RR DONNELLEY

2019 Summary of Material Modifications (SMM) for the RR Donnelley Group Benefits Plan and the RR Donnelley Flexible Benefits Plan

Issued November 2019

Introduction

The material that follows is a legally required notice of benefit plan changes. It describes changes to certain benefit programs provided under the RR Donnelley Group Benefits Plan and the RR Donnelley Flexible Benefits Plan (the "Plans").

The general rules related to each benefit program are detailed in the Plan's Summary Plan Description ("SPD"), and this notice which constitutes the Summary of Material Modifications ("SMM") to that SPD. If a capitalized term is not defined in this SMM, such term will have the definition set forth in the applicable SPD. To make sure you have the most up-to-date information, keep this document with your SPD. You can also access the SPDs and SMMs at www. http://myrrdbenefits.com.

This SMM was prepared to explain the Plans' new claims and appeals procedures effective in April 2018 and to highlight other changes to the Plans. Many, if not all of the other changes that are highlighted in this SMM were previously communicated to you in the Annual Enrollment Guides and/or other communications from the Plans, and are being re-published here for ease of use.

As described more fully in the SPD, the SPD and any appendices thereto along with this SMM is intended to be a complete, accurate, and up-to-date description of your coverage under the Plans. 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 insurer will have the authority or discretion to make the determination of whether an expense incurred is a covered expense, in accordance with its internal rules, guidelines, protocols, or other similar criteria.

If there is any inconsistency between the SMM and the SPD, this SMM will control. However, if there is any discrepancy between this SMM and the Plan, the Plan documents (including the applicable Certificates of Coverage, if any) govern.

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 the date on the cover of this SMM. R. R. Donnelley & Sons Company ("RR Donnelley") reserves the right to amend, change, or terminate the Plans or their component programs, 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). RR Donnelley Benefits Center Representatives are available from 8 a.m. to 5 p.m. CT, Monday through Friday, except holidays.

This SMM comes in five parts:

1. A section for changes to the benefit program options provided under the Plans.

2. A section for changes to the rules with respect to recovery of Medical Program premiums that fall into arrears during Short-Term Disability, Long-Term Disability, or other leave of absence.

3. A section for changes to the rules with respect to dependent audits conducted for the Group Benefits Plan.

4. A section for changes to the claims and appeal procedures in the Group Benefits Plan.

5. A section for changes to the Health Care and Dependent Care Spending Programs SPD.

In particular, this SMM addresses important changes to the following SPDs under the Group Benefits Plan:

Summary Plan Description for Medical and Prescription Drug Programs SPD (the "Group Health Program")
Summary Plan Description for Regional Medical Options Program SPD
Summary Plan Description for Dental Benefit Program SPD
Summary Plan Description for Vision Care Program SPD
Summary Plan Description for Short-Term Disability provided under the Disability Benefit Program
Summary Plan Description for Long-Term Disability provided under the Disability Benefit Program
Summary Plan Description for Life and Accident Insurance Program

This SMM also addresses changes to the following RR Donnelley Flexible Benefits Plan SPDs:

Summary Plan Description for Health Care and Dependent Care Spending Programs
Qualified Status Changes (and the Participant Premium Program)

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RR DONNELLEY

2019 Summary of Material Modifications (SMM) to the Group Benefits Plan and the Flexible Benefits Plan

Changes to Benefit Program Options

This SMM explains changes to the benefit program options available under the Group Benefits Plan and the Flexible Benefits Plan.

I. Changes at Annual Enrollment

Changes at 2019 Annual Enrollment

The following describes changes to your Plan options for 2019. Refer to the 2019 Benefits Enrollment Guide to learn more about your 2019 benefit program options.

HSA Contribution Limits

HSA contribution limits increased for 2019. The contribution limit for Employee Only Coverage is $3,500, and the contribution limit for other coverage levels is $7,000.

Health Care FSA Contribution Limits

The Heath Care FSA contribution limit increased to $2,650 for 2019.

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:

(1) reducing your elections under the Health Care FSA, Dependent Care FSA, and/or a Health Savings Account to levels that would not result in an overspent account;

(2) terminating your coverage in Group Benefits Plan elections other than the Medical Program; and/or

(3) 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 retroactively as stated above and you will be defaulted to no coverage.

The following subsection is added to the Group Health Program SPD at the end of the section entitled "Special Rules Under the BCBSIL Group Health Program Options" and before the section entitled "The Prescription Drug Program":

Individual Benefits Management Program ("IBMP")

Blue Cross Blue Shield of Illinois (BCBSIL) offers the Individual Benefits Management Program ("IBMP"), which is available to participants with Medical Program coverage administered by BCBSIL.

In addition to the benefits described in this SPD, if your condition would otherwise require continued care in a Hospital or other health care facility, provision of alternative benefits for services rendered by a Participating Provider in accordance with an alternative treatment plan may be available to you under the IBMP. For instance, if you are being treated for a condition and a health care facility has recommended that you be moved to a different type of health care facility because you have reached your maximum level of benefits under the Medical Program with respect to such treatment, but your current course of treatment is more appropriate under the circumstances, BCBSIL may provide alternative benefits under the Medical Program that will allow you to continue your current course of treatment in your current health care facility.

Alternative benefits will be provided only so long as the Claims Administrator determines that the alternative services are Medically Necessary and cost effective. The total maximum payment for alternative services shall not exceed the total benefits for which you would otherwise be entitled under the plan.

Provision of alternative benefits in one instance shall not result in an obligation to provide the same or similar benefits in any other instance. In addition, the provision of alternative benefits shall not be construed as a waiver of any of the terms, conditions, limitations or exclusions of the plan.

The following sections are added to the Group Health Program SPD as a new section entitled "Special Programs," after the section entitled "What is not covered," and before the section entitled "Special Rules Under the UHC Group Health Program Options":

ConsumerMedical Program

Medical Program participants are eligible to receive additional decision support concerning your medical care.

ConsumerMedical can provide personalized information to help you make informed decisions under its Ally Support Services program. A ConsumerMedical nurse will

answer your questions and provide free information and support on any medical condition, help you choose the best specialists for treatment, get a second opinion, help with a medical claim, and much more.

This service is available to you and your dependents if enrolled in an RR Donnelley national Medical Program option (HSA Value, HSA Advantage, Copay Value or Copay Advantage). There is no cost to you, and it is ***completely confidential***. The Medical Program does not provide ConsumerMedical with any information about your medical conditions for the Ally Support Program, nor does the Ally Support Program provide any medical information to the Medical Program. The Ally Support Program is a separate benefit provided by the Company and is not provided directly by the Medical Program.

Beginning in mid-November 2018, the ConsumerMedical program is being expanded to include Cancer Quality Program Services. Cancer Quality Program Services are provided by the Medical Program. Participants with an active diagnosis of cancer, specifically malignant neoplasm, leukemia, lymphoma, or multiple myeloma, are eligible to enroll for the Cancer Quality Program Services. Participants interested in, or about to receive, diagnostic testing, but without an active cancer diagnosis or those diagnosed with benign neoplasm (or other non-cancerous conditions) are not eligible for the Cancer Quality Program Services, however they remain eligible for Ally Support Services.

Participants can self-identify and enroll in the Cancer Quality Program Services, be referred by the Medical Program vendor partner(s), or they may be identified via analysis of medical and pharmacy claims data made available to ConsumerMedical. ConsumerMedical will reach out to identified Participants via mail, e-mail and/or phone.

The Cancer Quality Program Services focus on ensuring diagnosis accuracy, physician specialist and facility selection, education on and understanding of all relevant treatment options as well as providing information and access to support agencies and social groups targeted towards condition specific populations and will act as concierge to disease condition and behavioral support programs offered by the Medical Program.

Participants who complete the Ally Support Services or Cancer Quality Program Services may receive an incentive payment.

Livongo for Diabetes and Livongo for Hypertension

Effective December 1, 2018, the Group Benefits Plan offers the new Livongo for Diabetes and Livongo for Hypertension features under the four national Medical Program options. You and your covered dependents diagnosed with diabetes and/or hypertension will be able to receive the Livongo for Diabetes and/or the Livongo for Hypertension benefits as applicable, at no cost to you, if you have coverage through one of the national Medical Program options (which are the HSA Value, HSA Advantage, Copay Value, and Copay Advantage options provided by Blue Cross and Blue Shield of Illinois and UnitedHealthcare). Both benefits include coaching services for enrolled participants. Livongo for Diabetes also provides participants with a cellular-

connected blood glucose meter for your condition monitoring, a lancing device, and unlimited test strips. Livongo for Hypertension also provides participants with a blood pressure monitor and cuff.

Catapult Biometric Screening Program

Effective January 1, 2019, the Plan will begin offering the Catapult Biometric Screening Program on a pilot basis at a limited number of RR Donnelley sites.

Catapult is a mobile screening program that sets up temporary onsite clinics at select RR Donnelley locations and provides a "checkup" to employees who are enrolled in a national Medical Program option and who sign up to participate. Each checkup includes a biometric screen, personal history, medication review, and a consultation with a nurse practitioner. This checkup is provided at no cost to the employee. A limited number of employees may participate in each onsite clinic and advance signup is required.

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Changes at 2018 Annual Enrollment

The following describes changes in the benefit program options available and other changes regarding your Plan options for 2018. Refer to the 2018 Benefits Enrollment Guide to learn more about your 2018 benefit program options.

HSA Contribution Limits.

HSA contribution limits increased for 2018. The contribution limit for Employee Only Coverage was $3,450, and the contribution limit for other coverage levels was $6,900.

Health Care FSA Contribution Limits.

The Health Care FSA contribution limit increased to $2,600 for 2018.

Dental Benefit Program Changes

- Cigna is the new dental vendor for 2018. Your dental options include the Dental PPO; Dental PPO Plus; and a new option, the Dental HMO. The two PPO options allow you to choose any dentist (in-network or out-of-network), but you receive a higher level of coverage, which means lower out-of-pocket costs if you use participating network dentists. With the Dental HMO option, you must choose an in-network dentist. All participants will receive new ID cards from Cigna.

- To find an in-network dentist, once you enroll in a Cigna dental option, register at mycigna.com for information about your specific dental plan. After registering and logging in, click "Find a Dentist" to find a dentist in the Cigna Dental PPO network. To find a dentist in the Cigna Dental HMO network, register and log in to mycigna.com, and click "Find a Doctor, Dentist or Facility." Then click "Dentist."

The following table provides a high-level comparison of each of the dental plans:

	CIGNA DENTAL PPO		CIGNA DENTAL PPO PLUS		CIGNA DENTAL HMO*
	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network
Annual Deductible	$50	$150	$50	$150	$0
Annual Maximum (non orthodontia)	$1,500 per individual		$2,000 per individual		No annual maximum
Lifetime Orthodontia Maximum	N/A		$2,000 per individual		Limited to 1 treatment per person, per lifetime Contact Cigna for details
Preventive Care Type A	100%		100%		100%
Basic Care Type B	50%		80%		100%
Major Care Type C	50%		50%		60%
Orthodontia Type D	N/A		50%		50%

* The military dependent age limit for coverage in the Dental HMO is 26 years of age (compared to 30 years of age for the Dental PPO and Dental PPO Plus). For orthodontia coverage, make sure the provider is in the Dental HMO network.

Changes to Short-Term Disability (STD) Provided Under the Disability Benefit Program

STD coverage will change to a monthly benefit of 50% of pre-disability earnings for disabilities that begin on or after January 1, 2018. If your disability began on or before December 31, 2017, then your benefits will continue to be paid at the 60% benefit level for the duration of that episode of disability (including if you briefly return to work and then have a recurrence of the same disability).

Changes to Long-Term Disability (LTD) Buy-Up Coverage Provided Under the Disability Benefit Program

LTD buy-up coverage will no longer be offered effective January 1, 2018. You will, however, continue to receive the company-paid basic LTD benefit of 50% of your pre-disability earnings, up to $10,000 a month, if you are unable to work because of a covered illness or injury. If you elected the buy-up coverage for 2017, your coverage

continues through December 31, 2017 and will apply to any claim beginning on or before that date (while coverage was in effect).

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II. Other Plan Changes

Group Benefits Plan and Flexible Benefits Plan Coverage Effective Date.

The following language clarifications regarding an employee's eligibility and coverage effective date apply to all SPDs:

When Coverage Begins

As a new benefits-eligible employee, you receive 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 Flexible Benefits Plan 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.

Group Health Program SPD Clarifications Regarding Mental Health Parity.

The following clarifications regarding mental health and substance abuse benefits apply to the Group Health Program SPD:

Provider Directories

For a list of network providers for the Medical Program, including mental health and substance abuse providers, see the BCBSIL* website at https://www.bcbsil.com/find-a-doctor-or-hospital or the UHC** website at https://www.uhc.com/find-a-physician.

* Your health plan or network is shown on the front of your Blue Cross and Blue Shield of Illinois (BCBSIL) member ID card. If you have questions about which network you have, call the Customer Service number on the back of your card. You can also sign into the BCBSIL website on this page to get personalized, accurate search results for your particular plan.

** Sign into myuhc.com on this page in order to find the most up-to-date list of network providers personalized for your particular plan.

Summary Charts of the Benefit program options

The following sentence is added to the In-Network Physician Office Visits section of the summary chart for the Copay Value plan:

Office visits for mental health and substance abuse services will be charged the Primary Care copay.

Special Rules Under the UHC Group Health Program Options

The following language (located under the subsection entitled UHC Group Health Program – Prior Notification Requirements), which states: "You are required to notify the claims administrator before you receive certain covered services. You are also required to notify the claims administrator before you receive mental health and substance abuse services. You must notify Personal Health Support (or the Mental Health/Substance Abuse Administrator before you receive the following services" *is replaced in its entirety with the following*:

You are required to notify the claims administrator before you receive certain covered medical or mental health and substance abuse services. You must notify Personal Health Support (or the Mental Health/Substance Abuse Administrator) before you receive the following services:

And the following bulleted phrase is deleted from the list of services:

- Mental health and substance abuse services;

Group Health Program SPD Clarifications Regarding BCBSIL Medical Program Inter-Plan Arrangements

The following new section is added to the Medical and Prescription Drug Programs (also known as the "Group Health Program") SPD to describe procedures with respect to claims for out-of-area services.

BCBSIL MEDICAL PROGRAM INTER-PLAN ARRANGEMENTS

Out-of-Area Services

Overview

BCBSIL has a variety of relationships with Blue Cross and/or Blue Shield Licensees. Generally, these relationships are called "Inter-Plan Arrangements." Inter-Plan Arrangements work based on rules and procedures issued by the Blue Cross Blue Shield Association. Whenever you* access healthcare services outside the geographic area BCBSIL serves, your claim for those services may be processed through one of these Inter-Plan Arrangements. The Inter-Plan Arrangements are described below.

*For purposes of this section, all references to you include your enrolled eligible dependents.

When you receive care outside of BCBSIL's service area (i.e., outside of the "Home Blue" service area), you will receive it from one of two kinds of providers. Participating Providers contract with the local Blue Cross and/or Blue Shield Plan in that geographic area ("Host Blue"). Non-Participating Providers don't contract with the Host Blue. How the Medical Program pays both kinds of providers is explained below. You should carefully review the provisions below in the section entitled "*Non-Participating Providers Outside BCBSIL's Service Area*" with respect to the amount payable under the Medical Program when you receive services from a Non-Participating Provider in non-emergency situations.

Inter-Plan Arrangements Eligibility – Claim Types

All claim types are eligible to be processed through Inter-Plan Arrangements, as described above.

BlueCard® Program

Under the BlueCard® Program, when you receive covered services within the geographic area served by a Host Blue, the Medical Program will be responsible for doing what BCBSIL agreed to do in its contract with that Host Blue. However, each Host Blue is responsible for contracting with and generally handling all interactions with its Participating Providers.

When you receive covered services outside BCBSIL's service area and the claim is processed through the BlueCard® Program, the amount you pay for covered services

generally is calculated based on the lower of the (i) billed charges for covered services, or (ii) negotiated price that the applicable Host Blue makes available to BCBSIL.

Often, this "negotiated price" will be a simple discount that reflects an actual price that the Host Blue pays to your healthcare provider. Sometimes, it is an estimated price that takes into account special arrangements with your Participating Provider (or the Participating Provider's group) that may include types of settlements, incentive payments and/or other credits or charges. Occasionally, it may be an average price, based on a discount that results in expected average savings for similar types of healthcare providers after taking into account the same types of transactions as with an estimated price.

Estimated pricing and average pricing also take into account adjustments to correct for over- or underestimation of past pricing of claims, as noted above. However, such adjustments will not affect the price BCBSIL uses for your claim because they will not be applied after a claim has already been paid.

Negotiated (non-BlueCard® Program) Arrangements

With respect to one or more Host Blues, instead of using the BlueCard® Program, BCBSIL may process your claims for covered services through a "Negotiated Arrangement" for "National Accounts." A "Negotiated Arrangement" is an agreement negotiated between your Home Blue and one or more Host Blues for any "National Account" that is not delivered through the BlueCard® Program. A "National Account" is a plan sponsored by an employer (like RRD) that is headquartered in a Home Blue's service area but that has employees/participants in other geographic areas served by a Host Blue.

The amount you pay for covered services under a Negotiated Arrangement generally is calculated based on the lower of the (i) billed charges for covered services, or (ii) negotiated price that the applicable Host Blue makes available to BCBSIL (refer to the description of negotiated price under the section above entitled "*BlueCard® Program*."

If reference-based benefits, which are service-specific benefit dollar limits for specific procedures, based on a Host Blue's local market rates, are made available to you, you will be responsible for the amount that the healthcare provider bills above the specific reference benefit limit for the given procedure. For a Participating Provider, that amount will be the difference between the negotiated price and the reference benefit limit. For a Non-Participating Provider, that amount will be the difference between the provider's billed charge and the reference benefit limit. Where a reference benefit limit is greater than either a negotiated price or a provider's billed charge, you will incur no additional liability, other than any related patient cost sharing under the BCBSIL Medical Program.

Special Cases: Value-Based Programs

A Value-Based Program ("VBP") is an outcomes-based payment arrangement and/or a coordinated care model facilitated with one or more local providers that is evaluated

against cost and quality metrics/factors and is reflected in provider payment. See below for the definitions of these and other capitalized terms used in this section.

VBP Definitions

- Accountable Care Organization ("ACO"): A group of healthcare providers who agree to deliver coordinated care and meet performance benchmarks for quality and affordability in order to manage the total cost of care for their member populations.
- Care Coordination: Organized, information-driven patient care activities intended to facilitate the appropriate responses to a member's healthcare needs across the continuum of care.
- Care Coordinator: An individual within a provider organization who facilitates Care Coordination for patients.
- Care Coordination Fee: A fixed amount paid by a Blue Cross and/or Blue Shield Licensee to providers periodically for Care Coordination under a VBP.
- Global Payment/Total Cost of Care: A payment methodology that is defined at the patient level and accounts for either all patient care or for a specific group of services delivered to the patient such as outpatient, physician, ancillary, hospital services and prescription drugs.
- Patient-Centered Medical Home ("PCMH"): A model of care in which each patient has an ongoing relationship with a primary care physician who coordinates a team to take collective responsibility for patient care and, when appropriate, arranges for care with other qualified physicians.
- Provider Incentive: An additional amount of compensation paid to a healthcare provider by a Blue Cross and/or Blue Shield Plan, based on the provider's compliance with agreed-upon procedural and/or outcome measures for a particular group of covered persons.
- Shared Savings: A payment mechanism in which the provider and payer share cost savings achieved against a target cost budget based upon agreed upon terms and may include downside risk.

You may access covered services from providers that participate in a VBP, such as an ACO, Global Payment/Total Cost of Care Arrangement, a PCMH, and/or a Shared Savings arrangement.

BlueCard® Program

If you receive covered services under a VBP inside a Host Blue's service area, you will not be responsible for paying any of the Provider Incentives, risk-sharing, and/or Care Coordinator Fees that are a part of such an arrangement, except when a Host Blue passes these fees to BCBSIL through average pricing or fee schedule adjustments. Additional information is available upon request.

Negotiated (non-BlueCard Program) Arrangements

If BCBSIL has entered into a Negotiated Arrangement with a Host Blue to provide VBPs to the BCBSIL Medical Program, BCBSIL will follow the same procedures for VBP administration and Care Coordinator Fees as described above with respect to VBPs under the BlueCard Program.

Inter-Plan Programs: Federal/State Taxes/Surcharges/Fees

Federal or state laws or regulations may require a surcharge, tax or other fee that applies to self-funded accounts. If applicable, BCBSIL may include any such surcharge, tax or other fee as part of the claim charge passed on to the Medical Program.

Non-Participating Providers Outside BCBSIL's Service Area

If you receive covered services from a Non-Participating Provider in a non-emergency situation, the amount the Medical Program pays for the covered services will be the lower of the (i) the Non-Participating Provider's billed charges, or (ii) the Medicare reimbursement rate as determined by the Centers for Medicare & Medicaid Services ("CMS"). (See the definition of "**Maximum Reimbursable Expense**" in the *Glossary of Key Terms – General)*.

If you receive covered services from a Non-Participating Provider, you will be responsible for the difference between what the Non-Participating Provider charges and what the Medical Program pays. Because that amount is in excess of the Maximum Reimbursable Expense, it does not count toward your annual Deductible or your annual Out-of-Pocket Limit.

If you receive covered services from a Non-Participating Provider in an emergency situation, the amount the Medical Program pays for the covered services will be determined in accordance with the Patient Protection and Affordable Care Act.

Blue Cross Blue Shield Global Core® Program

If you are outside the United States, the Commonwealth of Puerto Rico, and the U.S. Virgin Islands (the "BlueCard service area"), you may be able to take advantage of the Blue Cross Blue Shield Global Core® Program when accessing covered services. The Blue Cross Blue Shield Global Core® Program is unlike the BlueCard Program available in the BlueCard service area in certain ways. For instance, although the Blue Cross Blue Shield Global Core® Program assists you with accessing a network of inpatient, outpatient and professional providers, the network is not served by a Host Blue. As such, when you receive care from providers outside the BlueCard service area, you will typically have to pay the providers and submit the claims yourself to obtain reimbursement for these services.

If you need medical assistance services (including locating a doctor or hospital) outside the BlueCard service area, you should call the service center at 1.800.810.BLUE (2583) or call collect at 1.804.673.1177, 24 hours a day, seven (7) days a week. An assistance

coordinator, working with a medical professional, can arrange a physician appointment or hospitalization, if necessary.

Inpatient Services

In most cases, if you contact the service center for assistance, hospitals will not require you to pay for covered inpatient services, except for your cost-share amounts, deductibles, or co-insurance. In such cases, the hospital will submit your claims to the service center to begin claims processing. However, if you paid in full at the time of service, you must submit a claim to receive reimbursement for covered services. You must contact BCBSIL to obtain precertification for non-emergency inpatient services.

Outpatient Services

Physicians, urgent care centers and other outpatient providers located outside the BlueCard service area will typically require you to pay in full at the time of service. You must submit a claim to obtain reimbursement for covered services.

Submitting a Blue Cross Blue Shield Global Core® Program Claim

When you pay for covered services outside the BlueCard service area, you must submit a claim to obtain reimbursement. For institutional and professional claims, you should complete a Blue Cross Blue Shield Global Core® Program claim form and send the claim form with the provider's itemized bill(s) to the service center (the address is on the form) to initiate claims processing. Following the instructions on the claim form will help ensure timely processing of your claim. The claim form is available from BCBSIL, the service center or online at www.bcbsglobalcore.com. If you need assistance with your claim submission, you should call the service center at 1.800.810.BLUE (2583) or call collect at 1.804.673.1177, 24 hours a day, seven (7) days a week.

Group Health Program SPD Clarifications Regarding the Prescription Drug Program*.*

The following clarifications regarding prescription drug benefits apply to the Group Health Program SPD:

The following sentences are added to the end of the definition for Copayment in the section entitled Glossary of Terms:

The Prescription Drug Program and/or claims administrator may receive rebates or other discounts in connection with your prescriptions. The amount you are required to pay is based on the price of the prescription before the application of any rebate or other discount.

The following sentence replaces the last sentence of the definition for Participating Pharmacy in the section entitled Glossary of Terms:

Contact the claims administrator for a free listing of participating pharmacies, or view the current listing on the claims administrator's website at www.caremark.com or download the CVS Caremark app for iPhone or Android to access the pharmacy search tool.

The following sentence is added to the end of the last paragraph in the section entitled How Your Prescription Drug Coverage Works:

See Maintenance Choice Program below for more information.

The following paragraph replaces in its entirety the second paragraph in the section entitled How to Fill Your Prescriptions at a Retail Pharmacy:

You can obtain a list of participating retail pharmacies by contacting the claims administrator at the phone number listed on your prescription drug ID card or by visiting the claims administrator's website at www.caremark.com or download the CVS Caremark app for iPhone or Android to access the pharmacy search tool.

The following paragraph is added to the end of the section entitled How to Fill Your Prescriptions at a Retail Pharmacy:

Please note that the presentation of a prescription for fill at a pharmacy counter is not considered a submission of a formal claim under the Group Benefits Plan. To initiate these formal claims and appeals procedures, you must submit a Prescription Drug Claim Form in accordance with the procedures set forth in "*Filing Prescription Drug Program Claims and Filling Prescriptions at Non-Participating Retail Pharmacies*."

The following section is added after the section entitled How to Fill Your Prescriptions Through the Mail Service Pharmacy and before the section entitled What is a Covered Expense:

The Maintenance Choice Program.

You can save time and money by getting a 90-day supply of your maintenance medication filled at your local CVS pharmacy, including those inside Target stores, OR mailed directly to your home.

If you use the Mail Service to fill your 90-day supply, you can choose to spread your payments over three months.

The Maintenance Choice program does not apply to one-time or short-term medications (those taken for 90 days or less).

To learn more about the CVS Maintenance Choice and Mail Service Programs, visit www.caremark.com or call CVS Caremark at 1-800-268-5187.

IMPORTANT: If you continue to order 30-day supplies of your maintenance medications after the first fill without using the CVS pharmacy Maintenance Choice Program or CVS

Caremark Mail Service, you may be asked to pay the full cost of your prescriptions. If you prefer to obtain long-term medications through any network pharmacy, you must contact CVS Caremark to opt out of the Maintenance Choice Program.

The following sections are added after the section entitled Prior Authorization and before the section entitled Quantity Limits:

Step Therapy

The step therapy program is another form of prior authorization. This program encourages you and your doctors to start treatment with an appropriate generic medicine with a lower copay before "stepping up" to higher-priced brand drugs for certain drug classes. Examples of affected drug classes include: Acne, Allergy, Asthma, Enlarged Prostrate, Glaucoma, Headache, High Blood Pressure, High Cholesterol, Insomnia, Osteoporosis, and Urinary Incontinence.

Using the standard protocol, certain drugs are not covered unless participants have tried one or more "prerequisite therapy" medication(s) first. The look-back period for determining if a generic has previously been attempted is generally 12-18 months, depending on the drug class.

If medically necessary/appropriate, your physician can work with the pharmacy benefit provider, Caremark, to request a medical exception for approval to use a brand drug as initial therapy without trying a prerequisite therapy drug. If no other generic option is available, your doctor may provide clinical documentation to CVS Caremark to obtain prior approval so you may receive coverage for a brand drug. Without prior approval, the brand-name medicine may not be covered and you may have to pay the full-cost.

The list of drugs that require step therapy is subject to change from time to time and may not be all-inclusive. Drugs that require step therapy or other prior authorizations are noted in the Check Drug Cost tool on the Caremark website with a "PA" notation. You can log onto www.caremark.com to check your specific medicine coverage or call Customer Care toll-free at 1-888-528-7457.

Dispense as Written Penalty

If a generic drug is available, but your doctor notes "Dispense as Written/No Substitutions" on the prescription for the brand name drug, you will pay the coinsurance plus the difference between the generic and the brand price.

Group Health Program SPD Exclusions

The following section replaces in its entirety the section entitled What is Not Covered:

What Is Not Covered

The Medical Program options administered by BCBSIL and UHC do not cover all services and supplies. The claims administrator makes a determination as to whether an expense is a covered expense in accordance with its internal protocols and medical management guidelines.

Excluded Services

The following expenses are not covered expenses of the Medical Program options administered by BCBSIL and UHC (except where indicated otherwise):

- Expenses incurred before your coverage effective date.
- Services, treatments, and supplies that are not reasonably necessary for medical care or to treat an illness or injury, as determined by the claims administrator (except as specifically outlined under preventive care).
- Medicine, supplies, or services that are not ordered by a properly licensed physician (or another properly licensed practitioner of the healing arts) who is acting within the scope of his or her license.
- Certain drugs that have limited clinical value and which have clinically-appropriate, lower-cost alternatives (e.g., brand name drugs that are combinations of existing generic or over-the-counter drugs, new formulations of existing drugs).
- Testing or checkup procedures that are not necessary to diagnose or treat an illness or injury (except as specifically outlined under preventive care).
- Experimental and investigational services or unproven services, unless the Medical Program has agreed to cover them as stated within. This exclusion applies even if the experimental and investigational or unproven service is the only available treatment option for the condition.
- Educational or experimental treatments, procedures, devices, drugs, or medicines for which one or more of the following are true:
  - The service or supply is not approved for marketing by the FDA at the time the device, drug, or medicine is furnished.
  - The treatment method is not approved by the American Medical Association or the appropriate medical specialty society, or published in authoritative medical and scientific material.
  - The treatment, procedure, device, or drug is the subject of ongoing trials to determine tolerated dose, toxicity, safety, or efficacy.

- Routine physicals or mental health or substance abuse examinations and administrative documentation that are not required for health reasons but are required for (but not limited to):
  - Employment, insurance, school, or athletic exams;
  - Government licenses; or
  - Court-ordered, forensic, foreign travel, or custodial evaluations (except if the physical examination would have been performed as part of a routine exam and is within the scope of regular preventive care services covered under the Medical Program).
- Vaccinations and inoculations for any purpose, including non-employment-related foreign travel (except as specifically outlined under preventive care).
- Expenses for vision services, including hardware and eye exams unless to treat a sickness or injury. The Medical Program pays benefits for the purchase of contacts or eyeglasses only when necessary to treat a sickness or injury (this includes the first pair after cataract surgery).
- Expenses associated with the replacement of an external prosthetic appliance due to loss, theft, or destruction; or for any biomechanical external prosthetic appliance.
- Tests and treatments that are directly related to the actual or attempted impregnation or fertilization that involves the covered individual as a surrogate, donor, or recipient, including (but not limited to):
  - Artificial insemination;
  - In vitro fertilization;
  - Infertility surgical treatment;
  - Gamete intrafallopian transfer (GIFT);
  - Zygote intrafallopian transfer (ZIFT); and
  - Depo-Provera, when administered in the office of a provider who does not participate in the network (except as part of adjunctive therapy and palliative treatment of inoperable, recurrent, and metastatic endometrial or renal carcinoma).
- Services or supplies that are related to penile prostheses, except appliances such as semi-rigid internal or erectoid vacuum external prosthetics used to correct a neurogenic bladder of organic etiology.
- Services or supplies that are related to the reversal of voluntary sterilization.
- Cosmetic surgery or procedures, unless:
  - While covered under the Medical Program, you are injured and your injury results in bodily damage that requires reconstructive surgery; or
  - It qualifies as reconstructive surgery following medically necessary surgery for the specific illness or injury; or

  - It is required to provide or restore a normal bodily function; or
  - It is considered medically necessary in light of an underlying medical diagnosis in accordance with the claims administrator's medical management guidelines; or
  - It is cosmetic surgery or therapy to repair or correct severe facial disfigurements or severe physical deformities that are congenital or result from developmental abnormalities (other than abnormalities of the jaw or TMJ disorder); tumors; trauma; disease; complications of medically necessary, non-cosmetic surgery or reconstructive surgery to correct a congenital birth defect; or developmental abnormalities performed prior to the age of 19.

- Services or supplies that are related to breast augmentation (except as outlined immediately above).
- Nursing care and speech, occupational, or physical therapy provided by you, your spouse, or your spouse's child, sibling, or parent.
- Expenses associated with maintenance care, or any service that you may receive to maintain a level of function at which no demonstrable and/or measurable improvement of condition will occur.
- Exercise and maintenance therapies designed to improve general physical condition, including (but not limited to) Phase III cardiac and pulmonary rehabilitation.
- Outpatient rehabilitative therapy provided by a licensed physical, occupational, or speech therapist that is neither short-term nor restorative in nature, or that is in excess of the stated benefit level.
- Routine outpatient treatment of a structural imbalance, distortion, or subluxation of the vertebrae (except for outpatient rehabilitative therapy, up to the maximum benefit level).
- Routine chiropractic adjustments and manipulation, except for the treatment of a specific musculoskeletal disorder, up to the maximum benefit level.
- Custodial care that helps with functions of daily living and personal needs.
- Educational services or supplies, when the primary purpose is one of the following:
  - Training in the activities of daily living (except training that is directly related to an illness or injury that results in a loss of a previously demonstrated ability);
  - Scholastic instruction;
  - Vocational training;
  - Treatment of a learning disability; or
  - Prenatal instruction and exercise classes.

Educational services or supplies also include any service or supply that is designed to promote development beyond any level of function previously demonstrated.

- Expenses made by a provider, to the extent they result from scholastic, educational, or vocational training (as determined by the claims administrator).
- Consumable medical supplies, except as noted in the "What Is Covered" section.
- Non-medical services and supplies, such as:
  - Air conditioners;
  - Air filters or non-allergenic blankets; and
  - Modifications made to a home, property, or automobile (such as ramps, elevators, spas, air conditioners, and car hand controls).
- Artificial aids, including (but not limited to) corrective orthotic devices and orthotic shoes (except if medically necessary), dentures, garter belts, corsets, and wigs (except if medically necessary).
- Hygienic or self-help items, environmental control items, and institutional or athletic items.
- Expenses made by a physician for or in connection with a surgery that exceeds the following maximum (only applies if you receive care from a Non-Participating Provider): When two or more surgical procedures are performed at one time, the maximum amount covered is the amount that otherwise would be covered for the most expensive procedure, and one-half of the amount that would otherwise be covered for all surgical procedures.
- Expenses made by an assistant or co-surgeon in excess of 20% of the primary surgeon's allowable charge. These charges apply only if you receive care from a Non-Participating Provider. **Note:** Under the BCBSIL Group Health Program, the charges apply regardless of whether you receive care from a Participating Provider or a Non-Participating Provider.
- Any expense that is made for or in connection with tired, weak, or strained feet for which treatment consists of routine foot care, including (but not limited to) the removal of calluses and corns, or the trimming of nails (unless medically necessary for orthotics or corrective shoes).
- Nutritional supplements provided in the home setting for a condition such as diabetes mellitus, anorexia, bulimia, and amino acid deficiency.
- Transportation expenses via an air ambulance, unless medically necessary for the specific illness or injury (the claims administrator determines the medical necessity for an air ambulance).

- Non-covered services and penalties associated with the failure to precertify a hospital admission or surgery.
- Expenses related to an injury or disease that is covered by Workers' Compensation or similar law.
- Expenses for or in connection with an injury that arises out of or in the course of any employment for wage or profit.
- Services and supplies you receive:
  - By or from the U.S. government, or any other government unless payment of the expense is required by law; or
  - By any law or government plan under which you, your spouse, or your child(ren) is or could be covered.
- Expenses related to a sickness or injury due to a declared or undeclared act of war.
- Expenses in connection with injuries that result from acts of armed aggression by you or your covered dependents who commit such acts while covered by the Plan.
- Expenses for you or your covered dependents that would in any way be paid or be entitled to payment by or through a public program (other than Medicaid).
- Expenses for which payment is unlawful where you reside when the expense is incurred.
- Expenses that you are not legally required to pay.
- Expenses that would not have been paid if you had no coverage.
- Expenses for late or missed appointments.
- Expenses related to the transfer of medical records.
- Expenses incurred as a result of an accident for which, in the opinion of the claims administrator, third-party liability exists. In such case, the plan shall have the right to subrogation.
- Court-ordered treatments, unless deemed medically necessary for the specific illness or injury.
- Expenses under the mandatory part of any auto insurance policy written to comply with:
  - A "no-fault" insurance law; or
  - An uninsured motorist insurance law.

- Elective medical care that is received outside the United States (only emergency care, as determined by the claims administrator, is covered). **Note:** For the BCBSIL Group Health Program, this is not considered an exclusion.
- Organ transplant travel services associated with cornea transplants, costs incurred due to travel within a specific number of miles of the home (miles dependent upon your option), laundry bills, telephone bills, alcohol and tobacco products, and transportation charges that exceed coach class rates.
- The Medical Program does not pay benefits if you or your covered dependent is a donor.
- Dental services, other than those listed under the 'What Is Covered" section, or for oral surgery to remove impacted teeth, or to operate on gums or mouth as long as the operation is not performed for routine extractions or repairing of teeth.
- Dental services rendered in a case of TMJ dysfunction syndrome that affects the jaw but not the teeth.
- Expenses in excess of Maximum Reimbursable Expenses.
- Expenses that a third party is obligated to cover, such as under another plan or insurance policy, or a tort recovery or Workers' Compensation recovery by you.
- Foreign language and sign language interpreters.
- Enteral nutrition, including infant formula available over the counter, unless it is the only source of nutrition.
- Expenses for care that is not provided at an appropriate treatment facility. Appropriate treatment facilities generally do not include half-way houses, supervised living, group homes, wilderness programs, boarding houses, or other facilities that provide primarily a supporting environment and that address long-term social needs, even if counseling is provided in such facilities.

Regional Medical Options Program SPD Clarifications Regarding Right to Choose a Primary Care Provider

The first paragraph in the section entitled "Receiving Care" in the Regional Medical Options Program SPD is replaced in its entirety by the following:

When you join an HMO, you are generally required to designate a primary care physician ("PCP") for yourself and each of your covered dependents. You have the right to designate any PCP who participates in the HMO network and is available to accept you or your family members. For information on how to select a PCP and a list of participating PCPs, contact the HMO directly at the number or website included in your enrollment materials. For children, you may designate a pediatrician as the PCP. (In some HMOs, you select a group or site through which you receive medical care.) Your

PCP then coordinates all of your care. When you need care, you simply call or visit your PCP first, except in the case of obstetrical or gynecological care, as explained below. If necessary, your PCP then refers you to a specialist.

The following new paragraph is added after the first paragraph in the section entitled "Receiving Care" in the Regional Medical Options Program SPD:

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

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RR DONNELLEY

2019 Summary of Material Modifications (SMM) to the Group Benefits Plan and the Flexible Benefits Plan

Changes to Recovery of Medical Program Premiums that go into Arrears during Disability

This SMM explains changes effective July 1, 2019, wherein RRD changed its practice for recovering Medical Program (i.e., Group Health Program and Regional Medical Options Program) premiums that fall into arrears during a Short-Term Disability absence, a Long-Term Disability absence, or other leave of absence. Under the new policy, RRD will recover only 50% of one past deduction, plus 100% of the current deduction, from each paycheck until the employee pays the outstanding balance due.

This change in policy affects the Group Health Program SPD, the Regional Medical Options Program SPD, the Short-Term Disability Provided Under the Disability Benefit Program SPD, and the Long-Term Disability Provided Under the Disability Benefit Program SPD as described below.

Changes to the Group Health Program SPD and the Regional Medical Options Program SPD

Effective July 1, 2019, the penultimate paragraph in the subsection entitled "During a Leave of Absence" is replaced in its entirety with the following:

The advanced premiums will be recovered by your Participating Employer by taking 50% of one past deduction plus 100% of the current deduction, beginning with your first available pay upon your return to work or when you commence being paid. Deductions from your pay will continue until you repay your outstanding balance. If you separate employment from your Participating Employer with an outstanding balance due, the remaining balance will be recovered from your final pay as permitted by law or through deductions from disability pay.

Changes to the Short-Term Disability (STD) Provided Under the Disability Benefit Program SPD

Effective July 1, 2019, the second paragraph in the subsection entitled "Payment" is replaced in its entirety with the following:

If your weekly STD check is more than $250 after being reduced by Other Income and taxes, Aetna will withhold only Medical Program, Dental Program and Vision Program deductions from your check. If there are not enough funds to take all three deductions (if coverage was elected), only full deductions will be taken in the order listed above. For example, if you carry only Medical Program and Dental Program benefits through RR Donnelley and there are only enough funds in your disability pay to take the Medical Program deduction, the Dental Program deduction will go into arrears. Please also note, the deductions may not be taken from your initial disability checks due to timing. If this happens, any missed deductions will go into arrears and will be taken from your active pay when you return to work on a 1 + 1 basis (one active deduction and one arrears deduction) until the arrears amounts are paid in full (except that in the case of Medical

Program premiums, RR Donnelley will one recover 50% of one past deduction, plus 100% of the current deduction, from each paycheck).

Changes to the Long-Term Disability (LTD) Provided Under the Disability Benefit Program SPD

Effective July 1, 2019, the last paragraph in the subsection entitled "During a Leave of Absence" is replaced in its entirety with the following:

The advanced premiums will be recovered by RR Donnelley 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 Medical Program premiums, RR Donnelley will one 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 RR Donnelley 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.

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RR DONNELLEY

2018 Summary of Material Modifications (SMM) to the Group Benefits Plan

Dependent Audit Procedures

Changes to the Dependent Audit Procedures

This SMM explains changes to the Group Benefits Plan's dependent audit procedures. The following paragraphs replace, in its entirety, the section entitled "Dependent Audit" in the Group Health Program SPD, the Dental Benefit Program SPD, and the Vision Care Program SPD:

Dependent Audit

RR Donnelley and the Group Benefits Plan may conduct an audit of certain covered dependents, both periodically and at the time of enrollment. A Dependent Audit Notice is mailed 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 dependent(s) 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 dependents by the date specified in the Dependent Audit Notice, or coverage for your dependent(s) will end on the date specified in the Dependent Audit 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 Participant). A Results Notice will be mailed out prior to 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 terminates for your dependent, but, prior to the next audit, you submit the required documentation and confirm your dependent's eligibility, your dependent may be allowed to be re-enrolled 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 1st 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 which may allow for a change in elections, your premium may again be payable on a pre-tax basis. Please see page 13 for a discussion on after-tax premiums.

If a second 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 which 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 dependent(s) will be confirmed as eligible for coverage, even for a future annual enrollment.

Ineligible dependents or dependents for whom you either: (i) were unable to provide required documentation, or (ii) 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 audit is not itself a qualifying event to continue coverage through the Consolidated Omnibus Budget Reconciliation Act ("COBRA"). COBRA is a federal law that requires employers to offer plan participants the opportunity to continue their health care coverage in a number of situations that would otherwise ordinarily end their coverage. Dependents who lose coverage during a dependent 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 time frames required by COBRA.

Required Documentation for Dependent Audit

During a dependent eligibility 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 Plan to verify your dependent's eligibility.

Domestic Partner Tax Affidavits

In most cases, Domestic Partners and their children do not qualify as the employee's tax dependent(s). If your Domestic Partner (or his or her child) does not meet the IRS definition of a tax dependent, then you will need to pay taxes on the value of their Plan benefits. This means that your share of the premiums for their coverage will be paid on an after-tax basis, and that extra taxes will be withheld from your pay to reflect the value of benefits subsidized by RR Donnelley. See "Your Premiums" for a discussion of how this "imputed income" is calculated.

However, the IRS definition of a tax dependent for health insurance purposes is broader than the definition of who is claimed as a dependent on your income tax return, and in some cases these individuals will qualify as your tax dependent for health insurance 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 an individual is your tax dependent ($4,150 for 2018, indexed for inflation annually) are disregarded, and children can be considered your dependent to age 26.

You should consult with a tax advisor to determine if your Domestic Partner or his/her child(ren) qualify as your tax dependent for health insurance purposes. You will be required to provide the 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 Plan.

In general, the requirements for a Domestic Partner (or your partner's child) to be your tax dependent for purposes of medical insurance are:

- the individual lives with you for the entire calendar year (and the relationship does not violate local law);
- during the calendar year, you must provide more than half of the total support (as described below) for the individual;
- the individual cannot be claimed as a qualifying child on anyone else's federal tax return; and
- the individual must be 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 your Domestic Partner or his/her child, you must compare the amount of support you provide with the amount of support your Domestic Partner (or your partner's child) receives from all sources, including Social Security, welfare payments, the support you provide, alimony and child support, and the support the Domestic Partner (or the child) 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 your Domestic Partner (or child), you should complete the support worksheet in IRS Publication 501 (Exemptions, Standard Deduction, and Filing Information).

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 RR Donnelley for any liability it may incur for failure to withhold Federal, state, or local income taxes, Social Security taxes, or other taxes related to such benefits.

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RR DONNELLEY

2018 Summary of Material Modifications (SMM) to the Group Benefits Plan

Claims and Appeals Procedures

I. Medical and Prescription Drug Programs ("Group Health Program") and Regional Medical Options Program SPDs

Changes to Claims and Appeals Procedures

The following describes changes made to the Medical and Prescription Drug Programs (also known as the "Group Health Program") and Regional Medical Options Program SPDs with respect to the procedures for filing claims and appeals.

The following identifies changes that occur within the section entitled "Claims and Appeals Procedures":

The following paragraphs replace in its entirety the subsection entitled "General Information":

General Information

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 Medical and Prescription Drug Programs.

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 is a claim to receive coverage for a particular type of surgery. If you are filing a benefit claim, you need to contact the 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 described in "*Filing Prescription Drug Program Claims and Filling Prescriptions at Non-Participating Retail Pharmacies*" and 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 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 for the Group Health Program due to disability, then the additional procedures applicable to disability claims will also apply to your benefit claim.

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 the "Administrative and Contact Information" section 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).

The first sentence in the subsection entitled "Procedure for Filing a Claim" is amended to state the following:

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.

The following paragraph is added to the end of the subsection entitled "Initial Claim Review":

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.

The following sentence is added to the end of the second paragraph in the subsection entitled "Pre-Service Claim":

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.

The following sentence is added to the end of the second paragraph in the subsection entitled "Post-Service Claim":

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.

The following subsection is inserted following the subsection entitled "Post-Service Claim" and before the subsection entitled "Manner and Content of Notification of Denied Claim":

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.

The subsection entitled "Manner and Content of Notification of Denied Claim" is replaced in its entirety with the following:

Manner and Content of Notification of Denied Claim

The claims administrator will provide the claimant with notice of any denial, in a culturally and linguistically appropriate manner, 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.

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;
  - 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 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 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.

The section entitled "Procedure for Filing an Appeal of a Denial" is renamed "Procedure for Filing an Initial Appeal of a Denial."

The section entitled "Review Procedures for Denials" is renamed "Review Procedures for Appeals of Denials" and is replaced in its entirety by the following:

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.

- 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 rational, 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.

The subsection entitled "Timing of Notification of Benefit Determination on Review" is renamed "Timing of Notification of Initial Benefit Determination on Review" and is replaced in the entirety with the following chart:

Time Limit for:	Urgent Care Claim	Pre-Service Claim	Post-Service Claim
THE PLAN TO NOTIFY YOU OF THE INITIAL APPEAL DECISION			
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.
UHC	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 30 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.

Time Limit for:	Urgent Care Claim	Pre-Service Claim	Post-Service Claim
• In the case of a benefit claim, 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 Patient Protection and 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.			

The subsection entitled "Manner and Content of Notification of Benefit Determination on Review" is replaced in its entirety with the following:

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 a culturally and linguistically appropriate manner, in accordance with applicable U.S. Department of Labor ("DOL") regulations. If the claimant's appeal is denied, the notification 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 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.

A new subsection entitled "Second Review of Initial Benefit Denial" is inserted following the subsection entitled "Manner and Content of Benefit Determination on Review" and before the subsection entitled "External Review Procedures."

Second Review of Initial Benefit Denial

Procedure for Filing a Second Appeal of a Denial
BCBSIL does not provide a second level of internal appeals. CVS Caremark and UHC require 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 entitled "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 the subsection entitled "Review Procedures for Appeals of Denials."

Timing and Notification of Second Benefit Determination on Review

Time Limit for:	Urgent Care Claim	Pre-Service Claim	Post-Service Claim
YOU TO FILE A SECOND INTERNAL APPEAL			
BCBSIL	N/A	N/A	N/A
UHC	If an initial appeal is denied, UHC will automatically initiate the second level appeal.	60 days after receiving the initial notification of benefit determination on review.	60 days after receiving the initial notification of benefit determination on review.
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:	Urgent Care Claim	Pre-Service Claim	Post-Service Claim
THE PLAN TO NOTIFY YOU OF THE FINAL APPEAL DECISION			
BCBSIL	N/A	N/A	N/A
UHC	*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.	Within a reasonable period, but no more than 30 days after receiving the second appeal.
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, UHC and 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 manner and content of a Notification of Second Benefit Determination on Review will include all of the same elements that are described above in the subsection entitled "*Manner and Content of Notification of Benefit Determination on Review*."

The subsection entitled "External Review Procedures" is replaced in its entirety by the following:

External Review Procedures

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.

The first paragraph of the subsection entitled "Legal Action" is replaced in its entirety by the following:

Legal Action

A claimant cannot bring legal action to recover any benefit under, or for eligibility in, the 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 insurance certificate; or
- If you forfeited a benefit based on the two-year forfeiture rule described in the "Forfeiture After Two Years" subsection of the "Situations Affecting Your Benefits" section of this SPD.

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 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 bases, 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 claimant's receipt of such notice.

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II. Dental Benefit Program SPD and Vision Care Program SPD

Changes to Claims and Appeals Procedures

The following describes changes made to the Dental Benefit Program SPD and to the Vision Care Program SPD with respect to the procedures for filing claims and appeals.

The following identifies changes that occur within the section entitled "Claims and Appeals Procedures":

The following paragraphs replace in its entirety the subsection entitled "General Information":

General Information

The following claim review and claim appeal procedures apply to all benefit and eligibility claims (including rescissions of coverage) of any nature related to the Dental Benefit Program and the Vision Care Program, each under the Group Benefits Plan.

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 is a claim to receive coverage for a particular type of service or supply. If you are filing a benefit claim, you need to contact the claims administrator.

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 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 for the Group Health Program due to disability, then the additional procedures applicable to disability claims will also apply to your benefit claim.

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 the “Administrative and Contact Information” section 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).

The first sentence in the subsection entitled “Procedure for Filing a Claim” is amended to state the following:

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.

The following sentence is added to the end of the second paragraph in the subsection entitled "Pre-Service Claim":

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.

The following sentence is added to the end of the second paragraph in the subsection entitled "Post-Service Claim":

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.

The following subsection is inserted following the subsection entitled "Post-Service Claim" and before the subsection entitled "Manner and Content of Notification of Denied Claim":

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.

The subsection entitled "Manner and Content of Notification of Denied Claim" is replaced in its entirety with the following:

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.

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;
- 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; and
  - 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;
- 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;
    - 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
    - Such denial will be provided in a culturally and linguistically appropriate manner, in accordance with applicable DOL regulations.
- A description of the Group Benefits Plan's review procedures, 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.

The section entitled "Review Procedures for Appeals of Denials" replaced in its entirety:

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 disability claims, the claims administrator must 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 rational, as applicable, will 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 Group Benefits Plan 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.

The subsection entitled "Manner and Content of Notification of Benefit Determination on Review" is replaced in its entirety with the following:

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:

- 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; and
  - 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;
- 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;
  - 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
  - Such denial will be provided in a culturally and linguistically appropriate manner, in accordance with applicable DOL regulations.

- A statement describing any voluntary appeal procedures offered by the Group Benefits Plan 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 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.

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.

The subsection entitled "External Review Procedures" is deleted in its entirety.

The first paragraph of the subsection entitled "Legal Action" is replaced in its entirety by the following:

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 insurance certificate; or
- If you forfeited a benefit based on the two-year forfeiture rule described in the "Forfeiture After Two Years" subsection of the "Situations Affecting Your Benefits" section of this SPD.

In the case of disability claims, notwithstanding the previous paragraph, if the Plan fails to adhere to all of the requirements of the procedures set forth above for disability claims, then to the extent required by law, the claimant may 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 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 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 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 bases, if any, for asserting the violation should not cause the internal claims and appeals process to be deemed exhausted. If a court rejects the claimant's request for immediate review on the basis that the Plan met the requirements for the exception, then the 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 claimant's receipt of such notice.

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III. Disability Benefit Program SPDs

The following describes changes made to the Short-Term Disability Provided Under the Disability Benefit Program SPD and to the Long-Term Disability Provided Under the Disability Benefit Program SPD.

Effective February 1, 2018, The Hartford replaces Aetna as the claims administrator for Disability Benefit Program benefits. The Hartford's contact information for claims and appeals is:

The Hartford
P.O. Box 14869
Lexington, KY 40512-4869
Phone: 866-271-0744
Fax: 833-357-5153

The Group Benefits Plan has designated and named The Hartford as the claims administrator for benefits provided under the Disability Benefits Program. The Plan has granted The Hartford full discretion and authority to determine eligibility for benefits and to construe and interpret all terms and provisions of the Disability Benefits Program, to the extent permitted by applicable state law.

The following paragraphs are added at the end of the subsection entitled "General Information" under the "How the Program Works" section in the Short-Term Disability Provided Under the Disability Benefit Program SPD:

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 the "Administrative and Contact Information" section 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).

For claims filed on or after April 1, 2018, the following Claims Procedures replace the Certificate of Coverage language incorporated by reference in the section entitled "Claims and Appeals Procedures" in the Long-Term Disability Provided Under the Disability Benefit Program SPD, and replace the following sections in the Short-Term Disability Provided Under the Disability Benefit Program SPD:

- Time Frames for Claim Decisions
- Extension of Time Frames
- Manner and Content of Notification of Denied Claim
- Appealing a Claim Denial Decision
- How to Appeal a Claim Denial
- The Appeal Process
- Extension of Time Frames

Notwithstanding the above, in the Short-Term Disability Provided Under the Disability Benefit Program SPD, wherever the term "Insurance Company" appears it is replaced with "claims administrator," and wherever "Policy" appears it is replaced with "Plan." Furthermore, the subsection entitled "Second Level of Appeal for Short-Term Disability Claims" shall be added to the Short-Term Disability SPD only.

CLAIM PROCEDURES

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 Insurance Company 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 Insurance Company 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 Insurance Company demonstrates that the violation was for good cause or due to matters beyond the control of the Insurance Company and that the violation occurred in the context of an ongoing, good faith exchange of information between the Insurance Company and you. This exception is not available if the violation is part of a pattern or practice of violations by the Insurance Company. Before filing a civil action, you may request a written explanation of the violation from the Insurance Company, and the Insurance Company must provide such explanation within 10 days, including a specific description of its bases, 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 Insurance Company met the standards for the exception, your claim shall be considered as re-filed on appeal upon the Insurance Company's receipt of the decision of the court. Within a reasonable time after the receipt of the decision, the Insurance Company 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 (1) you, (2) the Employer or Plan Administrator and (3) the attending physician or hospital. Following completion, the claim form(s) must be forwarded to the Insurance Company's claim representative. The Insurance Company will evaluate your claim and determine if benefits are payable.

The Insurance Company 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 Insurance Company notifies you in writing that an extension is necessary due to matters beyond the control of the Insurance Company, 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 decision may be tolled from the date on which the notification of the extension is sent to you until the date the Insurance Company receives your response to its request. If the Insurance Company 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: 1) the specific reason or reasons for the decision; 2) specific references to the Policy provisions on which the decision is based; 3) 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; 4) a description of the Insurance Company's review procedures and time limits applicable to such procedures; 5) 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; 6) a discussion of the decision, including an explanation of the basis for disagreeing with or not following: (a) the views presented by you to the Insurance Company of health care professionals treating you and vocational professionals who evaluated you, (b) the views of medical or vocational experts whose advice was obtained on behalf of the Insurance Company in connection with the adverse benefit determination, without regard to whether the advice was relied upon in making the benefit determination, and (c) a disability determination regarding you presented by you to the Insurance Company made by the Social Security Administration; 7) 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; 8) either the specific internal rules, guidelines, protocols, standards or other similar criteria of the Insurance Company relied upon in making the adverse determination or, alternatively, a statement that such rules, guidelines, protocols, standards or other similar criteria of the Insurance Company do not exist; 9) 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 10) a statement prominently displayed in any applicable non-English language clearly indicating how to access the language services provided by the Insurance Company.

Appealing Denials of Claims for Benefits

On any wholly or partially denied claim, you or your representative may appeal to the Insurance Company 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 Insurance Company no later than the expiration of 180 days from the date you received your claim denial. As part of your appeal:

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

The Insurance Company'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 Insurance Company can issue an adverse benefit determination on review, the Insurance Company shall provide you, free of charge, with any new or additional

evidence considered, relied upon, or generated by the Insurance Company (or at the direction of the Insurance Company) 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 Insurance Company can issue an adverse benefit determination on review based on a new or additional rationale, the Insurance Company 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 Insurance Company will make a final decision no more than 45 days after it receives your timely appeal. The time for final decision may be extended for one additional 45 day period provided that, prior to the extension, the Insurance Company 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 decision shall be tolled from the date on which the notification of the extension is sent to you until the date the Insurance Company receives your response to the request. The Insurance Company 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 Insurance Company provides you with new or additional evidence or a new or additional rationale, and end when the Insurance Company receives the response or on the date by which the Insurance Company 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 Insurance Company 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 Insurance Company 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: 1) the specific reason or reasons for the decision; 2) specific references to the Policy provisions on which the decision is based; 3) 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; 4) 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; 5) a discussion of the decision, including an explanation of the basis for disagreeing with or not following: (a) the views presented by you to the Insurance Company of health care professionals treating you and vocational professionals who evaluated you, (b) the views of medical or vocational experts whose advice was obtained on behalf of the Insurance Company in connection with the adverse benefit determination, without regard to whether the advice was relied upon in making the benefit determination, and (c) a disability determination regarding you presented by you to the Insurance Company made by the Social Security Administration; 6) 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; 7) either the specific internal rules, guidelines, protocols, standards or other similar criteria of the Insurance Company 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; 8) a statement prominently displayed in any applicable non-English language clearly indicating how to access the language services provided by the Insurance Company; and 9) 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 (1) you, (2) the Employer or Plan Administrator and (3) the attending physician or hospital. Following completion, the claim form(s) must be forwarded to the Insurance Company's claim representative. The Insurance Company will evaluate your claim and determine if benefits are payable.

The Insurance Company will make a decision no more than 90 days after receipt of your properly filed claim. However, if the Insurance Company 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 Insurance Company 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 Insurance Company 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: 1) specific reasons for the decision; 2) specific references to Policy provisions on which the decision is based; 3) 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; 4) a description of the review procedures and time limits applicable to such, and 5) 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 Insurance Company 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 Insurance Company no later than the expiration of 60 days from the date you received your claim denial. As part of your appeal:

1. you may request, free of charge, copies of all documents, records, and other information relevant to your claim; and

2. you may submit written comments, documents, records and other information relating to your claim.

The Insurance Company'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 Insurance Company will make a final decision no more than 60 days after it receives your timely appeal. However, if the Insurance Company 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 Insurance Company 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 Insurance Company 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: 1) specific reasons for the decision and specific references to the Policy provisions on which the decision is based, 2) 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, 3) a statement of your right to bring a civil action under section 502(a) of ERISA, and 4) any other notice(s), statement(s) or information required by applicable law.

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IV. Life and Accident Insurance Program SPD

For claims filed on or after April 1, 2018, the following Claims Procedures modify the Certificate of Coverage language incorporated by reference in the section entitled "Claims and Appeals Procedures."

The section entitled "Loss of Benefits" is replaced in its entirety by the following:

Loss of Benefits

You must continue to be a member of a class of eligible employees or beneficiaries to which the plan pertains and continue to make any contributions or payments that are due, including those you agreed to when you enrolled for coverage. Failure to make required contributions may result in partial or total loss of your benefits.

The following section is added immediately after the section entitled "Loss of Benefits":

Plan Sponsor May Amend or Terminate the Plan at any Time

It is intended that this plan will be continued for an indefinite period of time. But, the Plan Sponsor reserves the right to change or terminate the plan at any time. This Booklet elsewhere describes your rights upon termination of the plan.

The following claims procedures apply to claims filed on or after April 1, 2018.

Claim Procedures

1. Determination of Benefits

Prudential shall notify you of the claim determination within 45 days of the receipt of your claim. This period may be extended by 30 days if such an extension is necessary due to matters beyond the control of the plan. A written notice of the extension, the reason for the extension and the date by which the plan expects to decide your claim, shall be furnished to you within the initial 45-day period. This period may be extended for an additional 30 days beyond the original 30-day extension if necessary due to matters beyond the control of the plan. A written notice of the additional extension, the reason for the additional extension and the date by which the plan expects to decide on your claim, shall be furnished to you within the first 30-day extension period if an additional extension of time is needed. However, if a period of time is extended due to your failure to submit information necessary to decide the claim, the period for making the benefit determination by Prudential will be tolled (i.e., suspended) from the date on which the notification of the extension is sent to you until the date on which you respond to the request for additional information.

If your claim for benefits is denied, in whole or in part, you or your authorized representative will receive a written notice from Prudential of your denial. The notice will include:

(a) the specific reason(s) for the denial, which will include a discussion of the decision describing, if applicable, the basis for disagreeing with or not following (i) the views of your treating providers, (ii) the views of medical or vocational experts whose advice was obtained on behalf of the plan in connection with your adverse benefit determination, without regard to whether the advice was relied upon in making the benefit determination, and (iii) an award of Social Security Administration disability benefits,

(b) references to the specific plan provisions on which the benefit determination was based,

(c) a description of any additional material or information necessary for you to perfect a claim and an explanation of why such information is necessary,

(d) 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,

(e) a description of Prudential's appeals procedures and applicable time limits, including a statement of your right to bring a civil action under section 502(a) of ERISA following your appeals,

(f) a statement that, if an adverse benefit determination is based on a medical necessity or experimental treatment or similar exclusion or limit, an explanation of the scientific or clinical judgment for the determination will be provided free of charge upon written request, and

(g) copies of any internal rules or guidelines relied upon in making this determination, if applicable.

2. Appeals of Adverse Determination

If your claim for benefits is denied, you or your representative may appeal your denied claim in writing to Prudential within 180 days of the receipt of the written notice of denial or 180 days from the date such claim is deemed denied. Similarly, if Prudential does not decide your claim within the time described in Section 1 above, you may appeal, although you are not required to do so. You may submit with your appeal any written comments, documents, records and any other information relating to your claim. Upon your request, you will also have access to, and the right to obtain copies of, all documents, records and information relevant to your claim free of charge.

A full review of the information in the claim file and any new information submitted to support the appeal will be conducted by Prudential, utilizing individuals not involved in the initial benefit determination. This review will not afford any deference to the initial benefit determination.

Prudential shall make a determination on your appeal within 45 days of the receipt of your appeal request. This period may be extended by up to an additional 45 days if Prudential determines that special circumstances require an extension of time. A written notice of the extension, the reason for the extension and the date that Prudential expects to render a decision shall be furnished to you within the initial 45-day period. However, if the period of time is extended due to your failure to submit information necessary to decide the appeal, the period for making the benefit determination will be tolled (i.e., suspended) from the date on which the notification of the extension is sent to you until the date on which you respond to the request for additional information.

Prudential will provide you, free of charge and prior to any adverse decision on appeal, with any new or additional evidence that is considered by Prudential in connection with the claim (including evidence that may be the basis for denial as well as any evidence that may support granting the claim), and any new or additional rationale that will form the basis for the Prudential's decision on appeal. Any such evidence will be provided as soon as possible and sufficiently in advance of the date on which the notice of adverse benefit determination must be provided in order to give you a reasonable opportunity to respond prior to that date.

If the appeal is denied in whole or in part, you will receive a written notification from Prudential of the denial. The notice will include:

(a) the specific reason(s) for the adverse determination, which will include a discussion of the decision describing, if applicable, the basis for disagreeing with or not following (i) the views of your treating providers, (ii) the views of medical or vocational experts whose advice was obtained on behalf of the plan in connection with your adverse benefit determination, without regard to whether the advice was relied upon in making the benefit determination, and (iii) an award of Social Security Administration disability benefits,

(b) references to the specific plan provisions on which the determination was based,

(c) a statement that you are entitled to receive upon request and free of charge reasonable access to, and make copies of, all records, documents and other information relevant to your benefit claim upon request,

(d) a description of Prudential's review procedures and applicable time limits,

(e) a statement that if an adverse benefit determination is based on a medical necessity or experimental treatment or similar exclusion or limit, an explanation of the scientific or clinical judgment for the determination will be provided free of charge upon written request,

(f) copies of internal rules or guidelines relied upon in making this determination, if applicable, and

(g) a statement describing any appeals procedures offered by the plan, and your right to bring a civil suit under ERISA.

If a decision on appeal is not furnished to you within the time frames mentioned above, the claim shall be deemed denied on appeal.

If the appeal of your benefit claim is denied, you or your representative may make a second, voluntary appeal of your denial in writing to Prudential within 180 days of the receipt of the written notice of denial or 180 days from the date such claim is deemed denied. Similarly, if Prudential does not decide your appeal within the time described in Section 1 above, you may appeal again, although you are not required to do so. You may submit with your second appeal any written comments, documents, records and any other information relating to your claim. Upon your request, you will also have access to, and the right to obtain copies of, all documents, records and information relevant to your claim free of charge.

Prudential shall make a determination on your second claim appeal within 45 days of the receipt of your appeal request. This period may be extended by up to an additional 45 days if Prudential determines that special circumstances require an extension of time. A written notice of the extension, the reason for the extension and the date by which Prudential expects to render a decision shall be furnished to you within the initial

45-day period. However, if the period of time is extended due to your failure to submit information necessary to decide the appeal, the period for making the benefit determination will be tolled from the date on which the notification of the extension is sent to you until the date on which you respond to the request for additional information.

Your decision to submit a benefit dispute to this voluntary second level of appeal has no effect on your right to any other benefits under this plan. If you elect to initiate a lawsuit without submitting to a second level of appeal, the plan waives any right to assert that you failed to exhaust administrative remedies. If you elect to submit the dispute to the second level of appeal, the plan agrees that any statute of limitations or other defense based on timeliness is tolled during the time that the appeal is pending.

If the claim on appeal is denied in whole or in part for a second time, you will receive a written notification from Prudential of the denial. The notice will be written in a manner calculated to be understood by the applicant and shall include the same information that was included in the first adverse determination letter. If a decision on appeal is not furnished to you within the time frames mentioned above, the claim shall be deemed denied on appeal.

Time Limit To File Suit

If your claim for benefits and any required appeals are denied (or not decided within the time periods discussed above), you may file suit as discussed below. If you elect to file suit, you should do so as soon as possible. However, you must file suit no later than three years after proof of your claim was first due as explained elsewhere in this Booklet, regardless of whether your claim is still pending in the claim or appeal process.

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RR DONNELLEY

2019 Summary of Material Modifications (SMM) to the Health Care and Dependent Care Spending Programs SPD

Changes to the Health Care and Dependent Care Spending Programs SPD

The following describes changes to the Health Care and Dependent Care Spending Programs SPD:

Effective January 1, 2018, the contact information for the FSA claims administrator is:

Your Spending Account
P.O. Box 64030
The Woodlands, TX 77387-4030
1-877-RRD-4BEN (1-877-773-4236)

***The following describes changes that occur within the section entitled "Who is Eligible"*:**

The following language is added after the third bullet in the first paragraph in the subsection entitled "General Information":

- In addition to each of the foregoing eligibility requirements, the following eligibility requirements apply:
  - with respect to the Health Care FSA, you must be eligible for the RR Donnelley Medical and Prescription Drug Program.
  - with respect to the Dependent Care FSA, you must have an eligible dependent that is a qualifying individual as described in the section entitled "How the Dependent Care FSA Works – General Information."

The following replaces the section entitled "Ineligible Expenses" in its entirety:

Certain expenses are not reimbursable through the Health Care FSA, including expenses incurred by a domestic partner or child(ren) of a domestic partner that is not your tax dependent.

***The following describes changes that occur within the section entitled "How the Health Care FSA Works"*:**

The following replaces in its entirety the first paragraph and the bullet points that follow in the subsection entitled "How to Access Funds or Receive Reimbursement from Your Health Care FSA" under the heading "Debit Card":

When you're enrolled in the Health Care Spending Account, you have the opportunity to pay for eligible health care expenses with the YSA card. The YSA card allows you to avoid paying for eligible expenses out of pocket. When you use your YSA card, your eligible expenses are deducted automatically from your

account. You cannot request claim reimbursement for any expenses purchased with your YSA card.

- As you make payments with your YSA card, the balance of your Health Care FSA account will be reduced to reflect the payment. Reimbursement for eligible items and services will be made up to the annual amount you have allocated to your Health Care FSA account at the time you submit the claim. The total contribution amount elected for the plan year will be available in your Health Care FSA account for claim reimbursement at all times, reduced by any amount that has already been used for reimbursement. Only current plan year funds will be available for card transactions.
- If you do not have sufficient funds left in your Health Care FSA to cover the entire expense at the time of sale, then your attempt to use the YSA card will be declined. Please note that the attempted use of the YSA card to pay a provider is not considered submission of a claim under the Plan, and the claims administrator's determination that an expense for which a card swipe is made is not an eligible expense does not constitute a claim denial under the Plan. To initiate the Plan's claims and appeals procedure, you must submit a claim in accordance with the Plan's claims procedures.
- Understand that all YSA card transactions must be validated. As part of the validation process, Your Spending Account will notify you if itemized receipts are needed to validate your YSA card purchases. Although many transactions can be validated automatically, it's important that you save all itemized receipts for your YSA card transactions in case supporting documentation is requested. Frequently substantiation can take place automatically, such as if your card swipe was at a qualifying provider and matches your Medical Program copay amount, where a recurring claim amount has previously been substantiated, or if the vendor where you made your card purchase utilizes an IIAS inventory system. Other times, the claims administrator will require that you submit additional documentation to substantiate that you made an eligible purchase.
- If the YSA card is used to pay an expense that is not electronically substantiated at the point of sale, then you will be notified and will be required to submit acceptable documentation of the transaction, such as an Explanation of Benefits (EOB), itemized bills or receipts, or other information requested by the claims administrator to substantiate that the amount charged was an eligible expense. When you use the YSA card, you should save all receipts and supporting documentation in the event you need to submit them to the claims administrator.
- If you fail to provide information to satisfy the claims administrator that amounts paid with the card are eligible expenses, then the claims administrator, Plan Administrator and/or RRD may take whatever action they deem appropriate to require you to repay the unsubstantiated amount, including:
  - requesting that you reimburse the Plan for the unsubstantiated amount;

  - suspending your YSA card and requiring you to submit forms to obtain future reimbursements of eligible expenses;
  - offsetting future Health Care FSA reimbursement claims by the unsubstantiated amount paid with the YSA card;
  - suspending your eligibility to participate in the Plan;
  - to the extent permitted by law, having RRD deduct from your taxable wages the amount of the unsubstantiated expense paid via with the YSA card; and
  - where recovery is not made by the end of the taxable year, reporting the amount of the ineligible expense as taxable income to the Internal Revenue Service (IRS) on form W-2 and taking appropriate withholdings from other pay.
- If the Plan's correction efforts prove unsuccessful, you still owe the Plan the amount of the unsubstantiated payment. In that event, and consistent with its business practices, RRD may treat the unsubstantiated amount as it would any other business debt.
- You can use the YSA card to pay for eligible items or services at health care providers (medical, dental or vision, as appropriate) and retail merchants with an IRS-approved inventory system that sell eligible over-the-counter items and prescriptions (called "IIAS merchants"). You can also use your YSA card for prescription amounts that are not covered under the Prescription Drug Program at merchants where 90 percent of the store's gross receipts for the last tax year consisted of items that qualify as medical expenses under IRS guidelines (called "90 percent merchants"). If you try to use your YSA card at any other retail merchant, the card will be declined and you must pay the provider by another means and request reimbursement using the claim form process described above.
- Do not use the YSA card for ineligible items or services. The card cannot be used to purchase certain items and services, such as over-the-counter medicines, drugs and biologicals. Such items are only reimbursable if you submit a claim form accompanied by a physician's prescription or other documentation of medical necessity for the item(s).
- You can only use your YSA card to purchase eligible health care items or services—dependent care expenses are not eligible for payment with your card. Always separate eligible health care items (e.g., prescriptions, reading glasses, contact lenses) from ineligible items (e.g., magazines, cosmetics) before using your YSA card. Ineligible items must be purchased with another form of payment
- Choose "credit" when you swipe your card. The YSA card is a signature based debit card. This means you'll be required to provide your signature, similar to when you use a credit card. If you choose the "debit" option, your transaction will not be processed. Each time you sign, you are affirming that the medical expense has not been reimbursed from any other source, and that you will not seek reimbursement from any other source.

- If the expense is determined to be ineligible, your YSA card may be suspended from further use until the overpayment is repaid. To the extent the overpayment is not repaid or recaptured, it will be included as wages and reported on IRS Form W-2.
- If your YSA card is suspended, you won't be able to use the card, but you will be able to submit claims via the Web site or through postal mail. You'll always have access to your account, regardless of the status of your YSA card. Once the overpayment is corrected, you'll receive notification (via email or postal mail, based on whether we have an email address on file) that your YSA card was reinstated.
- The claims administrator has adopted other rules to ensure that the YSA card is used only for eligible expenses, such as canceling the card upon termination of employment, and establishing transaction limits. Please be sure to read the separate communication explaining the special rules and requirements that apply to your card.

The following identifies changes that occur within the section entitled "Claims and Appeals Procedures":

The following paragraphs replace in its entirety the subsection entitled "General Information":

General Information

The following claim review and claim appeal procedures apply to all benefit claims and eligibility claims of any nature related to the Health Care FSA and Dependent Care FSA.

A "benefit claim" is a claim for a particular benefit under the Plan. It will typically include your initial request for benefits. An example of a benefit claim is a claim to receive reimbursement for a particular expense. If you are filing a benefit claim, you need to contact the claims administrator.

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). An example of an eligibility claim is a claim to clarify a dependent's eligibility or to change contributions midyear. If you are filing an eligibility claim, you need to contact the 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 dependent is disabled, then the additional procedures applicable to disability claims will also apply to your benefit claim.

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 the "Administrative and Contact Information" section 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).

The first sentence in the subsection entitled "Procedure for Filing a Claim" is amended to state the following:

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 claims administrator by first-class postage-paid mail, to the address for the claims administrator.

The following subsection, entitled "Disability Claim," is added to the section entitled "Claims and Appeal Procedures" following the subsection "Initial Benefit Determination" and before the subsection "Manner and Content of Notification of Denied Claim":

Disability Claim

In the case of a benefit claim that is filed that requires a disability determination (including, but not limited to, a claim involving a decision whether a dependent is disabled for purposes of eligibility), 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 expect 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.

The subsection entitled "Manner and Content of Notification of Denied Claim" is replaced in its entirety with the following:

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.

The notification of a denial will include:

- The specific reason or reasons for the denial;
- Reference to the specific 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;
- In the case of a denial involving a benefit claim under the Health Care FSA, 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 Plan to the claimant's medical circumstances, or a statement that such explanation will be provided free of charge upon request; and
  - 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;
- 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 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 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 Plan made by the Social Security Administration;
  - Either:
    - the specific internal rules, guidelines, protocols, standards, or other similar criteria of the Plan that was relied upon in the claim denial; or
    - a statement that such rules, guidelines, protocols, standards, or other similar criteria of the 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 Plan to the claimant's medical circumstances; or
    - a statement that such explanation will be provided free of charge upon request;
  - 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

- Such denial will be provided in a culturally and linguistically appropriate manner, in accordance with applicable DOL regulations.
- A description of the Plan's review procedures, the time limits applicable to such procedures, and the claimant's right to bring a civil action under Section 502(a) of ERISA following a claim denial on review (see below).

The section entitled "Review Procedures for Appeals of Denials" is replaced in its entirety with the following:

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 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 disability claims, 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 rational, as applicable, will 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 Plan 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.

The subsection entitled "Manner and Content of Notification of Benefit Determination on Review" is replaced in its entirety with the following:

Manner and Content of Notification of Benefit Determination on Review

The claims administrator will provide a written or electronic notice of the Plan's benefit determination on review, in accordance with applicable DOL regulations. If the claimant's appeal is denied, the notification will include:

- The specific reason or reasons for the denial;
- Reference to the specific 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 under the Health Care FSA, 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 Plan to the claimant's medical circumstances, or a statement that such explanation will be provided free of charge upon request; and
  - 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;
- 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 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 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 Plan made by the Social Security Administration;
    - Either:
        - the specific internal rules, guidelines, protocols, standards, or other similar criteria of the Plan that was relied upon in the claim denial; or
        - a statement that such rules, guidelines, protocols, standards, or other similar criteria of the 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 Plan to the claimant's medical circumstances; or
        - a statement that such explanation will be provided free of charge upon request;
    - 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
    - Such denial will be provided in a culturally and linguistically appropriate manner, in accordance with applicable DOL regulations.
- A statement describing any voluntary appeal procedures offered by the Plan 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 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.

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.

The subsection entitled "External Review Procedures" is deleted in its entirety.

The subsection entitled "Legal Action" is replaced in its entirety by the following:

Legal Action

A claimant cannot bring legal action to recover any benefit under, or for eligibility in, the 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 insurance certificate; or
- If you forfeited a benefit based on the two-year forfeiture rule described in the "Forfeiture After Two Years" subsection of the "Situations Affecting Your Benefits" section of this SPD.

In the case of disability claims, notwithstanding the previous paragraph, if the Plan fails to adhere to all of the requirements of the procedures set forth above for disability claims, then to the extent required by law, the claimant may 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 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 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 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 bases, if any, for asserting the violation should not cause the internal claims and appeals process to be deemed exhausted. If a court rejects the claimant's request for immediate review on the basis that the Plan met the requirements for the exception, then the 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 claimant's receipt of such notice.

The Plan requires that any legal action involving or related to the Plan, including but not limited to any legal action to recover any benefit under the 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 Plan, the person bringing such action is not entitled to recover any legal fees or expenses from the Plan, RR Donnelley, other participating employers, the Benefits Committee, the claims 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: (i) administrative proceedings under, or legal actions involving, the Plan, and (ii) 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 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.

Changes to Administrative and Contact Information

The following describes a change in the section entitled "Administrative and Contact Information":

The following sentence is added to the end of the subsection entitled "Claims Administrator for Eligibility Claims":

Initial eligibility claims involving a determination of disability will be made by a subset of the Benefits Committee, and appeals of those denials will be decided by a different subset of the Benefits Committee, and no one in the second subset will report to anyone in the first subset.

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