Important Notices and Disclosures

Contents

Special Enrollment Period for Group Health Coverage

If you decline health coverage (medical, dental, vision and/or Health Care FSA) 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 dependents' 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 Donnelley Financial Group Benefits Plan (the "Plan"); and
- 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. You must enroll within 30 days after such event (or 60 days following the birth of a child). To request special enrollment or if you have questions regarding special enrollment rights, please contact the Benefits Center at **1-877-308-1464.**

For a full list of qualifying life events, go to **dfinsolutionsBenefits.com** to view your Summary Plan Description (SPD) and any related Summary of Material Modifications (SMM).

Newborns' and Mothers' Health Protection Act

The Plan does not restrict benefits for any hospital stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery or less than 96 hours following a cesarean section. Your provider is not required to obtain Plan approval for prescribing a length of stay within those time frames. However, you, your doctor or your newborn's attending physician may agree to a shorter length of stay. You may also need to obtain precertification to use certain providers or facilities. The physician will need to obtain approval in advance from the Plan for any stay beyond 48 or 96 hours to avoid any reduction in benefits. The Plan may not set the level of benefits or out-of-pocket costs so that any later portion of the 48-hour (or 96-hour) stay is treated in a manner less favorable to the mother or newborn than any earlier portion of the stay.

Women's Health and 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;
- Prosthesis; and
- Treatment of physical complications of the mastectomy, including lymphedema.

Such coverage is subject to all Plan provisions, limitations and requirements, including any annual deductible and coinsurance limitations, outlined in your SPD and any related SMMs. If you would like more information, visit the Plan's website at **dfinsolutionsBenefits.com** or call the Benefits Center at **1-877-308-1464.**

Important Information About Your DFIN Coverage and Medicare

Why Are You Receiving This Notice?

You are receiving this Notice about the coordination of Medicare and DFIN medical coverage under the Plan to assist you, your spouse or domestic partner (if applicable), and your dependents (all referred to in this Notice as "you") in making enrollment decisions under the medical program of the Plan and Medicare (if available).

Federal law determines how benefits are coordinated when a person has employer sponsored medical coverage and is also entitled to Medicare. For example, sometimes DFIN's coverage is primarily responsible for medical claims and Medicare will pay certain expenses not paid by DFIN's coverage (i.e., Medicare is secondary). Other times, Medicare will be primarily responsible for paying medical claims and DFIN's medical coverage will be secondary.

Medicare eligibility is based on any of the following factors: age 65 or older, disability, or end-stage renal disease (i.e., permanent kidney failure). NOTE: In some instances, COBRA coverage could be your primary insurance coverage if you are eligible for Medicare because of this disease.

If you are eligible for Medicare because of your age or disability and you are covered as an active employee...

DFIN's medical coverage will be your primary coverage and pays up to the limits of its coverage for so long as you are a covered active employee. Medicare is the secondary payer and only pays if there are costs the company's medical coverage didn't cover, but may not pay all the uncovered costs.

If you are eligible for Medicare because of end-stage renal disease (i.e., permanent kidney failure)...

DFIN's medical coverage will be your primary coverage for the first 30 months of Medicare eligibility or entitlement. After 30 months, Medicare becomes your primary coverage and DFIN's coverage will be secondary.

If DFIN's medical coverage becomes secondary for a person that became entitled to Medicare, it will not become secondary for other family members covered by the DFIN plan. For example, if John and his wife both have DFIN's medical coverage and John later becomes eligible for Medicare because he is diagnosed with end stage renal disease, DFIN's coverage will become secondary for John after 30 months, but not his wife if she does not also have end stage renal disease.

IMPORTANT: *Carefully consider whether Medicare eligibility or entitlement could be a factor for you. If so, be sure to take the rules discussed above into account when making decisions to elect coverage and/or enroll in Medicare. Please contact the DFIN Benefits Center if you have any questions.*

What Action Do You Need To Take?

- **Carefully review this Notice.** If you or your eligible dependents fall into any of the above categories, contact your local Medicare office to determine which insurer is primary.
- **Carefully review the Benefits Highlights Guide included in this packet.** Share this information with anyone who helps you make health care and financial decisions.
- **Determine if you need to enroll in Medicare or change your DFIN coverage.** If you have questions, please call the DFIN Benefits Center at **1-877-308-1464** Monday – Friday, 7:30 a.m. – 6:00 p.m. Central Time.
- **You can take action to enroll or elect NO COVERAGE by calling the DFIN Benefits Center** at **1-877-308-1464** Monday – Friday, 7:30 a.m. – 6:00 p.m. Central Time or by going to the benefits portal at mydfinbenefits.com.
- **Be sure to take action by electing NO COVERAGE or enrolling by the enrollment deadline.** ***If you don't take action*****,** you will default to the coverage specified in the Benefits Highlights Guide included with this document.
- **A confirmation of your enrollment will be mailed to you**. It is important to keep your confirmation statement if questions should ever arise about your elections.
- **If you have any questions or need more information,** please call the DFIN Benefits Center.

Important Notice from Donnelley Financial, LLC About Your Prescription Drug Coverage and Medicare

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage under the Donnelley Financial Group Benefits Plan and about your options under Medicare's prescription drug coverage. This information can help you decide whether or not you want to join a Medicare drug plan. If you are considering joining, you should compare your current coverage, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare prescription drug coverage in your area. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

There are two important things you need to know about your current coverage and Medicare's prescription drug coverage:

1. Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.

2. Donnelley Financial, LLC has determined that the prescription drug coverage offered by the Group Benefits Plan is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

When Can You Join A Medicare Drug Plan?

You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15th to December 7th.

However, if you lose your current creditable prescription drug coverage, through no fault of your own, you will also be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan.

What Happens To Your Current Coverage If You Decide to Join A Medicare Drug Plan?

If you decide to join a Medicare drug plan, your current Group Benefits Plan coverage will be affected. If you remain enrolled in medical and prescription drug coverage under the Group Benefits Plan, then your Group Benefits Plan coverage will become secondary to Medicare. You may also decide to drop your Group Benefits Plan coverage after joining a Medicare drug plan.

If you do decide to join a Medicare drug plan and drop your current Group Benefits Plan coverage, be aware that you and your dependents will not be able to get this coverage back. You and your dependents may be eligible to elect COBRA continuation coverage under the Group Benefits Plan at the COBRA premium rate then in effect (which may be as high as 102% of the full, unsubsidized cost of active employee coverage).

When Will You Pay A Higher Premium (Penalty) To Join A Medicare Drug Plan?

You should also know that if you drop or lose your current coverage with Donnelley Financial, LLC and don't join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.

If you go 63 continuous days or longer without creditable prescription drug coverage, your monthly premium may go up by at least 1% of the Medicare base beneficiary premium per month for every month that you did not have that coverage. For example, if you go nineteen months without creditable coverage, your premium may consistently be at least 19% higher than the Medicare base beneficiary premium. You may have to pay this higher premium (a penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to join.

For More Information About This Notice Or Your Current Prescription Drug Coverage...

For further information please contact the Benefits Center at 1-877-308-1464. **NOTE**: You'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage through Donnelley Financial, LLC changes. You also may request a copy of this notice at any time.

For More Information About Your Options Under Medicare Prescription Drug Coverage...

More detailed information about Medicare plans that offer prescription drug coverage is in the "Medicare & You" handbook. You'll get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare drug plans.

For more information about Medicare prescription drug coverage:

- Visit www.medicare.gov
- Call your State Health Insurance Assistance Program (see the inside back cover of your copy of the "Medicare & You" handbook for their telephone number) for personalized help
- Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

If you have limited income and resources, extra help paying for Medicare prescription drug coverage is available. For information about this extra help, visit Social Security on the web at www.socialsecurity.gov, or call them at 1-800-772-1213 (TTY 1-800-325-0778).

Remember: Keep this Creditable Coverage notice. If you decide to join one of the Medicare drug plans, you may be required to provide a copy of this notice when you join to show whether or not you have maintained creditable coverage and, therefore, whether or not you are required to pay a higher premium (a penalty).

Notice of Privacy Practices Under HIPAA

This Notice of Privacy Practices describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

I. The Plan's Legal Duty to Safeguard Your Protected Health Information

This Notice of Privacy Practices (this "Notice") describes the legal obligations of the Plan (as defined below) and your legal rights regarding your protected health information ("PHI") held by the Plan under the Health Insurance Portability and Accountability Act of 1996, as amended and the Health Information Technology for Economic and Clinical Health Act, as amended (together, "HIPAA"). Generally, PHI is health information, including demographic information, collected from you or created or received by a health care provider, a health care clearinghouse, a health plan, or Donnelley Financial, LLC (the "Company") on behalf of a Plan, from which it is possible to individually identify you and that relates to:

- Your past, present or future physical or mental health or condition;
- The provision of health care to you; or
- The past, present or future payment for the provision of health care to you.

This Notice describes how your PHI may be used or disclosed to carry out treatment, payment or health care operations, or for any other purposes that are permitted or required by law. We are required to provide this Notice to you pursuant to HIPAA.

If you have questions about this Notice or about our privacy practices, please contact the HIPAA Privacy Official, VP, Benefits at **312-326-8000.**

For purposes of this Notice, the "Plan" means any of the following:

- The Medical and Prescription Drug Programs, the Dental Benefit Program, the Vision Care Program, and any health-related services provided by the RealLife Resources Program (EAP) of the Donnelley Financial Group Benefits Plan.
- The Health Care Spending Program of the Donnelley Financial Flexible Benefits Plan.

In addition, any PHI created or received by a Plan, where the benefits are provided by an insurance company or health maintenance organization, will be subject to the notice of privacy practices delivered to you by that insurance company or health maintenance organization.

II. Effective Date

This Notice is effective as of July 1, 2016.

III. Our Responsibilities

We are required by law to:

- Maintain the privacy of your PHI;
- Provide you with certain rights with respect to your PHI;
- Provide you with a copy of this Notice of our legal duties and privacy practices with respect to your PHI; and
- Follow the terms of the Notice that is currently in effect.

We reserve the right to change the terms of this Notice and to make new provisions regarding your PHI that we maintain, as allowed or required by law. If we make any material change to this Notice, we will provide you with a copy of the revised Notice posted prominently on our website and included with the next annual open enrollment materials.

IV. How We May Use and Disclose Your PHI

Under the law, we may use or disclose your PHI under certain circumstances without your permission. The following categories describe the different ways that we may use and disclose your PHI. For each category of uses or disclosures, we will explain what we mean. We have also provided some examples. Not every use or disclosure in a category will be listed; however, all of the ways we are permitted to use and disclose information will fall within one of the categories.

A. **For Treatment.** We may use or disclose your PHI to facilitate medical treatment or services by providers. We may disclose medical information about you to providers, including doctors, nurses or other hospital personnel who are involved in taking care of you. For example, prior to providing a health service to you, your doctor may ask the Plan for information concerning whether and when the service was previously provided to you.

B. **For Payment.** We may use or disclose your PHI to determine your eligibility for Plan benefits (including coordination of benefits or the determination of cost sharing amounts), and adjudication or subrogation of health benefit claims; or to facilitate billing, claims management, collection activities, obtaining payment under a contract for reinsurance (including stop-loss insurance and excess of loss insurance), and related health care data processing. For example, the Plan will use your PHI in reviewing a claim submitted by you or your doctor to determine payment. It may also disclose your PHI to another carrier to determine which carrier is primary or to otherwise determine cost sharing between the Plan and the other carrier.

C. **For Health Care Operations.** We may use or disclose your PHI for other Plan operations. This may include conducting quality assessment and improvement activities, as well as population based activities relating to improving health or reducing health care costs, protocol development, case management and care coordination, contacting health care providers and patients with information about treatment alternatives and performing related functions that do not include treatment or performing underwriting, premium rating, and other activities

relating to the creation, renewal or replacement of health benefits, and ceding, securing, or placing a contract for reinsurance of risk relating to claims for health care (including stop-loss and excess of loss insurance). However, we will not use your genetic information for underwriting purposes.

D. **For Treatment Alternatives or Health-Related Benefits and Services.** We may use and disclose your PHI to send you information about treatment alternatives or other health-related benefits and services that might be of interest to you.

E. **To Business Associates.** We may contract with individuals or entities known as "Business Associates" to perform various functions on our behalf or to provide certain types of services. In order to provide these functions or services, Business Associates will receive, create, maintain transmit, use and/or disclose your PHI, but only after they agree in writing with us to implement appropriate safeguards regarding your PHI. For example, we may disclose your PHI to a Business Associate to process your claims for Plan Benefits or to provide other support services, but only after the Business Associate enters into a Business Associate contract with us.

F. **As Required by Law.** We will disclose your PHI when required to do so by federal, state or local law. For example, we may disclose your PHI when required by national security laws or public health disclosure laws.

G. **To Avert a Serious Threat to Health or Safety.** We may use and disclose your PHI when necessary to prevent a serious threat to your health and safety, or the health and safety of the public or another person. Any disclosure, however, would only be to someone able to help prevent the threat. For example, we may disclose your PHI in a proceeding regarding the licensure of a physician.

H. **To the Plan Sponsor.** The Company may ask the Plan for your PHI for purposes of administering the Plan. The Plan will disclose your PHI to certain employees of the Company only as necessary to perform plan administration functions or as otherwise required under HIPAA, unless you have authorized further disclosures, unless it is prohibited by law from doing so. The Plan will not disclose your PHI to the Company for the purpose of employment-related actions or decisions or in connection with any other benefit or employee benefit plan of the Company without your specific authorization.

V. Special Situations Where We May Use and Disclose Your PHI

In addition to the reasons described in Section IV above, the following categories describe other possible ways we may use and disclose your PHI without your specific authorization. For each category of special uses or disclosures, we will explain what we mean and present one or more examples. Not every use or disclosure in a category will be listed; however, all of the ways we are permitted to use and disclose information will fall within one of the categories.

A. **Organ and Tissue Donation.** If you are an organ donor, we may release your PHI after your death to organizations that handle organ procurement or organ, eye, or tissue transplantation or to an organ donation bank, as necessary to facilitate organ or tissue donation and transplantation.

B. **Military.** If you are a member of the armed forces, we may release your PHI as required by military command authorities. We may also release PHI about foreign military personnel to the appropriate foreign military authority.

C. **Workers' Compensation.** We may release your PHI for workers' compensation or similar programs, but only as authorized by, and to the extent necessary to comply with, laws relating to workers' compensation and similar programs that provide benefits for work-related injuries or illness.

D. **Public Health Risks.** We may disclose your PHI for public health activities. These activities may include, the prevention or control of disease, injury or disability; to report births or deaths, to report child abuse or neglect or to report reactions to medications or problems with products.

E. **Health Oversight Activities.** We may disclose your PHI to a health oversight agency for activities authorized by law. These oversight activities include, for example, audits, investigations, inspections and licensure.

F. **Lawsuits and Disputes.** If you are involved in a lawsuit or dispute, we may disclose your PHI in response to a court or administrative order. We may disclose your PHI in response to a subpoena, discovery request, or other lawful process by someone involved in a legal dispute, but only if efforts have been made to tell you about the request or to obtain a court or administrative order protecting the information requested.

G. **Law Enforcement.** We may disclose your PHI if asked to do so by a law enforcement official in response to a court order, to identify or locate a suspect, or if such information is related to criminal conduct.

H. **Coroners and Medical Examiners.** We may release PHI to a coroner or medical examiner. This may be necessary to identify a deceased person or to determine a cause of death.

I. **National Security and Intelligence Activities.** We may release your PHI to authorized federal officials for intelligence, counterintelligence and other national security activities authorized by law.

J. **Inmates.** If you are an inmate of a correctional institution or are in the custody of a law enforcement official, we may disclose your PHI to the correctional institution or law enforcement official if necessary for the institution to provide you with health care; to protect your health and safety or the health and safety of others; or for the safety and security of the correctional institution.

K. **Research.** We may disclose your PHI to researchers when your individual identifiers have been removed or when an institutional review board or privacy board has reviewed the

research proposal and established protocols to ensure the privacy of the requested information, and approves the research.

VI. Required Disclosures of Your PHI

The following is a description of disclosures of your PHI we are required to make:

A. **Government Audits.** We are required to disclose your PHI to the Secretary of the United States Department of Health and Human Services when the Secretary is investigating or determining our compliance with HIPAA's Privacy Rule.

B. **Disclosures to You.** When you request, we are required to disclose to you the portion of your PHI that contains medical records, billing records, and any other records used to make decisions regarding your health care benefits. We are also required, when requested, to provide you with an accounting of most disclosures of your PHI if the disclosure was for reasons other than for payment, treatment or health care operations, and if the PHI was not disclosed pursuant to your individual authorization.

VII. Other Disclosures of Your PHI

A. **Personal Representatives.** We will disclose your PHI to individuals authorized by you, or to an individual designated as your personal representative, so long as you provide us with a written notice/authorization and any supporting documents. However, under HIPAA's Privacy Rule, we do NOT have to disclose information to your personal representative if we have a reasonable belief that:

- You have been, or may be, subjected to domestic violence, abuse, or neglect by such person; or
- Treating such person as your personal representative could endanger you; or
- In the exercise or professional judgment, it is not in your best interest to treat the person as your personal representative.

B. **Spouses, Covered Dependents and Other Family Members.** With only limited exceptions, we will send all mail to an employee of the Company. This includes mail relating to the employee's spouse, and dependents covered under the Plan, and includes mail with information on the use of Plan benefits by an employee's spouse and other covered dependents and information on the denial of any Plan benefits to an employee's spouse and other covered dependents. However, if you request restrictions or confidential communications (see Section VIII below), and if we have agreed to the request, we will send mail as provided by such request.

C. **Authorizations.** Other uses or disclosures of your PHI not described above will only be made with your written authorization. For example, in general and subject to specific conditions, we will not use or disclose your psychiatric notes; we will not use or disclose your PHI for marketing; and we will not sell your PHI, unless you give us a written authorization. You may revoke written authorizations at any time, so long as the revocation is in writing. Once we receive your written revocation, it will only be effective for future uses and disclosures. It will not be effective for any

information that may have been used or disclosed in reliance upon the written authorization and prior to receiving your written revocation.

VIII. Your Rights Regarding Your PHI

You have the following rights described below with respect to your PHI:

A. **The Right to Inspect and Copy.** You have the right to inspect and copy certain PHI that may be used to make decisions about your Plan benefits. If the information you request is maintained electronically, and you request an electronic copy, we will provide a copy in the electronic form and format you request, if the information can be readily produced in that form and format. If the information cannot be readily produced in that form and format, we will work with you to come to an agreement on form and format. If we cannot agree on an electronic form and format, we will provide you with a paper copy.

To inspect and copy your PHI, you must submit your request in writing to the HIPAA Privacy Official, 35 W. Wacker Drive, Chicago, IL 60601. If you request a copy of the information, we may charge a reasonable fee for the costs of copying, mailing or other supplies associated with your request.

We may deny your request to inspect and copy in certain very limited circumstances. If you are denied access to your PHI, you may request that such denial be reviewed by submitting a written request to the HIPAA Privacy Official at the same address.

B. **The Right to Amend Your PHI.** If you believe that there is a mistake in your PHI or that a piece of important information is missing, you may ask us to correct the existing information or to add the missing information. You have the right to ask for an amendment as long as the information is kept by or for the Plan.

To request an amendment, you must make the request in writing and submit it to the HIPAA Privacy Official, 35 W. Wacker Drive, Chicago, IL 60601. In addition, you must provide a reason supporting your request for an amendment.

We may deny your request for an amendment if it is not in writing or does not include a reason to support the request. In addition, we may deny your request if you ask us to amend information that:

- Is not part of the medical information kept by or for the Plan;
- Was not created by us, unless the person or entity that created the information is no longer available to make the amendment;
- Is not part of the information that you would be permitted to inspect and copy; or
- Is already complete and accurate.

If we deny your request, you have the right to file a statement of disagreement with us and any future disclosures of the disputed information will include your statement.

C. **The Right to an Accounting of Disclosures of Your PHI.** You have the right to get a list of instances in which the Plan has disclosed your PHI (hereinafter sometimes referred to as an "accounting"). The list will not include uses or disclosures: (i) made to you, (ii) made for treatment, payment, or health care operations, (iii) made pursuant to an authorization, (iv) made to friends or family in your presence or because of an emergency; (v) made for national security purposes; or (vi) which are incidental to otherwise permissible disclosures.

To request this list or accounting of disclosures, you must submit your request in writing to the HIPAA Privacy Official, 35 W. Wacker Drive, Chicago, IL 60601. Your request must state the time period you want the accounting to cover, which may not be longer than six years before the date of the request. Your request should indicate in what form you want the list (for example, paper or electronic). The first list you request within a 12-month period will be provided free of charge. For additional lists, we may charge you for the costs of providing the list.

We will notify you of the cost involved and you may wish to withdraw or modify your request at that time before any costs are incurred.

D. **The Right to Request Limits on Uses and Disclosures of Your PHI.** You have the right to request a restriction or limitation on how we use and disclose your PHI for treatment, payment and health care operations. You also have the right to request a limit on your PHI that we disclose to someone who is involved in your care or payment for your care.

Except as provided in the next paragraph, we are not required to agree to your request. However, if we do agree to the request, we will honor the restriction until you revoke it or we notify you.

We will comply with any restriction request if (i) except as otherwise required by law, the disclosure is to a health plan for purposes of carrying out payment or health care operations (and is not for purposes of carrying out treatment); and (ii) the PHI pertains solely to a health care item or service for which the health care provider involved has been paid in full by you or another person.

To request restrictions, you must make your request in writing to the HIPAA Privacy Official, 35 W. Wacker Drive, Chicago, IL 60601. In your request you must tell us (1) what information you wish to limit; (2) whether you want to limit our use, disclosure or both; and (3) to whom you want the limits to apply.

E. **Right to Request Confidential Communications.** You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that we only contact you at work or by mail.

To request confidential communications, you must make your request in writing to the HIPAA Privacy Official, 35 W. Wacker Drive, Chicago, IL 60601. We will not ask you the reason for your request. Your request must specify how or where you wish to be contacted. We will accommodate all reasonable requests.

F. **Right to Be Notified of a Breach.** You have the right to be notified in the event that we (or a Business Associate) discover a breach of your unsecured PHI.

G. **Right to a Paper Copy of this Notice.** You have the right to a paper copy of this Notice. You may ask us to give you a copy of this Notice at any time. Even if you have agreed to receive this Notice electronically, you are still entitled to a paper copy of this Notice.

You may obtain a copy of this Notice at **dfinsolutionsBenefits.com** (under Legal Notices) or by calling the DFIN Benefits Center at **1-877-308-1464** Monday – Friday, 7:30 a.m. – 6:00 p.m. Central Time.

IX. Complaints

If you think that your privacy rights have been violated, you may file a written complaint with the Plan or with the Office for Civil Rights of the United States Department of Health and Human Services. To file a complaint with the Plan, contact the HIPAA Privacy Official, 35 W. Wacker Drive, Chicago, IL 60601. All complaints must be submitted in writing. You can file a complaint with the Office for Civil Rights of the United States Department of Health and Human Services by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling **1-877-696-6775** or visiting **www.hhs.gov/ocr/privacy/hipaa/complaints/.**

You will not be penalized, or in any other way retaliated against, for filing a complaint with the Office for Civil Rights or us.

New Health Insurance Marketplace Coverage Options and Your Health Coverage

Form Approved
OMB No. 1210-0149
(expires 9-30-2023)

PART A: General Information

When key parts of the health care law take effect in 2014, there will be a new way to buy health insurance: the Health Insurance Marketplace. To assist you as you evaluate options for you and your family, this notice provides some basic information about the new Marketplace and employment-based health coverage offered by your employer.

What is the Health Insurance Marketplace?

The Marketplace is designed to help you find health insurance that meets your needs and fits your budget. The Marketplace offers "one-stop shopping" to find and compare private health insurance options. You may also be eligible for a new kind of tax credit that lowers your monthly premium right away. Open enrollment for health insurance coverage through the Marketplace begins in October 2013 for coverage starting as early as January 1, 2014.

Can I Save Money on my Health Insurance Premiums in the Marketplace?

You may qualify to save money and lower your monthly premium, but only if your employer does not offer coverage, or offers coverage that doesn't meet certain standards. The savings on your premium that you're eligible for depends on your household income.

Does Employer Health Coverage Affect Eligibility for Premium Savings through the Marketplace?

Yes. If you have an offer of health coverage from your employer that meets certain standards, you will not be eligible for a tax credit through the Marketplace and may wish to enroll in your employer's health plan. However, you may be eligible for a tax credit that lowers your monthly premium, or a reduction in certain cost-sharing if your employer does not offer coverage to you at all or does not offer coverage that meets certain standards. If the cost of a plan from your employer that would cover you (and not any other members of your family) is more than 9.5% of your household income for the year, or if the coverage your employer provides does not meet the "minimum value" standard set by the Affordable Care Act, you may be eligible for a tax credit.[1]

Note: If you purchase a health plan through the Marketplace instead of accepting health coverage offered by your employer, then you may lose the employer contribution (if any) to the employer-offered coverage. Also, this employer contribution -as well as your employee contribution to employer-offered coverage- is often excluded from income for Federal and State income tax purposes. Your payments for coverage through the Marketplace are made on an after-tax basis.

How Can I Get More Information?

For more information about your coverage offered by your employer, please check your summary plan description or contact **The Donnelley Financial Solutions Benefits Center at 1-877-308-1464**.

The Marketplace can help you evaluate your coverage options, including your eligibility for coverage through the Marketplace and its cost. Please visit **HealthCare.gov** for more information, including an online application for health insurance coverage and contact information for a Health Insurance Marketplace in your area.

[1] An employer-sponsored health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs.

PART B: Information About Health Coverage Offered by Your Employer

This section contains information about any health coverage offered by your employer. If you decide to complete an application for coverage in the Marketplace, you will be asked to provide this information. This information is numbered to correspond to the Marketplace application.

3. Employer name Donnelley Financial, LLC		4. Employer Identification Number (EIN) 13-2618477
5. Employer address 35 W. Wacker Drive		6. Employer phone number 1-800-224-9001
7. City Chicago	8. State IL	9. ZIP code 60601
10. Who can we contact about employee health coverage at this job? Donnelley Financial Solutions Benefits Ceneter		
11. Phone number (if different from above) 1-877-308-1464	12. Email address Not available	

Here is some basic information about health coverage offered by this employer:

- As your employer, we offer a health plan to:

☐ All employees. Eligible employees are:

☒ Some employees. Eligible employees are:

Regular full time employees (as defined in Company Policy HR 2 1 Employee Classifications). For further information, please see the Summary Plan Description.

- With respect to dependents:

☒ We do offer coverage. Eligible dependents are:

Spouses, domestic partners, children up to age 26. For further information, please see the Summary Plan Description.

☐ We do not offer coverage.

☒ If checked, this coverage meets the minimum value standard, and the cost of this coverage to you is intended to be affordable, based on employee wages.

** Even if your employer intends your coverage to be affordable, you may still be eligible for a premium discount through the Marketplace. The Marketplace will use your household income, along with other factors, to determine whether you may be eligible for a premium discount. If, for example, your wages vary from week to week (perhaps you are an hourly employee or you work on a commission basis), if you are newly employed mid-year, or if you have other income losses, you may still qualify for a premium discount.

If you decide to shop for coverage in the Marketplace, **HealthCare.gov** will guide you through the process. Here's the employer information you'll enter when you visit **HealthCare.gov** to find out if you can get a tax credit to lower your monthly premiums.

Premium Assistance Under Medicaid and the Children's Health Insurance Program (CHIP)

If you or your children are eligible for Medicaid or CHIP and you're eligible for health coverage from your employer, your state may have a premium assistance program that can help pay for coverage, using funds from their Medicaid or CHIP programs. If you or your children aren't eligible for Medicaid or CHIP, you won't be eligible for these premium assistance programs but you may be able to buy individual insurance coverage through the Health Insurance Marketplace. For more information, visit **www.healthcare.gov**.

If you or your dependents are already enrolled in Medicaid or CHIP and you live in a State listed below, contact your State Medicaid or CHIP office to find out if premium assistance is available.

If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, contact your State Medicaid or CHIP office or dial **1-877-KIDS NOW** or **www.insurekidsnow.gov** to find out how to apply. If you qualify, ask your state if it has a program that might help you pay the premiums for an employer-sponsored plan.

If you or your dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under your employer plan, your employer must allow you to enroll in your employer plan if you aren't already enrolled. This is called a "special enrollment" opportunity, and **you must request coverage within 60 days of being determined eligible for premium assistance**. If you have questions about enrolling in your employer plan, contact the Department of Labor at **www.askebsa.dol.gov** or call **1-866-444-EBSA (3272)**.

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of July 31, 2023. Contact your State for more information on eligibility –

ALABAMA – Medicaid	ALASKA – Medicaid
Website: http://myalhipp.com/ Phone: 1-855-692-5447	The AK Health Insurance Premium Payment Program Website: http://myakhipp.com/ Phone: 1-866-251-4861 Email: CustomerService@MyAKHIPP.com Medicaid Eligibility: https://health.alaska.gov/dpa/Pages/default.aspx
ARKANSAS – Medicaid	**CALIFORNIA – Medicaid**
Website: http://myarhipp.com/ Phone: 1-855-MyARHIPP (855-692-7447)	Health Insurance Premium Payment (HIPP) Program Website: http://dhcs.ca.gov/hipp Phone: 916-445-8322 Fax: 916-440-5676 Email: hipp@dhcs.ca.gov
COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)	**FLORIDA – Medicaid**
Health First Colorado Website: https://www.healthfirstcolorado.com/ Health First Colorado Member Contact Center: 1-800-221-3943/State Relay 711 CHP+: https://hcpf.colorado.gov/child-health-plan-plus CHP+ Customer Service: 1-800-359-1991/State Relay 711 Health Insurance Buy-In Program (HIBI): https://www.mycohibi.com/ HIBI Customer Service: 1-855-692-6442	Website: https://www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html Phone: 1-877-357-3268

GEORGIA – Medicaid	INDIANA – Medicaid
GA HIPP Website: https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp Phone: 678-564-1162, Press 1 GA CHIPRA Website: https://medicaid.georgia.gov/programs/third-party-liability/childrens-health-insurance-program-reauthorization-act-2009-chipra Phone: 678-564-1162, Press 2	Healthy Indiana Plan for low-income adults 19-64 Website: http://www.in.gov/fssa/hip/ Phone: 1-877-438-4479 All other Medicaid Website: https://www.in.gov/medicaid/ Phone: 1-800-457-4584
IOWA – Medicaid and CHIP (Hawki)	**KANSAS – Medicaid**
Medicaid Website: https://dhs.iowa.gov/ime/members Medicaid Phone: 1-800-338-8366 Hawki Website: http://dhs.iowa.gov/Hawki Hawki Phone: 1-800-257-8563 HIPP Website: https://dhs.iowa.gov/ime/members/medicaid-a-to-z/hipp HIPP Phone: 1-888-346-9562	Website: https://www.kancare.ks.gov/ Phone: 1-800-792-4884 HIPP Phone: 1-800-967-4660
KENTUCKY – Medicaid	**LOUISIANA – Medicaid**
Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP) Website: https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx Phone: 1-855-459-6328 Email: KIHIPP.PROGRAM@ky.gov KCHIP Website: https://kidshealth.ky.gov/Pages/index.aspx Phone: 1-877-524-4718 Kentucky Medicaid Website: https://chfs.ky.gov/agencies/dms	Website: www.medicaid.la.gov or www.ldh.la.gov/lahipp Phone: 1-888-342-6207 (Medicaid hotline) or 1-855-618-5488 (LaHIPP)
MAINE – Medicaid	**MASSACHUSETTS – Medicaid and CHIP**
Enrollment Website: https://www.mymaineconnection.gov/benefits/s/?language=en_US Phone: 1-800-442-6003 TTY: Maine relay 711 Private Health Insurance Premium Webpage: https://www.maine.gov/dhhs/ofi/applications-forms Phone: 1-800-977-6740 TTY: Maine relay 711	Website: https://www.mass.gov/masshealth/pa Phone: 1-800-862-4840 TTY: 711 Email: masspremassistance@accenture.com
MINNESOTA – Medicaid	**MISSOURI – Medicaid**
Website: https://mn.gov/dhs/people-we-serve/children-and-families/health-care/health-care-programs/programs-and-services/other-insurance.jsp Phone: 1-800-657-3739	Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005
MONTANA – Medicaid	**NEBRASKA – Medicaid**
Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084 Email: HHSHIPPProgram@mt.gov	Website: http://www.ACCESSNebraska.ne.gov Phone: 1-855-632-7633 Lincoln: 402-473-7000 Omaha: 402-595-1178

NEVADA – Medicaid	NEW HAMPSHIRE – Medicaid
Medicaid Website: http://dhcfp.nv.gov Medicaid Phone: 1-800-992-0900	Website: https://www.dhhs.nh.gov/programs-services/medicaid/health-insurance-premium-program Phone: 603-271-5218 Toll free number for the HIPP program: 1-800-852-3345, ext. 5218
NEW JERSEY – Medicaid and CHIP	**NEW YORK – Medicaid**
Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ Medicaid Phone: 609-631-2392 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710	Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831
NORTH CAROLINA – Medicaid	**NORTH DAKOTA – Medicaid**
Website: https://medicaid.ncdhhs.gov/ Phone: 919-855-4100	Website: https://www.hhs.nd.gov/healthcare Phone: 1-844-854-4825
OKLAHOMA – Medicaid and CHIP	**OREGON – Medicaid**
Website: http://www.insureoklahoma.org Phone: 1-888-365-3742	Website: http://healthcare.oregon.gov/Pages/index.aspx Phone: 1-800-699-9075
PENNSYLVANIA – Medicaid and CHIP	**RHODE ISLAND – Medicaid and CHIP**
Website: https://www.dhs.pa.gov/Services/Assistance/Pages/HIPP-Program.aspx Phone: 1-800-692-7462 CHIP Website: Children's Health Insurance Program (CHIP) (pa.gov) CHIP Phone: 1-800-986-KIDS (5437)	Website: http://www.eohhs.ri.gov/ Phone: 1-855-697-4347, or 401-462-0311 (Direct RIte Share Line)
SOUTH CAROLINA – Medicaid	**SOUTH DAKOTA - Medicaid**
Website: https://www.scdhhs.gov Phone: 1-888-549-0820	Website: http://dss.sd.gov Phone: 1-888-828-0059
TEXAS – Medicaid	**UTAH – Medicaid and CHIP**
Website: Health Insurance Premium Payment (HIPP) Program | Texas Health and Human Services Phone: 1-800-440-0493	Medicaid Website: https://medicaid.utah.gov/ CHIP Website: http://health.utah.gov/chip Phone: 1-877-543-7669
VERMONT– Medicaid	**VIRGINIA – Medicaid and CHIP**
Website: Health Insurance Premium Payment (HIPP) Program | Department of Vermont Health Access Phone: 1-800-250-8427	Website: https://coverva.dmas.virginia.gov/learn/premium-assistance/famis-select https://coverva.dmas.virginia.gov/learn/premium-assistance/health-insurance-premium-payment-hipp-programs Medicaid/CHIP Phone: 1-800-432-5924
WASHINGTON – Medicaid	**WEST VIRGINIA – Medicaid and CHIP**
Website: https://www.hca.wa.gov/ Phone: 1-800-562-3022	Website: https://dhhr.wv.gov/bms/ http://mywvhipp.com/ Medicaid Phone: 304-558-1700 CHIP Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)

WISCONSIN – Medicaid and CHIP	WYOMING – Medicaid
Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm Phone: 1-800-362-3002	Website: https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/ Phone: 1-800-251-1269

To see if any other states have added a premium assistance program since July 31, 2023, or for more information on special enrollment rights, contact either:

U.S. Department of Labor
Employee Benefits Security Administration
www.dol.gov/agencies/ebsa
1-866-444-EBSA (3272)

U.S. Department of Health and Human Services
Centers for Medicare & Medicaid Services
www.cms.hhs.gov
1-877-267-2323, Menu Option 4, Ext. 61565

Paperwork Reduction Act Statement

According to the Paperwork Reduction Act of 1995 (Pub. L. 104-13) (PRA), no persons are required to respond to a collection of information unless such collection displays a valid Office of Management and Budget (OMB) control number. The Department notes that a Federal agency cannot conduct or sponsor a collection of information unless it is approved by OMB under the PRA, and displays a currently valid OMB control number, and the public is not required to respond to a collection of information unless it displays a currently valid OMB control number. See 44 U.S.C. 3507. Also, notwithstanding any other provisions of law, no person shall be subject to penalty for failing to comply with a collection of information if the collection of information does not display a currently valid OMB control number. See 44 U.S.C. 3512.

The public reporting burden for this collection of information is estimated to average approximately seven minutes per respondent. Interested parties are encouraged to send comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the U.S. Department of Labor, Employee Benefits Security Administration, Office of Policy and Research, Attention: PRA Clearance Officer, 200 Constitution Avenue, N.W., Room N-5718, Washington, DC 20210 or email ebsa.opr@dol.gov and reference the OMB Control Number 1210-0137.

OMB Control Number 1210-0137 (expires 1/31/2026)

Your Rights and Protections Against Surprise Medical Bills

When you get emergency care or get treated by an out-of-network provider at an in-network hospital or ambulatory surgical center, you are protected from surprise billing or balance billing.

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 a 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 your health plan's network.

"Out-of-network" describes providers and facilities that haven't signed a contract with your health plan to provide services. Out-of-network providers may be permitted to bill you for the difference between what your 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 your 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 are 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 the provider or facility may bill you is your 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 your 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 care out-of-network. You can choose a provider or facility in your plan's network.

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

- You are only responsible for paying your share of the cost (like the copayments, coinsurance, and deductibles that you would pay if the provider or facility was in-network). Your health plan will pay any additional costs to out-of-network providers and facilities directly.
- Generally, your health 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.

If you think you've been wrongly billed, you should contact the No Surprises Help Desk of the U.S. Centers for Medicare & Medicaid Services (CMS) at 1-800-985-3059 from 8 a.m. to 8 p.m. EST, 7 days a week, or www.cms.gov/nosurprises/consumers for more information about your rights under federal law.

In addition to federal law, you may have protections available to you through state law. If state law protection is available, contact information will be included on your Explanation of Benefits (EOB) for any applicable services.

IMPORTANT: *The descriptions provided in this communication are based on official plan documents. Every effort has been made to ensure the accuracy of this material. In the unlikely event that there is a discrepancy between this communication and the official plan documents, the official plan documents will control. DFIN reserves the right to amend or terminate the plans or programs at any time for any reason.*

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