Medical and Prescription Drug Programs

Summary Plan Description Appendices

As of January 1, 2013

Contents

Introduction

These appendices list the material cumulative changes that have been made to the Medical, Prescription Drug, and Mental Health and Substance Abuse Programs Summary Plan Description dated January 1, 2013 (the "SPD') since the last version of the SPD was published dated January 1, 2009.

These appendices are designed to help summarize the changes made to the Group Health Program described in the SPD. It is designed to help to explain your coverage as of any date between January 1, 2009 through January 1, 2013 and highlights the changes that were made each year. Each of the changes described in these appendices that were made in 2011 or 2012 were previously communicated to you in a summary of material modifications ("SMM"). The changes that were made by the 2013 SPD were communicated to you in your 2013 Annual Enrollment Guide.

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

These appendices only cover the Group Health Program. In addition, nothing in these appendices or the SPD should be interpreted as an employment contract. These appendices merely describe the material changes to the coverages and benefits offered to eligible employees between January 1, 2009 and January 1, 2013. RR Donnelley reserves the right to amend, change, or terminate the Group Benefits Plan or Group Health Program, in whole or in part, at any time.

This content contains a summary in English to supplement the information provided in the SPD. These appendices are intended to be for your convenience only and are not intended to replace any formal SPD or SMM you may have received. 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.

Changes Made by the 2011 Summary of Material Modification (the "2011 SMM")

Participating Employers

The 2011 SMM listed the following employers as Participating Employers in the Group Benefits Plan:

- Anthology, Inc.
- Banta Corporation
- Banta Global Turnkey, LTD
- Banta Integrated Media-Cambridge, Inc.
- Check Printers Inc.
- RR Donnelley & Sons Company
- R.R. Donnelley Printing Company
- R.R. Donnelley Receivables, Inc.
- Moore Wallace North America, Inc.
- Office Tiger, LLC
- OfficeTiger Global Real Estate Services, Inc.
- Von Hoffmann Corporation

Termination of the R.R. Donnelley & Sons Company Welfare Benefit Trust

Effective December 31, 2011, RR Donnelley terminated the R.R. Donnelley & Sons Company Welfare Benefit Trust (the "Trust"). As a result, after such termination, any reference in the SPD to the "R.R. Donnelley & Sons Company Welfare Benefit Trust," "trust," or "trustee" with respect to how a Group Health Program was funded or who held plan assets was deleted.

Effective January 1, 2012, any self-insured Group Health Program that was funded by the Trust prior to termination of the Trust is now funded by RR Donnelley's general assets. Also, if the Trust was the policyholder for the group insurance policy for any insured Group Health Program prior to January 1, 2012, effective January 1, 2012, RR Donnelley became the new policyholder.

RR Donnelley has reserved the right to adopt a new trust in the future.

Forfeiture After Two Years.

Prior to the issuance of the 2011 SMM, the subsection at the end of the section titled "Situation Affecting Your Benefits" which reads:

> *"**Forfeiture After Two Years***

"Any check issued after December 31, 2011 to pay self-funded benefits under the Plan will be void and not reissued if it is not cashed within two years after the date the original check was issued, and the self-funded benefit for which the check was issued will be forfeited. For self-funded benefits, any expense incurred after December 31, 2011 will be ineligible for benefits under the Plan if a claim for the expense is not submitted to the appropriate claims administrator by the end of the plan year which contains the second anniversary of the date the expense was incurred, and any claim related to such expense will be forfeited."

was not included as part of the Group Benefits Plan or described in the SPD.

In addition, a bullet point was added at the end of the "Legal Action" subsection under the "Claims and Appeals Procedures" section which reads:

"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."

to correspond with the change described above.

Who is Eligible

Prior to the issuance of the 2011 SMM, certain terms used in the Group Benefits Plan had different meanings. The definitions in the SPD are current, however, prior to the issuance of the 2011 SMM, the terms below had the following meanings:

*"**Child(ren) (or individually, a "child") –** your "children" who qualify as an IRS Tax Dependent—and who are:*

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

*"**Domestic Partner** – The person of the same- or opposite-sex with whom you have a domestic partner relationship, which is registered with a state or local governmental entity or which satisfies the criteria described in the last paragraph of this definition. A domestic partner is generally eligible for all eligible spouse coverage offered under the Group Health Program if you are employed at locations that qualify for such coverage, and you are an eligible employee of:*

• Banta Corporation or any of its subsidiaries that is a Participating Employer (collectively, "Banta");

• Check Printers, Inc. ("Check Printers");
• Moore Wallace North America, Inc. ("Moore Wallace"); or
• OfficeTiger, LLC, or OfficeTiger Global Real Estate Services, Inc. (collectively, "OfficeTiger"); or

"If you enroll for domestic partner coverage and you subsequently move to a Participating Employer other than Banta, Check Printers, Moore Wallace, or OfficeTiger, your domestic partner will remain treated as an eligible domestic partner for as long as your Grandfathered Legacy Indicator ("GLI") is set to Banta, Check Printers, Moore Wallace, or OfficeTiger and you remain a benefits-eligible employee. Once your GLI changes to something other than Banta, Check Printers, Moore Wallace, or OfficeTiger, your domestic partner is no longer eligible for coverage under the Group Health Program. For rules regarding GLI changes, see the "Participating Employers" subsection of the "Administrative and Contact Information" section of this SPD.

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

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

*"**Eligible Dependents (or individually, a "dependent")** – Your eligible dependents include your eligible:*

• Spouse;
• Domestic partner; or
• Children (as each is defined in this section).

"This reference to the word "dependent" does not carry the meaning of this word as it is used for Section 152 of the Code. Your parents, grandparents, adult brothers, adult sisters, and other relatives are not eligible for coverage. Also, if you cover an eligible dependent who is later called to active military duty, such eligible dependent cannot be covered under the Group Health Program as an eligible dependent during such assignment. In addition, your eligible dependent who is already covered under the Group Health Program as an employee may

not simultaneously be enrolled and covered under the Group Health Program as an eligible dependent.

"You also may be required to provide documentation to the Plan Administrator, the eligibility administrator or the claims administrator that substantiates your claim for coverage or benefits of an eligible dependent."

Dependent Eligibility Audit

RR Donnelley conducts audits of certain covered dependents in the Group Benefits Plan on a regular, semi-annual basis. Therefore the subsection titled "Dependent Audit" was added to the SPD under the "Who is Eligible Section" effective with the 2011 SMM.

Extended Coverage for Certain Children

As a result of a change in federal law, the term "child" was revised to mean all dependent children until they reach 26 years of age. Therefore, it was no longer necessary for RR Donnelley to require Participants to submit additional documentation to cover students between the ages of 19 to 23 as dependents. Such students would qualify as dependents until they reach the age of 26. Therefore, the following subsection was removed from the SPD by the 2011 SMM:

*"**Extended Coverage for Full-Time Students Age 19 and Older***

"You must verify student status of your enrolled eligible child from age 19 until age 23 to continue coverage for such child. If you fail to provide verification of student status when requested, your child will no longer be an eligible child as of the end of the month in which he or she attains age 19 and will be removed from coverage under the Group Health Program for the remainder of the calendar year.

"Each year, the eligibility administrator will perform a student verification process. During this process, any student dependent will need to provide proof of his or her student status. If the student status is not verified by the specified deadline, he or she will automatically be removed from coverage as of the last day of the process. To reenroll the student for the next year, if the child is eligible, please work with the eligibility administrator.

"If your enrolled eligible child is no longer a student, contact the eligibility administrator to have the child removed from coverage. Eligibility ends as of the end of the month in which he or she is no longer eligible. If your child again becomes an eligible child, you may enroll the child for coverage during the next Annual Enrollment period provided the child continues to be an eligible child at that time, or possibly sooner if you report a Qualified Status Change.

"Eligibility for coverage for your eligible child who is a full-time student ends at the end of the month in which your enrolled eligible child reaches age 23, unless he or she is disabled or continues COBRA coverage."

In addition, the subsection titled "Extended Coverage for Disabled Children" was revised to change the age for continuing coverage in the first paragraph from *"19 (or after age 23 if a student*)" to "26."

Finally, the example given in the subsection titled "Extended Coverage for Certain Dependents" was revised to eliminate the example of if the dependent is "no longer a full-time student."

Eligibility Administrator

As a result of a change in the formal name of the Eligibility Administrator, the SPD was revised by the 2011 SMM to remove the name "*Hewitt Associates LLC*" as the formal name of the Eligibility Administrator found in the "Eligibility Administrator" subsection under the "Administrative and Contact Information" Section and replace it with "Aon Hewitt."

Full and Fair Review of Claims

As a result of a change in federal law, the Group Benefits Plan's claims and review procedures were modified. Prior to the issuance of the 2011 SMM, the following subsection appeared in the SPD in place of the current subsection titled "Review Procedures for Denials:"

*"**Review Procedures for Denials***

• The claims administrator will provide a 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 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."

Notification of Benefit Determination on Review

As a result of a change in federal law, the Group Benefits Plan's procedures for notifying participants of a benefit determination on review were modified. Prior to the issuance of the 2011 SMM, the following subsection appeared in the SPD in place of the current subsection titled "Manner and Content of Notification of Benefit Determination on Review:"

"Manner and Content of Notification of Benefit Determination on Review

The claims administrator will provide a written or electronic notice of the Group Benefits Plan's benefit determination on review, in accordance with applicable 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;
• 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;
• 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
• If the denial is based on medical necessity or an experimental treatment or similar exclusion or limit, an explanation of the scientific or clinical judgment relied upon
for the determination or a statement that such explanation will be provided free of charge upon request.

External Review Procedures

As a result of a change in federal law, the subsection "External Review Procedures" was added to the SPD by the 2011 SMM immediately prior to the heading titled "Legal Action" to describe the procedures related to the availability of an external review should a participant's claim be denied on an internal appeal. Prior to the change in federal law, there was no external review procedure.

How the Group Health Program Works

The Section titled "How The Group Health Program Works" was revised by the 2011 SMM by changing the definition of "Deductibles" and removing the term "Lifetime Maximum." Prior to such change, the terms below had the following meanings:

> *"**Deductibles –** the deductible amount depends on which option you choose and the coverage category you select under the Group Health Program (You Only, You + Spouse, You + Child(ren), or You + Family). The deductible is the fixed-dollar amount that you pay out of your pocket each calendar year before the Group Health Program begins to pay benefits. You can only apply the amounts you incur for covered expenses toward your annual deductible, and any amount that you pay toward your deductible also is counted toward your annual out-of-pocket limit (except for the excluded charges listed under the Out-of-Pocket Limits definition under this subsection). If you enroll in the Preferred Access or CIGNA Indemnity option, prescription drug expenses are not applied toward your deductible.*
>
> > *"**Collective/Non-Embedded Deductible***
> > *If you enroll in the HSA Basic or HSA Plus option and elect "You Only" coverage, the individual deductible applies. If you elect any other tier of coverage, the total family deductible applies collectively to all enrolled persons in the same family. As a result, the Group Health Program does not pay benefits for an individual's claims until the total family deductible is satisfied. Two individual deductibles are not required to satisfy the annual family deductible. One individual can meet the entire annual family deductible by himself or herself.*
> >
> > *"**Aggregate/Embedded Deductible***
> > *If you enroll in the HRA Select, Preferred Access, or CIGNA Indemnity option and elect "You Only" coverage, the individual deductible applies. If you elect any other tier of coverage, the family deductible applies to the family collectively, but no individual within the family will ever have to exceed the individual deductible before coinsurance begins for the individual. Once one individual within the family has met the individual deductible, the Group Health Program pays benefits at the applicable*

coinsurance level for all services received for that individual who has already met his or her individual deductible amount. The family must still meet the collective family deductible amount before the Group Health Program pays benefits for other enrolled members of the family."

*"**Lifetime Maximum** – the aggregate amount of covered expenses that will be paid by the Group Health Program for you and your covered dependents during your period of employment with all Participating Employers."*

In addition, effective with the 2011 SMM, all references to "lifetime maximums" made throughout the SPD no longer apply and were removed from the SPD. This includes removing the subsection "Lifetime Maximum Benefit for the Group Health Program" under the section under the "Summary Charts of the Coverage Options" which read:

*"**Lifetime Maximum Benefit for the Group Health Program***

If you are enrolled in the Group Health Program, the Group Health Program pays a combined lifetime maximum of $5 million in benefits for each covered individual.

This maximum applies for all covered expenses (including the HRA dollars provided
by the Company) under the following options provided by the Medical Program claims administrators (CIGNA, UHC, and BCBSIL):

- *HSA Basic*
- *HSA Plus*
- *HRA Select*
- *Preferred Access*

This maximum also applies for all covered expenses under the CIGNA Indemnity option, the Mental Health and Substance Abuse Program, and the Prescription Drug Program.

Summary Charts of the Coverage Options

The changes below were made to the coverage options under the HSA Basic, HSA Plus, HRA Select, Preferred Access and CIGNA Indemnity Options and included as part of the 2011 SMM. Prior to the issuance of the 2011 SMM, the following provisions were in effect, rather than the provisions currently listed in the SPD:

- Chiropractic Therapy under each option was limited to $1,500 each calendar year for in- and out-of-network services combined.

- There was Lifetime Maximum coverage of $5 million per individual for covered expenses paid by the Group Health Program, including benefits from the Mental Health and Substance Abuse Program.
- Annual Deductibles in the Preferred Access Plan were as follows:

Key Feature	*Preferred Access*	
	In-Network	*Out-of-Network**
Annual Deductible	***You Pay***	
• You Only	$300	$600
• You + Spouse	$450	$900
• You + Child(ren)	$450	$900
• You + Family	$600	$1,200
Annual Out-of-Pocket Limit (includes deductible)	***You Pay***	
• You Only	$1,500	$3,000
• You + Spouse	$2,250	$4,500
• You + Child(ren)	$2,250	$4,500
• You + Family	$3,000	$6,000
Annual Out-of-Pocket Limit (Prescription Drug)**	***You Pay***	
• You Only	$1,500	
• You + Spouse	$3,000	
• You + Child(ren)	$3,000	
• You + Family	$3,000	

A Special Note About HMO Coverage

The 2011 SMM added a subsection title “A Special Note About HMO Coverage” under the section ‘Enrolling for Coverage.” Prior to the issuance of the 2011 SMM, such subsection was not a part of the Group Benefits Plan.

Changes Made by the 2012 Summary of Material Modification (the "2012 SMM")

Participating Employers

The 2012 SMM listed the following employers as Participating Employers in the Group Benefits Plan:

- Banta Corporation
- Banta Global Turnkey, LTD
- Banta Integrated Media-Cambridge, Inc.
- RR Donnelley & Sons Company
- R.R. Donnelley Printing Company
- R.R. Donnelley Receivables, Inc.
- RR Donnelley Financial, Inc.
- Moore Wallace North America, Inc.
- Office Tiger, LLC
- OfficeTiger Global Real Estate Services, Inc.
- Von Hoffmann Corporation

Summary Charts of the Coverage Options

The changes below were made to the coverage options under the HSA Basic, HSA Plus, HRA Select, Preferred Access and CIGNA Indemnity Options and included as part of the 2012 SMM. Prior to the issuance of the 2012 SMM, the following provisions were in effect, rather than the provisions currently listed in the SPD:

- Annual Deductibles in the HRA Select Plan were as follows:

	HRA Select	
Key Feature	***In-Network***	***Out-of-Network****
Annual Deductible	***You Pay***	
• You Only	$1,500	$3,000
• You + Spouse	$2,250	$4,500
• You + Child(ren)	$2,250	$4,500
• You + Family	$3,000	$6,000
Annual Out-of-Pocket Limit (includes deductible)	***You Pay***	
• You Only	$3,000	$6,000
• You + Spouse	$4,500	$9,000
• You + Child(ren)	$4,500	$9,000
• You + Family	$6,000	$12,000

- Annual Deductibles in the Preferred Access Plan were as follows:

Key Feature	*Preferred Access*	
	In-Network	*Out-of-Network**
Annual Deductible	***You Pay***	
• You Only	$500	$1,000
• You + Spouse	$750	$1,500
• You + Child(ren)	$750	$1,500
• You + Family	$1,000	$2,000
Annual Out-of-Pocket Limit (includes deductible)	***You Pay***	
• You Only	$3,000	$6,000
• You + Spouse	$4,500	$9,000
• You + Child(ren)	$4,500	$9,000
• You + Family	$6,000	$12,000
Annual Out-of-Pocket Limit (Prescription Drug)*	***You Pay***	
• You Only	$1,500	
• You + Spouse	$3,000	
• You + Child(ren)	$3,000	
• You + Family	$3,000	

Prescription Drug Program

The section of the SPD titled "The Prescription Drug Program was revised by the 2012 SMM. The 2012 SMM added "Medco" as a Prescription Drug Program Claims Administrator if you were a Participant in the Legacy Bowne Medical Program Option. The Legacy Bowne Medical Program Option included HSA Basic, HSA Plus, Preferred Access and CIGNA Indemnity.

A Summary Chart of Your Prescription Drug Coverage

The 2012 SMM also revised the summary chart outlining prescription drug coverages under each Prescription Drug Program option Prior to the revision by the 2012 SMM, the summary chart read as follows:

The Prescription Drug Program				
HSA Basic, HSA Plus, and HRA Select (CIGNA, UHC, BCBSIL)				
	In-Network		***Out-of-Network***	
	You Pay	***Prescription Drug Program Pays***	***You Pay***	***Prescription Drug Program Pays***
• Retail Generic**	20% after deductible*	80% after deductible*	40% after deductible*	60% after deductible*
• Retail Brand Formulary**	20% after deductible*	80% after deductible*	40% after deductible*	60% after deductible*
• Retail Brand Non-Formulary**	20% after deductible*	80% after deductible*	40% after deductible*	60% after deductible*
• Generic preventive medicine for hypertension and hyperlidemia	0%	100%	40% after deductible*	60% after deductible*
HSA Basic, HSA Plus, and HRA Select (CIGNA, UHC, BCBSIL)				
	You Pay		***Prescription Drug Program Pays***	
• Mail Order Generic**	20% after deductible*		80% after deductible*	
• Mail Order Brand Formulary**	20% after deductible*		80% after deductible*	
• Mail Order Brand Non-Formulary**	20% after deductible*		80% after deductible*	
• Generic preventive medicine for hypertension and hyperlidemia	0%		100%	
Preferred Access (CIGNA, UHC, BCBSIL)***				
	In-Network		***Out-of-Network***	
	You Pay**	***Prescription Drug Program Pays***	***You Pay*****	***Prescription Drug Program Pays***
• Retail Generic**	10% ($10 minimum)	90%	30% ($10 minimum)	70%
• Retail Brand Formulary**	30% ($10 minimum)	70%	50% ($10 minimum)	50%
• Retail Brand Non-Formulary**	40% ($10 minimum)	60%	60% ($10 minimum)	40%

The Prescription Drug Program				
• Generic preventive medicine for hypertension and hyperlidemia	0%	100%	30%	70%
Preferred Access (CIGNA, UHC, BCBSIL)***				
	You Pay**		***Prescription Drug Program Pays***	
• Mail Order Generic** • Mail Order Brand Formulary** • Mail Order Brand Non-Formulary** • Generic preventive medicine for hypertension and hyperlidemia	10% ($30 minimum) 30% ($30 minimum) 40% ($30 minimum) 0%		90% 70% 60% 100%	
CIGNA Indemnity Option*****				
	You Pay**		***Prescription Drug Program Pays***	
• Retail Generic** • Retail Brand Formulary** • Retail Brand Non-Formulary** • Generic preventive medicine for hypertension and hyperlidemia	10% ($10 minimum) 30% ($10 minimum) 40% ($10 minimum) 0%		90% 70% 60% 100%	
	You Pay**		***Prescription Drug Program Pays***	
• Mail Order Generic** • Mail Order Brand Formulary** • Mail Order Brand Non-Formulary** • Generic preventive medicine for hypertension and hyperlidemia	10% ($30 minimum) 30% ($30 minimum) 40% ($30 minimum) 0%		90% 70% 60% 100%	

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

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

***A $1,500 individual and $3,000 family out-of-pocket limit (separate from the Medical Program out-of-pocket limit) applies for Prescription Drug Program expenses under these Medical Program options. This means that once

your eligible out-of-pocket expenses reach this limit, the Prescription Drug Program starts paying 100% of eligible Prescription Drug Program covered expenses.

****A $2,500 individual and $4,500 family out-of-pocket limit (separate from the Medical Program out-of-pocket limit) applies for Prescription Drug Program expenses under these options. This means that once your eligible out-of-pocket expenses reach this limit, the Prescription Drug Program starts paying 100% of eligible Prescription Drug Program expenses.

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

Quantity Limits

The 2012 SMM added the subsection titled “Quantity Limits” to the SPD under the section “The Prescription Drug Program.”

Allocation and Delegation of Fiduciary Responsibilities by the Benefits Committee

The 2012 SMM added the subsection titled “Allocation and Delegation of Fiduciary Responsibilities by the Benefits Committee” to the SPD under the section “The Prescription Drug Program.”

Self-Funded Benefits

The 2012 SMM added the subsection titled “Self-Funded Benefits” to the SPD under the section “The Prescription Drug Program.”

Changes Made by the 2013 Medical, Prescription Drug, and Mental Health and Substance Abuse Programs Summary Plan Description (the "2013 SPD")

Participating Employers

The 2013 SPD lists the following employers as Participating Employers in the Group Benefits Plan:

- 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
- OfficeTiger Global Real Estate Services, Inc.
- Von Hoffmann Corporation

Introduction

As of January 1, 2013, CIGNA Healthcare ("CIGNA") is no longer a Medical Program administrator. Therefore, each reference to CIGNA has been removed from the SPD in each place it appears. If you were a participant in the Group Benefits Plan prior to January 1, 2013, CIGNA may have been your Medical Program Administrator. While each instance of where CIGNA's name has been removed below, we have listed the sections which were removed from the SPD where the provisions applicable to CIGNA were materially different from those provisions applicable to the other Medical Program Administrators.

In addition, the CIGNA Indemnity Option has also been removed as a choice under the Group Benefits Plan. In its place is a new Blue Cross Blue Shield of Illinois ("BCBSIL") Indemnity Option. The SPD has been revised to replace the term "CIGNA Indemnity Option" in each place it appears with the term "BCBSIL Indemnity Option."

Claims Administrators and Network Managers

Prior to January 1, 2013, the following Claims Administrators and Network Managers were applicable to each Medical Program listed below:

The Medical Program (Includes coverage under the Mental Health and Substance Abuse Program)	***Claims Administrators and Network Managers***
CIGNA HSA Basic	CIGNA HealthCare (CIGNA)*
CIGNA HSA Plus	CIGNA HealthCare (CIGNA)*
CIGNA HRA Select	CIGNA HealthCare (CIGNA)*
CIGNA Preferred Access	CIGNA HealthCare (CIGNA)*
CIGNA Indemnity	CIGNA HealthCare (CIGNA)*
The Prescription Drug Program	
CIGNA HSA Basic	CVS Caremark
CIGNA HSA Plus	CVS Caremark
CIGNA HRA Select	CIGNA Pharmacy
CIGNA Preferred Access	CVS Caremark
CIGNA Indemnity	CVS Caremark

*CIGNA is the claims administrator and network manager for the Medical Program. CIGNA Behavioral Health, Inc. is the claims administrator and network manager for the Mental Health and Substance Abuse Program. CIGNA and CIGNA Behavioral Health, Inc. are subsidiaries of CIGNA Corporation.

In addition, effective January 1, 2013, the following Claims Administrators and Network Managers were added to the chart listed below:

The Prescription Drug Program	
BCBSIL Indemnity Program	CVS Caremark

How the Group Health Program Works

The 2013 SPD revised the first sentence of the second full paragraph under the "General Information" subsection to clarify that your home ZIP code also determines which national medical program claims administrator option is available to you. Prior to the 2013 SPD, this sentence read: "*Your home ZIP code determines which options are available to you."*

The 2013 SPD also revised fifth paragraph under the "General Information" subsection to remove the reference to a separate Mental Health and Substance Abuse Program, as this benefit is now being provided through the Medical Program you select.

Finally, the 2013 SPD revised the final paragraph under the "General Information" subsection to add that you (or your covered dependent who incurred the expense) are responsible for paying any amount over what is the "reasonable and customary charge" for an out-of-network service.

How the Group Health Program Works Glossary of Key Terms

The 2013 SPD revised the definition of "Maximum Reimbursable Expense." Prior to the 2013 SPD, such definition read:

> *"**Maximum Reimbursable Expense** – the maximum amount that is recognized for a covered expense, as determined by the claims administrator. This maximum is based on normal charges that are submitted by most doctors and other providers in the provider's geographic area for comparable services and supplies. This means that the charge must be within the range of charges. These limits are adjusted periodically to reflect current charges.*
>
> *"If you receive your care from a participating provider, the reimbursable rates are already negotiated at a rate that does not exceed the maximum reimbursable expense(s). If, however, you or your enrolled eligible dependents receive care from a non-participating provider (or if you or your enrolled eligible dependents participate in the CIGNA Indemnity coverage option), you are responsible for paying any amount over the maximum reimbursable expenses(s).*
>
> *"Any amount in excess of the maximum reimbursable expense does not count toward your annual deductible or your annual out-of-pocket limit.*
>
> *"Note: If you participate in one of the Group Health Program options, the claims administrator for your particular option may use a variety of terms instead of "maximum reimbursable expense." For example, the claims administrator may use the term "eligible expense," "usual and customary charge (U&C)," or "reasonable and customary charge (R&C).""*

The 2013 SPD revised the definition of "Out-of-Pocket Limits." Prior to the 2013 SPD, such definition read:

> *"**Out-of-Pocket Limits** – the annual out-of-pocket limit is the most you have to pay in coinsurance for covered expenses for you and your enrolled eligible dependents in any calendar year. Once you reach the individual out-of-pocket limit, the Group Health Program pays 100% of your additional covered expenses for the remainder of that calendar year. The out-of-pocket limit rules vary based on your option.*
>
> > *"**Collective/Non-Embedded Out-of-Pocket Limit***
> > *If you enroll in the HSA Basic or HSA Plus option and choose individual coverage, you will only need to meet the individual out-of-pocket limit before the Group Health Program begins to pay benefits at the 100% level. If you elect any other tier of coverage, the total family out-of-pocket limit applies collectively to all enrolled persons in the same family. The Group Health Program will not begin to pay benefits at the 100% level for*

any member of the family until the total family out-of-pocket limit has been satisfied. One individual can meet the entire family out-of-pocket amount by himself or herself.

*"**Aggregate/Embedded Out-of-Pocket Limit***
For the HRA Select, Preferred Access, and CIGNA Indemnity options, the family out-of-pocket limit applies to all enrolled family members. However, an individual within the family will only need to satisfy the individual out-of-pocket limit before the Group Health Program begins to pay benefits at the 100% level. Once one individual within the family has met the individual out-of-pocket limit, the 100% coinsurance will apply to all covered services received for that specific individual. One individual cannot meet the entire family out-of-pocket amount by himself or herself. Once the family out-of-pocket limit is met, the Group Health Program pays 100% of covered expenses for any enrolled family member for the remainder of that calendar year. The out-of-pocket limit includes your deductible.

"Certain expenses, however, do not apply toward the out-of-pocket limit. These include:

• Expenses for outpatient prescription drug services (unless you participate in the HSA Basic, HSA Plus, or HRA Select option);
• Chiropractic expenses, if you participate in the HRA option and BCBSIL is the claims administrator for your option;
• Any amount you pay above the maximum reimbursable expense when seeking care outside the network;
• Any additional penalty amount you may be required to pay for not precertifying a hospital admission or stay (where applicable); and
• Any expense that is not considered a covered expense, is above the contract amount, or exceeds other Group Health Program limits."

How the Group Health Program Works- Key Features

The 2013 SPD revised the key features of the new BCBSIL Indemnity Option. Under the CIGNA Indemnity option, you could receive care from any provider that you wished. There was no network of providers. Under the new BCBSIL Indemnity Option, the program pays one level of benefits because there is no network of providers.

Health Savings Account

The 2013 SPD revised the final paragraph under the "Health Savings Account ("HSA")" subsection to state that if you use your HSA funds for nonqualified or reimbursed expenses or for ineligible dependent's expenses, those dollars are subject to income taxes and a possible 10% penalty. Prior to the 2013 SPD, such sentence read: "*If you*

use your HSA funds for nonqualified or reimbursed expenses, those dollars are subject to income taxes and a possible 10% penalty."

Health Reimbursement Account

The 2013 SPD revised the scenarios under the "Health Reimbursement Account ("HRA")" subsection to clarify that if you enroll in the HRA Select option at Annual Enrollment, your full HRA Annual Contribution is available to you on January 1, and to provide that if the HRA Select option should be discontinued in the future, there is no carryover of the dollars remaining.

Summary Charts of the Coverage Options

The changes below were made to the coverage options under the Preferred Access and CIGNA Indemnity Options and included as part of the changes made in the 2013 SPD. Prior to the issuance of the 2013 SPD, the following provisions were in effect, rather than the provisions currently listed in the SPD:

- Annual Deductibles in the Preferred Access Plan were as described under the changes made by the 2012 SMM heading outlined above in this appendix.
- The BCBSIL Indemnity Option was not offered under the Group Benefits Plan. Rather, a CIGNA Indemnity Option was offered under the Group Benefits Plan. The provisions of the CIGNA Indemnity Option were as follows:

Key Feature	***CIGNA Indemnity***
Annual Deductible	***You Pay***
• Individual	$1,000
• Family	$2,000
Annual Out-of-Pocket Limit (includes deductible)	***You Pay***
• Individual	$3,000
• You + Family	$6,000
Annual Out-of-Pocket Limit (Prescription Drug)*	***You Pay***
• You Only	$2,500
• You + Spouse	$4,500
• You + Child(ren)	$4,500
• You + Family	$4,500
Coinsurance	***Medical Program Pays*****
• Physician Office Visits	80% after deductible is met
• Annual Physical Exam	100% per covered individual per calendar year
• Immunizations (children and adults)	100% per covered individual per calendar year

Error! Bookmark not defined.

Key Feature	*CIGNA Indemnity*
• Independent X-Ray and Lab Facility***	80% after deductible is met
• Inpatient Hospital Facility Services	80% after deductible is met
• Outpatient Surgery	80% after deductible is met
• Inpatient/Outpatient Professional Services (for ***non-emergency/urgent*** services)	80% after deductible is met
• Inpatient/Outpatient Professional Services (for ***emergency/urgent*** services)	80% after deductible is met
• Emergency/Urgent Care Facility (for ***emergency/urgent*** services)	80% after deductible is met
• Outpatient Rehabilitation Services, Including Speech, Occupational, Physical, Pulmonary, and Cognitive Therapy (limited to 90 visits per calendar year)	80% after deductible is met
• Outpatient Cardiac Rehabilitation Therapy Phases I and II (limited to 36 visits per calendar year)	80% after deductible is met
• Chiropractic Therapy (limited to 20 visits each calendar year)	80% after deductible is met
• Inpatient Skilled Nursing/Rehabilitation subject to preauthorization of medical necessity (limited to 90 days per calendar year)	80% after deductible is met
• Home Health Care subject to preauthorization of medical necessity (limited to 120 visits per calendar year)	80% after deductible is met
• Durable Medical Equipment/External Prosthetic Appliances	80% after deductible is met
Mental Health and Substance Abuse	
• Inpatient, subject to preauthorization of medical necessity (a 90-day lifetime maximum applies)	80% after deductible is met (up to 30 days per calendar year)
• Outpatient (a 450-visit lifetime maximum applies)	80% after deductible is met (up to 30 visits per calendar year)
Prior Authorization	Please see the "Preadmission Certification" section for each respective claims administrator earlier in this SPD for details.
Prescription Drug Program	Please see the "A Summary Chart of Your Prescription Drug Coverage" section for details.

*The prescription drug out-of-pocket maximum is separate from the medical out-of-pocket maximum.

**Expenses above the amounts recognized as covered expenses are your responsibility. These amounts do not count toward the deductible or the out-of-pocket limit.

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

What Is Covered

The 2013 SPD removed the definition of the term “Infertility diagnosis” and replaced it with the defined term “Infertility.” Prior to the 2013 SPD, the term “Infertility Diagnosis meant:

> *“**Infertility diagnosis** – services provided to diagnose conditions related to fertility, including (the BCBSIL Group Health Program only provides coverage for diagnostic services and not treatment):*
> *- Testing and treatment services performed in connection with an underlying medical condition; and*
> *- Treatment and/or procedures performed specifically to restore fertility (for example, procedures to correct an infertility condition).”*

Special Rules Under the CIGNA Group Health Program Options

The 2013 SPD removed the section relating to “Special Rules Under the CIGNA Group Health Program Options” because CIGNA is no longer a Medical Program Administrator under the Group Benefits Plan. Prior to the 2013 SPD, such section read as follows:

> *“**Special Rules Under the CIGNA Group Health Program Options***
>
> ***“General Information – CIGNA Mental Health and Substance Abuse Program, CIGNA Preadmission Certification, and CIGNA Special Services***
>
> *“In addition to the provisions described under the “How the Group Health Program Works – General,” the “What Is Covered,” and the “What Is Not Covered” sections, the following information is unique to the Medical Program, as well as the Mental Health and Substance Abuse Program available through CIGNA. CIGNA is the claims administrator and network manager, and is responsible for selecting the providers who participate in the CIGNA network. If your home ZIP code is in the CIGNA network area, you can elect coverage under the following options for yourself and your enrolled eligible dependents:*
>
> *• HSA Basic;*
> *• HSA Plus;*
> *• HRA Select; or*
> *• Preferred Access.*
>
> *“A listing of in-network providers is available free of charge. Contact the claims administrator, or visit the claims administrator’s website for this information. If your home ZIP code is outside the CIGNA, UHC, and BCBSIL network areas, you can elect coverage under the CIGNA Indemnity option (an out-of-area option) for yourself and your enrolled eligible dependents.*

*"**CIGNA Mental Health and Substance Abuse Services***

"If you enroll yourself and your eligible dependents in one of the Group Health Program options through the claims administrator, CIGNA, the Mental Health and Substance Abuse Program pays benefits for mental health and substance abuse covered expenses.

"CIGNA Behavioral Health (CBH) is the network manager for mental health and substance abuse care. CBH is the claims administrator. Mental health and substance abuse claims count toward your annual deductible and out-of-pocket limit.

"Before you or your enrolled eligible dependent receives care for mental health or substance abuse, you or your enrolled eligible dependent needs to call the claims administrator at the number listed on your ID card to have the care approved. By calling ahead, you or your enrolled eligible dependent will ensure that the highest available benefits to cover the cost of the care are received. If you or your enrolled eligible dependent does not call and seek care management and approval, the Mental Health and Substance Abuse Program may not pay benefits or it may pay benefits at the out-of-network level (given your option). See the Summary Chart for your option for details.

"You must precertify all inpatient services with the claims administrator. Failure to obtain precertification results in a $500 penalty charge. Outpatient services do not require precertification. For an emergency admission, you must notify the claims administrator by the next business day. For additional details regarding certification requirements, see the "Preadmission Certification" section for the CIGNA Group Health Program.

*"**What Is Covered – CIGNA Mental Health and Substance Abuse Program***
The Mental Health and Substance Abuse Program administered by CIGNA pays benefits for the following covered expenses. The following are examples that may qualify as a covered expense:

• Hospital charges for room and board in a semiprivate room;
• Licensed ambulance services to or from the nearest hospital that can provide the necessary mental health or substance abuse treatment;
• Licensed inpatient or outpatient hospital services to treat mental health or substance abuse;
• Licensed outpatient facility charges to treat mental health and/or substance abuse; and
• Professional services to treat a mental health and/or substance abuse condition.

"Services must be provided by an appropriately licensed or certified mental health and/or substance abuse provider (or other), other than a relative.

*"**What Is Not Covered – CIGNA Mental Health and Substance Abuse Program***

CIGNA makes a final determination as to whether an expense is a covered expense. The following expenses are not covered expenses of the Mental Health and Substance Abuse Program administered by CIGNA:

• Services that extend beyond the period that is necessary to evaluate and diagnose mental retardation or autism.
• Any mental health or substance abuse condition that, according to generally accepted professional standards, is not usually amenable to favorable modification.
• Services that are within the scope of usual mental health and substance abuse practice, but are normally provided by a non-mental health or substance abuse clinician.
• Any expense that you incur because of an accident and for which (in the claims administrator's opinion) a third-party liability exists. The Mental Health and Substance Abuse Program pays benefits as otherwise payable. However, you must first agree in writing to refund the lesser of:
- The amount actually paid for such expense by the Mental Health and Substance Abuse Program; or
- An amount equal to the sum you actually receive from the third party (or the insurance carrier of the third party) for such expense at the time that such third party liability is determined and satisfied – whether by settlement, judgment, arbitration, or otherwise.
• Any benefit that you receive or that is payable under the mandatory part of any auto insurance policy written to comply with:
- A "no-fault" insurance law; or
- An uninsured motorist insurance law.
• Any amount that is in excess of the amount that the provider has agreed to accept for the service.
• Structured sexual therapy programs, or treatment for sexual offenders or perpetrators of sexual or physical violence.
• Smoking or nicotine addiction treatment.
• Treatment of chronic pain (other than by psychotherapy if it is determined such pain has a psychological origin).
• Narcotic maintenance therapy in which an agonist, antagonist, or agonist/antagonist drug is used for chronic administration. Detoxification services related to such chronic drug maintenance use also are excluded from coverage.
• Weight loss or personal growth treatments.
• Rehabilitative treatment associated with permanent or temporary disability that results from an accident or injury (this applies to circumstances where such treatment is part of a comprehensive rehabilitation program).

• Rehabilitative treatment that is associated with education, or hearing and/or vision impairment.
• Expenses made by any provider who is a member of a covered individual's family.
• Transportation services for non-emergency transportation between institutional care facilities, or to and from your residence.
• Court-ordered treatment for a mental health and substance abuse condition that is not a covered service, as determined by the claims administrator.
• Protective services ordered for a mental health and substance abuse condition that is not a covered service, as determined by the claims administrator.
• Expenses for which you or your enrolled eligible dependent receives or is entitled to receive benefits by or through a public program other than Medicaid.
• Expenses to the extent that payment is unlawful where you reside.
• Expenses incurred in connection with an injury or disease covered by Workers' Compensation or similar law.
• Expenses that you or your enrolled eligible dependent is not legally required to pay.
• Expenses for late or missed appointments.
• Expenses you incur to transfer medical records.
• Any expense you incur before your coverage effective date.
• Any expense that is connected with a mental illness or injury due to a declared or undeclared act of war, including armed aggression.
• Services not ordered by a properly licensed clinician acting within the scope of his or her license.
• Provider expenses, to the extent they result from a scholastic or vocational intervention, as determined by the claims administrator.
• Any non-compliance penalties you are required to pay because you fail to follow precertification requirements.
• Any expense for a non-covered service or penalty charge that you are required to pay because you fail to precertify a hospital admission.
• Expenses in excess of usual and customary limits.
• Expenses that a third party is obligated to cover, such as under another plan or insurance policy, tort recovery, or Workers' Compensation recovery by you.

*"**CIGNA Group Health Program – Preadmission Certification***

"The Group Health Program covers expenses, up to the maximum reimbursable expense, for covered expenses. To help ensure that you receive appropriate care, you must precertify any hospital admission.

"How to Precertify Your Hospital Admission
You must call the claims administrator to precertify a scheduled hospital admission at least 24 hours before you are admitted. When you call, be prepared to provide information regarding your upcoming hospitalization, including the full name, address, and phone number of your provider.

"The toll-free phone number is listed on your ID card. Your regular physician or authorized specialist may work directly with the claims administrator to obtain approval for your admission. However, it is your responsibility to make sure your hospital stay is approved.

"A health care professional reviews your request, and you and your physician are notified as soon as possible regarding the approved length of stay. If your request for hospitalization is not approved, the claims administrator discusses your case with your provider to reach an agreement regarding the appropriate treatment to follow.

*"**If You Do Not Precertify a Hospital Admission***
The Group Health Program reduces benefits by $500 if you fail to precertify a hospital admission. This means that you are responsible for paying $500 more than you would have paid if you had precertified the admission (this does not apply to emergency admissions). The $500 precertification penalty is not a covered expense. Therefore, it does not apply to your annual deductible requirement or your out-of-pocket limit. In addition, any other covered expense for a hospitalization, surgery, or an unauthorized day may be denied. This means that your share of out-of-pocket costs could be significantly higher.

*"**Emergency Notification***
In the case of an emergency, go directly to the nearest emergency facility or call 911. If admitted, you, a family member, or your provider must call the claims administrator within 48 hours of the admission. If you do not, the level at which the Group Health Program pays benefits may be impacted.

*"**CIGNA Special Services***

"If you enroll in one of the Group Health Program options through the claims administrator, CIGNA, the following services are available to you through CIGNA HealthCare.

*"**The CIGNA HealthCare Healthy Babies® Program***
This program provides education and support for mothers-to-be, along with special attention for high risk pregnancies. Through this program, expectant mothers receive:

• A free copy of a book on health care before, during, and after pregnancy, as well as discount coupons for other nutrition books, exercise books, etc.;
• Precertified hospital admission for the delivery;
• Access to nurses who are available by phone to answer questions; and
• Counseling in the event of a high-risk pregnancy or premature delivery.

"To participate, call the claims administrator at the toll-free number listed on your ID card. You should call as soon as your provider confirms your pregnancy.

*"**CIGNA HealthCare Healthy Rewards®***
This program offers you discounts on various CIGNA services and health and wellness products, including (but not limited to):

- *Massage therapy;*
- *Eyewear;*
- *Hearing aids;*
- *Laser vision correction; and*
- *Non-prescription health and beauty products.*

"Take charge and learn more about how you can save money through Healthy Rewards.

*"**CIGNA HealthCare Health Information LineSM***
Whether you are traveling or you need medical advice at a time when it is difficult to reach a provider, CIGNA HealthCare makes it easy for you to get the help you need. The Health Information Line is available 24 hours a day, seven days a week. Via this line, a registered nurse can answer your questions, direct you to a nearby health care facility, make suggestions for home care, or help you obtain emergency assistance.

*"**CIGNA HealthCare Health Information Library***
CIGNA HealthCare is providing health information for you with the push of a button. You can call the Health Information Line and access the library to find out information on many health care topics, from adult day care to women's health.

*"**CIGNA HealthCare Medical Self-Service***
This web-based tool allows you to track claims and check eligibility details with the ease of the Internet. To learn more about any of the services listed above, call the toll-free number listed on your ID card or visit the CIGNA HealthCare website.

UHC Mental Health and Substance Abuse Services

The 2013 SPD removed the section relating to "UHC Mental Health and Substance Abuse Services" because such services are no longer offered as a separate program from Group Benefits Plan. Prior to the 2013 SPD, such section read as follows:

*"**UHC Mental Health and Substance Abuse Services***

"If you enroll yourself and your eligible dependents in one of the Group Health Program options through the claims administrator, UHC, the Mental Health and

Substance Abuse Program pays benefits for mental health and substance abuse covered expenses.

"United Behavioral Health (UBH) is the network manager for mental health and substance abuse care. UHC is the claims administrator. Mental health and substance abuse claims count toward your annual deductible and out-of-pocket limit.

"Before you or your enrolled eligible dependent receives inpatient care for mental health or substance abuse, you or your enrolled eligible dependent needs to call the claims administrator at the number listed on your ID card to have the care approved. By calling ahead, you or your enrolled eligible dependent will ensure that the highest available benefits to cover the cost of the care are received. If you or your enrolled eligible dependent does not call and seek care management and approval, the Mental Health and Substance Abuse Program may not pay benefits or it may pay benefits at the out-of-network level (given your option). See the Summary Chart for your option for details.

"You must precertify all inpatient services with the claims administrator. Failure to obtain precertification results in a $500 penalty charge. Outpatient services do not require precertification. For an emergency admission, you must notify the claims administrator by the next business day. For additional details regarding certification requirements, see the "Preadmission Certification" section for the UHC Group Health Program.

*"**What Is Covered – UHC Mental Health and Substance Abuse Program***
The Mental Health and Substance Abuse Program administered by UHC pays benefits for mental health and substance abuse treatments, including inpatient and intermediate, that are:

• Preauthorized by the claims administrator, who is responsible for coordinating all of your care; and
• Received on an inpatient or intermediate care basis in a hospital or an alternate facility that provides mental health or substance abuse treatments.

"The Mental Health and Substance Abuse Program only pays for treatment of the diagnoses, which is identified in the current edition of the American Psychiatric Association's (APA's) Diagnostic and Statistical Manual of Mental Disorders. Benefits include detoxification from abusive chemicals or substances when necessary to protect your health. APA's website is www.apa.org.

"If the claims administrator determines that an inpatient stay is required, it is covered on a semiprivate room (a room with two or more beds) basis. At the sole discretion of the claims administrator, two sessions of intermediate care (such as partial hospitalization) may be provided in lieu of one inpatient day. Inpatient

treatment is subject to the calendar year limits, which apply to both network and non-network benefits combined.

"The Mental Health and Substance Abuse Program pays benefits for treatment received on an outpatient basis in a provider's office or at an alternate facility, including:

• Mental health/substance abuse evaluations and assessment;
• Diagnosis;
• Treatment planning;
• Referral services;
• Medical management;
• Short-term individual, family, and group therapeutic services (including intensive outpatient therapy);
• Crisis intervention; and
• Psychological testing.

*"**What Is Not Covered – UHC Mental Health and Substance Abuse Program***
UHC makes a final determination as to whether an expense is a covered expense. The following expenses are not covered expenses of the Mental Health and Substance Abuse Program administered by UHC:

• Services performed in connection with conditions not classified in the current edition of the Diagnostic and Statistical Manual of Mental Disorders of the American Psychiatric Association.
• Services that extend beyond the period necessary for short-term evaluation, diagnosis, treatment, or crisis intervention.
• Treatment for insomnia, other sleep disorders, neurological disorders, and other disorders with a known physical basis.
• Treatment for conduct and impulse control disorders, personality disorders, paraphilias (sexual behavior that is considered deviant or abnormal), and other mental illnesses that will not substantially improve beyond the current level of functioning, or that are not subject to favorable modification or management according to prevailing national standards of clinical practice, as determined by UBH.
• Services that use methadone, L.A.A.M. (Levo-Alpha Acetyl Methadol), cyclazocine, or their equivalents as maintenance treatment for drug addiction.
• Treatment provided in connection with involuntary commitments, police detentions, and other similar arrangements, unless preauthorized by UBH.
• Residential treatment services, which provide overnight services to those who do not require acute care.
• Services for a patient who has repeatedly and intentionally not complied with treatment recommendations.
• Psychosurgery (lobotomy).
• Treatment of autism.

• Treatment of tobacco dependency.
• Routine use of psychological testing without specific authorization.
• Pastoral counseling.
• Services and supplies for the diagnosis or treatment of mental illness, alcoholism, or substance abuse disorders that, in the reasonable judgment of UBH, typically do not result in outcomes demonstrably better than other available treatment alternatives that are less intensive or more cost-effective, or are not consistent with:
- Prevailing national standards of clinical practice for the treatment of such conditions;
- Prevailing professional research demonstrating that the services or supplies will have a measurable and beneficial health outcome; or
- UBH's level of care guidelines (as modified from time to time).

"The claims administrator may consult with professional clinical consultants, peer review committees, or other appropriate sources for recommendations and information regarding whether a service or supply meets any of these criteria.

BCBSIL Mental Health and Substance Abuse Services

The 2013 SPD removed the section relating to "BCBSIL Mental Health and Substance Abuse Services" because such services are no longer offered as a separate program from Group Benefits Plan. Prior to the 2013 SPD, such section read as follows:

*"**BCBSIL Mental Health and Substance Abuse Services***

"If you enroll yourself and your eligible dependents in one of the Group Health Program options through the claims administrator, BCBSIL, the Mental Health and Substance Abuse Program pays benefits for mental health and substance covered expenses.

"BCBSIL is the claims manager and network administrator for mental health and substance abuse care. Mental health and substance abuse claims count toward your annual plan deductible and out-of-pocket limit.

"Before you or your enrolled eligible dependent receives inpatient care for mental health or substance abuse, you or your enrolled eligible dependent needs to call the claims administrator at the number listed on your ID card to have the care approved. By calling ahead, you or your enrolled eligible dependent will ensure that the highest available benefits to cover the cost of the care are received. If you or your enrolled eligible dependent do not call and seek care management and approval, the Mental Health and Substance Abuse Program may not pay benefits or it may pay benefits at the out-of-network level (given your option). See the Summary Chart for your option for details.

"You must precertify all inpatient services with the claims administrator. You must call one day prior to an elective admission and within two days following an emergency admission. Failure to obtain precertification results in a $500 penalty charge. This penalty will apply for any inpatient hospital stay or any inpatient mental health or substance abuse treatments for which the stay is not precertified. This penalty applies for both in-network and out-of-network services. Outpatient services do not require precertification. For additional details regarding certification requirements, see the "Preadmission Certification" section for the BCBSIL Group Health Program.

*"**What Is Covered – BCBSIL Mental Health and Substance Abuse Program***
The Mental Health and Substance Abuse Program administered by BCBSIL pays benefits for the following covered expenses. The following are examples that may qualify as a covered expense:

• Hospital charges for room and board in a semiprivate room;
• Licensed ambulance services to or from the nearest hospital that can provide the necessary mental health or substance abuse treatment;
• Licensed inpatient or outpatient hospital services to treat mental health or substance abuse;
• Licensed outpatient facility charges to treat mental health and/or substance abuse; and
• Professional services to treat a mental health and/or substance abuse condition.

"Services must be provided by an appropriately licensed or certified mental health and/or substance abuse provider (or other), other than a relative.

*"**What Is Not Covered – BCBSIL Mental Health and Substance Abuse Program***
BCBSIL makes a final determination as to whether an expense is a covered expense. The following expenses are not a covered expense of the Mental Health and Substance Abuse Program administered by BCBSIL:

• Services that extend beyond the period that is necessary to evaluate and diagnose mental retardation or autism.
• Any mental health or substance abuse condition that, according to generally accepted professional standards, is not usually amenable to favorable modification.
• Services that are within the scope of usual mental health and substance abuse practice, but are normally provided by a non-mental health or substance abuse clinician.

• Any expense that you incur because of an accident and for which (in the claims administrator's opinion) a third-party liability exists. The Mental Health and Substance Abuse Program pays benefits as otherwise payable. However, you must first agree in writing to refund the lesser of:
- The amount actually paid for such expense by the Mental Health and Substance Abuse Program; or
- An amount equal to the sum you actually receive from the third party (or the insurance carrier of the third party) for such expense at the time that such third party liability is determined and satisfied – whether by settlement, judgment, arbitration, or otherwise.
• Any benefit that you receive or that is payable under the mandatory part of any auto insurance policy written to comply with:
- A "no-fault" insurance law; or
- An uninsured motorist insurance law.
• Any amount that is in excess of the amount that the provider has agreed to accept for the service.
• Structured sexual therapy programs, or treatment for sexual offenders or perpetrators of sexual or physical violence.
• Smoking or nicotine addiction treatment.
• Treatment of chronic pain (other than by psychotherapy if it is determined such pain has a psychological origin).
• Narcotic maintenance therapy in which an agonist, antagonist, or agonist/antagonist drug is used for chronic administration. Detoxification services related to such chronic drug maintenance use also are excluded from coverage.
• Weight loss or personal growth treatments.
• Rehabilitative treatment associated with permanent or temporary disability that results from an accident or injury (this applies to circumstances where such treatment is part of a comprehensive rehabilitation program).
• Rehabilitative treatment that is associated with education, or hearing and/or vision impairment.
• Expenses made by any provider who is a member of a covered individual's family.
• Transportation services for non-emergency transportation between institutional care facilities, or to and from your residence.
• Court-ordered treatment for a mental health and substance abuse condition that is not a covered service, as determined by the claims administrator.
• Protective services ordered for a mental health and substance abuse condition that is not a covered service, as determined by the claims administrator.
• Expenses for which you or your enrolled eligible dependent receives or is entitled to receive benefits by or through a public program other than Medicaid.
• Expenses to the extent that payment is unlawful where you reside.
• Expenses incurred in connection with an injury or disease covered by Workers' Compensation or similar law.
• Expenses that you or your enrolled eligible dependent is not legally required to pay.

• Expenses for late or missed appointments.
• Expenses you incur to transfer medical records.
• Any expense you incur before your coverage effective date.
• Any expense that is connected with a mental illness or injury due to a declared or undeclared act of war, including armed aggression.
• Services not ordered by a properly licensed clinician acting within the scope of his or her license.
• Provider expenses, to the extent they result from a scholastic or vocational intervention, as determined by the claims administrator.
• Any non-compliance penalties you are required to pay because you fail to follow precertification requirements.
• Any expense for a non-covered service or penalty that you are required to pay because you fail to precertify a hospital admission.
• Expenses in excess of usual and customary limits.
• Expenses that a third party is obligated to cover, such as under another plan or insurance policy, tort recovery, or Workers' Compensation recovery by you.

Prescription Drug Program

The section of the SPD titled "The Prescription Drug Program was revised by the 2013 SPD. The 2013 SPD removed the Legacy Bowne Medical Program Option previously added by the 2012 SMM. The Legacy Bowne Medical Program Option included HSA Basic, HSA Plus, Preferred Access and CIGNA Indemnity. In addition, the 2013 SPD removed reference to CIGNA and the CIGNA Pharmacy Prescription Drug Program Claims Administrator.

A Summary Chart of Your Prescription Drug Coverage

The 2013 SPD also revised the summary chart outlining prescription drug coverages under each Prescription Drug Program option Prior to the revision by the 2013 SPD, the summary chart read as follows:

The Prescription Drug Program				
HSA Basic, HSA Plus, and HRA Select – Retail Stores (CIGNA, UHC, BCBSIL)				
	In-Network		***Out-of-Network***	
	You Pay	***Prescription Drug Program Pays***	***You Pay***	***Prescription Drug Program Pays***
• Retail Generic**	20% after deductible*	80% after deductible*	40% after deductible*	60% after deductible*
• Retail Brand Formulary**	30% after deductible*	70% after deductible*	40% after deductible*	60% after deductible*
• Retail Brand Non-Formulary**	40% after deductible*	60% after deductible*	40% after deductible*	60% after deductible*

The Prescription Drug Program				
• Generic preventive medicine for hypertension and hyperlidemia	0%	100%	40% after deductible*	60% after deductible*
HSA Basic, HSA Plus, and HRA Select – Mail Order (CIGNA, UHC, BCBSIL)				
	You Pay		***Prescription Drug Program Pays***	
• Mail Order Generic**	20% after deductible*		80% after deductible*	
• Mail Order Brand Formulary**	30% after deductible*		70% after deductible*	
• Mail Order Brand Non-Formulary**	40% after deductible*		60% after deductible*	
• Generic preventive medicine for hypertension and hyperlidemia	0%		100%	
Preferred Access – Retail Stores (CIGNA, UHC, BCBSIL)***				
	In-Network		***Out-of-Network***	
	You Pay***	***Prescription Drug Program Pays***	***You Pay******	***Prescription Drug Program Pays***
• Retail Generic**	10% after deductible*	90% after deductible*	30% after deductible*	70% after deductible*
• Retail Brand Formulary**	30% after deductible*	70% after deductible*	50% after deductible*	50% after deductible*
• Retail Brand Non-Formulary**	40% after deductible*	60% after deductible*	60% after deductible*	40% after deductible*
• Generic preventive medicine for hypertension and hyperlidemia	0%	100%	30% after deductible*	70% after deductible*
Preferred Access - Mail Order (CIGNA, UHC, BCBSIL)***				
	You Pay***		***Prescription Drug Program Pays***	
• Mail Order Generic**	10% after deductible*		90% after deductible*	
• Mail Order Brand Formulary**	30% after deductible*		70% after deductible*	
• Mail Order Brand Non-Formulary**	40% after deductible*		60% after deductible*	
• Generic preventive medicine for hypertension and hyperlidemia	0%		100%	

The Prescription Drug Program		
CIGNA Indemnity Option***		
	You Pay***	***Prescription Drug Program Pays***
• Retail Generic**	10% after deductible*	90% after deductible*
• Retail Brand Formulary**	30% after deductible*	70% after deductible*
• Retail Brand Non-Formulary**	40% after deductible*	60% after deductible*
• Generic preventive medicine for hypertension and hyperlidemia	0%	100%
	You Pay***	***Prescription Drug Program Pays***
• Mail Order Generic**	10% after deductible*	90% after deductible*
• Mail Order Brand Formulary**	30% after deductible*	70% after deductible*
• Mail Order Brand Non-Formulary**	40% after deductible*	60% after deductible*
• Generic preventive medicine for hypertension and hyperlidemia	0%	100%

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

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

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

Your Legal Right to COBRA Continuation Coverage

The 2013 SPD revised the subsection titled "When COBRA Continuation Coverage Ends" under the section "Your Legal Right to COBRA Continuation Coverage" to add "the date a Medicare eligible COBRA continuation coverage beneficiary becomes effective under Medicare or 60 days" as a factor for which COBRA continuation coverage of a COBRA continuation coverage beneficiary continues.

Coordinating Benefits with Other Programs- Medicare

The 2013 SPD revised the subsection titled “Medicare” under the section “Coordinating Benefits with Other Programs” to add the final paragraph before the bulleted heading: “Important Note.”

Claims Administrators

The 2013 SPD revised the addresses for the Claims Administrator for the BCBSIL Group Health Program Options, the CVS Caremark Prescription Drug Program and the Prime Therapeutics Prescription Drug Program. Prior to the 2013 SPD the contact information for the Claims Administrators were as follows:

> “*Claims Administrator for the BCBSIL Group Health Program Options and the Prime Therapeutics Prescription Drug Program:*
>
> *Blue Cross and Blue Shield of Illinois*
> *P.O. Box 1220*
> *Chicago, IL 60690-1220*
> *1-800-537-9765.*
>
> *Claims Administrator for the CVS Caremark Prescription Drug Program*
>
> *CVS Caremark*
> *Attn: Claims Department*
> *P.O. Box 686005*
> *San Antonio, TX 78268-6005.*