RR DONNELLEY

Health Care Spending Program and Dependent Care Spending Program

Summary Plan Description

January 1, 2013

Introduction

The Flexible Benefits Plan (the "Plan"), offered by R.R. Donnelley & Sons Company and its participating subsidiaries or Participating Employers (referred to herein as "RR Donnelley"), provides a before-tax opportunity to help you save on certain eligible health and dependent care-related expenses by contributing to the:

- Health Care Spending Program (Health Care Flexible Spending Account or "Health Care FSA"); and
- Dependent Care Spending Program (Dependent Care Flexible Spending Account or "Dependent Care FSA," and collectively with the Health Care FSA, the "FSAs").

With the Health Care FSA, you can set aside money from your paycheck before taxes through the Participant Premium Program of the Plan to be used to reimburse eligible health care expenses not covered by a medical, prescription drug, dental, or vision programs. If you participate in the Group Health Program and elect either the HSA Basic or HSA Plus Medical Program option through any of the Medical Program administrators (UnitedHealthCare ("UHC") or Blue Cross and Blue Shield of Illinois ("BCBSIL")), you can use the Health Care FSA for eligible expenses only after you have met your medical option's deductible requirement. This is because these options offer a Health Savings Account ("HSA"), and under Internal Revenue Service ("IRS") regulations you cannot be reimbursed by the Health Care FSA until you satisfy the deductible. Alternatively, if you participate in the HRA Select option, your coverage offers a Health Reimbursement Account ("HRA"). Special provisions apply for your Health Care FSA if you have a balance in your HRA. Please see the "About Your Health Reimbursement Account (HRA)" section for details. Separate materials also are available during Annual Enrollment that describe the HSA and HRA in detail.

With the Dependent Care FSA, you can set aside money before it is taxed through the Participant Premium Program to be used to reimburse eligible dependent care expenses.

You decide how much tax-free income you want to contribute (between $200 and $5,000 annually for dependent care and between $200 and $2,500 annually for health care) to each FSA. You will either pay an eligible expense and submit a claim for reimbursement, or use a debit card to pay an eligible health care expense. Because you do not have to pay taxes on the money you set aside, the IRS requires that you forfeit any money that you do not use for the year in which you participate ("use it or lose it"). Keep this in mind when you decide how much to contribute.

This Summary Plan Description ("SPD") summarizes each FSA as of January 1, 2013 (unless noted otherwise). It details who is eligible to participate, how to enroll, when participation begins and ends, and which expenses are and are not eligible for reimbursement. This SPD, and the related portions of the "Qualified Status Changes" SPD, explain how the Participant Premium Program operates for your contributions to an FSA. It also describes the health care account debit card option, how to submit a claim for reimbursement, as well as your rights under the FSAs. Please read this information to familiarize yourself with both FSAs.

Union employees covered by a collective bargaining agreement need to refer to such agreement for any differences from the options offered, eligibility rules, waiting periods for participation, and contribution amounts described in this SPD. In the case of a conflict between this SPD and your collective bargaining agreement, your collective bargaining agreement will control.

The Plan has contracted with a third party to render services necessary to the operation and administration of the FSAs. Your Spending Account, Aon Hewitt, LLC is the eligibility administrator and claims administrator for the FSAs.

You are eligible to participate in either one or both FSAs only if you are an employee of a Participating Employer or subsidiary. If you are an employee of an employer or subsidiary that is not a Participating Employer or subsidiary, you are not eligible for the benefits described in this SPD. To find out if you are eligible for these benefits, contact the eligibility administrator.

This SPD and any supplemental information are intended to be a complete, accurate, and up-to-date description of your FSAs. However, since laws and regulations change periodically, this document cannot adequately define every potentially reimbursable expense or exclusion. In each case, the claims administrator will have the authority or discretion to make the determination of whether an expense incurred is a reimbursable expense. If there is any discrepancy between this SPD and the Plan document, the Plan document always governs.

In addition, nothing in this SPD should be interpreted as an employment contract. This summary merely describes the FSAs and benefits offered to eligible employees as of January 1, 2013. RR Donnelley reserves the right to amend, change, or terminate the Plan or FSAs, in whole or in part, at any time.

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

Who Is Eligible

General Information

You are eligible to participate in the FSAs if you are classified as a:

- Full-time benefits-eligible employee of a Participating Employer;
- Part-time "A" employee of a Participating Employer; or
- Union employee of a Participating Employer who is covered by a collective bargaining agreement and such agreement provides for your FSA participation.

You are not eligible to participate in the FSAs if you are:

- An employee of a non-Participating Employer;
- A part-time "B" employee;
- Hired for seasonal or vacation relief work;
- In any classification other than a full-time benefits-eligible or part-time "A" employee; or
- A union employee represented by a collective bargaining agreement, except if such agreement allows for participation in the FSAs.

Once you become a participant, your participation may be terminated, suspended, or otherwise affected under certain circumstances.

If You Are Reemployed

If you terminate employment with a Participating Employer and are reemployed by a Participating Employer within 30 days of your termination date as a full-time benefits-eligible or part-time "A" employee of a Participating Employer, you are not treated as a new hire. Your prior period of employment will be recognized, and your previous annual contribution election will automatically resume. In order to still meet your annual contribution amount, your per pay period contribution will be recalculated based on the remaining pay periods. If you previously participated in the Health Care FSA and/or the Dependent Care FSA, your participation will resume effective immediately, retroactive to the date of termination. Your participation will be subject to any Annual Enrollment changes that became effective during your absence.

If you are reemployed by a Participating Employer more than 30 days after your termination date, you will be considered a new hire and will have to meet the applicable FSA's eligibility requirements. Any additional amounts you elect to contribute must be within the IRS limits.

Enrolling to Participate

General Information

If you meet the eligibility requirements, you can enroll in an FSA. You must enroll each year to participate in the FSA for that year.

If you and your spouse are both RR Donnelley employees eligible to participate, each of you may elect to contribute to the Health Care FSA and/or the Dependent Care FSA. However, certain limits apply.

When you enroll in an FSA, you are automatically enrolling in the Participant Premium Program in order to make your premiums before tax.

Your Contributions

When you enroll in the Health Care and/or Dependent Care FSAs, you authorize the deduction of the required contributions from your paycheck through the Participant Premium Program

Your elections for the FSAs and the Participant Premium Program are binding for the remainder of the calendar year for which the elections were made, unless a Qualified Status Change occurs during the calendar year. Your elections are subject to changes in the provisions of the FSAs and compliance with applicable state and federal laws. Provisions of the FSAs or the Participant Premium Program limiting your election to one calendar year will not apply if RR Donnelley has advanced contributions for you which are unpaid at the end of the calendar year.

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

“Before-tax” means that your contribution is taken from your paycheck before federal and Social Security/Medicare (FICA) taxes (and, in most cases, state and local taxes) are deducted. This reduces your taxable income (your gross pay minus contributions), so you pay less in taxes. Because your contributions to the FSAs are before-tax, the IRS limits the instances when the Participant Premium Program will allow you to change your contributions to the FSAs to those that are considered Qualified Status Changes.

When Participation Begins

As a new benefits-eligible employee, you receive enrollment information that details the FSAs. This information also includes specific instructions on how to enroll. You must enroll by the enrollment deadline set forth in your enrollment materials. As long as you enroll by the deadline, you begin participating on the first day of the month after you complete one full calendar month of employment.

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

If You Start on the 1st of or During the Month Of:	**Your Participation Begins On:**
January	March 1
February	April 1
March	May 1
April	June 1
May	July 1
June	August 1
July	September 1
August	October 1
September	November 1
October	December 1
November	January 1
December	February 1

If you are not eligible for coverage when you are first hired with a Participating Employer, you become eligible on the date you transfer from benefits-ineligible to benefits-eligible status with that Participating Employer (provided you have at least one full calendar month of employment, as determined above, from your original hire date). If you become a new benefits eligible employee because you have transferred your employment from a non-Participating Employer which is an affiliate of RR Donnelley, the following special rules will apply:

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

If you do not have a least one full calendar month of employment, these special rules do not apply and you are treated as a newly hired benefits-eligible employee on your date of transfer.

- If you transfer from a U.S. affiliate and you were either covered by or elected not to be covered by a Health Care Spending Program and/or Dependent Care Spending Program on the date of the transfer, you will continue to participate in these programs until the end of the calendar year in which you transfer. As a result, your coverage under this Health Care Spending Program and/or Dependent Care Spending Program begins on the following January 1.

- If you transfer from a non-U.S. affiliate, your coverage under the Health Care Spending Program and/or Dependent Care Spending Program begins on the date you transfer.

If You Are Not Actively at Work

If you are not actively at work (due to an approved leave) on the day participation is scheduled to begin, your participation still takes effect on that day. You do not need to return to active work for your participation to take effect.

If You Do Not Enroll by the Deadline

If you do not enroll by the deadline set forth in your enrollment materials either as a new hire or during the Annual Enrollment period, you will not be able to do so until the next Annual Enrollment period. The only exception is if you report a Qualified Status Change within the required time frame.

Qualified Status Changes (and the Participant Premium Program)

Because of IRS rules governing before-tax deductions, the contribution elections you make remain in effect until the beginning of the next calendar year (assuming you remain an employee of RR Donnelley). However, you may make limited changes to your elections during the calendar year when certain circumstances in your life or family status change.

These changes in circumstances, called "Qualified Status Changes," are defined by the IRS and may change from time to time. Some examples of Qualified Status Changes include marriage, birth, adoption, divorce, and the death of your spouse or child. You must make the change within 30 days after the event has occurred. If you do not, the election change will not be allowed.

An election change due to a Qualified Status Change is effective on the date of the Qualified Status Change if you report the Qualified Status Change to the eligibility administrator within 30 days.

A list of the Qualified Status Changes and other allowed changes to your contributions in connection with such Qualified Status Changes is included in the "Qualified Status Changes" SPD. Contact the eligibility administrator if you have questions about Qualified Status Changes.

Because the Participant Premium Program is an integral part of each FSA, its provisions have been made part of "Enrolling for Coverage" in this SPD and the "Qualified Status Changes" SPD.

Annual Enrollment

Every fall during the Annual Enrollment period, you receive information about the FSAs for which you are eligible. You also receive instructions on how to make your Health Care and Dependent Care FSA contribution elections for the upcoming calendar year. You then have the opportunity to enroll, change your contribution amounts, or choose not to participate. IRS regulations stipulate that FSA elections must be made for each plan year; they do not automatically renew from year to year.

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

A Few Words about Taxes

By contributing to an FSA, you authorize a certain amount from your pay to be set aside before taxes are withheld. This reduces your federal income taxes, most state and local income taxes, and your Social Security and Medicare (FICA) taxes (if you earn less than the Social Security wage base).

An Example of the Before-Tax Advantage

To illustrate how contributing to an FSA could affect you, assume that you earn $30,000 each year and you do not contribute to the Dependent Care FSA. You do, however, contribute $1,500 to your Health Care FSA. Here is how you may save on taxes by contributing.

	You Contribute	You Do Not Contribute
Gross Salary	$30,000	$30,000
Health Care FSA Contributions	– 1,500	– 0
Adjusted Gross Income	$28,500	$30,000
Standard Deduction & Exemptions	$8,750	$8,750
Taxable Income	$19,750	$21,250
Less Federal Income and Social Security Taxes*	$4,755.25	$5,095
Take-Home Pay (excluding deductions)	$23,744.75	$24,905
Out-of-Pocket Health Expenses	– 0	– 1,500
Net Income	$23,744.75	$23,405
Tax Savings	**$339.75**	

*This example assumes a single employee.

As you can see, an employee using the Health Care FSA instead of paying out-of-pocket for medical expenses saves almost $340 in federal income taxes, not including any applicable state income taxes. Remember, this is only an example. Your tax savings will depend on current laws and your own personal financial and medical situation. You should consult a tax adviser for tax advice.

Keep in mind that any contributions you make to the Health Care FSA or Dependent Care FSA and do not use by year-end are forfeited. You lose these contributions because they may not be used to reimburse you for eligible expenses incurred after that calendar year. The forfeited contributions are used only to pay the administrative costs of the FSAs.

How the Health Care FSA Works

Contribution Limits

Each plan year, you decide how much, if any, you want to contribute. You make all of your contributions on a tax-free basis. Your projected total annual contribution is divided by the number of times you are expected to be paid during the year, and that amount is deducted each pay period. For instance, if you want to contribute $360 for the year and you are paid twice a month, $15 is deducted from each of your paychecks ($360 ÷ 24 pay periods = $15 per pay period). Your total annual contribution must be at least $200 **but** cannot be more than $2,500.

When you decide how much to contribute to your Health Care FSA, keep in mind that any of your contributions that remain at the end of the plan year will be forfeited. Forfeited amounts are then used to pay the administrative expenses of operating the FSA. You should carefully consider how much you want to contribute to your Health Care FSA.

Eligible Expenses

In general, you may use the amounts you contribute to reimburse eligible expenses incurred by you or your eligible dependents not paid for by the Group Benefits Plan or programs outside of the Group Benefits Plan. This also includes any eligible expenses that your spouse's medical, dental, vision, or prescription drug plan does not cover. You may use the debit card option or file a claim for reimbursement of an eligible expense you have paid. You may be asked to provide additional documentation related to your claimed expense.

If you participate in the Group Health Program and select the HSA Basic or HSA Plus option, you can use the Health Care FSA to reimburse eligible expenses only after you have met your medical option's deductible requirement. This is because these options offer you an HSA, and under IRS regulations you cannot be reimbursed by the Health Care FSA until you satisfy your medical option's deductible.

In addition, you cannot use the Health Care FSA to reimburse:

- Contributions you or your spouse makes to pay for coverage under a medical, dental, or vision plan; or
- A medical expense that is also eligible to be paid from your HRA.

See the "About Your Health Reimbursement Account (HRA)" section for additional information.
Only certain expenses are eligible for reimbursement from the Health Care FSA. For a complete listing of eligible expenses, visit the Your Spending Account web site. Please note that the listing is subject to change at any time.

Ineligible Expenses

Certain expenses are not reimbursable through the Health Care FSA, including expenses incurred by a spouse, domestic partner or child (ren) of a domestic partner. For a listing of expenses that are excluded from reimbursement, visit the Your Spending Account web site. Please note that the listing is subject to change at any time.

How to Access Funds or Receive Reimbursement from Your Health Care FSA

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 health expenses out of pocket. When you use your YSA card, your eligible expenses are deducted automatically from your account.

- 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. If you do not provide the required documentation when requested, your YSA card transaction will be considered an "overpayment" and your YSA card may be suspended.

- Do *not* use the YSA card for ineligible items or services. 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.

- If the expense is determined to be ineligible, your YSA card may be suspended from further use until the overpayment is repaid.

- 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.

Generally, you can file a claim whenever you incur an eligible expense while you are a participant and after the service has been rendered, but no later than March 31 of the following calendar year. To file a claim, complete a claim form and submit it electronically. Or, complete a claim form and return it with the required documentation to the claims administrator at the address on the form. You must attach documentation to your claim form for it to be processed. This documentation may include:

- An Explanation of Benefits (EOB) from the health, dental, or vision program (if you, your spouse, or your dependent is covered under multiple plans or programs, submit an EOB from each plan or program, as applicable);
- An itemized bill with the patient's name and address, the date of service, the description of service, total fees charged for services, and the name and address of the provider;
- The itemized receipt that includes the provider's name and address, the date of service, total charges, insurance payment (or denial), and the patient's copayment amount (if any);
- A receipt from your provider for payment; or
- The receipt you receive from the pharmacist that indicates the date of service, the patient's name, the drug purchased, and the out-of-pocket cost.

After your claim is processed, you will be reimbursed by a check mailed to your home address or via direct deposit, depending on your preference. Special situations apply to submitting claims for the following two medical services:

- **LASIK:** You cannot submit a claim for the deposit that you make for LASIK before you have the procedure. However, once the LASIK procedure is performed, you can submit a claim for the entire amount, including the deposit.
- **Orthodontia:** You can submit a claim for orthodontia services before the services are provided, but only to the extent that you have actually made payments in advance of the orthodontia services in order to receive the services.

If you terminate employment during the year, you can submit claims incurred only on or before your termination date, unless you elect COBRA continuation coverage as described in the "Your Legal Right to COBRA Continuation Coverage" section.

You can submit claims postmarked by March 31 of the following calendar year, as long as you received the service and you incurred the expense prior to the end of your participation in the Health Care FSA. You are reimbursed for the amount of the expense, up to the total amount of your annual contribution election. You forfeit any money that remains in your Health Care FSA at the end of the calendar year, and for

which you do not submit a claim by March 31 of the year after the calendar year in which you participated.

The Heroes Earnings Assistance and Relieve Tax Act of 2008 (HEART) and Your Health Care FSA

The HEART Act allows a Health Care FSA to offer a special distribution called a Qualified Reservist Distribution (QRD) to those who, by reason of being a member of a reserve component (as defined in the Code) are ordered or called to active duty ("reservists").

As a reservist, you can receive all or a portion of your unused contributions in your Health Care FSA if:

- You are called or ordered to active duty for a period of 180 days or more, or for an indefinite period; and
- The distribution is made after the order/call and before the April 1st following the plan year that includes the order/call.

About Your Health Reimbursement Account (HRA) Under the HRA Select Option

Unused HRA dollars may carry forward to the next year. Please refer to the Group Health Program SPD for details. If you have a balance that remains in your HRA, the Medical Program claims administrators automatically reimburse claims for eligible expenses from the HRA. You cannot be reimbursed by your FSA for any expense paid for by your HRA.

Statutory Benefit

Health Care FSA benefits are regulated by the Internal Revenue Code (the "Code"). You will receive only those benefits which may be provided through a Health Care FSA under the Code. For more information on what is an eligible expense payable as a benefit and for definitions of terms used in this summary, consult your tax advisor or see IRS Publication 969.

How the Dependent Care FSA Works

General Information

You can use the Dependent Care FSA to reimburse eligible expenses to care for one or more of the following qualifying individuals (as defined in section 21(b)(1) of the Code) who has the same principal residence as you for more than half the year and who is:

- Your child under age 13 and who is a dependent on your federal income tax return;
- Physically or mentally disabled and who is a dependent on your federal income tax return (such as a parent whom you support); or
- Your spouse who is mentally or physically disabled.

If you are divorced or legally separated from your spouse, you may use your Dependent Care FSA for child care expenses if you have custody of your child during more of the year than the child's other parent/dependent.

Contribution Limits

Each plan year, you decide how much, if any, you want to contribute. You must estimate how much you will need for the upcoming year to help pay for your eligible care expenses. You make all of your contributions on a tax-free basis. Your total annual contribution is divided by the number of times you are paid in a year, and that amount is deducted each pay period. For instance, if you want to contribute $360 for the year, and you are paid twice a month, $15 is deducted from each of your paychecks ($360 ÷ 24 pay periods = $15 per pay period).

When you decide how much to contribute, keep in mind that the IRS requires you to forfeit any money that remains in your account at the end of the plan year. Forfeited amounts are then used to pay the administrative expenses of operating the FSA. You should carefully consider how much you want to contribute to your Dependent Care FSA.

If you choose to participate, your minimum contribution amount is $200 each year. Your annual contributions to the Dependent Care FSA are limited to:

- $5,000 if you are a single parent, or married and filing taxes jointly;
- $2,500 if you are married and filing taxes separately; or
- $5,000 total, including your spouse's contributions, if your spouse's employer offers a similar program.

In addition:

- If you are not married at the end of the calendar year, your annual contributions can never be more than your earnings.
- If you are married at the end of the calendar year, your annual contributions can never be more than the lesser of:
  - Your earnings; and
  - Your spouse's earnings.

Special rules apply if you are a "highly compensated" employee as defined by the Code. If you meet the definition, your contributions may be limited. You will be notified if you are affected by these rules.

Eligible Expenses

Eligible expenses are for services provided while you are a participant during the calendar year in which the service is rendered and the expense is incurred. You can use the Dependent Care FSA to reimburse payments you make to institutions or individuals, including a:

- Child care center or nursery school that provides care for six or more children;
- Family day care provider;
- Baby-sitter;
- Neighbor;
- Day camp;
- Live-in helper;
- Nanny; or
- Member of your family – other than your spouse or a dependent.

A child care provider is eligible if he or she meets state and local requirements where they apply.

To be reimbursed for an eligible expense, you must be working during the time you incur eligible expenses for the qualifying individual, who meets the criteria above. If you are married when you incur the eligible expenses, your spouse must be:

- Working or seeking work;
- A full-time student; or
- Mentally or physically disabled and unable to care for himself/herself.

Ineligible Expenses

Certain expenses are not considered eligible expenses and therefore you cannot use the Dependent Care FSA to reimburse them. For a complete listing of expenses that are excluded from reimbursement, visit the Your Spending Account web site. Please note that the listing is subject to change at any time.

How to Receive Reimbursement from Your Dependent Care FSA

You can file a claim provided the service is an eligible expense. As long as your claim satisfies the requirement for reimbursement and the funds are available in your Dependent Care FSA, you are reimbursed for the eligible expense.

You can submit claims as long as they are postmarked by March 31 of the following calendar year. You will be reimbursed up to the lesser of:

- The total amount of the eligible expense; and
- The amount that is in your Dependent Care FSA at the time you submit the claim.

To file a claim, complete a claim form and submit it electronically. Or, complete a claim form and return it with the required documentation (i.e., receipt from the provider) to the claims administrator at the address on the form. Remember, in any calendar year, you can be reimbursed only for completely rendered services and for eligible expenses you incurred for a qualified individual while you and your spouse worked, even though you may submit the expense after the year is over. You forfeit any money that remains in your Dependent Care FSA at the end of the calendar year, and for which you do not submit a claim by March 31 of the year following the calendar year in which you participated.

After your claim is processed, you will be reimbursed by a check mailed to your home address or via direct deposit, depending on your preference.

Statutory Benefit

Dependent Care FSA benefits are regulated by the Code. You will receive only those benefits which may be provided through a Dependent Care FSA under the Code. For more information on what is an eligible expense payable as a benefit and for definitions of terms used in this summary, consult your tax advisor or see IRS Publication 503.

When Participation Ends

When Health Care FSA Benefits End

Your participation in the Health Care FSA ends when your employment ends, or if earlier, when you are no longer eligible or decline to participate. Participation also ends on December 31 if you do not re-enroll during the Annual Enrollment period.

If you do not use the amount of your projected total annual contributions minus eligible expenses paid to you by the time your participation ends, the only way you can continue submitting receipts for expenses incurred after your participation ends is to continue coverage under the FSA for a specified period of time, as described in the "Your Legal Right to COBRA Continuation Coverage" section. However, after you leave RR Donnelley, any contributions for continuation coverage are made after taxes. As a result, the before-tax advantage of the Participant Premium Program is lost.

When Dependent Care FSA Benefits End

Your participation in the Dependent Care FSA ends when your employment ends, or if earlier, when you are no longer eligible or decline to participate. Participation also ends on December 31 if you do not re-enroll during the Annual Enrollment period.

If you have made more Dependent Care FSA contributions than eligible expenses have been paid to you at the time your participation ends, you can still receive the unspent balance by submitting claims for eligible expenses incurred after you cease to participate and through the end of the calendar year in which your participation ends. You will not be able to make new contributions to your Dependent Care FSA account after your participation ends.

If You Accept New Employment or Continue Employment While on an Approved Leave of Absence

While you are on an approved leave of absence, if you continue employment with any other employer outside of RR Donnelley, or if you accept new employment, either of which can include self-employment, you will be considered to have voluntarily abandoned your job at RR Donnelley. This will be treated as a voluntary separation thus ending employment with RR Donnelley and termination of coverage under its benefit programs. For example, this termination of employment with RR Donnelley will result in a loss of all Group Benefit Plan benefits, including the Health Care and Dependent Care FSAs. Voluntary separation will be deemed to occur in these circumstances regardless of the amount of income generated from the new or existing employment and regardless of the length of time you intend to perform the services associated with the other job or self-employment.

If the Plan is Modified or Ended

RR Donnelley reserves the right to amend or terminate the Plan or the FSAs at any time, in whole or in part. If the Plan or the FSAs are ever terminated, suspended, or modified, reimbursements for any eligible expense you incur before the change are paid under the Plan's former conditions, provided that a written notice of claims is timely given. The FSAs do not reimburse eligible expenses incurred after such action (unless specific provisions are adopted).

Special Extensions of Participation

General Information

Depending on your situation when you leave employment with your Participating Employer, you may be eligible to continue your participation in an FSA. Situations in which an extension of participation is available are described below.

During a Leave of Absence

If you are granted a leave of absence pursuant to RR Donnelley's Human Resources Core Policy 6-4, Leaves of Absence, or you are laid off pursuant to Human Resources Core Policy 6-8, Temporary Layoffs, you have the right to discontinue coverage when your unpaid leave begins. See the Qualified Status Changes SPD for additional information. This includes leaves:

- For your own personal disability;
- Covered by the Family and Medical Leave Act of 1993 (FMLA); and
- Covered under the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA).

If you do not terminate either of your FSA contributions (and the withholding of FSA contributions from your pay through the Participant Premium Program) while you are on a leave of absence (including a military leave), RR Donnelley will advance on your behalf the required Health Care FSA contributions until you are able to return to work, you separate from employment, or you are reclassified as benefits-ineligible, whichever is earliest. Your Dependent Care FSA contributions will go into arrears for any deductions missed during your absence, however, you will still participate in the Dependent Care FSA but only up to your account balance on the day your leave commenced. Your election to authorize RR Donnelley to reduce your future wages on a before-tax basis for your required FSA contributions includes an authorization to withhold from your pay, in the calendar year you return to work or commence to be paid, the amount of Health Care FSA contributions advanced for you by RR Donnelley and the arrears amount for your Dependent Care FSA contributions during the time of your leave of absence. Therefore, if RR Donnelley advances FSA contributions for you or places your deductions in arrears in the calendar year in which you are reemployed by, or commence to be paid by, a Participating Employer, you will be deemed to have elected to:

- Participate in the Plan for each calendar year to the extent required to repay advanced contributions made on your behalf or contributions placed in arrears beginning with the calendar year in which your leave of absence begins and ending in the calendar year in which your leave of absence ends; and
- Repay RR Donnelley for the advanced contributions.

The FSA contributions will be recovered 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. 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 as permitted by law.

Your Legal Right to COBRA Continuation Coverage

General Information

A federal law called the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended (COBRA), requires that most employers, including RR Donnelley, who sponsor health care flexible spending programs offer employees the opportunity to extend participation temporarily after participation under the health care spending program would otherwise end. The extension of coverage to employees is called "COBRA continuation coverage."

In general, the Health Care FSA coverage that may be continued is the same as the coverage that was in effect under the Plan on the day before the qualifying event (as listed below). However, if you elected not to participate in the Health Care FSA as an active employee, you would not be eligible for any COBRA continuation coverage.

To be eligible for COBRA continuation coverage, a qualifying event must take place and the maximum amount payable to you under the Health Care FSA during the period of COBRA continuation coverage must equal or exceed the maximum contributions made to the Health Care FSA during the period of COBRA continuation coverage. The following are qualifying events:

Who Can Continue Coverage	In What Situations	For How Long
Employee	• A reduction in work hours that would cause the employee to be classified as a benefits-ineligible employee • Termination of the employee's employment (other than for gross misconduct)	From the date of the qualifying event, until the end of the plan year in which the qualifying event occurs

Notification

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

Election Procedure

Under the law, to continue Health Care FSA coverage, you have 60 days from the later of the:

- Date you ordinarily would have lost coverage because of one of the qualifying events described above; and
- Date the notice of your right to elect COBRA continuation coverage is sent by the COBRA administrator.

If you do not choose COBRA continuation coverage within this 60-day period, Health Care FSA coverage will end.

COBRA continuation coverage under the law is provided subject to eligibility for coverage under the Health Care FSA. The Health Care FSA reserves the right to terminate your COBRA continuation coverage retroactively if you are determined to be ineligible. Once your COBRA continuation coverage terminates for any reason, it cannot be reinstated.

Payment

Generally, you must pay to the Health Care FSA 102% of your contribution amount during the period of COBRA continuation coverage. Your initial COBRA continuation coverage payment is due by the 45th day after coverage is elected. All other payments are due on the first day of the month for which you are buying coverage, subject to a 30-day grace period. If you do not make payment on or before the first day of the month, your claim(s) will not be paid by the Health Care FSA until payment is received within the 30-day grace period.

When COBRA Continuation Coverage Ends

Your COBRA continuation coverage continues until the earliest of:

- The end of the plan year in which the qualifying event occurs;
- The date your employer no longer provides a Health Care FSA to any of its employees;
- The date you fail to pay the required contribution by the specified deadline; or
- The date you first become covered after the date of your COBRA continuation coverage election under another group flexible spending account that does not contain a pre-existing exclusion that affects your benefits.

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

Remember to notify the COBRA administrator of any address or telephone number change.

Trade Act Implications

The Trade Act of 2002 (the "Trade Act") is a law that provides trade adjustment assistance (TAA) for eligible individuals. It includes a federal tax credit that COBRA continuation coverage beneficiaries who are eligible under the law can use to offset part of the cost of COBRA continuation coverage. This special tax credit is available for workers who lose their jobs and are found eligible for TAA benefits, or are between ages 55 and 64 and are receiving monthly benefits from the Pension Benefit Guaranty Corporation (PBGC).

In addition to the COBRA continuation coverage tax credit, the Trade Act adds a special 60-day COBRA continuation coverage election period for individuals who are deemed eligible for TAA benefits and the tax credit. The new election period applies to those who had not previously elected COBRA continuation coverage and are deemed eligible for the tax credit provisions, but only if the eligibility determination occurs within six months of the loss of group health coverage. Additionally, if COBRA continuation coverage is elected during this special time period, such coverage is not retroactive to the date of the qualifying event, but commences on the first day of the special new 60-day period.

The law also clarifies that the period between the loss of coverage and the beginning of the special 60-day election period does not count against the 63-day break-in-coverage rule under the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

For more information about the tax credit, you can call the Health Coverage Tax Credit Customer Contact Center toll-free at 1-866-628-4282. TDD/TTY callers may call toll-free at 1-866-626-4282. More information may also be found at www.doleta.gov/tradeact/2002act_index.cfm.

Claims and Appeal Procedures

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 request to participate or to change a contribution election during the year. If you are filing an eligibility claim, you need to contact the Benefits Center.

Procedure for Filing a Benefit Claim

A communication from you ("claimant") constitutes a valid benefit 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) to the claims administrator by first-class postage-paid mail, to the address for the claims administrator. If a claimant fails to properly file a claim for a benefit under the Plan, he or she will be considered not to have exhausted all administrative remedies under the Plan, and this will result in his or her inability to bring a legal action for that benefit. Claims and appeals of denied benefit 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.

Defective Benefit Claims

If a claimant fails to follow the Plan's procedures for filing a valid benefit claim, the claims administrator will notify him or her of the failure and the proper procedures to follow in filing a benefit claim, provided that the communication received by the claims administrator from the claimant names the specific claimant and the specific treatment, service, or product for which reimbursement is requested. The notice will be provided by the claims administrator.

Initial Benefit Claim Review

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

Initial Benefit Determination

The claims administrator will notify the claimant of the approval or denial within 30 days after receipt of the claim for a benefit under the Health Care FSA and within 60 days after receipt of the claim for a benefit under the Dependent Care FSA. The claims administrator may extend the period for making the benefit determination by [15] days if it determines that such an extension is necessary due to matters beyond the Plan's control. The claims administrator will notify the claimant, prior to the expiration of the initial 30-day or 60-day period, of the circumstances that require the extension of time and the date by which the claims administrator expects to render a decision.

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

Manner and Content of Notification of Denied Claim

If the benefit claim is denied, the claims administrator will provide the claimant with notice of any denial, in accordance with applicable U.S. Department of Labor 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 benefit claim, and an explanation of why such material or information is necessary;
- 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; and
- A description of the Plan's review procedures, and the time limits applicable to such procedures.

Review of Initial Benefit Denial

Procedure for Filing an Appeal of a Denial

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

Review Procedures for Denials

- The claims administrator for eligibility claims 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 benefit claim.
- The claimant will have the opportunity to review the claim file, if any, created by the claims administrator for eligibility claims during the initial benefit claim.
- The claimant will have the opportunity to present evidence and testimony as part 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 claimant may receive, free of charge and as soon as possible, any new or additional evidence considered, relied upon, or generated by the claims administrator for eligibility claims in connection with the benefit claim.
- The review of a denial does not defer to the initial determination made by the claims administrator for eligibility claims.
- The individual who conducts the review process is neither the individual who made the initial denial nor the subordinate of such individual.

Timing of Notification of Benefit Determination on Review

The claims administrator for eligibility claims will notify the claimant of the benefit determination on review within 60 days after receipt of the request for review.

Manner and Content of Notification of Benefit Determination on Review

The claims administrator for eligibility claims will provide a written or electronic notice of the Plan's benefit determination on review, in a culturally and linguistically appropriate

manner, in accordance with applicable U.S. Department of Labor regulations. If the claimant's appeal is denied, the notification will include:

- The specific reason or reasons for the denial;
- Specific information to identify the claim involved, including, the date of service, the health care provider, the claim amount (if applicable), and a statement describing the availability, upon request, of the diagnosis and treatment codes (if applicable, along with the corresponding meaning of such codes);
- 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;
- 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 such appeal is an appeal of a denial of claim for benefits under the Health Care FSA, a description of available external review procedures, including information on how to initiate such review and a disclosure of the availability of, and contact information for, any applicable office of health insurance consumer assistance or ombudsman established under health care reform available to assist the claimant with external review procedures.

External Review Procedures

You have the right to have an independent group of health care professionals who have no association with the Plan review any denied appeal of a claim for benefits under the Health Care FSA (an "external review"). Your request for an external review must be filed within four months after the date you receive the notice of a denied appeal from the claims administrator for eligibility claims. Within five days of receiving your request for external review, the Plan will review whether the requirements for an external review are met, and within one day of completing this review the Plan will provide you with its determination of whether you are eligible for external review or whether additional information may be needed.

If your request for external review meets the criteria for external review, the 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. Within 45 days of receiving the external review request, the assigned independent review organization will provide written notice of its final external review decision. If the independent review organization's decision is to reverse the Plan's denial, the Plan will immediately provide coverage or payment for the claim under review.

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 file a valid claim and seek timely review of a denial of that claim. In addition, no legal action may be brought:

- Two or more years after the claims administrator for eligibility claims first received your claim; or
- If you received a denial on appeal of such claim, two or more years after such receipt; 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 the Medical and Prescription Drug Program SPD.

Administrative and Contact Information

General Information

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

Type of Plan
The Program is a welfare benefits plan. Its objective is to reimburse eligible expenses of covered employees and their spouse and eligible dependents in accordance with the terms of the Program.

Plan Sponsor
RR Donnelley & Sons Company
35 W Wacker Drive
Chicago, IL 60601
(312) 326-8000

Employer Identification Number of Plan Sponsor
36-1004130

Plan Number
For federal income tax purposes, the following Programs are treated as separate, written plans:

- Health Care FSA – 510
- Dependent Care FSA – 509

Plan Year End
December 31

Agent for Service of Legal Process
Corporate Secretary
RR Donnelley & Sons Company
35 W Wacker Drive
Chicago, IL 60601
(312) 326-8000

Legal process also may be served on the Benefits Committee.

Benefits Committee and Plan Administrator
Benefits Committee
c/o Vice President, Benefits
RR Donnelley & Sons Company
35 W Wacker Drive
Chicago, IL 60601
(312) 326-8000

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

Participating Employers
The following employers participate in the Group Health Program of the Plan (a "Participating Employer"):

- Banta Corporation
- Banta Global Turnkey, LTD
- Banta Integrated Media-Cambridge, Inc.
- Helium, Inc.
- RR Donnelley & Sons Company
- R.R. Donnelley Printing Company
- R.R. Donnelley Receivables, Inc.
- RR Donnelley Financial, Inc.
- RRDigital LLC
- RRD Secaucus Financial, Inc.
- Office Tiger, LLC
- Office Tiger Global Real Estate Services, Inc.
- Von Hoffman Corporation

You have a Grandfathered Legacy Indicator ("GLI") established that notes the Participating Employer you are linked to under the Program. Your GLI is established either as of your initial eligibility for the Program or as of January 1, 2008, whichever is later. Even if you transfer among Participating Employers, your coverage and premium are based on the benefits provided for by your GLI. Your GLI may be subject to change, and this decision will be made by the Benefits Committee in coordination with your work location. You will be notified if for any reason your benefit coverage options change due to a change in GLI.

The Program described in this document applies to employees of Participating Employers. If you become an employee of RR Donnelley due to an acquisition, your effective date for a benefit generally is that date on which benefits are extended. That date will be announced in each affected location.

If you have questions concerning your eligibility to participate in this Program, call the eligibility administrator listed under "Eligibility Administrator" below.

Eligibility Administrator

The eligibility administration is performed by Aon Hewitt, at the following address and phone number:

RR Donnelley Benefits Center
4 Overlook Point
P.O. Box 1496
Lincolnshire, IL 60069-1496
1-877-RRD-4BEN (1-877-773-4236)

Benefits Center Representatives are available from 8 a.m. to 5 p.m. CT, Monday through Friday, except holidays.

Website: **www.mybenefitsdirectory.com/rrd**

Contact the Benefits Center for:

- General questions about flexible benefits;
- Questions about Qualified Status Changes;
- Questions about expenses eligible for reimbursement;
- Instructions on how to get a claim form; or
- Instructions on filing FSA claims.

If you want to participate, you must follow the enrollment procedures provided herein and included in the Annual Enrollment materials established by the Benefits Committee.

Claims Administrator

If you have questions about a specific benefit, contact Your Spending Account at the following address and phone number:

Your Spending Account™
P.O. Box 785040
Orlando, FL 32878-5040
1-877-RRD-4BEN (1-877-773-4236)
1-888-211-9900 (fax number for claim and/or receipt submission)

Website: **www.mybenefitsdirectory.com/rrd**

Claims Administrator for Eligibility Claims

The Benefits Committee is the claims administrator for claims related to eligibility and appeals of denied claims related to eligibility.

COBRA Administrator for COBRA Continuation Coverage

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

RR Donnelley Benefits Center
4 Overlook Point
P.O. Box 1496
Lincolnshire, IL 60069-1496
1-877-RRD-4BEN (1-877-773-4236)

Website: **www.mybenefitsdirectory.com/rrd**

Allocation and Delegation of Fiduciary Responsibilities by the Benefits Committee

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

Self-Funded Benefits

The benefits paid from your Health Care Spending Program or your Dependent Care Spending Program are from the general assets of RR Donnelley. The benefits provided by the Programs are not guaranteed by the claims administrator. The claims administrator's role is to provide services to the Programs.

Your ERISA Rights

General Information

As a participant in the Health Care FSA portion of the Plan, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974, as amended ("ERISA"). ERISA provides that you are entitled to the following.

Receive Information about the Health Care FSA and Benefits

- Examine, without charge, at the Plan Administrator's office and at other specified locations, such as work sites and union halls, all documents governing the Health Care FSA, including collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the Plan for the Health Care FSA with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.
- Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Health Care FSA, including collective bargaining agreements, copies of the latest annual report (Form 5500 Series), and an updated SPD. The Plan Administrator may make a reasonable charge for the copies.
- Receive a summary of the Plan's annual financial report for the Health Care FSA. The Plan Administrator is required by law to furnish each Health Care FSA participant with a copy of this Summary Annual Report.

Continue Group Health Plan Coverage

- Continue health care coverage for yourself if there is a loss of coverage under the Health Care FSA as a result of a qualifying event. You may have to pay for such coverage. Review this SPD and the documents governing the Health Care FSA on the rules governing your COBRA continuation coverage rights.

Prudent Actions by Plan Fiduciaries of the Health Care FSA

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

Enforce Your Rights

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

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

If you have a claim for benefits under the Health Care FSA that is finally denied or ignored, in whole or in part, you may file suit in a state or federal court. In addition, if you disagree with the Health Care FSA's decision or lack thereof concerning the qualified status of a domestic relations order, you may file suit in federal court. If it should happen that plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees; for example, if it finds your claim is frivolous.

Assistance with Your Questions

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