life and accident insurance provide important financial protection if something happens to you, your spouse/domestic partner or child(ren).

Important! Designate Your Beneficiaries

Protect your family and your money by making sure your beneficiary designations are up to date on **rrd.bswift.com**.

Employee Life Insurance

Basic employee life insurance provided through Securian is automatic, and RRD pays the full cost of your coverage. If you die, your beneficiary receives one times your annual base pay, up to a maximum benefit of $250,000 in accordance with Plan provisions.

Optional Employee Life Insurance

You may purchase optional employee life insurance from one to 10 times your annual base pay, up to a maximum of $2 million. If you die, the Program pays a benefit to your designated beneficiary in accordance with Plan provisions. Your premium for coverage is based on your age, smoker status and coverage amount. As your coverage amount or age increases, so do your premiums.

Optional Spouse/Domestic Partner & Child Life Insurance

You may purchase spouse/domestic partner and child life insurance coverage for your eligible dependents. If your covered eligible spouse, domestic partner or child(ren) dies, the Program will pay the life insurance benefit in accordance with Plan provisions, up to a maximum of $250,000. You cannot cover another employee as a spouse/domestic partner or child under the Life and Accident Insurance Program. The same dependent cannot be covered by more than one RRD employee (e.g., two parents who are both RRD employees cannot both cover the same child(ren) under the Plan provisions; only one employee may cover the child(ren)).

If you and the child's other parent are both employees of RRD and if a covered dependent child dies, this policy will only pay the death benefit once and to one parent. See the applicable Certificate of Insurance (**myRRDbenefits.com/life-add-insurance**) for more information.

Optional AD&D Insurance

You may purchase optional AD&D insurance for yourself and your family. The Program pays a benefit of one to 10 times your annual base pay, up to $2 million for yourself, in accordance with Plan provisions, for accidental death and certain other losses. The amount a beneficiary would receive on claim approval differs for an employee and covered eligible dependents:

- **If you enroll for spouse/domestic partner coverage**, the benefit amount for an eligible spouse/domestic partner is 60% of the employee's amount (up to $750,000).
- **If you enroll for child(ren) coverage**, the amount for an eligible dependent child is 25% of the employee's amount (up to $150,000).

To learn more, review the **SPD and any related SMMs**.
To view your cost for optional life and accident insurance, log in to **rrd.bswift.com**.

Providing Evidence of Insurability (EOI)

- If you elect or increase optional employee life insurance, you must provide EOI.
- If your spouse/domestic partner is newly eligible for life insurance, EOI is required for coverage amounts over $25,000. Current spouse/domestic partner participants and those who previously waived coverage must provide EOI for increased coverage amounts.
- EOI is not required for optional AD&D insurance or optional child life insurance.

DISABILITY BENEFITS

Disability coverage provides income protection if you are unable to work due to a covered illness or injury.

Short-Term Disability (STD)

RRD provides STD coverage at no cost to you. If you're an hourly employee, your coverage pays a weekly benefit of 50% of your pre-disability earnings for up to 26 weeks. If you're a salaried employee, your coverage pays 100% of your pre-disability earnings for the first three weeks of disability and 50% for up to 23 additional weeks.

Long-Term Disability (LTD)

For additional income protection, LTD is offered as an optional benefit. Premiums are paid via payroll deduction on an after-tax basis. You must elect this benefit if you want coverage.

Coverage provides a monthly benefit of 50% of your earnings, up to $10,000 a month. Monthly LTD benefits continue until the earlier of age 65 or the date you are no longer disabled according to the Program. If you become disabled after age 60, your LTD benefits duration schedule may vary. LTD benefits end after 24 months for mental health and substance use disabilities. For details about STD and LTD, refer to the **SPDs**.





YOUR LIFE

VOLUNTARY BENEFITS

Customize and enhance your benefits to fit your needs.

RRD has arranged to facilitate payroll deductions to help you pay for certain non-RRD benefit programs. Learn more about all the voluntary benefits (Allstate Identity Protection, commuter benefits, auto and home insurance, pet insurance, pet wellness and Purchasing Power) available to you at:

- **myRRDbenefits.com/voluntary-benefits**
- **myRRDbenefits.com/rrdperks**

LEGAL BENEFITS

Get convenient and affordable access to a qualified network of attorneys for everyday personal legal matters. Coverage will be in effect from the start of your enrollment through December 31, 2027. You can only enroll in this benefit when you first become eligible or during Annual Enrollment.

SUPPORTLINC EMPLOYEE ASSISTANCE PROGRAM

When life throws you a curve ball, it's good to know you have resources to support you.

You and your family have access to confidential, professional referrals and up to five sessions of face-to-face counseling for a variety of concerns, such as family/marital problems and relationship issues, anxiety, depression, grief and loss, substance abuse, anger management, work-related pressures and stress.

SupportLinc can also provide referrals and consultation to expert resources for legal and financial assistance, as well as referrals for everyday family issues like dependent care, auto repair, pet care, home improvement and more.



YOUR CONTACTS

rrd.bswift.com

RRD Benefits Center
1-877-RRD-4BEN (1-877-773-4236),
Mon. – Fri., 7 a.m. – 7 p.m. CT

myRRDbenefits.com

News and information about your benefits, important plan documents, links to your benefits vendors and more!

MEDICAL & PRESCRIPTION DRUG

Blue Cross and Blue Shield of Illinois (BCBSIL)
bcbsil.com/rrd
1-800-537-9765, Mon. – Fri., 7 a.m. – 7 p.m. CT

CVS Caremark (Prescription Drug Benefits)
caremark.com
1-866-273-8402, 24/7

Twin Health (Diabetes & Weight Management)
partner.twinhealth.com/rr-donnelley

Transform Diabetes Care
caremark.com
1-800-348-5238

Teladoc Health (Hypertension Management)
teladochealth.com/expert-care/condition-management/hypertension (registration code: RRD)
1-800-Teladoc (1-800-835-2362)

PrudentRx
1-800-578-4403, Mon. – Fri. 7 a.m. – 7 p.m. CT

Go Wellbeing
bcbsil.com/rrd

Wondr Health (Weight Management)
wondrhealth.com/RRD

AccessHope (Cancer Support)
1-800-537-9765

Carrum Health
carrum.me/rrd
1-888-855-7806, 8 a.m. – 7 p.m. CT

SleepCharge
sleepcharge.com/rrd
1-877-615-7257

WellTheory
welltheory.com/partner/rrd
760-288-8258

OneImaging
join.oneimaging.com/RRD
For Members: Call or text 1-833-619-0837, or email **help@oneimaging.com**

Maven
mavenclinic.com

DENTAL (CIGNA)

mycigna.com
1-800-656-1691, 24/7

VISION (EYEMED)

eyemed.com
1-866-723-0514,
Mon. – Sat., 6:30 a.m. – 10 p.m. CT
Sun., 10 a.m. – 7 p.m. CT

SUPPLEMENTAL HEALTH CARE (METLIFE)

metlife.com/mybenefits

Plan questions:
1-800-GETMET8 (1-800-438-6388)
Mon. – Fri., 7 a.m. – 10 p.m. CT

Eligibility, deduction & general information:
1-877-RRD-4BEN (1-877-773-4236)

HSA (FIDELITY)

NetBenefits.com
1-800-544-3716, Mon. – Fri., 7:30 a.m. – 7 p.m. CT

FSAS (HEALTHEQUITY)

healthequity.com
1-866-346-5800, 24/7

HEALTH CARE PAYMENT CARD (PAYTIENT)

paytient.com/rrd
1-866-345-9591, 8 a.m. – 8 p.m. CT

EMPLOYEE ASSISTANCE PROGRAM (EAP) (SUPPORTLINC)

supportlinc.com (username: rrd)
1-888-881-LINC (1-888-881-5462), 24/7

LIFE & ACCIDENT INSURANCE (SECURIAN)

securian.com/rrd-life-insurance
1-866-293-6047, Mon. – Fri., 7 a.m. – 6 p.m. CT

DISABILITY (LINCOLN FINANCIAL)

lincolnfinancial.com (company code: RRDONNELLEY)
1-800-331-4914, Mon. – Fri., 7 a.m. – 9 p.m. CT

VOLUNTARY BENEFITS

MetLife Legal Plans
metlife.com/insurance/legal-plans
1-800-821-6400, 7 a.m. – 7 p.m. CT

RRD Perks
(Auto, Home & Pet Insurance, Wagmo)
rrd.corestream.com
312-757-1908

Allstate Identity Protection
1-800-789-2720

RRD SAVINGS PLAN (FIDELITY)

NetBenefits.com
1-800-835-5095, Mon. – Fri., 7 a.m. – 9 p.m. CT

ENDNOTES

National Medical Program Options

1. Routine adult physicals and gynecological exams, well-child care, routine vision or hearing screenings, related testing (includes routine pap tests, cholesterol tests, urinalysis, etc.), routine colonoscopies (outpatient/office), and immunizations.
2. Copay waived if admitted. Balance billing is not allowed for out-of-network emergency care. No charge for COVID treatment.
3. Through CVS Caremark. There is no out-of-network coverage for prescription drugs.
4. Certain specialty medications may be eligible for additional benefits through the PrudentRx Program so your cost-sharing is reduced to $0 (after your deductible if you enroll in an HSA-eligible option). See the list of specialty medications covered under the PrudentRx Program at **prudentrx.com/prudentes**. If you opt out of the PrudentRx Program, you will pay 30% coinsurance for specialty medications that are covered by the PrudentRx Program. If your specialty medication is not covered by the PrudentRx Program, then you will be responsible for a $210 copay if enrolled in Copay Edge or $150 copay if enrolled in Copay Advantage. The Plan and the PrudentRx Program categorize specialty medications as either "essential health benefits" or "non-essential health benefits." Employee cost-sharing for "essential health benefits" counts toward the Plan out-of-pocket maximum but does not count toward the Plan deductible. On the other hand, employee cost-sharing for "non-essential health benefits" does not count toward either the Plan deductible or out-of-pocket maximum. Also, even if you reach your out-of-pocket maximum, you will still be responsible for your cost-sharing amount for specialty medications that are "non-essential health benefits." Specialty medications that have been deemed "non-essential health benefits" are denoted with a "1" on the list of PrudentRx specialty medications. If you have any questions, contact PrudentRx at **1-800-578-4403**.
5. For out-of-network coverage, the Plan only pays benefits based on charges up to the maximum reimbursable expense (sometimes referred to as a "usual and customary charge (U&C)" or "reasonable and customary charge (R&C)"). You will be responsible for paying your out-of-network provider's billed amounts that exceed the maximum reimbursable expense; this is called balance billing. Balance billing payments don't count toward and aren't subject to the Plan's deductible or out-of-pocket maximum. This can result in significant additional cost to you.
6. Combined in- and out-of-network.
7. Certain specialty medications may be eligible for additional benefits through the PrudentRx Program so your cost-sharing is reduced to $0 (after your deductible if you enroll in an HSA-eligible option). See the list of specialty medications covered under the PrudentRx Program at **prudentrx.com/prudentes**. If you opt out of the PrudentRx Program, you will pay 30% coinsurance for specialty medications that are covered by the PrudentRx Program. If your specialty medication is not covered by the PrudentRx Program, then you also will be responsible for 30% coinsurance. The Plan and the PrudentRx Program categorize specialty medications as either "essential health benefits" or "non-essential health benefits." Employee cost-sharing for "essential health benefits" counts toward the Plan out-of-pocket maximum but does not count toward the Plan deductible. On the other hand, employee cost-sharing for "non-essential health benefits" does not count toward either the Plan deductible or out-of-pocket maximum. Also, even if you reach your out-of-pocket maximum, you will still be responsible for your cost sharing amount for specialty medications that are "non-essential health benefits." Specialty medications that have been deemed "non-essential health benefits" are denoted with a "1" on the list of PrudentRx specialty medications. If you have any questions, contact PrudentRx at **1-800-578-4403**.
8. If admitted, inpatient stay applies to deductible and out-of-pocket maximum.

LEGAL NOTICES

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 Medical 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 2027 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 Plan (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), prior SMMs, and Certificates of Insurance 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.

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