GROUP BENEFITS PLAN

PLAN ADMINISTRATION INFORMATION BOOKLET

This Plan Administration Information Booklet (Administration Booklet) describes the common administrative provisions applicable to the programs under the RR Donnelley Group Benefits Plan (GBP). This Administration Booklet describes the eligibility provisions, election change rules, claims appeals procedures, ERISA rights, and other administrative information as of January 1, 2021.

RRD BENEFITS
HEALTH | WEALTH | LIFE

September 2021

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INTRODUCTION

Several welfare benefit programs offered by R. R. Donnelley & Sons Company and its participating subsidiaries (collectively RRD or the Company), combined, make up the RR Donnelley Group Benefits Plan (Group Benefits Plan or Plan). Generally, each welfare benefit program (or in some cases, a portion of a program) under the Group Benefits Plan is described in a separate program booklet, and the common administrative provisions applicable to each of the welfare benefit programs are set forth in this *Plan Administration Information Booklet* (*Administration Booklet*). In some cases, the detailed provisions of a program are described in an insurance certificate (referred to in this *Administration Booklet* as a *Member Certificate*), which may be titled a "Member Certificate," "Certificate of Coverage," "Evidence of Coverage," "Certificate," or something similar. Together, each of the program booklets and this *Administration Booklet*, as well as any applicable Member Certificates, Summaries of Material Modifications (SMMs), the Annual Enrollment materials, and other plan summaries, make up the complete Summary Plan Description (SPD) for the Group Benefits Plan.

This *Administration Booklet* describes the common administrative provisions applicable to the following welfare benefit programs under the Group Benefits Plan as of January 1, 2021:

- Group Health Program – Medical Program and Prescription Drug Program
- Regional Medical Options Program – Medical and prescription drug programs through regional health insurance and Health Maintenance Organization (HMO) providers
- Supplemental Benefits Program – Hospital Indemnity, Critical Illness and Accident Insurance
- Dental Benefit Program – Dental insurance
- Vision Care Program – Vision insurance
- Employee Assistance Program (EAP) – Resource, referral and counseling program
- Life and Accident Insurance Program – Life and Accidental Death & Dismemberment insurance
- Short Term Disability Program – Wage replacement benefits in the event you become disabled
- Long Term Disability Program – Wage replacement benefits in the event you become disabled

If capitalized terms are used in this *Administration Booklet* and are not defined in the sentence where first used, such terms are defined in the in the subsection titled **Terms to Know** in the section titled **Who is Eligible** or, as indicated, in the applicable Member Certificate.

Please review this *Administration Booklet*, including the documents linked at the end, to become familiar with the applicable eligibility requirements, how to enroll in the welfare benefit programs under the Group Benefits Plan, a description of your continuation of coverage rights, the applicable claims and appeals procedures, a description of how the Group Benefits Plan is administered, and an explanation of your ERISA rights.

If there is any discrepancy between this *Administration Booklet* and the Group Benefits Plan document, the Group Benefits Plan document always governs. If there is any discrepancy

between this *Administration Booklet* and the applicable Member Certificate, the Member Certificate always governs (except where this Administration Booklet is specifically intended to supplement the Member Certificate).

Each of the welfare benefit programs under the Group Benefits Plan is described in a separate booklet. See the section titled **Documents that Make Up the Complete SPD for the Group Benefits Plan** at the end of this *Administration Booklet* for more information.

Group Benefits Plan Summary Plan Description

Your Group Benefits Plan Summary Plan Description (SPD) includes this ***Administration Booklet***; the Group Health Program Booklet; Regional Medical Options Program Booklets; Supplemental Benefits Program Booklet; Dental Benefit Program Booklet; Vision Care Program Booklet; EAP Booklet; Life and Accident Insurance Program Booklet; STD Program Booklet and LTD Program Booklet; the Member Certificates, policies and contracts; any SMMs, the Annual Enrollment materials, and other plan summaries. Together, these documents make up the complete SPD for the RR Donnelley Group Benefits Plan as of January 1, 2021. Please read this information to familiarize yourself with the administration information that affects your coverage. If changes to the Group Benefits Plan occur, you will be notified through a SMM or the Annual Enrollment materials.

This *Administration Booklet* (along with any SMMs and Annual Enrollment materials) is intended to be a complete, accurate and up-to-date description of the common administrative provisions of the welfare benefit programs under the Group Benefits Plan.

Union employees covered by a collective bargaining agreement need to refer to such agreement for any differences from the administrative information described in this *Administration Booklet*. If there are conflicts between the rules contained in the SPD for the Group Benefits Plan and the rules contained in your applicable collective bargaining agreement, your collective bargaining agreement will control.

Nothing in this *Administration Booklet* should be interpreted as an employment contract. This *Administration Booklet* merely describes the common administrative provisions of the welfare benefit programs offered to eligible employees under the Group Benefits Plan as of January 1, 2021. RRD reserves the right to amend, change or terminate the Group Benefits Plan in whole or in part at any time. Group Benefits Plan benefits do not vest.

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

WHO IS ELIGIBLE

Terms to Know

Certain terms have special meaning as they pertain to the Plan. The definitions provided in this section apply to eligibility and other rules that apply under the Group Benefits Plan.

Affordable Care Act (ACA) – means the Patient Protection and Affordable Care Act of 2010, as amended, a federal law that requires employers to provide health care coverage to full-time employees, and which has certain minimum requirements for that health care coverage.

Annual Enrollment – means the window of time, usually occurring in the fall of each year, when you may make new elections for plan benefits without a qualifying event that allows for an election change.

Child(ren) (or individually, a "child") – means your children who are:

- Natural children of you or your spouse/domestic partner (including your stepchildren);
- Children legally adopted by you or your spouse/domestic partner;
- Children placed for adoption with you or your spouse/domestic partner; or
- Any other children who live with you and your spouse/domestic partner and for whom you or your spouse/domestic partner are the sole legal guardian (as defined in this **Terms to Know** section).

Claims administrators – the vendors hired by the Plan to make benefit determinations with respect to each program. For fully-insured programs, the insurer is the claims administrator. For self-funded programs, the Plan generally hires a third party administrator. See the section titled **Claims Administrators** for more information.

COBRA – means the Consolidated Omnibus Budget Reconciliation Act of 1985, a federal law that requires employers to offer plan participants the opportunity to continue their health care coverage in a number of situations (called "qualifying events") that would otherwise ordinarily end their coverage.

Domestic partner – means the person of the same- or opposite-sex with whom you have a domestic partner relationship, which is registered with a state or local governmental entity or which satisfies the criteria described below. A domestic partner is generally eligible for all eligible spouse coverage offered under the Group Benefits Plan, although you may not be able to pay for your domestic partner's coverage on a before-tax basis unless your domestic partner is your IRS tax dependent (see **Imputed Income**).

If your domestic partnership is not registered with a state or local governmental entity, it must satisfy the following criteria for your domestic partner to be eligible for coverage:

- Neither you nor your domestic partner are legally married to or are the legal domestic partner of anyone else;
- You and your domestic partner intend to remain each other's sole domestic partner indefinitely;
- You and your domestic partner live together in the same principal residence and intend to do so indefinitely;
- You and your domestic partner are committed to each other and share joint responsibilities for your common welfare and financial obligations; and
- You and your domestic partner are not related by blood, closer than would prohibit marriage in the state in which you live.

Eligibility administrator – the vendor hired by RRD to conduct Plan enrollment and make eligibility determinations with respect to the Plan. See the section titled **Eligibility Administrator** for more information.

Eligible dependents (or individually, a "dependent") – your eligible spouse or domestic partner, and children (as each is defined in this section). For purposes of the Group Benefits Plan, the word "dependent" does not have the same meaning as when it is used for purposes of your income tax return. Your parents, grandparents, adult brothers, adult sisters and other relatives are not eligible for Plan coverage, even if they are your dependents on your tax return. In addition, your eligible dependent who is also covered under the Group Benefits Plan as an employee may not simultaneously be enrolled and covered under the Group Benefits Plan as an eligible dependent. You may be required to provide documentation to the Plan Administrator, the eligibility administrator or the claims administrator that substantiates your claim for coverage or benefits of an eligible dependent.

ERISA – means the Employee Retirement Income Security Act of 1974, as amended, which is a federal law that governs the operation of private sector employee benefit plans.

IRS – means the Internal Revenue Service, the federal agency in charge of enforcing collection of federal taxes.

IRS tax dependent – for purposes of this booklet, means a child or domestic partner who:

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

To determine whether you provide more than half of the total support for an individual, you must compare the amount of support you provide with the amount of support that individual receives from all sources, including Social Security, welfare payments, the support you provide, alimony and child support, and the support the individual provides from his or her own funds. Support includes food, shelter, clothing, medical and dental care, education, and similar expenses. If you believe you might provide more than half of the support for an individual (e.g., your domestic partner (or domestic partner's child who is not your stepchild)), you should complete the support worksheet in IRS Publication 501 (Exemptions, Standard Deduction, and Filing Information).

An IRS tax dependent for purposes of the Group Benefits Plan is defined more broadly than the definition of who can be claimed as a dependent on your income tax return, and in some cases these individuals will qualify as your IRS tax dependent for purposes of the Group Benefits Plan even if they are not claimed as a dependent when you file your taxes. For example, the income limits that normally apply to determine whether a child is your tax dependent ($4,300 for 2021, indexed for inflation annually) are disregarded, and children can be considered your dependents to age 26.

Medical Child Support Order – means an order, judgment or decree issued by a court that:

- provides for child support with respect to a child of an employee or provides for health benefit coverage for the child;
- is made pursuant to a state domestic relations law; and
- relates to benefits under the Plan.

Participating Employer – means RRD and its affiliates that provide employee benefits to its employees under the Plan.

Permanently and totally disabled – means an individual is unable to engage in any substantial gainful activity by reason of any medically determinable physical or mental impairment which can be expected to result in death or which has lasted or can be expected to last for a continuous period of not less than 12 months.

Premiums (contributions) – means the amount you pay for coverage in which you have enrolled under the Group Benefits Plan. The term "contribution" has the same meaning as premium.

Qualified Medical Child Support Order (QMCSO) – means a Medical Child Support Order or a National Medical Support Notice (as defined in Section 401 of the Child Support Performance and Incentive Act of 1998) that orders you to cover a child who is an eligible dependent under the Plan, and complies with the following requirements established under ERISA, as determined by the Plan Administrator:

- The QMCSO must indicate the name and last known mailing address of the eligible employee and each child covered by the order, except that, to the extent provided in the order, the name and mailing address of an official of a State or a political subdivision thereof may be substituted for the mailing address of any such child;
- The QMCSO must include a reasonable description of the type of coverage to be provided to the child, or the manner in which such type of coverage is to be determined; and
- the QMCSO must indicate the date on which coverage of the child will commence, and when such coverage will terminate under the QMCSO.

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

Spouse – means the individual to whom you are currently legally married. The Group Benefits Plan also considers common-law spouses in states that recognize common-law marriages.

Eligibility for You

Group Health, Regional Medical Options, Dental Benefit, Vision Care and EAP Programs

You are automatically eligible for the EAP Program on your date of hire. Except as otherwise provided below, you are eligible for coverage under the Group Health, Regional Medical Options, Dental Benefit, and Vision Care Programs if you are classified as a:

- Full-time benefits-eligible employee of a Participating Employer;
- Part-time "A" employee of a Participating Employer;
- For the Group Health and Regional Medical Options Programs: Part-time "B" or Contingent employee of a Participating Employer who has met the requirements with regard to full-time employment status as determined by the Affordable Care Act and as a result changed to class "Z" for duration of such stability period; or
- Union employee of a Participating Employer who is covered by a collective bargaining agreement and such agreement provides for your Group Benefits Plan participation.

You are not eligible for coverage under the Group Health, Regional Medical Options, Dental Benefit, and Vision Care Programs if you are:

- An employee of a non-Participating Employer;
- A part-time "B" employee;
- Hired for seasonal or vacation relief work;
- In any employee classification other than a full-time benefits-eligible, part-time "A", or for the Group Health and Regional Medical Options Programs, class "Z"; or
- A union employee represented by a collective bargaining agreement, except if such agreement allows for participation in the Group Health, Regional Medical Options, Dental Benefit, and Vision Care Programs.

Once you become an eligible employee, coverage for you and your eligible dependents may be terminated, suspended or otherwise affected under certain circumstances.

Supplemental Benefits and Life and Accident Insurance Programs

You are eligible for the Supplemental Benefits and Life and Accident Insurance Programs if you are a regular full-time or part-time employee of a Participating Employer who is actively at work and you work 20 hours a week or more.

Eligibility for Your Dependents

Group Health, Regional Medical Options, Dental Benefit, Vision Care and EAP Programs

You may cover your current eligible spouse, domestic partner, or child on Plan benefits, as those terms are defined in **Terms to Know**.

Eligibility for your spouse or domestic partner ends on the date of divorce or dissolution of the domestic partnership, if applicable, unless he or she elects to continue Plan coverage under COBRA.

Eligibility for your eligible child ends at the end of the month in which your enrolled child reaches age 26, unless he or she is permanently and totally disabled, or elects to continue Plan coverage under COBRA.

Your dependents are eligible for EAP coverage if they are members of your household; that is, someone who qualifies as an eligible dependent or who is living with you. COBRA coverage is automatically provided free of charge to dependents who cease to be eligible for the EAP.

Supplemental Benefits and Life and Accident Insurance Programs

Your spouse/domestic partner and dependent children can enroll for MetLife Accident Insurance coverage, Hospital Indemnity Insurance coverage or Critical Illness Insurance coverage. You must be enrolled for such coverage in order for your spouse/domestic partner and/or dependent child(ren) to be eligible for coverage. Child(ren) are eligible for coverage from birth to age 26, except as otherwise provided in the applicable Member Certificate. Dependents must not be subject to any medical restrictions as set forth on the enrollment form and in the Member Certificate. The definition of domestic partner and children varies by state. Please refer to the plan summaries and Member Certificates for details.

You may obtain optional life and accident insurance for your spouse/domestic partner or children. Child(ren) are eligible for coverage from birth to age 26, except as otherwise provided in the applicable Member Certificate.

Dependent Audit

RRD and the Group Benefits Plan may conduct an audit of certain covered dependents, both periodically and at the time of enrollment. A “Dependent Eligibility Verification Notice” is mailed (or emailed) to each participant who must verify a covered dependent(s) and informs them that they must send documentation to verify the eligibility of their covered dependents as indicated in the notice. The notice will include a list of required and acceptable documentation.

You must submit the required documentation for each of your covered dependent(s) by the date specified in the Dependent Eligibility Verification Notice, or coverage for your

dependent(s) will be deactivated until documentation is submitted and approved as specified in the Dependent Eligibility Verification Notice (unless the Group Benefits Plan takes action to terminate coverage for an ineligible covered dependent at an earlier date and reports imputed taxable income to the employee participant). A "Results Notice" will be mailed out before any coverage termination date to advise you of the outcome of the review of the documentation provided.

If you fail to provide the required documentation by the deadline and coverage is not activated for your dependent, but you later provide the required documentation and confirm your dependent's eligibility, your dependent may be allowed to be re-enrolled in the Plan as follows:

- If there is no change in your coverage tier as a result of covering your dependent (e.g., if you have You + Children or You + Family coverage and as a result of this dependent being added back to your coverage, you will continue to have the same level of coverage), there will be no change in your premium amount and your dependent will be re-enrolled in coverage effective as of the first of the following month.
- If there is a change to coverage tier (e.g., if you have single coverage and as a result of this dependent being added back to your coverage, you will now have You + Spouse (or other) coverage), your dependent will be re-enrolled in coverage on an after-tax basis for the remainder of the calendar year. Please note, however, if later in the year you experience a subsequent qualifying event that may allow for a change in elections, your premium may again be payable on a before-tax basis.

If a full Plan dependent eligibility verification audit commences before you take any action to certify your dependent's eligibility from the first audit, you are still required to submit the required documentation for both audit responses. Your dependent's eligibility will be confirmed with appropriate documentation; however, you will only be allowed to re-enroll your dependent during the next Annual Enrollment period (or if you experience a qualifying event that may allow for an election change, at such time the election change is permitted) and the provisions in the bullets above do not apply. In all cases, you must provide the required documentation before your dependents will be confirmed as eligible for coverage, even for a future Annual Enrollment.

Ineligible dependents or dependents for whom you either:

- Were unable to provide required documentation, or
- Did not take any action for,

are no longer eligible for coverage and their current coverage will be terminated. Loss of coverage due to a dependent eligibility verification audit is not itself a qualifying event to continue coverage through COBRA. Dependents who lose coverage during a dependent eligibility verification audit will only be offered COBRA continuation coverage if they qualify for COBRA due to a COBRA qualifying event that is reported or discovered within the timeframes required by COBRA.

Required Documentation for Dependents

During a dependent eligibility verification audit, you will be required to provide documentation to verify:

- Relationship of the dependent to the employee; and
- Age of the dependent.

Before submitting information, cross out the following if they appear on your documentation:

- Social Security numbers;
- Account numbers; and
- Financial information.

The letter mailed to you during the dependent audit will include a list of documentation required by and acceptable to the Group Benefits Plan to verify your dependent's eligibility.

Note: Regonal Medical Options Program and HMOs

The fully insured regional medical coverages and/or HMOs may require you to provide additional or different proof of a child's continuing disability to maintain coverage for such child beyond such child's 26th birthday. Failure to comply with the carrier's request will result in permanent loss of eligibility for such extended coverage.

If the carrier terminates coverage for you, your spouse or your eligible dependent before coverage would otherwise end, coverage will end under the program. In such case, you may be able to change your coverage options under the Group Benefits Plan, or have a COBRA election with the program or Group Benefits Plan for continuation of coverage. If you have any questions, please contact the eligibility administrator.

Domestic Partner Tax Affidavits

In most cases, domestic partners and their children do not qualify as the employee's IRS tax dependent(s). If your domestic partner (or his or her child that is not your stepchild) does not meet the IRS definition of a tax dependent, then you will need to pay taxes on the value of their Group Benefits Plan coverage. This means that your share of the premiums for their coverage will be paid on an after-tax basis in the form of imputed income, and that extra taxes will be withheld from your pay to reflect the value of benefits subsidized by RRD. See the subsection entitled **Imputed Income** under Your Premiums for a discussion of how this imputed income is calculated.

You should consult with a tax advisor to determine if your domestic partner or his/her child(ren) qualify as your IRS tax dependents for purposes of the Group Benefits Pan. You will be required to provide the Group Benefits Plan with a signed affidavit attesting to the dependent's tax qualified status in order to avoid imputed income with respect to such individual's participation in the Group Benefits Plan.

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

Extended Coverage for Disabled Children

For Group Health, Regional Medical Options, Dental Benefit, Vision Care and Life and Accident Insurance Programs

If your enrolled eligible child is permanently and totally disabled and unable to support himself or herself, you can continue coverage for that child beyond the end of the month in which the child reaches age 26. To be eligible for continued coverage, your child must be enrolled under the program immediately before the coverage would otherwise end, and the disability must begin while your enrolled eligible child's coverage under the program is in effect. To continue coverage, you must contact your claims administrator to request the form(s) to complete. You must provide proof (for example, a physician's certificate) of your child's disability within 30 days of the day the child's coverage would have otherwise ended. If you do not, coverage for your disabled child ends, and you will not have another opportunity to add or continue coverage for your disabled child based on his or her disability status.

If your permanently and totally disabled child has already reached age 26 when he or she first gains eligibility under the program, you must enroll him or her for coverage immediately. To confirm eligibility, you must contact your claims administrator to request the certification form(s) to complete. You must provide proof (for example, a physician's certificate) of your child's disability within 30 days of enrollment or your child's coverage will be ended and you will not have another opportunity to add coverage for your disabled child based on his or her disability status.

Your disabled child must continue to meet the following conditions to be an eligible child under the program:

- Be unmarried; and
- Be permanently and totally disabled (incapable of self-supporting employment because of a mental or physical handicap, disability, or injury).

You will need to provide proof (for example, a physician's certificate) of the continued disability each calendar year to maintain coverage. A request for proof of continued disability typically will be made around the time of your disabled child's birthday.

If any of the above conditions for extended coverage for your child is not met or you do not complete and return the proof of disability to the applicable claims administrator at the address and by the deadline indicated, your child will cease to be an eligible child and will lose extended Plan coverage.

For rules that apply to extended optional dependent coverage under the Life and Accident Insurance Program, you should review the Member Certificate and any special rules that apply to residents of your state.

Extended Coverage for Certain Dependents

You are responsible for notifying the eligibility administrator within 30 days of when your covered dependent no longer meets the eligibility requirements for an eligible dependent as outlined in **Terms to Know** (for example, he or she is no longer your current spouse). If you provide such notice within 60 days, your dependent's coverage will terminate as of the date the qualifying event occurred and you will be offered COBRA. If you fail to provide such notice within 60 days, the following significant consequences may occur:

- Your dependent's coverage will terminate the date the qualified event occurred.
- Your dependent will lose his or her rights to continued coverage through COBRA.
- You may be required to repay the Company for the share of premiums it contributed after the date eligibility was lost.
- Any benefits paid by the Plan after your dependent's loss of eligibility will be treated as an overpayment. See the section titled **Right of Recovery**.

Qualified Medical Child Support Order (QMCSO)

The Group Benefits Plan also makes coverage available under the Group Health, Regional Medical Options, Dental Benefit and Vision Care Programs for your child pursuant to the terms of a Qualified Medical Child Support Order (QMCSO). This coverage may apply even if you do not have legal custody of the child, the child is not dependent upon you for support, and regardless of any enrollment period restrictions that might otherwise exist for dependent coverage. Your Participating Employer may withhold from your wages any contributions required for such coverage.

A QMCSO may be either a National Medical Child Support Notice that is issued by a state child support agency, or a Medical Child Support Order from a state court or administrative body directing your Participating Employer to cover a child under the Group Benefits Plan. Federal law provides that a medical child support order must meet certain form and content requirements to be valid. The Group Benefits Plan follows certain procedures to determine if a child support notice is "qualified." If you have any questions or would like a copy at no charge of the written procedures used to determine whether a medical child support order is valid, please contact the RRD Benefits Center.

If you are enrolled in the specific programs, you may enroll an eligible child in the Group Health, Regional Medical Options, Dental Benefit and Vision Care Programs pursuant to the terms of a valid QMCSO. If you do not elect an option, the Group Benefits Plan will comply with the QMCSO's terms by enrolling you and the child in the default coverage option unless the terms of the QMCSO specify a different option.

If You Are Reemployed

If you terminate employment with a Participating Employer and are reemployed by a Participating Employer within 30 days of your termination date as a full-time benefits-eligible or part-time "A" employee of a Participating Employer, you are not treated as a new hire. Your prior period of employment will be recognized, and your previous elections will automatically be reinstated. If you were previously covered under the Group Benefits Plan, coverage will continue effective immediately, retroactive to the date of termination and subject to any Annual Enrollment changes that became effective during your absence.

If you are reemployed by a Participating Employer more than 30 days after your termination date, you will be considered a new hire and will have to meet each program's eligibility requirements.

ENROLLING FOR COVERAGE

You automatically receive EAP, basic employee life insurance, Short Term Disability (STD) and Long Term Disability (LTD) coverage when you are eligible. You do not need to enroll.

Once you meet the eligibility requirements, you can enroll yourself and your eligible dependents for coverage under the Group Benefits Plan for any programs paid through before-tax premiums under the Participant Premium Program of the R.R. Donnelley & Sons Company Flexible Benefits Plan (Participant Premium Program), as well as coverage under the Supplemental Benefits Program and optional coverage under the Life and Accident Insurance Program that are paid with after-tax premiums.

For Group Health, Regional Medical Options, Dental Benefit and Vision Care Programs

For the Group Health, Regional Medical Options, Dental Benefit and Vision Care Programs, the following coverage categories apply:

- No Coverage
- You Only
- You + Spouse/Domestic Partner
- You + Child(ren)
- You + Family
- If you elect No Coverage, you are bound by that election for the remainder of the calendar year for which you elect No Coverage, unless you report a Qualified Status Change during the calendar year or a special enrollment opportunity occurs during the calendar year.
- If you and any one of your eligible dependents are both employees eligible to enroll, each of you may enroll for You Only coverage, or one of you may enroll and cover the other as an eligible dependent. Neither of you can cover the other as an eligible dependent, nor double cover each other or your children as eligible dependents.
- An enrolled eligible dependent who subsequently becomes an employee of a Participating Employer cannot be simultaneously covered as an employee and as a dependent.

Your Premiums

To participate, you must pay the premiums under the Group Benefits Plan for you and your enrolled dependents. In general, the premium you pay is based on your program elections and, if applicable:

- Your base pay* as of the September 1 prior to the Plan Year (or your base pay when you are first hired until the next September 1). If you have a reduction in your base pay between September 1 and December 31 prior to the Plan Year as a result of reduced hours, relocation, or a position change resulting from current position eliminations, then the Plan will use your base pay as of December 31 prior to the Plan Year;
- Which of the Participating Employers you work for;
- The option or amount of coverage you elect;
- The coverage category you choose;
- Provisions that apply to you under an applicable collective bargaining agreement;
- Whether or not you or any of your enrolled eligible dependents use tobacco products or agree to participate in a tobacco cessation program;
- Any additional criteria announced in the Annual Enrollment materials; and
- Your completion of certain health and wellness initiatives during Annual Enrollment and throughout the Plan Year.

* **Important Note for Commissioned Sales Employees:** Your last three full years of base pay and commissions will be used to calculate your base pay amount. This calculated average amount will be frozen each September 1 prior to the Plan Year. If you have been employed less than three calendar years, each full calendar year of employment will be used and averaged for this calculation.

You and RRD share the cost for Group Health Program coverage. You pay the full cost for Supplemental Benefits, Dental Benefit and Vision Care Programs, and optional coverage under the Life and Accident Insurance Programs. RRD automatically provides employee basic life insurance, EAP, STD and LTD coverage at no cost to you.

If your pay changes during the calendar year, your premium payment remains the same until the next Annual Enrollment period.

When you enroll in the Group Benefits Plan, you authorize the deduction of your required premium payments from your paycheck. For you and your covered dependents, you generally pay for coverage under the Group Benefits Plan each pay period with:

- **For Group Health, Regional Medical Options, Dental Benefit and Vision Care Programs** – before-tax dollars deducted from your pay under the terms of the Participant Premium Program for your dependents who are IRS tax dependents. For domestic partners who are not your IRS tax dependents, for your domestic partner's children who are not your children, stepchildren, or your IRS tax dependents, and for coverage for individuals who have ceased to meet the eligibility requirements for an eligible dependent (as described in **Terms to Know**), you pay your premium on an after-tax basis in the form of imputed income. In other words, instead of having an after-tax

amount deducted from your paycheck or paying out-of-pocket for coverage that is not permitted to be paid on a before-tax basis under the applicable IRS rules, your deduction may appear to be before-tax on your paycheck, but your paycheck will also include a phantom or imputed income amount. See the section titled **Imputed Income** below for a description of how your imputed income is determined if you are covering dependents who do not meet the IRS definition of a dependent for this purpose.

- **For the Supplemental Benefits, and Life and Accident Insurance Programs –** after-tax dollars (not through the Participant Premium Program).

Your elections under the Group Benefits Plan for those benefits paid for with before-tax dollars and your elections under the Supplemental Benefits Program generally are binding for the remainder of the calendar year for which the elections were made, unless a Qualified Status Change or a special enrollment opportunity occurs during the calendar year. Your elections under the Life and Accident Insurance Programs may be changed at any time.

Imputed Income

The amount of your imputed income is determined:

- If you are covering a domestic partner who is not your IRS tax dependent and/or child of a domestic partner who is not your child, stepchild or IRS tax dependent, by subtracting the COBRA premium for You Only coverage from the COBRA premium for the coverage you have in effect for You + Spouse and/or You + Child(ren), as the case may be. The difference is your imputed income.
- If continued coverage is for your former spouse because you have failed to report the change of coverage, by subtracting the COBRA premium for You Only coverage from the COBRA premium for coverage of You + Spouse. The difference is your imputed income.
- If coverage is for a child for whom you have not reported their change in eligibility, by subtracting the COBRA premium for You Only coverage from the COBRA premium for You + Child(ren). The difference is your imputed income.

COBRA coverage for this purpose is 100% of the unsubsidized cost of coverage and not the 102% that is charged during COBRA continuation coverage (which includes a 2% administrative fee). When you have imputed income, it means that the an amount equal to the premium cost of coverage determined above is reflected on your IRS Form W-2 as taxable income and results in income tax and FICA withholdings. All of this is required to be charged as an after-tax premium because the IRS regulations governing before-tax premiums and non-taxable benefits do not apply for domestic partner coverage (unless your domestic partner is your IRS tax dependent), coverage for your domestic partner's children (unless the children are your stepchildren or your IRS tax dependents), or for coverage for individuals who have ceased to meet the eligibility requirements for an eligible dependent.

On occasion RRD may (on a uniform and consistent basis) create new election rights to add coverage on an after-tax basis, to address circumstances in which RRD, in its discretion, determines to allow coverage changes, but that cannot be paid with before-tax premiums.

Before-Tax

Because the premium payment for coverage under the Group Health, Regional Medical Options, Dental Benefit and Vision Care Programs for you and your enrolled spouse, domestic partner who is your IRS tax dependent, or your eligible child (but not a domestic partner's child unless the child is your stepchild or IRS tax dependent) are before-tax, the IRS limits the instances when the Participant Premium Program will allow you to change your coverage or premiums under the programs (and the Participant Premium Program) to those that are considered Qualified Status Changes.

Key Terms

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

Using before-tax dollars to pay premiums for your coverage may affect any Social Security benefits you may eventually receive. This is because you generally do not pay FICA taxes on before-tax dollars deducted from your gross pay. For most people, the Social Security benefit reduction is only a few dollars a month. In addition, the reduction is typically more than offset by the tax savings you experience over the course of your career. If you have any questions, contact your local Social Security Administration office.

Enrolling Yourself and Your Eligible Dependents

To receive coverage for yourself and your eligible dependents, you must enroll in the:

- Group Health Program or Regional Medical Options Program
- Supplemental Benefits Program
- Dental Benefit Program
- Vision Care Program
- Life and Accident Insurance Program – for optional coverage

If you enroll an individual who does not meet the eligibility requirements to be a dependent, these programs do not pay benefits for that individual. In addition, any benefits that the program may have paid are subject to recovery by the Group Benefits Plan.

Once you have successfully enrolled yourself and your eligible dependents, references within this *Administration Booklet* will be to you and your enrolled eligible dependents (e.g., your

enrolled eligible spouse, your enrolled eligible domestic partner, or your enrolled eligible child), as appropriate.

You are automatically enrolled in basic employee life insurance. Once you meet the eligibility requirements, you can also enroll yourself for optional employee life and accident insurance coverage and your eligible dependents for life or accident insurance coverages under the Life and Accident Insurance Program.

Note: For Supplemental Benefits and Life and Accident Insurance Programs

You may make changes to your supplemental benefits (accident insurance, critical illness insurance and hospital indemnity insurance) at Annual Enrollment.
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.

If You Do Not Enroll by the Deadline as a New Hire

If you do not enroll by the deadline set forth in your new hire enrollment materials, you will have default coverage, which consists of You Only coverage in the HSA Value coverage option with no HSA contributions, basic employee life insurance, STD and LTD coverages. You will have no coverage under the Supplemental Benefits, Dental Benefit, Vision Care or optional Life and Accident Insurance Programs. In addition, you will not be able to enroll your eligible dependents in the Group Health, Regional Medical Options, Dental Benefit or Vision Care Programs or make changes to your coverage under such Programs until the following Annual Enrollment period. The only exception is if you report a Qualified Status Change or you meet one of the special enrollment circumstances within the required timeframe. You may be able to enroll in the optional coverage under Life and Accident Insurance Programs.

Special Enrollment Opportunities

If you decline Group Health Program coverage for yourself or your dependents because you or your dependents have other coverage, and you or 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 Group Health Program coverage.

Your loss of other health coverage qualifies for special enrollment treatment only if both of the following apply:

- You and your dependents were covered under another group health care plan or health insurance coverage at the time you were offered coverage under the RRD Group Health Program; and
- You and your dependents lost the other coverage because you and your dependents exhausted your right to COBRA continuation coverage, you and your dependents were no longer eligible under that plan, or an employer's contributions for coverage terminated.

Generally, you must enroll within 30 days after your and your dependents' other coverage ends (or after the employer stops contributing toward the other coverage).

You may also be able to enroll if you and 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 and your dependents become eligible for premium assistance from Medicaid or CHIP toward the cost of the Group Health Program, 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 Group Health Program. Generally, you must enroll within 30 days after such event.

Note: The Group Health Program 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 about special enrollment rights, contact the RRD Benefits Center at **1-877-RRD-4BEN (1-887-773-4236).**

Your Right and Responsibility to Change Your Coverage

Because of Internal Revenue Service (IRS) rules governing before-tax premiums, the coverage you elect, including Default coverage, for so long as you are an employee of all Participating Employers, remains irrevocably in effect until the beginning of the next calendar year. However, you may make limited changes to your elections during the calendar year when certain circumstances in your life or family status change. These changes in circumstance, called "Qualified Status Changes," are defined by the IRS and may change from time to time. Some

examples of Qualified Status Changes include marriage, birth, adoption, divorce, and the death of your spouse or child. These events generally require that you must make the election change for Plan benefits within 30 days after the event has occurred. If you do not, the change will not be allowed (except in those instances noted in the **Special Enrollment Opportunities** section where you may have 60 or 90 days to enroll).

See **Qualified Status Changes** for a list of allowed changes to your and/or your eligible dependents' coverage. Contact the eligibility administrator if you have questions about Qualified Status Changes.

Also, the Benefits Committee has the discretionary authority to allow for election changes as a result of certain significant changes in the cost of, or coverage under, the Group Benefits Plan. You will be notified if you are eligible to make this election, and election changes will be limited to those allowed by the IRS for before-tax premiums. If an election change is available, your election change generally will become effective on the date you give notice of the change to the eligibility administrator.

If you have individuals who are covered dependents who cease to meet the eligibility requirements of a dependent (as described in **Terms to Know**), you must notify the RRD Benefits Center of the status change and request a change of coverage within 30 days of the status change event.

Your dependent loses coverage when he or she is no longer an eligible for coverage, even if you fail to report the status change event within the 30-day period, unless your dependent has elected COBRA continuation coverage within 60 days of the date of the status change event. In addition, any claims for services or expenses incurred after the date of the status change event will not be paid unless your dependent has elected COBRA continuation coverage, and any amounts paid after the status change event may have to be repaid. See the section titled **Right of Recovery**. If you fail to notify the RRD Benefits Center within 60 days of the status change, the individual also will lose his or her right to elect COBRA coverage.

When Coverage Begins

As a new benefits-eligible employee, you are sent enrollment information that details the coverages for which you are eligible. This information also includes specific instructions on how to enroll. You must enroll yourself and/or your eligible dependents by the enrollment deadline set forth in your enrollment materials. As long as you enroll by the deadline, coverage under the Group Benefits Plan and the Participant Premium Program begins on the first day of the calendar month following your one-month anniversary of employment. For purposes of determining whether you have satisfied this waiting period, all periods of your employment with a Participating Employer before a period of more than 30 consecutive days during which you are not employed with a Participating Employer are disregarded.

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

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

Note: For Disability Programs

The date giving rise to your disability must be on or after your coverage effective date. Approved leaves of absence that begin prior to your Disability Programs coverage effective date do not entitle you to disability pay under the Disability Programs. If you should be on an approved leave of absence prior to your LTD coverage effective date, your coverage then becomes effective after you return to active work status.

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

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

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

  If you do not have a least one full calendar month of employment, these special rules do not apply, and you are treated as a newly hired benefits-eligible employee on your date of transfer.
- If you transfer from a U.S. affiliate and you were either covered by or elected not to be covered by the program on the date of the transfer, you will continue to participate in these programs until the end of the calendar year in which you transfer. As a result, your coverage under this Group Benefits Plan begins on the following January 1.
- If you transfer from a non-U.S. affiliate, your coverage under the Group Benefits Plan begins on the date you transfer.

If You Are Not Actively at Work

If you are not actively at work (e.g., due to an approved leave or temporary layoff) on the day coverage is scheduled to begin, Group Health, Regional Medical Options, Supplemental Benefits, Dental Benefit and Vision Care Programs coverage for you and your eligible dependents still takes effect on that day provided you enrolled by the deadline. You do not need to return to active work for your coverage to take effect.

For Life and Accident Insurance and Disability Programs, you must be actively at work on the day your coverage begins. If you are not at work on that day, your coverage begins only after you return to active work.

Annual Enrollment

Every fall during the Annual Enrollment period, you receive information about the options for which you are eligible. You then have the opportunity to enroll yourself and your eligible dependents in any of the options available to you, switch to a different option (if available in your area) or elect No Coverage. If you do not enroll by the deadline set forth in your enrollment materials, you will default to coverage as outlined in the Annual Enrollment materials.

For EAP, Basic Employee Life Insurance and Disability Programs

You will not have to make an affirmative enrollment election during the Annual Enrollment period as you are automatically enrolled for EAP, basic employee life insurance, and STD and LTD coverage as soon as you are eligible for such coverage.

The choices you make during the Annual Enrollment period take effect the following January 1 and generally remain in effect throughout the calendar year, unless you experience and report a Qualified Status Change or a special enrollment opportunity.

Your Benefit Elections May Not Exceed Your Net Income

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

- Reducing your elections under the Health Care FSA, Dependent Day Care FSA, and/or a Health Savings Account to levels that would not result in an overspent account;
- Terminating your coverage in Group Benefits Plan elections other than the Medical Program; and/or
- If there is a Medical Program option available to you under the Group Benefits Plan that would comply with this rule, making you ineligible to elect any Medical Program option that is in violation of this rule. If you become ineligible for an option under the Group Benefits Plan under this rule, coverage will be terminated retroactively to the first date of the month in which the non-payment of premiums began. If you become ineligible for a Medical Program option under the Group Benefits Plan under this rule, this ineligibility will create a special enrollment right for you and your dependents and a notification will be mailed to you outlining your rights to elect alternate coverage. Within 35 days of the

date of such notification, you may elect an option for which you can pay the applicable premiums for you (and your dependents, if applicable). Should you take no action during this time, you will be defaulted to the lowest cost option available under the Medical Program. Should you elect alternate coverage or be defaulted to the lowest cost Medical Program option, you will be responsible for paying the premiums from the effective date of the new coverage, which will be the first date of the month in which the non-payment of premiums for your prior election began. In the event you continue to fail to pay the premium for the lowest cost option, your coverage will be terminated.

Your Rights and Responsibilities

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

Your Rights Under the Group Health Program

You have the right:

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

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

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

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

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

Your Responsibilities Under the Group Health Program

All participants are responsible for learning how the Group Health Program works by carefully studying and referring to the SPD. You have a responsibility:

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

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

Qualified Status Changes

In most cases, because of Internal Revenue Service (IRS) rules, the benefits you elect each year at Annual Enrollment must remain in effect for the next calendar year. However, when a significant change in your life occurs, you may be able to adjust your benefits program choices to meet your changing needs.

You are allowed to make adjustments to your benefits program choices between Annual Enrollment periods only in response to specific situations called “Qualified Status Changes.” If you experience a Qualified Status Change, you can make limited changes to the following benefits program choices:

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

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

depending whether it is a change under the Health Care Spending Program or Dependent Day Care Spending Program.

Key Terms

See **Terms to Know** in the Eligibility section for most definitions. Key definitions applicable to this section include:

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

Premiums – means the amount you pay for coverage in which you have enrolled under the Plans. Sometimes the term "Contribution" is used, but it has the same meaning as "Premium."

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

Benefits Changes You May Be Able to Make

The following chart highlights Qualified Status Changes that may allow you to change certain coverages under the Plan. However, to make any Qualified Status Change under the Plan, you generally must report the event which gives rise to the Qualified Status Change to the eligibility administrator within 30 days following such event (with the exception of certain events that permit 60 days or more to make an election change, as further described below).

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

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

contributions for the cost of coverage under the Group Benefits Plan takes effect as soon as administratively possible after you report the change to the eligibility administrator. In that case, any payroll deductions retroactive to the date of the change will be paid after-tax.

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

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

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

Eligibility Administrator

The rules governing when you or your eligible dependents may change coverage are governed by the terms of the Group Benefits Plan, the Internal Revenue Code, ERISA, and other applicable laws and regulations. The Plans' eligibility administrator has the discretionary authority to interpret these terms and apply them to your situation as appropriate.

Summary of Qualified Status Changes and Your Options

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

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

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

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

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

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

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

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

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

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

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

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

A Note About Medical Option Changes

Relocation of your primary residence may affect the options available to you under the Group Health Program and the Regional Medical Options Program. If the relocation results in the loss of eligibility for the coverage option in which you are enrolled and you do not make a new election as a result of the address change within 30 days of your relocation, you will default to the same coverage tier under a similar coverage option available in your new location for the remainder of the calendar year.

A Note About Health Care and Dependent Day Care FSA Changes

Your elections for the Flexible Benefits Plan are binding for the remainder of the calendar year for which the elections were made, unless a Qualified Status Change occurs during the calendar year. As described in the chart above, not all Qualified Status Change events permit you to make a change to your election for the Health Care or Dependent Care FSA. See the chart above for more information.

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

A Note About Life Insurance Election Changes

You may make changes to the employee supplemental life insurance, spousal life insurance, child life insurance, and/or voluntary accidental death & dismemberment insurance coverages any time during the calendar year.

Evidence of Insurability (EOI) may be required if you are enrolling for or increasing your employee supplemental life insurance. EOI also may be required if you are enrolling your spouse for or increasing your spousal life insurance coverage. An EOI Form will be available on the bswift website or mailed to your home if applicable.

You will need to return the EOI Form for yourself and/or your spouse (if applicable) via bswift's website or in the preaddressed envelope provided prior to the deadline. If you do not return the EOI Form by the deadline date, your requested change will not be made.

Any change in your employee supplemental life insurance coverage or spousal life insurance coverage takes effect on the day the claims administrator processes the EOI Form. The claims administrator will notify you if your or your spouse's EOI Form is approved or denied. You will receive a confirmation notice from the eligibility administrator once the coverage approval, increase in coverage, and payroll deduction change is processed.

Reporting a Qualified Status Change

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

Action Steps – Reporting a Qualified Status Change

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

Notification

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

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

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

Check Your Confirmation Statement

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

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

Responsibility for Reporting Ineligible Dependents

You are responsible for reporting your eligible dependent's loss of eligibility within 30 days after the date your eligible dependent is no longer eligible for coverage. Your eligible dependent loses coverage when he or she is no longer an eligible dependent, even if you fail to report the status change within the 30-day period, unless your eligible dependent has elected COBRA continuation coverage within 60 days of the date your eligible dependent is no longer eligible for coverage.

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

However, after that 30-day period, your eligible dependent will be dropped without any COBRA continuation coverage offered (unless the event occurred within the last 60 days). **If you do not report the qualifying event within 60 days, COBRA continuation coverage will not be offered to a dependent who is no longer eligible for coverage.**

Qualified Status Changes

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

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

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

- Legal marital status: Events that change your legal marital status, including:
  - Marriage
  - Death of a spouse
  - Divorce
  - Legal separation
  - Annulment
- Domestic partner status: Beginning or ending of your domestic partner relationship
- Number of dependents: Events that change your number of eligible dependents, including:
  - Birth
  - Death
  - Adoption
  - Placement for adoption

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

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

Judicial Order

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

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

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

Entitlement to Medicare

You may make an election change to:

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

Change in Coverage Under Another Employer Plan

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

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

Significant Cost or Coverage Changes

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

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

Loss of Coverage Under Other Health Coverage

You may make an election on a prospective basis to add coverage for you or your eligible dependents if you or your eligible dependents lose coverage under any health coverage sponsored by a governmental or educational institution.

Enrollment in Marketplace Coverage

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

Special Enrollment Rights

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

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

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

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

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

WHEN COVERAGE ENDS

Generally, coverage under the Group Benefits Plan for you and your enrolled eligible dependents ends if:

- You decline coverage;
- Your employment with all Participating Employers terminates;
- You are no longer eligible for the Group Benefits Plan;
- You participate in the R.R. Donnelley & Sons Company Retiree Welfare Benefit Plan (the "Retiree Welfare Benefit Plan"); or
- The Group Benefits Plan is terminated.

Except if COBRA continuation coverage is available and elected, the Group Benefits Plan does not extend benefits for services completed after coverage ends or pay benefits for any service that begins after coverage ends. This applies even if the services began while you were covered under the Group Benefits Plan and you received a prior authorization for such services.

If You Leave or Are No Longer Eligible

If you leave all Participating Employers on either a voluntary or involuntary basis, coverage under the Group Benefits Plan stops on the last day of the month in which you stop working for your Participating Employer. You and your enrolled eligible dependents who are COBRA continuation coverage beneficiaries may be eligible to continue coverage under the Group Health, Regional Medical Options, Dental Benefit, Vision Care and EAP Programs for a specified period of time, as described in **Your Right to COBRA Continuation Coverage** and subject to the gross misconduct clause.

If You Die

If you die while you are an active employee, your enrolled eligible dependent's coverage under the Group Health, Regional Medical Options, Dental Benefit, Vision Care and EAP Programs may continue at no cost until the end of the third month after the month in which you die, provided your surviving eligible dependent is a COBRA continuation coverage beneficiary and elects COBRA continuation coverage under the applicable Program. The three months of subsidized coverage count toward the period of COBRA continuation coverage for which such enrolled eligible dependents are eligible, as described in **Your Right to COBRA Continuation Coverage**.

If Your Collective Bargaining Unit Goes on Strike

If your collective bargaining unit goes on strike, your coverage under the Group Benefits Plan ends on the day the strike begins. You and your enrolled eligible dependents who are COBRA continuation coverage beneficiaries may be eligible to continue group health plan coverage for a specified period of time, as described in **Your Right to COBRA Continuation Coverage**.

Employment While on an Approved Leave

While you are on an approved leave of absence, if you continue employment with any other employer outside of RRD and its affiliates, or if you accept new employment, either of which can include self-employment, you will be considered to have voluntarily abandoned your job at your Participating Employer. This will be treated as a voluntary separation thus ending employment with all Participating Employers and will result in a loss of all Group Benefits Plan benefits. Voluntary separation will be deemed to occur in these circumstances regardless of the amount of income generated from the new or existing employment and regardless of the length of time you intend to perform the services associated with the other job or self-employment.

Special Extensions of Coverage

Depending on your situation when you leave employment with your Participating Employer, you and your enrolled eligible dependents may be eligible for continued coverage under the Group Benefits Plan. Situations in which an extension of coverage is available are described below.

Leave of Absence

If you are granted a leave of absence pursuant to RRD's Human Resources Core Policy 6-4, Leaves of Absence, or you are laid off pursuant to Human Resources Core Policy 6-8, Temporary Layoffs:

- *For Group Health, Regional Medical Options, Dental Benefit, Vision Care and Life and Accident Insurance Programs:* You have the right to discontinue coverage when your unpaid leave begins. See the **Qualified Status Changes** section for additional information. This includes leaves that:
  - Result in a loss of Plan eligibility;
  - Are unpaid and taken under the Family and Medical Leave Act of 1993 (FMLA); and
  - Are unpaid and taken under the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA).

- *For the EAP*: Your EAP coverage will automatically continue for the duration of your leave.
- *For Disability Programs*: Your STD and LTD coverage will automatically continue for 10 weeks following the month in which coverage would have terminated, subject to the satisfaction of any requirements set forth in the Plan Summaries for such continuation of coverage. Please see the Plan Summaries for additional information. This includes leaves:
  - For your own personal disability;
  - Covered by the Family and Medical Leave Act of 1993 (FMLA)
  - Covered under the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA).

If you do not terminate your coverage under the Group Benefits Plan (and the withholding of premiums from your pay) while you are on a leave of absence, including short term disability (excluding a military leave or temporary layoff), you are responsible for your premiums. If you are approved for short-term and/or long term disability and receive disability payments from the disability vendor, your premiums will be deducted from your disability pay as available. If you are not receiving short-term and/or long-term disability payments or do not have enough disability pay to cover your total premiums, RRD will advance on your behalf the required premiums until you are able to return to work, you separate from employment, or you are reclassified as benefits-ineligible, whichever is earliest. Your election to authorize RRD to reduce your future wages on a before-tax or after-tax basis for your required premiums includes an authorization to withhold from your pay, in the calendar year you return to work or commence to be paid, the amount of premiums advanced for you by RRD during the time of your leave of absence or layoff (excluding military leave or temporary layoff). Therefore, if RRD advances premiums for you, you will be deemed to have elected to:

- Participate in the Group Benefits Plan (and the Participant Premium Program) for each calendar year to the extent required to repay advanced contributions made on your behalf beginning with the calendar year in which your leave of absence or temporary layoff begins and ending in the calendar year in which your leave of absence ends, or you return to active service; and
- Repay RRD for the advanced premiums.

The advanced premiums will be recovered by RRD by taking one past deduction plus one current deduction, beginning with your first available pay upon your return to work or when you commence being paid (except that in the case of Group Health and Regional Medical Options Programs premiums, RRD will recover 50% of one past deduction, plus 100% of the current deduction, from each paycheck). Deductions from your pay will continue until you repay your outstanding balance. If you separate employment from RRD with an outstanding balance due, the remaining balance will be recovered from your final pay or through deductions from disability pay as permitted by law.

Upon your separation, you and your enrolled eligible dependents who are COBRA continuation coverage beneficiaries may be eligible for continued group health plan coverage, as described in **Your Right to COBRA Continuation Coverage**.

Military Leave

If you go on a military leave of absence under the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA), your employment and benefits under the Group Health, Regional Medical Options, Dental Benefit, Vision Care, and Employee Assistance Programs will be continued in accordance with RRD's Human Resources Core Policy 6-9 (Military Leave) which generally provides that you and your dependents shall continue to be covered by the Plan for the duration of the uniformed service period, or for a period equal to your length of service, whichever is shorter, with all premium costs borne by RRD. After that, you will be separated from employment and will have the opportunity to continue medical, dental, vision and EAP coverage under COBRA. Please refer to the applicable Member Certificate with respect to your rights under the Disability and Life and Accident Insurance Programs while you are on a military leave of absence.

Your Right to COBRA Continuation Coverage

A federal law called the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended (COBRA), requires that most employers, including RRD, who sponsor medical benefit plans (including HMOs) to offer employees and certain members of their families the opportunity to extend coverage temporarily at group rates after coverage under the medical benefit plan would otherwise end or if costs increase due to specific events. COBRA does not require employers who sponsor group health plans to offer such extended coverage to domestic partners of employees or children of such domestic partners. However, the Group Benefits Plan does offer to covered domestic partners and the covered children of domestic partners who are eligible dependents COBRA continuation coverage rights that are equivalent to those offered under COBRA to the covered spouses and enrolled children of employees, as described below. The extension of coverage to employees and their enrolled eligible dependents is called "COBRA continuation coverage."

In general, under the Group Health, Regional Medical Options, Dental Benefit, Vision Care and Employee Assistance Program, coverage that may be continued is the same as the coverage in which you and your eligible dependents were enrolled under the Group Benefits Plan as an active employee on the day before the qualifying event (as listed below). For example, if you and your spouse are enrolled in an available coverage option before you leave all Participating Employers, you can continue this same coverage. If you elected the No Coverage option as an active employee, you would not be eligible for any COBRA continuation coverage.

You may have other options available to you when you lose group health coverage. For example, you may be eligible to buy an individual plan through the Health Insurance Marketplace. By enrolling in coverage through the Marketplace, you may qualify for lower costs on your monthly premiums and lower out-of-pocket costs. Additionally, you may qualify for a

30-day special enrollment period for another group health plan for which you are eligible (such as a spouse's plan), even if that plan generally doesn't accept late enrollees.

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

Qualifying Event

To be eligible for COBRA continuation coverage, a qualifying event must take place. After the qualifying event, COBRA continuation coverage must be offered to each person who is a COBRA continuation coverage beneficiary. You, your enrolled spouse/domestic partner, your enrolled children and your domestic partner's enrolled children could become COBRA continuation coverage beneficiaries if coverage under the Group Benefits Plan is lost because of a qualifying event.

The following are qualifying events:

Who Can Continue Coverage	In What Situations	For How Long*
• Employee • Employee's enrolled spouse/domestic partner • Employee's enrolled child(ren) • Enrolled child(ren) of employee's domestic partner	• A reduction in work hours that would cause employee to be classified as a benefits-ineligible employee • Termination of employee's employment (other than for gross misconduct)	18 months
• Employee's enrolled spouse/domestic partner • Employee's enrolled child(ren) • Enrolled child(ren) of employee's domestic partner	• Employee's death • Divorce or legal separation • Employee's entitlement to Medicare (under Part A, Part B or both)**	36 months
• Employee's domestic partner • Employee's enrolled child(ren) • Enrolled child(ren) of employee's domestic partner	Domestic partner or children no longer meet the eligibility rules for coverage	36 months

* The duration of coverage is from the date of the qualifying event.

** The 36-month coverage begins on the day you enroll in Medicare.

A child who is born to the employee or placed for adoption with the employee during a period of COBRA continuation coverage may be added to the coverage. The child will have all of the COBRA continuation coverage rights that any other enrolled eligible dependent would have otherwise.

Notification

In the case of your termination of employment (other than for gross misconduct) or reduction in hours that would cause you to be classified as a benefits-ineligible employee, you will automatically be advised of the right to this continued coverage within 14 days of the date the COBRA administrator is notified by the employer of the event. In case you die while employed, your COBRA continuation coverage beneficiaries automatically will be advised of the right to this continued coverage within 14 days of the date the COBRA administrator is notified by the employer of your death. The employer has 30 days after the date of the qualifying event to notify the COBRA administrator.

You must give notice of certain qualifying events. Under the law, the employee or a family member who is a COBRA continuation coverage beneficiary must notify the COBRA administrator if one of the following qualifying events occurs:

- Divorce;
- Annulment, legal separation or termination of a domestic partnership; or
- A domestic partner or child fails to meet the eligibility rules for coverage under the Group Benefits Plan.

You will be allowed to make a COBRA election only if you notify the COBRA administrator within 60 days of the date a qualifying event occurs.

Upon such timely notification, coverage will be terminated retroactive to the date of the qualifying event. When the COBRA administrator is timely notified that one of these qualifying events has happened, your COBRA continuation coverage beneficiaries will in turn be notified within 14 days of the right to choose (e.g., elect) COBRA continuation coverage. Failure to provide this notification during the 60-day notice period results in the loss of COBRA continuation coverage rights. Contact information for the COBRA administrator can be found in **Claims Administrators**.

Election Procedure

Under the law, to continue coverage, you and your COBRA continuation coverage beneficiary have 60 days from the later of the date:

- You ordinarily would have lost coverage because of one of the qualifying events described above; or
- The notice of your and your COBRA continuation coverage beneficiary's right to elect COBRA continuation coverage is sent by the COBRA administrator.

If you and/or your COBRA continuation coverage beneficiary does not choose (e.g., elect) COBRA continuation coverage within this 60-day period, your and/or your COBRA continuation coverage beneficiary's coverage under the Group Benefits Plan will end.

Disability Extension

An 18-month period of COBRA continuation coverage may be extended for up to 11 months (for a total of up to 29 months of COBRA continuation coverage) if you, your enrolled spouse/domestic partner, your enrolled child(ren), or your domestic partner's enrolled child(ren) have been determined to be disabled (under Title II or XVI of the Social Security Act). The disability would have to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month COBRA continuation coverage period. The 11-month extension applies to all disabled and non-disabled COBRA continuation coverage beneficiaries entitled to COBRA continuation coverage as a result of the same qualifying event to which the disability extension applies, subject to the above notice requirements. If the disability ends, you (or your spouse/domestic partner, your child, or your domestic partner's child who is a COBRA continuation coverage beneficiary with respect to the qualifying event to which the disability extension relates) must notify the COBRA administrator within 30 days after the determination. COBRA continuation coverage will end on the first day of the month that is 31 or more days after the Social Security determination that the disability has ended.

Second Qualifying Event Extension

Your spouse/domestic partner, your children, and your domestic partner's children can experience additional qualifying events while COBRA continuation coverage is in effect. Such events may extend an 18- or 29-month period of COBRA continuation coverage to a period of up to 36 months. In no event will coverage extend beyond 36 months after the initial qualifying event. You should notify the COBRA administrator immediately if a second qualifying event occurs during a COBRA continuation coverage period.

A COBRA continuation coverage beneficiary does not have to show that he or she is insurable to choose COBRA continuation coverage. However, COBRA continuation coverage under the law is provided subject to eligibility for coverage under the Group Benefits Plan. The Group Benefits Plan reserves the right to terminate a COBRA continuation coverage beneficiary's COBRA continuation coverage retroactively if such COBRA continuation coverage beneficiary is determined to be ineligible. Once a COBRA continuation coverage beneficiary's COBRA continuation coverage terminates for any reason, it cannot be reinstated.

Payment

Generally, you must pay a premium to the Group Benefits Plan of 102% of the applicable unsubsidized active employee premium during the 18- or 36-month period of COBRA continuation coverage. However, during the additional 11 months of COBRA continuation coverage (for disability), if the disabled individual is covered, payment of up to 150% of the applicable unsubsidized active employee premium is required.

Your initial COBRA continuation coverage premium is due by the 45th day after coverage is elected. All other payments are due on the first day of the month for which you are buying coverage, subject to a 30-day grace period. If you or your COBRA continuation coverage

beneficiaries do not make payment on or before the first day of the month, your or your COBRA continuation coverage beneficiary's claim(s) will not be paid by the Group Benefits Plan until payment is received within the 30-day grace period.

When COBRA Continuation Coverage Ends

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

- The end of the 18-month, 29-month, or 36-month continuation period;
- The date your employer no longer provides coverage to any of its employees;
- The date a COBRA continuation coverage beneficiary fails to pay the required contribution by the specified deadline;
- The date a COBRA continuation coverage beneficiary first becomes covered after the date of his or her COBRA continuation coverage election under another group health care program that does not contain a pre-existing exclusion that affects his or her benefits;
- The date a COBRA continuation coverage beneficiary first becomes entitled to Medicare after the date of his or her COBRA continuation coverage election;
- The date a Medicare-eligible COBRA continuation coverage beneficiary becomes eligible under Medicare or 60 days; or
- The date that there has been a final determination by the Social Security Administration that the COBRA continuation coverage beneficiary who elected to extend coverage for up to 29 months due to disability is no longer disabled.

If COBRA continuation coverage is rejected in favor of an alternate coverage under the Group Benefits Plan, COBRA continuation coverage will not be offered at the end of that period. If an alternate coverage is offered, COBRA continuation coverage will be reduced to the extent such coverage satisfies the requirements of COBRA continuation coverage.

Other Coverage Options

When you lose group health coverage, there may be other, more affordable coverage options for you and your family through the Health Insurance Marketplace, Medicaid or other group health plan coverage options (such as a spouse's plan) through what is called a "special enrollment period." By enrolling in coverage through the Marketplace, you may qualify for lower costs on your monthly premiums and lower out-of-pocket costs. Additionally, you may qualify for a 30-day special enrollment period for another group health plan for which you are eligible (such as a spouse's plan), even if that plan generally doesn't accept late enrollees. Some of these options may cost less than COBRA continuation coverage. You can learn more about many of these options at **www.HealthCare.gov**.

Address Information

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

For More Information

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

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

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

Situations Affecting Your Benefits

Some situations could affect benefits or programs from the Group Benefits Plan, as summarized here:

- If you choose No Coverage when you are first hired or during any Annual Enrollment period, no benefits are payable.
- Coverage may be stopped, changed or delayed if you leave all Participating Employers, take a leave of absence, or experience an employment status change such that you are classified as a benefits-ineligible employee.
- If you do not apply for benefits (when necessary) or provide the necessary claim information, benefits may be delayed.
- You may change your coverage during the year only if you report a Qualified Status Change.
- Coverage for a spouse ends if you and such spouse are divorced or legally separated.
- Coverage for a domestic partner ends if he or she is no longer a domestic partner, as defined in **Terms to Know**.
- Coverage for an eligible dependent ends if he or she is no longer an eligible dependent as defined in **Terms to Know**.
- Coverage for you and your eligible dependents may be suspended or terminated if you are on an unauthorized leave of absence from work.
- An unauthorized leave of absence includes a failure to report to work as the result of a strike or other labor action where such failure to report is not authorized by your Participating Employer.

Right of Recovery

If for any reason the Group Benefits Plan pays a benefit for any individual who is not eligible for coverage under the Group Benefits Plan, or that is larger than the amount allowed, the Group Benefits Plan has the right to recover the excess amount from the person, entity or agency that received it. The recipient must produce any instruments or papers necessary to ensure this right of recovery.

For the STD Program – If The Hartford makes a benefit payment over the amount that you are entitled to under the Group Benefits Plan, The Hartford and the Plan Administrator have the right to:

- Require that the overpayment be returned or treat the overpayment as if it were a payment under another program of the Group Benefits Plan;
- Stop payment of any benefits until the overpayment is recovered;
- Take any legal action needed to recover the overpayment; and
- Place a lien, if not prohibited by law, in the amount of the overpayment on the proceeds of any other income, whether on a periodic or lump sum basis.

This right does not affect any other right of overpayment recovery The Hartford may have. If the overpayment:

- Occurs because you receive other income benefits for the same period for which you have received benefits under the Group Benefits Plan; and
- You incurred legal fees to obtain the other income benefits,

then The Hartford will exclude the legal fees from the amount to be recovered, as long as you return the overpayment within 30 days of The Hartford's written request for return of the overpayment.

If you do not return the overpayment to The Hartford within such 30-day period:

- The legal fees will not be excluded; and
- You will remain responsible for repayment of the total overpayment amount.

Right to Reimbursement, Assignment of Rights, and Duty to Notify

As a condition to receiving Group Benefits Plan benefits, each participant, former participant, or other person who has an interest in the Group Benefits Plan (Recipient) shall provide the Group Benefits Plan with a Right to Reimbursement and an Assignment of Rights (as both are described below). These rights enable the Group Benefits Plan to recover the amount it has expended to provide benefits to the Recipient from any proceeds the Recipient receives from a third party in connection with an illness, accident, or injury. The Group Benefits Plan's rights to recover are reduced by its share of the attorneys' fees incurred in obtaining the proceeds from the third party.

Repayments and Offsets of Overpayment of Benefits

In the event of administrative error in determining and/or paying a participant a benefit amount that results in one or more overpayments, such participant will be required to repay the overpayments to the Group Benefits Plan (including interest, at the discretion of the Plan Administrator or its delegates). A participant is responsible for promptly notifying the Administrator if such participant becomes aware of an overpayment. The Group Benefits Plan may decide to reduce any future payments, as applicable, rather than seek reimbursement for overpayments and interest. A participant's obligation to the Group Benefits Plan in the case of an overpayment continues to exist even after such participant spends the overpayment.

Right to Reimbursement

As a condition to receiving Group Benefits Plan benefits, the Recipient grants the Group Benefits Plan the right to recover from any proceeds (including any form of consideration whatsoever) that the Recipient receives from a third party (via judgment, settlement, or otherwise) in connection with the accident, injury, or other event that resulted in the Group Benefits Plan's expenditures, dollar for dollar beginning with the first dollar received by the Recipient from the third party, regardless of how those proceeds are characterized or labeled (for example, payment of medical expenses, pain and suffering damages, punitive damages, or any other type of non-economic or economic damages), in an amount equal to the expenditure made by the Group Benefits Plan in providing benefits to the Recipient.

Without in any way limiting the Group Benefits Plan's rights, and as illustrative examples, it is the intent of the parties that the Group Benefits Plan will be entitled to recover from any proceeds (including any form of consideration whatsoever) that the Recipient receives from a third party, regardless of how those proceeds are characterized or labeled:

- In the case of a judgment, by a court or jury;
- In the case of an arbitration, mediation, or any other form of dispute resolution, by the deciding person or persons or by the parties to that process;
- In the case of a settlement or other form of payment, by the parties to that transaction; and
- In any of the above situations or in any other situation, in accordance with any legal principle or applicable provision of statutory or common law that would purport to characterize the proceeds or attribute to them any particular purpose, in an amount equal to the expenditure made by the Group Benefits Plan in providing benefits to the Recipient.

The Group Benefits Plan disavows the "common fund" doctrine and shall not be responsible for any expenses or attorneys' fees incurred by a Recipient in the prosecution of any action or claim.

It is an additional condition to receiving benefits from the Group Benefits Plan that the Recipient grant the Group Benefits Plan a first lien with respect to any proceeds (including any form of consideration whatsoever) that the Recipient receives from a third party in connection

with the accident, injury, or other event that gave rise to the Group Benefits Plan's expenditures, so that every such dollar of any such proceeds will be paid to the Group Benefits Plan, beginning with the first dollar and continuing until the Group Benefits Plan has been paid an amount equal to the amount it expended to provide benefits to the Recipient, regardless of how that payment is labeled or characterized, and regardless of the injury or loss ostensibly redressed by the payment or the apparent cause or inducement for such payment. The parties hereby disavow and waive the "make whole" doctrine or any other principle of law that would require that the Recipient be fully compensated before payment is made to the Group Benefits Plan under its Right to Reimbursement or any of its other rights to recovery, whether contractual, legal, or equitable.

In the event the Recipient fails to reimburse the Group Benefits Plan under this provision within a reasonable time of receiving any proceeds (including any form of consideration) from any third party, the Group Benefits Plan shall have the right to offset the amounts it has expended to provide benefits to the Recipient against any other obligations to make expenditures to or on behalf of the Recipient, and to withhold payment of any such expenditures until it has been fully reimbursed for the expenditures it has made.

In the event that a court of competent jurisdiction determines that any part of the foregoing Right to Reimbursement is unenforceable for any reason, it is the intent of the parties that the Group Benefits Plan shall retain all the rights provided for in those parts that remain enforceable, including without limitation the Group Benefits Plan's right to recover the expenditures it has made to provide benefits to the Recipient, to the extent that any portion of the proceeds paid to the Recipient by any third party is designated as compensation for medical expenses or for other expenses paid by the Group Benefits Plan to or on behalf of the Recipient, or which are intended as, or can reasonably be attributed to, compensation for medical expenses or other expenses paid by the Group Benefits Plan, though not expressly designated as such, which determination shall be made in the sole discretion of the claims administrator or recovery vendor acting on behalf of the claims administrator.

Assignment of Rights

In addition to providing the Right to Reimbursement described above, and as an additional condition to receiving benefits from the Group Benefits Plan, the Recipient will assign to the Group Benefits Plan any and all rights to pursue an action or claim against any third party in connection with the accident, injury, or other event that gave rise to the Group Benefits Plan's expenditures. If the Group Benefits Plan pursues any such action or claim, the Recipient shall cooperate and assist the Group Benefits Plan and shall be prohibited from taking any action that would prejudice the Group Benefits Plan's rights or in any way diminish its prospects for a recovery.

Duty to Notify

The Recipient agrees to promptly notify the claims administrator or the recovery vendor acting on behalf of the claims administrator as to whether the Recipient or anyone acting on his or her behalf is pursuing or intends to pursue an action against, or to seek any type of recovery from,

any third party for damages, indemnity, recovery, insurance, or other payment of any kind whatsoever in connection with the accident, injury, or other event giving rise to the Group Benefits Plan's obligations to make expenditures to or on behalf of the Recipient, so that the Group Benefits Plan can protect its rights to recover.

Nothing in this section shall be deemed to waive or otherwise diminish any rights to reimbursement, subrogation, assignment, or other recovery available to the Group Benefits Plan under applicable common or statutory law.

If the Group Benefits Plan Is Modified or Ended

RRD reserves the right to amend or terminate the Group Benefits Plan or any program at any time, for any reason, in whole or in part. If the Group Benefits Plan or a program is ever terminated, suspended or modified, benefits for any service you receive before the change are paid under the Group Benefits Plan's former conditions, provided that a written notice of claims is timely given. The Group Benefits Plan does not pay benefits for services received or disabilities that take place after such action (unless specific provisions are adopted).

Forfeiture After Two Years

Any check issued to pay self-funded benefits under the Group Benefits Plan will be void and not reissued if it is not cashed within two years after the date the original check was issued, and the self-funded benefit for which the check was issued will be forfeited. For self-funded benefits, any expense incurred will be ineligible for benefits under the Group Benefits Plan if a claim for the expense is not submitted to the appropriate claims administrator by the end of the Plan Year which contains the second anniversary of the date the expense was incurred, and any claim related to such expense will be forfeited.

CLAIMS AND APPEALS PROCEDURES

Group Health, Regional Medical Options, EAP, Dental Benefit and Vision Care Programs

The following claim review and claim appeal procedures generally apply to all benefit and eligibility claims (including rescissions of coverage) of any nature related to the Group Health and Employee Assistance Programs. For the Regional Medical Options, Dental Benefit, and Vision Care Programs, the applicable benefit claims and appeals procedures are described in the Member Certificates. However, if the benefit claims and appeal procedures contained in the Member Certificate do not comply with ERISA, then the claim procedures in this *Administration Booklet* apply or supplement the claims and appeals procedures described in the applicable Member Certificate, as appropriate. If the timeframes described in the Member Certificate conflict with the timeframes described in this *Administration Booklet*, then the timeframes in the Member Certificate shall apply, to the extent they comply with ERISA.

A benefit claim is a claim for a particular benefit under a plan. It will typically include your initial request for benefits. An example of a benefit claim under the Group Health and Regional Medical Options Programs is a claim to receive coverage for a particular type of surgery. An example of a benefit claim under the Dental Benefit and Vision Care Programs is a claim to receive coverage for a particular type of service or supply. An example of a benefit claim under the Employee Assistance Program is a claim you have not received the maximum number of counseling visits. If you are filing a benefit claim, you need to contact the applicable claims administrator.

Unless otherwise specified under the Prescription Drug Program, the presentation of a prescription for fill at a pharmacy counter is not considered a submission of a formal benefits claim under the Group Benefits Plan. To initiate these formal claims and appeals procedures, you must submit a claim in accordance with the procedures as set forth below.

A coverage claim is a limited type of claim under the Prescription Drug Program. A coverage claim is a claim that only considers whether a particular drug is covered by the terms of the Group Benefits Plan. A coverage claim does not involve a determination regarding whether a requested drug is experimental, investigatory, or not medically necessary.

An eligibility claim is a claim to participate in an option or to change an election to participate during the year. An eligibility claim also includes any rescissions of coverage (i.e., a retroactive cancellation of coverage under the Group Benefits Plan (or portion thereof)). An example of an eligibility claim is a claim to enroll a dependent or to switch from one available coverage option to another midyear. If you are filing an eligibility claim, you need to contact the RRD Benefits Center.

A disability claim is a benefit claim that also requires a determination as to whether an individual is disabled. For example, if you are filing a benefit claim on the basis that a child age 26 or older is eligible due to disability, then the additional procedures applicable to disability claims will also apply to your benefit claim.

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

Authorized Representatives

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

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

- Specific Written Designation. The claimant may provide in writing the name, address, and phone number of his or her authorized representative and a statement that the representative is authorized to act on his or her behalf in the claims and appeals process.
- Other Legal Representative Status. In the event a claimant is deceased or incapacitated, an individual may demonstrate that he or she is the claimant's authorized representative by submitting certified letters testamentary, letters of administration, or valid documentation of power of attorney, as applicable.
- Employee as Authorized Representative of Dependents. An employee may act as the authorized representative of his or her covered dependents, or other individuals asserting an eligibility claim to become his or her covered dependents, without written authorization.
- Additional Authorization Required for Claims and Appeals Involving PHI. However, if the authorized representative is requesting access to HIPAA protected health information (PHI) in conjunction with the claims and appeals process, a valid HIPAA authorization form must also be submitted before PHI will be shared with the authorized representative (except in certain cases involving minor children).

Procedure for Filing a Claim

A communication from you, your eligible dependent, or your authorized representative (claimant) constitutes a valid claim if it is in writing on the appropriate claim form (or in such other manner acceptable to the claims administrator) and is delivered (along with any supporting comments, documents, records, and other information you'd like to submit in support of your claim) to the appropriate claims administrator by first-class postage-paid mail, to the address for the claims administrator.

To constitute a valid claim, the claim form must also be delivered not later than the earlier of:

- 12 months after the payment of the benefit or receipt by the claimant of a notice of non-payment of an expense to which such claim relates; and
- 24 months after the claimant incurs the expense to which such claim relates.

If a claimant fails to properly file a claim for a benefit under the Group Benefits Plan, he or she will be considered not to have exhausted all administrative remedies under the Group Benefits Plan, and this will result in his or her inability to bring a legal action for that benefit.

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

Defective Claims

If a claimant fails to follow the Group Benefits Plan's procedures for filing a valid claim, the claims administrator will notify him or her of the failure and the proper procedures to follow in filing a claim, provided that the communication received by the claims administrator from the claimant names the specific claimant, the specific condition or symptom, and the specific treatment, service, or product for which approval is requested. The notice will be provided within five days of receipt of the claim by the claims administrator. In the case of a failure to follow the proper procedures with respect to a claim that involves urgent care, the notice will be provided to the claimant within 24 hours of such receipt.

Initial Claim Review

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

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

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

Initial Benefit Determination

Claim Involving Urgent Care

In the case of a claim that involves urgent care, the claims administrator will notify the claimant of the benefit determination (whether adverse or not) no later than 72 hours after receipt of the claim by the claims administrator. The claimant must, however, provide sufficient information to determine whether and to what extent benefits are payable under the Group Benefits Plan.

If the claimant fails to provide sufficient information to determine whether, and to what extent, a claim involving urgent care is covered by the Group Benefits Plan, the claims administrator will notify the claimant within 24 hours after receipt of the claim of the specific information necessary to complete the claim.

The claimant will be given a reasonable amount of time, taking into account the circumstances, but in no event less than 48 hours, to provide the specified information. The claims administrator will notify the claimant of the benefit determination no later than 48 hours following the earlier of:

- The claims administrator's receipt of the specified information; or
- The end of the period afforded to the claimant to provide the specified additional information.

Concurrent Care Decision

In the case of a denial of coverage that involves a course of treatment (other than by amendment or termination of the Group Benefits Plan) before the end of such period of time or number of treatments, the claims administrator will notify the claimant of the denial in advance of the reduction or termination. This will enable the claimant to appeal and obtain a determination on review of that denial before the benefit is reduced or terminated. If the claimant wants to extend the course of treatment beyond the period of time or number of treatments and the claim involves urgent care, the claims administrator will notify the claimant of the benefit determination (whether adverse or not) within 24 hours after receipt of the claim by the claims administrator (provided that any such claim is made to the claims administrator at least 24 hours prior to the expiration of the prescribed period of time or number of treatments).

Pre-Service Claim

In the case of a claim that involves prior authorization, the claims administrator will notify the claimant of the benefit determination (whether adverse or not) within 15 days after receipt of the claim. The claims administrator may extend the period by 15 days if it determines that such an extension is necessary due to matters beyond the Group Benefits Plan's control. The claims administrator will notify the claimant, prior to the expiration of the initial 15-day period, of the circumstances that require the extension, and the date by which the claims administrator expects to render a decision.

If an extension is necessary due to the claimant's failure to submit the information necessary to decide the claim, the notice of extension will describe the required information. The claimant will then have at least 45 days from receipt of the notice within which to provide the specified information. The period within which the claims administrator is required to make a decision is then suspended from the date on which the notification is sent to the claimant until the earlier of the date the claimant responds to the request for additional information, or the due date established by the claims administrator for furnishing the requested information. If the claimant provides additional information in response to such a request, a decision will be rendered within 15 days of when the information is received by the Plan.

Post-Service Claim

In the case of a claim that is filed after the claimant receives care, the claims administrator will notify the claimant of the denial within 30 days after receipt of the claim. The claims administrator may extend the period for making the benefit determination by 15 days if it determines that such an extension is necessary due to matters beyond the Group Benefits Plan's control. The claims administrator will notify the claimant, prior to the expiration of the initial 30-day period, of the circumstances that require the extension of time and the date by which the claims administrator expects to render a decision. If the claimant provides additional information in response to such a request, a decision will be rendered within 15 days of when the information is received by the Plan.

If an extension is necessary due to the claimant's failure to submit the information necessary to decide the claim, the notice of extension will describe the required information. The claimant will then have at least 45 days from receipt of the notice within which to provide the specified information. The period in which the claims administrator is required to make a decision is then suspended from the date on which the notification is sent to the claimant until the earlier of the date the claimant responds to the request for additional information, or the due date established by the claims administrator for furnishing the requested information. If the claimant provides additional information in response to such a request, a decision will be rendered within 15 days of when the information is received by the Plan.

Disability Claim

In the case of a benefit claim that requires a determination of disability (including, but not limited to, a claim involving a decision whether a child is disabled for purposes of eligibility under the Group Benefits Plan), the claims administrator will notify the claimant of the denial within 45 days after receipt of the claim. The claims administrator may extend the period for making the benefit determination by 30 days if it determines that such extension is necessary due to matters outside the Group Benefits Plan's control. The claims administrator will notify the claimant, prior to the expiration of the 45-day period, of circumstances requiring the extension of time and the date by which the claims administrator expects to render a decision. The claims administrator may extend the period for making the benefit determination by an additional 30 days if it determines that such additional extension is necessary due to matters outside the Group Benefits Plan's control. The claims administrator will notify the claimant, prior to the expiration of the first 30-day extension period, of circumstances requiring the

additional extension of time and the date by which the claims administrator expects to render a decision. All notices of extension will specifically explain the standards on which entitlement to a benefit is based, the unresolved issues that prevent a decision on the claim, and the additional information needed to resolve those issues, and you will have at least 45 days from receipt of the notice within which to provide the specified information.

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

Manner and Content of Notification of Denied Claim

The claims administrator will provide the claimant with notice of any denial, in accordance with applicable U.S. Department of Labor (DOL) regulations. In the case of a denial concerning a claim that involves urgent care, notice of the denial may be provided orally, provided that a written or electronic notice is furnished to the claimant within three days of the oral notice. For the Group Health and Regional Medical Options Programs and for all disability claims under the Dental Benefits, Vision Care and Employee Assistance Programs, the notices will be provided in a culturally and linguistically appropriate manner.

The notification of a denial will include:

- The specific reason or reasons for the denial;
- Reference to the specific Group Benefits Plan provision(s) on which the determination is based;
- A description of any additional material or information necessary for the claimant to perfect the claim, and an explanation of why such material or information is necessary; and
- In the case of a denial involving a benefit claim, it will also include:
  - If an internal rule, guideline, protocol, or other similar criterion was relied upon in making the denial, the specific rule, guideline, protocol, or other similar criterion that was relied upon, or a statement that such rule, guideline, protocol, or similar criterion was relied upon and that a copy will be provided free of charge to the claimant upon request;
  - If the denial is based on medical necessity, experimental treatment, or a similar exclusion or limit, an explanation of the scientific or clinical judgment relied upon for the determination, applying the terms of the Group Benefits Plan to the claimant's medical circumstances, or a statement that such explanation will be provided free of charge upon request;

- Identification of any medical or vocational experts whose advice was obtained in connection with the denial, regardless of whether the advice was relied upon in making the determination;
- For Group Health and Regional Medical Options Programs –
  - Information sufficient to identify the claim involved, including the date of service, the health care provider, the claim amount (if applicable), and a statement describing, upon request, the diagnosis code and its corresponding meaning, and the treatment code and its corresponding meaning;
  - The denial code and its corresponding meaning (if applicable), as well as a description of the Group Benefits Plan's standard, if any, that was used in the claim denial; and
  - The availability of, and contact information for, any applicable office of health insurance consumer assistance or ombudsman to assist the claimant with the internal and external claims processes;

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

- A description of the Group Benefits Plan's review procedures (internal appeals and external review processes, including information regarding how to initiate an appeal), the time limits applicable to such procedures, the claimant's right to bring a civil action under Section 502(a) of ERISA following a claim denial on review (see below), and the expedited review process if the claim involves urgent care.

Review of Initial Benefit Denial

Procedure for Filing an Initial Appeal of a Denial

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

Review Procedures for Appeals of Denials

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

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

consulted in connection with the denial that is the subject of the review nor the subordinate of such individual.

- The claims administrator will identify any medical or vocational experts whose advice was obtained on behalf of the Group Benefits Plan in connection with the claimant's denial, without regard as to whether the advice was relied upon in making the benefit determination.
- In the case of a claim that involves urgent care, an expedited review process will be provided. The claimant must request an expedited appeal orally or in writing, and all necessary information, including the Group Benefits Plan's benefit determination on review, must be transmitted between the Group Benefits Plan and the claimant by telephone, facsimile, or other available similarly expeditious method.
- In the case of Group Health Program, Regional Medical Options Program, and for disability claims under the EAP, Dental Benefit and Vision Care Programs, the claims administrator will provide the claimant, free of charge, with any new or additional evidence considered, relied upon, or generated by the claims administrator (or at the direction of the claims administrator) in connection with the claim and any new or additional rationale for a claim determination. Such evidence or rationale, as applicable, must be provided as soon as possible and sufficiently in advance of the date on which the notice of final internal adverse benefit determination is required to be provided to give the claimant a reasonable opportunity to respond prior to that date. If new or additional rationale is received close to the date on which the claims administrator must provide notice of the claim determination on review, the period for providing the determination on review will be automatically tolled until such time as the claimant has a reasonable opportunity to respond. In the case of disability claims, the claims administrator may extend the time to respond where the claims administrator determines that special circumstances require an extension of time for processing the review of the claim.

Timing of Notification of Initial Benefit Determination on Review

The chart below shows the time limit for the Plan to notify you of the initial appeal decision:

Time Limit for…	Urgent Care Claim	Pre-Service Claim	Post-Service Claim
BCBSIL	As soon as possible, taking into account the medical exigencies, but no more than 72 hours after receiving the initial appeal.	Within a reasonable time appropriate to medical circumstances, but no more than 30 days after receiving the initial appeal.	Within a reasonable period, but no more than 60 days after receiving the initial appeal.
CVS Caremark – Benefit Claims	As soon as possible, taking into account the medical exigencies, but no more than 72 hours after receiving the initial appeal.	Within a reasonable time appropriate to medical circumstances, but no more than 15 days after receiving the initial appeal.	Within a reasonable period, but no more than 60 days after receiving the initial appeal.
CVS Caremark – Coverage Claims	As soon as possible, taking into account the medical exigencies, but no more than 72 hours after receiving the initial appeal.	Within a reasonable time appropriate to medical circumstances, but no more than 30 days after receiving the initial appeal.	Within a reasonable period, but no more than 60 days after receiving the initial appeal.
EAP, Dental Benefit and Vision Care Program Claims	Within 72 hours after receipt of the claimant's request for review.	Within 30 days after receipt of the request for review.	Within 60 days after receipt of the request for review.
In the case of a benefit claim under the Group Health and Regional Medical Options Programs, the Group Benefits Plan will continue to provide coverage pending the outcome of a claim on review (see below) to the extent required by the Affordable Care Act, which generally provides that benefits for an ongoing course of treatment cannot be reduced or terminated without providing advance notice and an opportunity for advance review.			

Manner and Content of Notification of Benefit Determination on Review

The claims administrator will provide a written or electronic notice of the Group Benefits Plan's benefit determination on review, in accordance with applicable DOL regulations. If the claimant's appeal is denied, the notification will include (and for the Group Health and Regional Medical Options Programs and for all disability claims under the Dental Benefits, Vision Care and Employee Assistance Programs, the notices will be provided in a culturally and linguistically appropriate manner):

- The specific reason or reasons for the denial;
- Reference to the specific Group Benefits Plan provision(s) on which the determination is based;
- A statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all relevant documents;
- In the case of a denial involving a benefit claim, it will also include:
  - If an internal rule, guideline, protocol, or other similar criterion was relied upon in making the denial, the specific rule, guideline, protocol, or other similar criterion that was relied upon, or a statement that such rule, guideline, protocol, or similar criterion was relied upon and that a copy will be provided free of charge to the claimant upon request;
  - If the denial is based on medical necessity, experimental treatment, or a similar exclusion or limit, an explanation of the scientific or clinical judgment relied upon for the determination, applying the terms of the Group Benefits Plan to the claimant's medical circumstances, or a statement that such explanation will be provided free of charge upon request;
  - Identification of any medical or vocational experts whose advice was obtained in connection with the denial, regardless of whether the advice was relied upon in making the determination;
  - For the Group Health and Regional Medical Options Programs:
    - Information sufficient to identify the claim involved, including the date of service, the health care provider, the claim amount (if applicable), and a statement describing, upon request, the diagnosis code and its corresponding meaning, and the treatment code and its corresponding meaning;
    - The denial code and its corresponding meaning (if applicable), as well as a description of the Group Benefits Plan's standard, if any, that was used in the claim denial, and a discussion of the decision; and
    - The availability of, and contact information for, any applicable office of health insurance consumer assistance or ombudsman to assist the claimant with the internal and external claims processes;
- In the case of a denial involving a disability claim, it will also include:

- A discussion of the decision, including an explanation of the basis for disagreeing with or not following:
  - The views presented by the claimant to the Group Benefits Plan of health care professionals treating the claimant and vocational professionals who evaluated the claimant;
  - The views of medical or vocational experts whose advice was obtained on behalf of the Group Benefits Plan in connection with a claimant's denial, without regard to whether the advice was relied upon in the claim denial; and
  - A disability determination regarding the claimant presented by the claimant to the Group Benefits Plan made by the Social Security Administration;

- Either:
  - The specific internal rules, guidelines, protocols, standards, or other similar criteria of the Group Benefits Plan that was relied upon in the claim denial; or
  - A statement that such rules, guidelines, protocols, standards, or other similar criteria of the Group Benefits Plan do not exist;

- If the denial was based on medical necessity or experimental treatment or similar exclusion or limit, the denial will provide either:
  - An explanation of the scientific or clinical judgment relied upon for the claim denial, applying the terms of the Group Benefits Plan to the claimant's medical circumstances; or
  - A statement that such explanation will be provided free of charge upon request; and

- A statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claimant's disability claim; and
- A statement describing any appeal procedures offered by the Group Benefits Plan (internal appeals, external review processes, and/or voluntary appeals, including information regarding how to initiate an appeal) and the claimant's right to obtain information about such procedures, including a statement of the claimant's right to bring a civil action under Section 502(a) of ERISA following a denial on review. With respect to claims:
- For the Group Health and Regional Medical Options Programs – requiring a determination of disability, if the statement is in connection with the final internal appeal (first or second as applicable), such statement will also include any applicable contractual limitations period that applies to the claimant's right to bring such action, including the calendar date on which the contractual limitations period expires for the claim.
- For the Dental Benefit and Vision Care Programs – regarding disability, such statement will also include any applicable contractual limitations period that applies to the claimant's right to bring such action, including the calendar date on which the contractual limitations period expires for the claim.

Second Review of Initial Benefit Denial

For additional information about the availability of a second review of initial benefit denial under the Regional Medical Options, Dental Benefit or Vision Care Programs, see the applicable Member Certificates. However, if the second level appeal procedures contained in the Member Certificate do not comply with ERISA, then the claim procedures in this *Administration Booklet* supplement the claims and appeals procedures described in the applicable Member Certificate.

Procedure for Filing a Second Appeal of a Denial

BCBSIL does not provide a second level of internal appeals nor does the Employee Assistance Program. CVS Caremark requires a second level of appeals for certain types of claims. If the claims administrator provides for a second level of internal appeals, a claimant must bring a second appeal of a denial to the claims administrator within the time period for the applicable type of claim described below in the chart under **Timing of Notification of Second Benefit Determination on Review**.

Review Procedures for Second Appeals of Denials

The claims administrator will review second appeals of denials in the same manner as described above in **Review Procedures for Appeals of Denials**.

Timing and Notification of Second Benefit Determination on Review

The chart below shows the time limit for you and the claims administrator on second level appeals:

Time Limit for…	Urgent Care Claim	Pre-Service Claim	Post-Service Claim
Time Limit for You to File a Second Internal Appeal			
EAP	N/A	N/A	N/A
BCBSIL	N/A	N/A	N/A
CVS Caremark – Benefit Claims	If an initial appeal is denied, CVS Caremark will automatically initiate the second level appeal.	180 days after receiving the initial notification of benefit determination on review.	180 days after receiving the initial notification of benefit determination on review.
CVS Caremark – Coverage Claims	N/A	N/A	N/A
Time Limit for the Plan to Notify You of the Final Appeal Decision			
EAP	N/A	N/A	N/A
BCBSIL	N/A	N/A	N/A
CVS Caremark – Benefit Claims	As soon as possible, taking into account the medical exigencies, but no more than 72 hours after receiving the second appeal.*	Within a reasonable time appropriate to medical circumstances, but no more than 15 days after receiving the second appeal.	N/A
CVS Caremark – Coverage Claims	N/A	N/A	N/A

* If the initial appeal involving an urgent care claim is denied, CVS Caremark will automatically initiate the second level appeal and will perform both the initial and second levels of appeals within 72 hours.

Manner and Content of Notification of Second Benefit Determination on Review

The claims administrator will provide a written or electronic notice of the Group Benefits Plan's benefit determination on review, in accordance with applicable DOL regulations. If the claimant's appeal is denied, the notification will include (for the Group Health and Regional Medical Options Programs and for all disability claims under the Dental Benefits, Vision Care and Employee Assistance Programs, the notices will be provided in a culturally and linguistically appropriate manner):

- The specific reason or reasons for the denial;
- Reference to the specific Group Benefits Plan provision(s) on which the determination is based;
- A statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all relevant documents;
- In the case of a denial involving a benefit claim, it will also include:
  - If an internal rule, guideline, protocol, or other similar criterion was relied upon in making the denial, the specific rule, guideline, protocol, or other similar criterion that was relied upon, or a statement that such rule, guideline, protocol, or similar criterion was relied upon and that a copy will be provided free of charge to the claimant upon request;
  - If the denial is based on medical necessity, experimental treatment, or a similar exclusion or limit, an explanation of the scientific or clinical judgment relied upon for the determination, applying the terms of the Group Benefits Plan to the claimant's medical circumstances, or a statement that such explanation will be provided free of charge upon request;
  - Identification of any medical or vocational experts whose advice was obtained in connection with the denial, regardless of whether the advice was relied upon in making the determination;
  - Information sufficient to identify the claim involved, including the date of service, the health care provider, the claim amount (if applicable), and a statement describing, upon request, the diagnosis code and its corresponding meaning, and the treatment code and its corresponding meaning;
  - The denial code and its corresponding meaning (if applicable), as well as a description of the Group Benefits Plan's standard, if any, that was used in the claim denial, and a discussion of the decision; and
  - The availability of, and contact information for, any applicable office of health insurance consumer assistance or ombudsman to assist the claimant with the internal and external claims processes;
- In the case of a denial involving a disability claim, it will also include:
  - A discussion of the decision, including an explanation of the basis for disagreeing with or not following:

- The views presented by the claimant to the Group Benefits Plan of health care professionals treating the claimant and vocational professionals who evaluated the claimant;
- The views of medical or vocational experts whose advice was obtained on behalf of the Group Benefits Plan in connection with a claimant's denial, without regard to whether the advice was relied upon in the claim denial; and
- A disability determination regarding the claimant presented by the claimant to the Group Benefits Plan made by the Social Security Administration;

- Either:
  - The specific internal rules, guidelines, protocols, standards, or other similar criteria of the Group Benefits Plan that was relied upon in the claim denial; or
  - A statement that such rules, guidelines, protocols, standards, or other similar criteria of the Group Benefits Plan do not exist;

- If the denial was based on medical necessity or experimental treatment or similar exclusion or limit, the denial will provide either:
  - An explanation of the scientific or clinical judgment relied upon for the claim denial, applying the terms of the Group Benefits Plan to the claimant's medical circumstances; or
  - A statement that such explanation will be provided free of charge upon request; and

- A statement describing any appeal procedures offered by the Group Benefits Plan (internal appeals, external review processes, and/or voluntary appeals, including information regarding how to initiate an appeal) and the claimant's right to obtain information about such procedures, including a statement of the claimant's right to bring a civil action under Section 502(a) of ERISA following a denial on review. With respect to claims requiring a determination of disability, if the statement is in connection with the final internal appeal (first or second as applicable), such statement will also include any applicable contractual limitations period that applies to the claimant's right to bring such action, including the calendar date on which the contractual limitations period expires for the claim.

External Review Procedures for Group Health Program

See the applicable Member Certificate for the external review procedures that apply to the Regional Medical Options Program.

A claimant may have the right to have an independent group of health care professionals who have no association with the Group Benefits Plan review any claimant's claim following a denial on review if such claim involves:

- Medical judgment (i.e., determinations based on requirements for medical necessity, appropriateness of care, health care setting, level of care, effectiveness of a covered benefit or determinations as to whether a treatment is experimental or investigational), as determined by an external reviewer; or
- A rescission of coverage (described above).

A claimant's request for an external review must be filed within four months after the date the claimant receives a denied appeal from the claims administrator.

Within five days of receiving the claimant's request for external review, the claims administrator will review whether certain requirements are met, and within one day of completing this review the claims administrator will provide the claimant with its determination of whether the claimant is eligible for external review, or whether additional information may be needed. If the claimant's request is not complete, such notification will describe the information or materials needed to make the request complete and the claimant will be allowed to perfect the request for external review within the four-month filing period or within the 48-hour period following the receipt of the notification, whichever is later.

If the claimant's request for external review meets the criteria for external review, the Group Benefits Plan will assign an accredited independent review organization to perform the external review. The independent review organization may request additional information in order to complete its review. The assigned independent review organization will include a statement that the claimant may submit additional information that the independent review organization will consider when conducting the external review. The independent review organization will review the claim de novo and will not be bound by any decisions or conclusions reached during the internal claims and appeals process.

Within 45 days of receiving the external review request, the assigned independent review organization will provide written notice of its final external review decision. The notice will contain:

- A general description of the reason for the request for external review, including information sufficient to identify the claim, including the date(s) of service, the health care provider, the claim amount (if applicable), the diagnosis code and its corresponding meaning, the treatment code and its corresponding meaning and the reason for the previous denial;
- The date the independent review organization received the assignment to conduct the external review and the date of the independent review organization's decision;
- References to the evidence or documentation, including the specific coverage provisions and evidence-based standards, considered in reaching the independent review organization's decision;
- A discussion of the principal reason or reasons for its decision, including the rationale for the independent review organization's decision and any evidence-based standards that were relied on in making the independent review organization's decision;
- A statement that the determination is binding except to the extent that other remedies may be available under state or federal law to either the claimant or the Plan;
- A statement that judicial review may be available to the claimant; and
- Current contact information, including the phone number, for any applicable office of health insurance consumer assistance or ombudsman.

If the independent review organization's decision is to reverse the Group Benefits Plan's denial, the Group Benefits Plan will immediately provide coverage or payment for the claim (including immediately authorizing care or immediately paying benefits) under review.

A claimant may request an expedited external review at the time he or she receives:

- A claim denial involving a medical condition for which the timeframe for completing an expedited internal appeal would seriously jeopardize claimant's life or health or would jeopardize the claimant's ability to regain maximum function and such claimant has filed an expedited internal appeal request; or
- A final claim denial involving: (i) a medical condition where the timeframe for completing a standard external review would seriously jeopardize the claimant's life or health or would jeopardize the claimant's ability to regain maximum function; or (ii) an admission, availability of care, continued stay, or health care service for which the claimant received emergency services, but has not been discharged from a facility.

Immediately upon receipt of a request for expedited external review, the claims administrator will determine whether the request meets the reviewability requirements for standard external review. The claimant will receive a notice regarding the claims administrator's reviewability assessment, containing the same information that would be provided under a standard external review notice. Upon a determination that a request is eligible for external review, the claims administrator will assign the claim to an independent review organization. The independent review organization will consider all appropriate information and documents, to the extent the information or documents are available. In reaching its decision, the independent review organization will review the claim de novo and is not bound by any decisions or conclusions reached during the internal claims and appeals process.

The independent review organization will provide the claimant with notice of the final external review decision as expeditiously as the claimant's medical condition or circumstances require, but in no event more than 72 hours after the independent review organization receives the request for an expedited external review. If the notice is not in writing, within 48 hours after the date of providing that notice, the independent review organization will provide the claimant with written confirmation of the decision. The notice must contain the same information that must be included in a written notice of a final decision in the context of standard external review, as described above.

Dental Benefit, Vision Care and Regional Medical Options Programs

Your Member Certificate may outline the claims and appeals procedures applicable to your claim with the dental benefit, vision care and regional fully insured HMO claims administrator. Those procedures will control unless they don't comply with ERISA or the ACA. If you have questions, you should contact the specific claims administrator to explain any difference.

Supplemental Benefits Program

For a detailed explanation of benefit claims and appeals procedures for the Supplemental Benefits Program, please refer to the applicable Member Certificate(s).

Life and Accident Program

For a detailed explanation of benefit claims and appeals procedures for the Life and Accident Insurance Program, please refer to the applicable Member Certificate.

Long-Term Disability Program

For a detailed explanation of benefit claims and appeals procedures for the Long-Term Disability Program please refer to the applicable Member Certificate.

Short-Term Disability Program

This section provides additional detail regarding filing disability claims and related information.

Claim Procedures for Claims Requiring a Determination of Disability

Claims and appeals for disability benefits will be adjudicated in a manner designed to ensure the independence and impartiality of the persons involved in making the decision. Accordingly, decisions regarding hiring, compensation, termination, promotion or other similar matters with respect to any individual (such as a claims adjudicator or medical or vocational expert) shall not be made based upon the likelihood that the individual will support the denial of benefits.

If the claims administrator fails to strictly adhere to all the requirements of ERISA with respect to a claim, you are deemed to have exhausted the administrative remedies available under the Plan, with certain exceptions. Accordingly, you are entitled to bring a civil action to pursue any available remedies under Section 502(a) of ERISA on the basis that the claims administrator has failed to provide a reasonable claims procedure that would yield a decision on the merits of the claim. If you choose to bring a civil action to pursue remedies under Section 502(a) of ERISA under such circumstances, your claim or appeal is deemed denied on review without the exercise of discretion by an appropriate fiduciary. However, the administrative remedies available under the Plan will not be deemed exhausted based on de minimis violations that do not cause, and are not likely to cause, prejudice or harm to you so long as the claims administrator demonstrates that the violation was for good cause or due to matters beyond the control of the claims administrator and that the violation occurred in the context of an ongoing, good faith exchange of information between the claims administrator and you. This exception is not available if the violation is part of a pattern or practice of violations by the claims administrator. Before filing a civil action, you may request a written explanation of the violation

from the claims administrator, and the claims administrator must provide such explanation within 10 days, including a specific description of its basis, if any, for asserting that the violation should not cause the administrative remedies available under the Plan to be deemed exhausted. If a court rejects your request for immediate review on the basis that the claims administrator met the standards for the exception, your claim shall be considered as re-filed on appeal upon the claims administrator's receipt of the decision of the court. Within a reasonable time after the receipt of the decision, the claims administrator shall provide you with notice of the resubmission.

Claims for Benefits

If you or your authorized representative would like to file a claim for benefits, you or your authorized representative should obtain a claim form(s) from your Employer or Plan Administrator. The applicable section of such form(s) must be completed by you, the Employer or Plan Administrator, and the attending physician or hospital. Following completion, the claim form(s) must be forwarded to the claims administrator's claim representative. The claims administrator will evaluate your claim and determine if benefits are payable.

The claims administrator will make a decision no more than 45 days after receipt of your properly filed claim. The time for decision may be extended for two additional 30-day periods provided that, prior to any extension period, the claims administrator notifies you in writing that an extension is necessary due to matters beyond the control of the claims administrator, identifies those matters and gives the date by which it expects to render its decision. If your claim is extended due to your failure to submit information necessary to decide your claim, the time for the decision may be tolled from the date on which the notification of the extension is sent to you until the date the claims administrator receives your response to its request. If the claims administrator approves your claim, the decision will contain information sufficient to reasonably inform you of that decision.

Any adverse benefit determination will be in writing and include:

- The specific reason or reasons for the decision;
- Specific references to the Plan provisions on which the decision is based;
- A description of any additional material or information necessary for you to perfect the claim and an explanation of why such material or information is necessary;
- A description of the claims administrator's review procedures and time limits applicable to such procedures;
- A statement that you have the right to bring a civil action under Section 502(a) of ERISA after you appeal the decision and after you receive a written denial on appeal;
- A discussion of the decision, including an explanation of the basis for disagreeing with or not following:
  - The views presented by you to the claims administrator of health care professionals treating you and vocational professionals who evaluated you;
  - The views of medical or vocational experts whose advice was obtained on behalf of the claims administrator in connection with the adverse benefit determination,

without regard to whether the advice was relied upon in making the benefit determination; and

- A disability determination regarding you presented by you to the claims administrator made by the Social Security Administration;

- If the adverse benefit determination is based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to your medical circumstances, or a statement that such explanation will be provided free of charge upon request;
- Either the specific internal rules, guidelines, protocols, standards or other similar criteria of the claims administrator relied upon in making the adverse determination or, alternatively, a statement that such rules, guidelines, protocols, standards or other similar criteria of the claims administrator do not exist;
- A statement that you are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to your claim for benefits; and
- A statement prominently displayed in any applicable non-English language clearly indicating how to access the language services provided by the claims administrator.

Appealing Denials of Claims for Benefits

On any wholly or partially denied claim, you or your representative may appeal to the claims administrator for a full and fair review. You must complete this claim appeal process before you file an action in court, with the exception of an action under the deemed exhausted process described above. Your appeal request must be in writing and be received by the claims administrator no later than the expiration of 180 days from the date you received your claim denial. As part of your appeal:

- You may request, free of charge, copies of all documents, records, and other information relevant to your claim; and
- You may submit written comments, documents, records and other information relating to your claim.

The claims administrator's review on appeal shall take into account all comments, documents, records and other information submitted by you relating to the claim, without regard to whether such information was submitted or considered in the initial benefit determination.

Before the claims administrator can issue an adverse benefit determination on review, the claims administrator shall provide you, free of charge, with any new or additional evidence considered, relied upon, or generated by the claims administrator (or at the direction of the claims administrator) in connection with the claim; such evidence must be provided as soon as possible and sufficiently in advance of the date on which the notice of adverse benefit determination on review is required to be provided to give you a reasonable opportunity to respond prior to that date.

Before the claims administrator can issue an adverse benefit determination on review based on a new or additional rationale, the claims administrator shall provide you, free of charge, with the rationale; the rationale must be provided as soon as possible and sufficiently in advance of the date on which the notice of adverse benefit determination on review is required to be provided to give you a reasonable opportunity to respond prior to that date.

The claims administrator will make a final decision no more than 45 days after it receives your timely appeal. The time for the final decision may be extended for one additional 45-day period provided that, prior to the extension, the claims administrator notifies you in writing that an extension is necessary due to special circumstances, identifies those circumstances and gives the date by which it expects to render its decision. If your claim is extended due to your failure to submit information necessary to decide your claim on appeal, the time for the decision shall be tolled from the date on which the notification of the extension is sent to you until the date the claims administrator receives your response to the request. The claims administrator may also toll the time for a decision to allow you a reasonable opportunity to respond to new or additional evidence or a new or additional rationale. Tolling will begin on the date that the claims administrator provides you with new or additional evidence or a new or additional rationale, and end when the claims administrator receives the response or on the date by which the claims administrator has requested a response, whichever comes first.

The individual reviewing your appeal shall give no deference to the initial benefit decision and shall be an individual who is neither the individual who made the initial benefit decision, nor the subordinate of such individual. The review process provides for the identification of the medical or vocational experts whose advice was obtained in connection with an initial adverse decision, without regard to whether that advice was relied upon in making that decision. When deciding an appeal that is based in whole or part on medical judgment, the claims administrator will consult with a medical professional having the appropriate training and experience in the field of medicine involved in the medical judgment and who is neither an individual consulted in connection with the initial benefit decision, nor a subordinate of such individual. If the claims administrator grants your claim appeal, the decision will contain information sufficient to reasonably inform you of that decision. However, any final adverse benefit determination on review will be in writing and include:

- The specific reason or reasons for the decision;
- Specific references to the Plan provisions on which the decision is based;
- A statement that you are entitled to receive, upon request and free of charge, copies of all documents, records, and other information relevant to your claim;
- A statement (a) that you have the right to bring a civil action under Section 502(a) of ERISA, and (b) in the case of a final level of appeal, describing any applicable contractual limitations period that applies to your right to bring such an action, including the calendar date on which the contractual limitations period expires for the claim;
- A discussion of the decision, including an explanation of the basis for disagreeing with or not following:
  - The views presented by you to the claims administrator of health care professionals treating you and vocational professionals who evaluated you;

  - The views of medical or vocational experts whose advice was obtained on behalf of the claims administrator in connection with the adverse benefit determination, without regard to whether the advice was relied upon in making the benefit determination; and
  - A disability determination regarding you presented by you to the claims administrator made by the Social Security Administration;
- If the adverse benefit determination is based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to your medical circumstances, or a statement that such explanation will be provided free of charge upon request;
- Either the specific internal rules, guidelines, protocols, standards or other similar criteria of the claims administrator relied upon in making the adverse determination or, alternatively, a statement that such rules, guidelines, protocols, standards or other similar criteria of the Plan do not exist;
- A statement prominently displayed in any applicable non-English language clearly indicating how to access the language services provided by the claims administrator; and
- Any other notice(s), statement(s) or information required by applicable law.

Second Level of Appeal for Short Term Disability Claims

If your Short Term Disability appeal is denied, you or your authorized representative can file a second level of appeal. A second level of appeal must be submitted in writing within 60 days after you receive notification of the decision on the first level of appeal. As with the first level of appeal, you should submit any additional information or documentation that you would like to have considered as part of the second level of appeal. You may also request copies, free of charge, of all documents, records, and other information relevant to your appeal. As with the first level of appeal, you will be notified of the decision, in writing, no later than 45 days after the appeal is received.

The individual reviewing your appeal will give no deference to the initial benefit or appeal decision and shall be an individual who is neither the individual who made the initial benefit or appeal decision, nor the subordinate of such individual. The review process provides for the identification of the medical or vocational experts whose advice was obtained in connection with an appeal decision, without regard to whether that advice was relied upon in making that decision. When deciding an appeal that is based in whole or part on medical judgment, the claims administrator will consult with a medical professional having the appropriate training and experience in the field of medicine involved in the medical judgment and who is neither an individual consulted in connection with the initial benefit or appeal decision, nor a subordinate of such individual.

In all other respects, the procedures for the second level of appeal will be the same as for the first level of appeal.

Claim Procedures for Claims Not Requiring a Determination of Disability

Claims and appeals for benefits will be adjudicated in a manner designed to ensure the independence and impartiality of the persons involved in making the decision. Accordingly, decisions regarding hiring, compensation, termination, promotion or other similar matters with respect to any individual (such as a claims adjudicator or medical expert) shall not be made based upon the likelihood that the individual will support the denial of benefits.

Claims for Benefits

If you or your authorized representative would like to file a claim for benefits for yourself or your insured dependents, you or your authorized representative should obtain a claim form(s) from your Employer or Plan Administrator. The applicable section of such form(s) must be completed by you, the Employer or Plan Administrator, and the attending physician or hospital. Following completion, the claim form(s) must be forwarded to the claims administrator's claim representative. The claims administrator will evaluate your claim and determine if benefits are payable.

The claims administrator will make a decision no more than 90 days after receipt of your properly filed claim. However, if the claims administrator determines that special circumstances require an extension, the time for its decision will be extended for an additional 90 days, provided that, prior to the beginning of the extension period, the claims administrator notifies you in writing of the special circumstances and gives the date by which it expects to render its decision. If extended, a decision shall be made no more than 180 days after your claim was received. If the claims administrator approves your claim, the decision will contain information sufficient to reasonably inform you of that decision.

However, any adverse benefit determination will be in writing and include:

- Specific reasons for the decision;
- Specific references to Plan provisions on which the decision is based;
- A description of any additional material or information necessary for you to perfect the claim and an explanation of why such material or information is necessary;
- A description of the review procedures and time limits applicable to such; and
- A statement that you have the right to bring a civil action under Section 502(a) of ERISA after you appeal our decision and after you receive a written denial on appeal.

Appealing Denials of Claims for Benefits

On any wholly or partially denied claim, you or your representative may appeal to the claims administrator for a full and fair review. You must complete this claim appeal process before you file an action in court. Your appeal request must be in writing and be received by the claims administrator no later than the expiration of 60 days from the date you received your claim denial. As part of your appeal:

- You may request, free of charge, copies of all documents, records, and other information relevant to your claim; and
- You may submit written comments, documents, records and other information relating to your claim.

The claims administrator's review on appeal shall take into account all comments, documents, records and other information submitted by you relating to the claim, without regard to whether such information was submitted or considered in the initial benefit determination.

The claims administrator will make a final decision no more than 60 days after it receives your timely appeal. However, if the claims administrator determines that special circumstances require an extension, the time for its decision will be extended for an additional 60 days, provided that, prior to the beginning of the extension period, the claims administrator notifies you in writing of the special circumstances and gives the date by which it expects to render its decision. If extended, a decision shall be made no more than 120 days after your appeal was received. If the claims administrator grants your claim appeal, the decision will contain information sufficient to reasonably inform you of that decision.

However, any final adverse benefit determination on review will be in writing and include:

- Specific reasons for the decision and specific references to the Plan provisions on which the decision is based;
- A statement that you are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records and other information relevant to the claim;
- A statement of your right to bring a civil action under Section 502(a) of ERISA; and
- Any other notice(s), statement(s) or information required by applicable law.

Legal Action

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

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

For the Group Health, Regional Medical Options and Employee Assistance Programs and disability claims in the Dental Benefit and Vision Care Programs, notwithstanding the previous paragraph, if the Plan fails to adhere to all of the requirements of the procedures set forth above for disability claims, benefits claims, or eligibility claims involving rescissions of coverage, then to the extent required by law, the claimant may initiate an external review (in the case of

certain Group Health and Regional Medical Options Program claims) or bring an action in an appropriate court under state law or Section 502(a) of ERISA, but only if the action is commenced no later than the earlier of (1) the applicable statute of limitations, or (2) the first anniversary of the claims administrator's decision on appeal. However, the claimant cannot initiate an external review or bring an action in an appropriate court under state law or Section 502(a) of ERISA without first exhausting the claims procedures set forth above if the violation:

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

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

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

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

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

PLAN ADMINISTRATION

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

Plan and Contact Information

Type of Plan

The Group Benefits Plan is a welfare benefit plan. Its objective, for eligible employees and their covered eligible dependents, is to provide the following types of benefits:

- Group Health, Regional Medical Options, Dental Benefit and Vision Care Programs – reimburse non-occupational health care expenses in accordance with the terms of the program
- Supplemental Benefits Program – provide accident, hospital indemnity and critical illness insurance benefits
- Employee Assistance Program (EAP) – provide resources, referrals and short-term counseling to help meet employees' work and home life needs
- Life and Accident Insurance Program – provide life and accidental death & dismemberment benefits in accordance with the terms of the program
- Disability Programs – provide short-term and long-term disability wage replacement benefits in accordance with the terms of the programs

Plan Sponsor

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

Employer Identification Number of Plan Sponsor

36-1004130

Plan Name and Number

R. R. Donnelley & Sons Company Group Benefits Plan – 504

Plan Year End

December 31

Agent for Service of Legal Process

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

Legal process also may be served on the Benefits Committee.

Benefits Committee and Plan Administrator

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

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

Participating Employers

The Group Benefits Plan described in this *Administration Booklet* applies to employees of Participating Employers to whom benefits have been extended. The Plan Administrator and eligibility administrator maintain records regarding Participating Employers.

If you have questions concerning your eligibility to participate in the Group Benefits Plan, call the RRD Benefits Center, which is the Group Benefits Plan's eligibility administrator.

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

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

If you have questions concerning your eligibility to participate in the Group Benefits Plan, call the eligibility administrator listed under *Eligibility Administrator* below.

A complete list of the employers sponsoring the Group Benefits Plan may be obtained for examination by you or your eligible dependents upon written request to the RRD Benefits Center. Also, you or your eligible dependents may receive from the RRD Benefits Center, upon written request, information as to whether a particular employer is a sponsor of the Group Benefits Plan and, if the employer is a sponsor, the sponsor's address.

Eligibility Administrator

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

RRD Benefits Center
P.O. Box 617907
Chicago, IL 60661

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

Contact the RRD Benefits Center to:

- Enroll
- Verify benefit eligibility
- Remove a former eligible dependent who is no longer eligible from coverage
- Report a Qualified Status Change
- Ask a question about Qualified Status Changes
- Report an address change (inactive participants only)
- Ask general benefit questions

If you want to enroll yourself or an eligible dependent in the Group Benefits Plan, you must follow the enrollment procedures provided herein and included in the Annual Enrollment materials established by the Benefits Committee.

Claims Administrators

If you have questions about a specific benefit, contact the appropriate claims administrator as shown in the chart below.

Program and Options	Claims Administrator
Eligibility • Eligibility questions and claims • Appeals of denials on eligibility	RRD Benefits Center P.O. Box 617907 Chicago, IL 60661 **1-877-RRD-4BEN (1-877-773-4236)** Benefits Center Representatives are available from 7 a.m. to 7 p.m. CT, Monday through Friday

Program and Options	Claims Administrator
Group Health Program	
Medical Program • HSA Value • HSA Advantage • Copay Value • Copay Advantage • BCBSIL Indemnity	Blue Cross and Blue Shield of Illinois P.O. Box 805107 Chicago, IL 60680 **1-800-537-9765,** Monday – Friday, 7 a.m. – 7 p.m. CT **www.bcbsil.com/rrd**
Prescription Drug Program	CVS Caremark Attn: Claims Department P.O. Box 52196 Phoenix, AZ 85072-2196 **1-866-273-8402** Caremark Customer Care Representatives are available 24 hours a day, 7 days a week. **www.caremark.com**
Regional Medical Options Program	
Illinois • Blue Advantage HMO • BCBS McKay	Blue Cross and Blue Shield of Illinois P.O. Box 805107 Chicago, IL 60680 **1-800-537-9765,** Monday – Friday, 7 a.m. – 7 p.m. CT **www.bcbsil.com/rrd**
Wisconsin • Dean Health Plan HMO • Prevea360 Health Plan	Dean Health Plan P.O. Box 56099 Madison, WI 53705-7674 **1-800-279-1301,** Monday – Friday, 7:30 a.m. – 5 p.m. CT **www.deancare.com** Prevea360 Health Plan P.O. Box 56099 Madison, WI 53705-7674 **www.prevea360.com** **1-877-230-7555,** Monday – Friday, 7 a.m. – 7 p.m. CT

Program and Options	Claims Administrator
California Kaiser Permanente HMO Kaiser HSA Option	Kaiser Permanente **Member Services Assistance number: 1-800-464-4000,** representatives available 24/7 excluding major holidays **Member Services claims number: 1-800-390-3510,** representatives are available Monday – Friday, 8 a.m. – 5 p.m. CT for claims filing requirements or status inquiries. **www.kp.org/memberservices** **Southern CA:** Claims Department P.O. Box 7004 Downey, CA 90242-7004 **Northern CA:** Claims Department P. O. Box 12923 Oakland, CA 94604-2923
Oregon Kaiser Permanente HMO Kaiser HSA Option	Kaiser Permanente **Member Services Assistance number: 1-800-813-2000,** representatives available Sunday – Saturday, 8 a.m. – 6 p.m. PT, except for major holidays **Member Services claims number: 1-800-390-3510,** representatives are available Monday – Friday, 8 a.m. – 5 p.m. CT **www.kp.org/memberservices** **Oregon:** Claims Department See the Member Certificate for information on where to send your claim.

Program and Options	Claims Administrator
Other Programs	
Supplemental Benefits Program	Metropolitan Life Insurance Company 200 Park Avenue New York, NY 10166 **1-800-GET-MET8 (1-800-438-6388)** Monday – Friday, 7 a.m. – 10 p.m. CT **metlife.com/mybenefits**
Dental Benefit Program	Cigna For mailing address, call the Customer Service number on your Cigna ID Card. **1-800-656-1691,** 24 hours a day, 7 days a week **cigna.com**
Vision Care Program	FAA/EyeMed Vision Care, LLC Attn: Quality Assurance Department 4000 Luxottica Place Mason, OH 45040 **1-866-939-3633,** Monday – Saturday 6:30 a.m. – 10 p.m. CT; Sunday 10 a.m. – 7 p.m. CT **eyemed.com** For out-of-network claims: FAA/EyeMed Vision Care, LLC Attn: OOC Claims P.O. Box 8504 Mason, OH 45040-7111
Employee Assistance Program (EAP) Life & Wellness Resource Center	SupportLinc **1-888-881-5462**, 24 hours a day, 7 days a week **SupportLinc at www.supportlinc.com Code: rrd**
Health Savings Account, Health Care Spending Program and Dependent Day Care Spending Program	HealthEquity Attn: Member Services 15 W Scenic Pointe Drive, Suite 100 Draper, UT 84020 **1-844-281-0928,** 24 hours a day, 7 days a week **healthequity.com** Claims can also be faxed to: **1-801-727-1005**

Program and Options	Claims Administrator
Life and Accident Insurance Programs	Metropolitan Life Insurance Company 200 Park Avenue New York, NY 10166 **1-800-GET-MET8 (1-800-438-6388)** Monday – Friday, 7 a.m. – 10 p.m. CT **metlife.com/mybenefits** Note, please see **Insured Benefits** for information about who the claims administrator is for Insured Benefits.
Disability Programs • Short Term Disability (STD) • Long Term Disability (LTD)	The Hartford P.O. Box 14869 Lexington, KY 40512-4869 **1-866-271-0744,** Monday – Friday 8 a.m. – 8 p.mm CT except for major holidays **Fax:** 1-836-357-5153

COBRA Administrator

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

RRD Benefits Center
P.O. Box 617907
Chicago, IL 60661

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

Leave of Absence Administrator.

Contact the leave of absence administrator at the following address and phone number:

The Hartford
P.O. Box 14869
Lexington, KY 40512

1-866-271-0744
Fax: 1-833-357-5153

Call The Hartford to initiate an FMLA medical or personal disability leave of absence that runs concurrently with your short term disability. Representatives are available from 8 a.m. to 8 p.m. CT, Monday through Friday, excluding major holidays.

Allocation and Delegation of Fiduciary Responsibilities

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

Self-Funded Benefits

All of your benefits under the Group Health Program and the Short-Term Disability Program are funded by RRD's general assets. The benefits funded by RRD's general assets are not guaranteed by the claims administrators or network managers. The claims administrator's role is to provide services to the program.

Insured Benefits

The Group Benefits Plan is the policyholder for the funding of the policy under the Dental, Life and Accident Insurance, and LTD Programs. RRD is the policyholder for the funding of the Regional Options Program fully insured HMO policies and for the Fidelity Security Life Insurance Company insurance contract (Vision Care Program). These contracts or policies are guaranteed by the issuer and not RRD or the Group Benefits Plan. In addition, the issuer of such contract is the claims administrator (and network manager) with respect to such contract of insurance. EyeMed is the claims administrator and network manager with respect to such contract of insurance for the Vision Care Program.

YOUR ERISA RIGHTS

As a participant in the Group Benefits Plan, you and your enrolled eligible dependents are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974, as amended (ERISA). ERISA provides that all participants in the Group Benefits Plan are entitled to the following.

Receive Information About Your Group Benefits Plan and Benefits

Examine, without charge, at the Plan Administrator's office and at other specified locations, such as work sites and union halls, all documents governing the Group Benefits Plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the Group Benefits Plan with the U.S. Department of Labor (DOL) and available at the Public Disclosure Room of the Employee Benefits Security Administration.

Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Group Benefits Plan, including insurance contracts and collective bargaining agreements, copies of the latest annual report (Form 5500 Series), and an updated SPD. The Plan Administrator may make a reasonable charge for the copies.

Receive a summary of the Group Benefits Plan's annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of this Summary Annual Report.

Continue Group Health Plan Coverage

Continue health care coverage for you and/or your enrolled eligible dependents if there is a loss of coverage under the Group Health, Regional Medical, Dental Benefits, Vision Care or Employee Assistance Programs as a result of a qualifying event. You or your covered spouse or domestic partner may have to pay for such coverage. Review this *Administration Booklet* and the documents governing the Group Benefits Plan on the rules governing your COBRA continuation coverage rights.

Prudent Actions by Plan Fiduciaries

In addition to creating rights for Group Benefits Plan participants, ERISA imposes duties upon the people who are responsible for the operation of the Group Benefits Plan. The people who operate the Group Benefits Plan, called "fiduciaries" of the Group Benefits Plan, have a duty to do so prudently and in the interest of you and other Group Benefits Plan participants and beneficiaries. No one – including your employer, your union, or any other person – may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA.

Enforce Your Rights

If your claim for a welfare benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

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

If you have a claim for benefits that is finally denied or ignored, in whole or in part, you may file suit in a state or federal court. In addition, if you disagree with the Group Benefits Plan's decision or lack thereof concerning the qualified status of a domestic relations order or medical child support order, you may file suit in federal court. If it should happen that Group Benefits Plan fiduciaries misuse the Group Benefits Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court.

The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees; for example, if it finds your claim is frivolous.

Assistance with Your Questions

If you have any questions about the Group Benefits Plan, you should contact the RRD Benefits Center or the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210. You also may obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

DOCUMENTS THAT MAKE UP THE COMPLETE SPD

The following documents make up the **complete SPD** for the Group Benefits Plan:

- This Administration Booklet
- Group Health Program Booklet
- Dental Benefit Program Booklet
- Vision Care Program Booklet
- HMO Booklets:
  - BCBSIL HMO Booklet
  - Kaiser Oregon HMO Booklet
  - Death Health HMO Booklet
- Long Term Disability Benefits Booklet
- Short Term Disability Benefits Booklet
- Employee Assistance Program Booklet
- Life and Accident Insurance Program Booklet
- Supplemental Benefits Program Booklet
- Any Member Certificate, Certificate of Coverage, Evidence of Coverage, Certificate, or Schedule of Benefits
- Any SMMs:
  - 2020 COVID-19 & Your RRD Benefits
  - 2020 COVID-19 Suspension of Deadlines SMM
  - 2020 Reduction in Hours Qualified Status Changes
- Any SBCs
- Annual Enrollment materials
- Other plan summaries

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