RR DONNELLEY

2015 Summary of Material Modifications (SMM) for the R.R. Donnelley & Sons Company Group Benefits Plan

(The list of participating employers found in the subsection of the following SPDs titled "Participating Employers" found under the section of the SPD titled "Administrative and Contact Information" is revised by adding the Participating Employers listed below.)

Summary Plan Description for Dental Benefit Program
Summary Plan Description for Vision Care Program
Summary Plan Description for Disability Benefit Program
Summary Plan Description for Life and Accidental Death & Personal Loss Insurance Program
Summary Plan Description for HealthCare Spending Program and Dependent Care Spending Program
Summary Plan Description for HMO Program
Summary Plan Description for Qualified Status Changes (and the Participant Premium Program)

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RR DONNELLEY

2015 Summary of Material Modifications (SMM) for the Medical and Prescription Drug Programs under the R.R. Donnelley & Sons Company Group Benefits Plan

Introduction

The material that follows is a legally required notice of benefit plan changes generally effective January 1, 2015. It describes changes to certain options provided under the R.R. Donnelley & Sons Company Group Benefits Plan (the "Plan") for eligible participants.

The general rules related to each program are detailed in the Plan's Summary Plan Description effective as of January 1, 2013 ("SPD"), and this notice which constitutes the Summary of Material Modifications ("SMM") to that SPD. Similar to the SPD, when the term "Group Health Program" is used in this SMM, it refers collectively to the Medical Program administered by either BlueCross and Blue Shield of Illinois ("BCBSIL") or United HealthCare ("UHC") and the Prescription Drug Program administered by CVS Caremark. To make sure you have the most up-to-date information, keep this document with your SPD.

Effective January 1, 2015, the Group Benefits Plan includes all new Medical Program options designed to give Plan participants more choices in how to manage their health care expenses based on individual needs. Additionally, CVS Caremark will be the Prescription Drug Program administrator for all Medical Program options.

The information contained on the following pages of this SMM was prepared to help explain your coverage as of January 1, 2015 and to highlight the changes that were made effective as of January 1, 2015. Many, if not all of the changes that are highlighted in this SMM were communicated to you in your 2015 Annual Enrollment Guide.

As described more fully in the SPD, the SPD, any appendices thereto, along with this SMM is intended to be a complete, accurate, and up-to-date description of your coverage under the Group Health Program. However, since treatments, protocols, and practices continually change, even this SMM cannot adequately define every potentially covered service or exclusion as of a certain date. In each case, the claims administrator or network manager will have the authority or discretion to make the determination of whether an expense incurred is a covered expense. If there is any discrepancy between the SPD, its appendices, this SMM and the Plan, the Plan document always governs.

This SMM only covers the Group Health Program. In addition, nothing in this SMM, the SPD or its appendices should be interpreted as an employment contract. This SMM merely describes the material changes to the coverages and benefits offered to eligible participants from the date of the last SPD until January 1, 2015. RR Donnelley reserves the right to amend, change, or terminate the Plan or Group Health Program, in whole or in part, at any time.

This SMM contains a summary in English to supplement the information provided in the SPD and its appendices. If you have difficulty understanding any part of this content, call the RR Donnelley Benefits Center at 1-877-RRD-4BEN (1-877-773-4236). Benefits Center Representatives are available from 8 a.m. to 5 p.m. CT, Monday through Friday, except holidays.

Claims Administrators

(The following two paragraphs replace the first two paragraphs of the section of the SPD titled "Claims Administrators" found beginning on page 2 of the SPD.)

The Group Benefits Plan has contracted with a number of third parties to render services necessary to the operation and administration of the Group Health Program.

The chart below highlights the claims administrators and network managers.

The Medical Program	***Claims Administrators and Network Managers***
• UHC HSA Value	United HealthCare Insurance Company (UHC)*
• UHC HSA Advantage	United HealthCare Insurance Company (UHC)*
• UHC Copay Value	United HealthCare Insurance Company (UHC)*
• UHC Copay Advantage	United HealthCare Insurance Company (UHC)*
• BCBSIL HSA Value	Blue Cross and Blue Shield of Illinois (BCBSIL)**
• BCBSIL HSA Advantage	Blue Cross and Blue Shield of Illinois (BCBSIL)**
• BCBSIL Copay Value	Blue Cross and Blue Shield of Illinois (BCBSIL)**
• BCBSIL Copay Advantage	Blue Cross and Blue Shield of Illinois (BCBSIL)**
• BCBSIL Indemnity Option	Blue Cross and Blue Shield of Illinois (BCBSIL)**
The Prescription Drug Program	
• UHC HSA Value	CVS Caremark
• UHC HSA Advantage	CVS Caremark
• UHC Copay Value	CVS Caremark
• UHC Copay Advantage	CVS Caremark
• BCBSIL HSA Value	CVS Caremark
• BCBSIL HSA Advantage	CVS Caremark
• BCBSIL Copay Value	CVS Caremark
• BCBSIL Copay Advantage	CVS Caremark
• BCBIL Indemnity Option	CVS Caremark

*UHC is the claims administrator and network manager for the Medical Program.
**BCBSIL is the claims administrator and network manager for the Medical Program.

(The following section replace the section of the SPD titled "General Information" found under the section of the SPD titled "Who Is Eligible" beginning on page 10 of the SPD.)

General Information

You are eligible for coverage under the Group Health Program if you are classified as a:

- Full-time benefits-eligible employee of a Participating Employer;
- Part-time "A" employee of a Participating Employer;
- 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 Patient Protection and 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 Health Program participation.

You are not eligible for coverage under the Group Health Program 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 class "Z"; or
- A union employee represented by a collective bargaining agreement, except if such agreement allows for participation in the Group Health Program.

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

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

How the Group Health Program Works- General

(The following two paragraphs replace the first two paragraphs of the subsection of the SPD titled "General Information" found under the section of the SPD titled "How the Group Health Program Works – General" beginning on page 22 of the SPD.)

When you are first hired or during the Annual Enrollment period, you can enroll yourself and your eligible dependents in the Group Health Program. The Group Health Program offers a variety of options, including the following provided by the two national Medical Program claims administrators (BCBSIL and UHC):

- HSA Value
- HSA Advantage
- Copay Value
- Copay Advantage

(The following definitions replace the definitions of "Deductible" and "Emergency Care" found on pages 24 and 25 of the SPD in the subsection of the SPD titled "General Information" found under the section of the SPD titled "How the Group Health Program Works – General.")

Deductible – the deductible amount depends on which option you choose and the coverage category you select under the Group Health Program (You Only, You + Spouse, You + Child (ren), or You + Family). The deductible is the fixed-dollar amount that you pay out of your pocket each calendar year before the Group Health Program begins to pay benefits. You can only apply the amounts you incur for covered expenses toward your annual deductible, and any amount that you pay toward your deductible also is counted toward your annual Out-of-Pocket Limit (except for the excluded charges listed under the *Out-of-Pocket Limits* definition under this subsection).

Note: Co-Payments do not apply to your Deductible.

> If you enroll and elect "You Only" coverage, the individual deductible applies. If you elect any other coverage category, the total coverage category deductible applies collectively to all enrolled persons in the same family. As a result, the Group Health Program does not pay benefits for any one individual's claims until the total coverage category deductible is satisfied. One individual can meet the entire annual coverage category deductible by him/herself.

Emergency Care – regardless of whether you participate in the HSA Value, HSA Advantage, Copay Value, Copay Advantage [or the BCBSIL Indemnity option], in a medical emergency:

- You or your enrolled eligible dependents can go to any emergency facility or hospital, even one that is not participating in the network. You do not need authorization for emergency care.
- If you or your enrolled eligible dependents go to a hospital or a facility that does not contract with the claims administrator, you may have to pay the full cost of the emergency care, then file a claim for reimbursement.
- Call the claims administrator at the number listed on your ID card if you have questions about submitting your claim.
- If you or your enrolled eligible dependents receive emergency care at an out-of-network facility and the Group Health Program does not consider your or their condition to be a true emergency, you may be responsible for additional costs associated with your claim.

Post-emergency follow-up visits may be covered at the out-of-network benefit level (if applicable given your option) if the treating emergency room provider is not a Participating Provider.

(The following paragraph and chart replaces the paragraph and chart found in the subsection of the SPD titled "Key Features" found under the section of the SPD titled "How the Group Health Program Works – General" beginning on page 31 of the SPD.)

The chart below highlights some of the key features of each of the Group Health Program options. Under the HSA Value, HSA Advantage, Copay Value and Copay Advantage options, you have the flexibility to use any provider you want at any time, but you pay more for your covered services if they are performed by Non-Participating Providers.

HSA Value	***HSA Advantage***	***Copay Value***	***Copay Advantage***	***BCBSIL Indemnity***
You do not have to fill out any claim forms, as long as you receive in-network care.	You do not have to fill out any claim forms, as long as you receive in-network care.	You do not have to fill out any claim forms, as long as you receive in-network care.	You do not have to fill out any claim forms, as long as you receive in-network care.	You do not have to fill out any claim forms, as long as you receive in-network care.
The Program pays a higher level of benefit when you receive in-network care.	The Program pays a higher level of benefit when you receive in-network care.	The Program pays a higher level of benefit when you receive in-network care.	The Program pays a higher level of benefit when you receive in-network care.	The Program pays one level of benefit because there is no network of providers.
You are responsible for paying coinsurance after you have met the deductible requirement.	You are responsible for paying coinsurance after you have met the deductible requirement.	You are responsible for paying copay for certain services. Co insurance for other services after you have met the deductible requirement.	You are responsible for paying copay for certain services. Co insurance for other services after you have met the deductible requirement.	You are responsible for paying coinsurance after you have met the deductible requirement.
Participating providers agree to a reimbursement schedule that is lower than the Maximum Reimbursable Expense. As a result, they cannot bill you for the difference between their billed expense and their reimbursement schedule.	Participating providers agree to a reimbursement schedule that is lower than the Maximum Reimbursable Expense. As a result, they cannot bill you for the difference between their billed expense and their reimbursement schedule.	Participating providers agree to a reimbursement schedule that is lower than the Maximum Reimbursable Expense. As a result, they cannot bill you for the difference between their billed expense and their reimbursement schedule.	Participating providers agree to a reimbursement schedule that is lower than the Maximum Reimbursable Expense. As a result, they cannot bill you for the difference between their billed expense and their reimbursement schedule.	You are responsible for paying any amount above the Maximum Reimbursable Expense for the services you receive.

(The following subsection replaces the subsections of the SPD titled "Health Savings Account ("HSA")" and "Health Reimbursement Account ("HRA")" beginning on page 32 of the SPD.)

Health Savings Account ("HSA") and Flexible Spending Account ("FSA")

An HSA and FSA can help pay medical expenses you would otherwise have to pay from your own pocket. The HSA Value and HSA Advantage options offer an HSA, while the Copay Value and Copay Advantage options offer an FSA. The following is an overview of the accounts. (Separate materials are available during Annual Enrollment that describe HSAs and FSAs in detail.)

These accounts are tax-exempt savings account vehicles to fund future medical expenses. You can contribute to the account, up to a maximum amount, and build savings to meet your deductible and pay many other "qualified medical expenses" incurred now or in the future. Contributions, earnings, and withdrawals are all tax-free, provided you use them to pay qualified medical expenses.

All amounts that are deposited in your HSA are yours to keep—even if you change jobs or retire. Your HSA is an actual, individual interest-bearing savings account that is separate from the Group Health Program. You decide how to use the money from your HSA. After you receive your bill for medical expenses, decide whether to pay the amount from your HSA (using a debit card or checking account attached to your HSA), or to pay with non-HSA money. If you pay with non-HSA dollars, you can save the HSA money in your account for the future. Important note: The IRS does not allow domestic partners to withdraw funds from an HSA.

Amounts that are deposited in your FSA can only be used to pay expenses incurred within the plan year After such time, you lose any money that you have left over in your FSA, so it is important to plan carefully and not to put more money in your FSA than you think you will spend within the plan year on qualified medical expenses.

You can use either account to pay your coinsurance, unreimbursed expenses for dental care, braces, eyeglasses, contact lenses, and more. You can learn more about qualified medical expenses by reviewing Publication 502 at www.irs.gov. However, you can only use your HSA for qualified medical expenses AFTER you have met your deductible. More information can be found in the Health Care Spending Program Summary Plan Description book. If you use your account funds for nonqualified or reimbursed expenses or for ineligible dependents' expenses, those dollars are subject to income taxes and a possible 10% penalty.

(The following subsection replaces the subsection of the SPD titled "Summary Charts of the Coverage Options" beginning on page 35 of the SPD.)

The charts that follow summarize coverage under the HSA Value, HSA Advantage, Copay Value, Copay Advantage and BCBSIL Indemnity options.

1. HSA Value

	HSA Value	
Key Feature	***In-Network***	***Out-of-Network****
Annual Deductible	***You Pay***	
• You Only	$3,750	
• You + Spouse	$5,500	
• You + Child(ren)	$5,500	
• You + Family	$7,350	
Annual Out-of-Pocket Limit (includes deductible)	***You Pay***	
• You Only	$6,450	
• You + Spouse	$9,675	
• You + Child(ren)	$9,675	
• You + Family	$12,900	
Coinsurance	***Medical Program Pays***	***Medical Program Pays***
• Physician Office Visits	70% after deductible is met	50% after deductible is met
• Annual Physical Exam	100% no deductible	50% after deductible is met
• Immunizations (children and adults)	100% no deductible	100% no deductible
• Independent X-Ray and Lab Facility**	70% after deductible is met	50% after deductible is met
• Inpatient/Outpatient Hospital Facility Services	70% after deductible is met	50% after deductible is met
• Outpatient Surgery	70% after deductible is met	50% after deductible is met
• Inpatient/Outpatient Professional Services (for ***non-emergency/urgent*** services)	70% after deductible is met	50% after deductible is met
• Inpatient/Outpatient Professional Services (for ***emergency/urgent*** services)	70% after deductible is met	70% after deductible is met, if true emergency as determined by the claims administrator 50% after deductible is met, if not a true emergency as determined by the claims administrator

Key Feature	HSA Value	
	In-Network	***Out-of-Network****
• Emergency/Urgent Care Facility (for ***emergency/urgent*** services)	70% after deductible is met	70% after deductible is met, if true emergency as determined by the claims administrator 50% after deductible is met, if not a true emergency as determined by the claims administrator
• Outpatient Rehabilitation Services, Including Speech, Occupational, Physical, Pulmonary, Cognitive, and ABA Therapy (limited to 90 visits per calendar year, in- and out-of-network services combined)	70% after deductible is met	50% after deductible is met
• Outpatient Cardiac Rehabilitation Services Phases I and II (limited to 36 visits per calendar year, in- and out-of-network services combined)	70% after deductible is met	50% after deductible is met
• Chiropractic Therapy (limited to 20 visits each calendar year), in- and out-of-network services combined	70% after deductible is met	50% after deductible is met
• Inpatient Skilled Nursing/ Rehabilitation, subject to preauthorization of medical necessity or covered service (limited to 90 days per calendar year), in- and out-of-network services combined	70% after deductible is met	50% after deductible is met
• Home Health Care, subject to preauthorization of medical necessity (limited to 120 visits per calendar year), in- and out-of-network services combined	70% after deductible is met	50% after deductible is met
• Durable Medical Equipment/ External Prosthetic Appliances	70% after deductible is met	50% after deductible is met
Mental Health and Substance Abuse • Inpatient • Outpatient	 70% after deductible is met, subject to preauthorization of medical necessity 70% after deductible is met	 50% after deductible is met 50% after deductible is met
Prior Authorization	Please see the "Preadmission Certification" section for each respective claims administrator later in this SPD for details.	
Prescription Drug Program	Please see the "A Summary Chart of Your Prescription Drug Coverage" section for details.	

*Expenses above the amounts recognized as covered expenses are your responsibility. These amounts do not count toward the deductible or the Out-of-Pocket Limit.

**If laboratory work and/or X-rays are done in an independent facility, claims will be processed at the applicable coinsurance levels.

2. HSA Advantage

Key Feature	HSA Advantage	
	In-Network	***Out-of-Network****
Annual Deductible	***You Pay***	
• You Only	$2,250	
• You + Spouse	$3,375	
• You + Child(ren)	$3,375	
• You + Family	$4,500	
Annual Out-of-Pocket Limit (includes deductible)	***You Pay***	
• You Only	$5,000	
• You + Spouse	$7,500	
• You + Child(ren)	$7,500	
• You + Family	$10,000	
Coinsurance	***Medical Program Pays***	***Medical Program Pays***
• Physician Office Visits	80% after deductible is met	60% after deductible is met
• Annual Physical Exam	100% no deductible	60% after deductible is met
• Immunizations (children and adults)	100% no deductible	100% no deductible
• Independent X-Ray and Lab Facility**	80% after deductible is met	60% after deductible is met
• Inpatient/Outpatient Hospital Facility Services	80% after deductible is met	60% after deductible is met
• Outpatient Surgery	80% after deductible is met	60% after deductible is met
• Inpatient/Outpatient Professional Services (for ***non-emergency/urgent*** services)	80% after deductible is met	60% after deductible is met
• Inpatient/Outpatient Professional Services (for ***emergency/urgent*** services)	80% after deductible is met	80% after deductible is met, if true emergency as determined by the claims administrator 60% after deductible is met, if not a true emergency as determined by the claims administrator
• Emergency/Urgent Care Facility (for ***emergency/urgent*** services)	80% after deductible is met	80% after deductible is met, if true emergency as determined by the claims administrator 60% after deductible is met, if not a true emergency as determined by the claims administrator

Key Feature	HSA Advantage	
	In-Network	**Out-of-Network***
• Outpatient Rehabilitation Services, Including Speech, Occupational, Physical, Pulmonary, Cognitive and ABA Therapy (limited to 90 visits per calendar year, in- and out-of-network services combined)	80% after deductible is met	60% after deductible is met
• Outpatient Cardiac Rehabilitation Services Phases I and II (limited to 36 visits per calendar year, in- and out-of-network services combined)	80% after deductible is met	60% after deductible is met
• Chiropractic Therapy (limited to 20 visits each calendar year), in- and out-of-network services combined	80% after deductible is met	60% after deductible is met
• Inpatient Skilled Nursing/ Rehabilitation, subject to preauthorization of medical necessity or covered service (limited to 90 days per calendar year), in- and out-of-network services combined	80% after deductible is met	60% after deductible is met
• Home Health Care, subject to preauthorization of medical necessity (limited to 120 visits per calendar year), in- and out-of-network services combined	80% after deductible is met	60% after deductible is met
• Durable Medical Equipment/ External Prosthetic Appliances	80% after deductible is met	60% after deductible is met
Mental Health and Substance Abuse		
• Inpatient	80% after deductible is met	60% after deductible is met
• Outpatient	80% after deductible is met	60% after deductible is met
Prior Authorization	Please see the "Preadmission Certification" section for each respective claims administrator later in this SPD for details.	
Prescription Drug Program	Please see the "A Summary Chart of Your Prescription Drug Coverage" section for details.	

*Expenses above the amounts recognized as covered expenses are your responsibility. These amounts do not count toward the deductible or the Out-of-Pocket Limit.

**If laboratory work and/or X-rays are done in an independent facility, claims will be processed at the applicable coinsurance levels.

3. Copay Value

Key Feature	Copay Value In-Network	Copay Value Out-of-Network*
Annual Deductible	***You Pay***	
• You Only	$3,750	
• You + Spouse	$5,550	
• You + Child(ren)	$5,550	
• You + Family	$7,350	
Annual Out-of-Pocket Limit (includes deductible)	***You Pay***	
• You Only	$6,450	
• You + Spouse	$9,675	
• You + Child(ren)	$9,675	
• You + Family	$12,900	
Coinsurance	***Medical Program Pays***	***Medical Program Pays***
• Physician Office Visits	$35 for PCP, $55 for Specialist	50% after deductible is met
• Annual Physical Exam	100% no deductible	50% after deductible is met
• Immunizations (children and adults)	100% no deductible	100% no deductible
• Independent X-Ray and Lab Facility**	70% after deductible is met	50% after deductible is met
• Inpatient/Outpatient Hospital Facility Services	70% after deductible is met	50% after deductible is met
• Outpatient Surgery	70% after deductible is met	50% after deductible is met
• Inpatient/Outpatient Professional Services (for ***non-emergency/urgent*** services)	70% after deductible is met	50% after deductible is met
• Inpatient/Outpatient Professional Services (for ***emergency/urgent*** services)	$600 copay and 70% of remaining balance.	$600 copay and 70% of remaining balance if true emergency as determined by the claims administrator $600 copay and 50% of remaining balance , if not a true emergency as determined by the claims administrator
• Emergency/Urgent Care Facility (for ***emergency/urgent*** services)	70% after deductible is met	70% after deductible is met, if true emergency as determined by the claims administrator 50% after deductible is met, if not a true emergency as determined by the claims administrator

Key Feature	Copay Value	
	In-Network	*Out-of-Network**
• Outpatient Rehabilitation Services, Including Speech, Occupational, Physical, Pulmonary, Cognitive and ABA Therapy (limited to 90 visits per calendar year, in- and out-of-network services combined)	70% after deductible is met	50% after deductible is met
• Outpatient Cardiac Rehabilitation Services Phases I and II (limited to 36 visits per calendar year, in- and out-of-network services combined)	70% after deductible is met	50% after deductible is met
• Chiropractic Therapy (limited to 20 visits each calendar year), in- and out-of-network services combined	70% after deductible is met	50% after deductible is met
• Inpatient Skilled Nursing/ Rehabilitation, subject to preauthorization of medical necessity or covered service (limited to 90 days per calendar year), in- and out-of-network services combined	70% after deductible is met	50% after deductible is met
• Home Health Care, subject to preauthorization of medical necessity (limited to 120 visits per calendar year), in- and out-of-network services combined	70% after deductible is met	50% after deductible is met
• Durable Medical Equipment/ External Prosthetic Appliances	70% after deductible is met	50% after deductible is met
Mental Health and Substance Abuse		
• Inpatient	70% after deductible is met	50% after deductible is met
• Outpatient	70% after deductible is met	50% after deductible is met
Prior Authorization	Please see the "Preadmission Certification" section for each respective claims administrator later in this SPD for details.	
Prescription Drug Program	Please see the "A Summary Chart of Your Prescription Drug Coverage" section for details.	

*Expenses above the amounts recognized as covered expenses are your responsibility. These amounts do not count toward the deductible or the Out-of-Pocket Limit.

**If laboratory work and/or X-rays are done in an independent facility, claims will be processed at the applicable coinsurance levels.

4. Copay Advantage

Key Feature	Copay Advantage	
	In-Network	**_Out-of-Network*_**
Annual Deductible	**_You Pay_**	
• You Only	$2,250	
• You + Spouse	$3,375	
• You + Child(ren)	$3,375	
• You + Family	$4,500	
Annual Out-of-Pocket Limit (includes deductible)	**_You Pay_**	
• You Only	$5,000	
• You + Spouse	$7,500	
• You + Child(ren)	$7,500	
• You + Family	$10,000	
Coinsurance	**_Medical Program Pays_**	**_Medical Program Pays_**
• Physician Office Visits	$25 for PCP; $40 for specialist	40% after deductible is met
• Annual Physical Exam	100% no deductible	40% after deductible is met
• Immunizations (children and adults)	100% no deductible	100% no deductible
• Independent X-Ray and Lab Facility**	80% after deductible is met	60% after deductible is met
• Inpatient/Outpatient Hospital Facility Services	80% after deductible is met	60% after deductible is met
• Outpatient Surgery	80% after deductible is met	60% after deductible is met
• Inpatient/Outpatient Professional Services (for ***non-emergency/urgent*** services)	80% after deductible is met	60% after deductible is met
• Inpatient/Outpatient Professional Services (for ***emergency/urgent*** services)	$500 copay + 20% of the remaining balance	$500 copay + 20% of the remaining balance if true emergency as determined by the claims administrator 60% after deductible is met, if not a true emergency as determined by the claims administrator
• Emergency/Urgent Care Facility (for ***emergency/urgent*** services)	80% after deductible is met	80% after deductible is met, if true emergency as determined by the claims administrator 60% after deductible is met, if not a true emergency as determined by the claims administrator

Key Feature	*Copay Advantage*	
	In-Network	***Out-of-Network****
• Outpatient Rehabilitation Services, Including Speech, Occupational, Physical, Pulmonary, Cognitive, and ABA Therapy (limited to 90 visits per calendar year, in- and out-of-network services combined)	80% after deductible is met	60% after deductible is met
• Outpatient Cardiac Rehabilitation Services Phases I and II (limited to 36 visits per calendar year, in- and out-of-network services combined)	80% after deductible is met	60% after deductible is met
• Chiropractic Therapy (limited to 20 visits each calendar year), in- and out-of-network services combined	80% after deductible is met	60% after deductible is met
• Inpatient Skilled Nursing/ Rehabilitation, subject to preauthorization of medical necessity or covered service (limited to 90 days per calendar year), in- and out-of-network services combined	80% after deductible is met	60% after deductible is met
• Home Health Care, subject to preauthorization of medical necessity (limited to 120 visits per calendar year), in- and out-of-network services combined	80% after deductible is met	60% after deductible is met
• Durable Medical Equipment/ External Prosthetic Appliances	80% after deductible is met	60% after deductible is met
Mental Health and Substance Abuse		
• Inpatient	80% after deductible is met	60% after deductible is met
• Outpatient	80% after deductible is met	60% after deductible is met
Prior Authorization	Please see the "Preadmission Certification" section for each respective claims administrator later in this SPD for details.	
Prescription Drug Program	Please see the "A Summary Chart of Your Prescription Drug Coverage" section for details.	

*Expenses above the amounts recognized as covered expenses are your responsibility. These amounts do not count toward the deductible or the Out-of-Pocket Limit.

**If laboratory work and/or X-rays are done in an independent facility, claims will be processed at the applicable coinsurance levels.

(The following two paragraphs replace the first two paragraphs found in the subsection of the SPD titled "General Information – UHC Preadmission Certification, UHC Prior Notification Requirements, and UHC Special Services" found under the section of the SPD titled "Special Rules Under the UHC Group Health Program Options" beginning on page 58 of the SPD.)

In addition to the provisions described under the "How the Group Health Program Works – General," the "What Is Covered," and the "What Is Not Covered" sections, the following information is unique to the Medical Program available through UHC. UHC is the claims administrator and network manager, and is responsible for selecting the providers who participate in the UHC network. If your home ZIP code is in the UHC network area, you can elect coverage under the following options for yourself and your enrolled eligible dependents:

- HSA Value;
- HSA Advantage;
- Copay Value; or
- Copay Advantage.

(The following two paragraphs replace the first two paragraphs found in the subsection of the SPD titled "General Information – BCBSIL Preadmission Certification, BCBSIL Special Services" found under the section of the SPD titled "Special Rules Under the BCBSIL Group Health Program Options" beginning on page 62 of the SPD.)

In addition to the provisions described under the "How the Group Health Program Works – General," the "What Is Covered," and the "What Is Not Covered" sections, the following information is unique to the Medical Program available through BCBSIL. BCBSIL is the claims administrator and network manager, and is responsible for selecting the providers who participate in the BCBSIL network. If your home ZIP code is in the BCBSIL network area, you can elect coverage under the following options for yourself and your enrolled eligible dependents:

- HSA Value;
- HSA Advantage;
- Copay Value; or
- Copay Advantage.

(The following paragraph replaces the first paragraph found in the subsection of the SPD titled "General Information" found under the section of the SPD titled "The Prescription Drug Program" beginning on page 67 of the SPD. The subsection titled "Prescription Drug Program Claims Administrators" is deleted in its entirety.)

The Prescription Drug Program described throughout this SPD is available to you and you enrolled eligible dependents, provided you enroll for coverage under the Group Health program. Your Prescription Drug Program Claims Administrator is CVS Caremark.

(The following paragraph and chart replaces the information found in the subsection of the SPD titled "A summary chart of Your Prescription Drug Coverage" found under the section of the SPD titled "The Prescription Drug Program" beginning on page 68 of the SPD.)

Your prescription drug coverage is dependent upon the option you elect under the Medical Program. Here is a summary of the prescription drug coverage under each option:

The Prescription Drug Program		
HSA Value (BCBSIL and UHC)		
	In-Network	
	You Pay Retail Store	***You Pay Mail Order***
• Generic**	30% after deductible*	30% after deductible*
• Brand Formulary**	40% after deductible*	40% after deductible*
• Brand Non-Formulary*	50% after deductible*	50% after deductible*
• Specialty*	50% after deductible*	50% after deductible*
• Generic preventive medicine for hypertension and hyperlidemia	0%	100%
HSA Advantage) (BCBSIL and UHC)		
	You Pay Retail Store	***You Pay Mail Order***
• Generic**	20% after deductible*	20% after deductible*
• Brand Formulary**	30% after deductible*	30% after deductible*
• Brand Non-Formulary**	40% after deductible*	40% after deductible*
• Specialty	40% after deductible*	40% after deductible*
• Generic preventive medicine for hypertension and hyperlidemia	0%	100%
Copay Value (BCBSIL and UHC) DOES NOT APPLY TO YOUR DEDUCTIBLE***		
	In-Network	
	You Pay Retail Store***	***You Pay Mail Order***
• Generic**	30%;Min $10-Max $45	30%;Min $25-Max $115
• Brand Formulary**	40%; Min $40 – Max $100	40%; Min $100 – Max $250
• Brand Non-Formulary**	50%; Min $75 – Max $150	50%; Min $185 – Max $375
• Specialty	$210	More than 30 days supply not allowed
• Generic preventive medicine for hypertension and hyperlidemia	0%	100%

The Prescription Drug Program		
Copay Advantage (BCBSIL and UHC) DOES NOT APPLY TO YOUR DEDUCTIBLE***		
	You Pay*** **Retail Store**	***You Pay*** *Mail Order*
• Generic**	20%;Min $10-Max $4015%	20%;Min $25-Max $100
• Brand Formulary**	30%; Min $40 – Max $75	30%; Min $100 – Max $185
• Brand Non-Formulary**	40%; Min $55 – Max $125	40%; Min $140 – Max $315
• Specialty	$150	More than 30 days supply not allowed
• Generic preventive medicine for hypertension and hyperlidemia	0%	0%
BCBSIL Indemnity Option***		
	You Pay***	***Prescription Drug Program Pays***
• Retail Generic**	20%	80%
• Retail Brand Formulary**	30%	70%
• Retail Brand Non-Formulary**	40%	60%
• Generic preventive medicine for hypertension and hyperlidemia	0%	100%
	You Pay***	***Prescription Drug Program Pays***
• Mail Order Generic**	20%	80%
• Mail Order Brand Formulary**	30%	70%
• Mail Order Brand Non-Formulary**	40%	60%
• Generic preventive medicine for hypertension and hyperlidemia	0%	100%

*This is the applicable Medical Program option's deductible.

**A 30-day supply limit applies for retail, and a 90-day supply limit applies for mail-order prescription drug expenses.

***If the total cost of the prescription is less than the coinsurance, you are still responsible for the total cost of the prescription.

(The final sentence of the first paragraph of the subsection of the SPD titled "How to Fill Your Prescriptions at a Retail Pharmacy" found under the section of the SPD titled "The Prescription Drug Program" beginning on page 70 of the SPD is deleted in its entirety.)

(The charts listing the claims administrators found in the subsection of the SPD titled “Claims Administrators” found under the section of the SPD titled “Administrative and Contact Information” beginning on page 104 of the SPD are deleted in their entirety and replaced with the charts shown below.)

The Medical Program and the Mental Health and Substance Abuse Program

Options	***Claims Administrator***
UHC Group Health Program Options • HSA Value • HSA Advantage • Copay Value • Copay Advantage	UnitedHealthcare Insurance Company 450 Columbus Blvd. P.O. Box 150450 Hartford, CT 06115-0450 ***Claims Office**:* P.O. Box 30555 Salt Lake City, UT 84130-0555 1-877-442-5999 Website: ***www.myuhc.com***
BCBSIL Group Health Program Options • HSA Value • HSA Advantage • Copay Value • Copay Advantage	Blue Cross and Blue Shield of Illinois P.O. Box 805107 Chicago, IL 60680 1-800-537-9765 Website: ***www.bcbsil.com/rrd*** (for online provider directories and other resources)

The Prescription Drug Program

Options	***Claims Administrator for Paper Claim Reimbursements***
CVS Caremark 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. Website: ***www.caremark.com***