RR DONNELLEY

2017 Summary of Material Modifications (SMM) for the R.R. Donnelley & Sons Company Medical and Prescription Drug Programs

Effective as of January 1, 2017

This Summary of Material Modifications (the "SMM") only covers the Group Health Program of the RR Donnelley Group Benefits Plan (the "Plan"). The "Medical Program" and the "Prescription Drugs Program" are component programs of the Group Health Program. In addition, nothing in this SMM, the Summary Plan Description of the Group Health Program (the "SPD") or its appendices should be interpreted as an employment contract. This SMM merely describes the material changes to the coverages and benefits offered to eligible participants from the date of the last SPD until January 1, 2017. R.R. Donnelley & Sons Company ("RR Donnelley") reserves the right to amend, change, or terminate the Plan or the Group Health Program, in whole or in part, at any time. If a capitalized term is not defined in this SMM, such term shall have the definition set forth in the SPD.

This SMM contains a summary in English to supplement and/or replace the information provided in the SPD and its appendices. If there is any inconsistency between the SMM and the SPD, this SMM shall control. You should keep this SMM with your SPD, and other Group Health Program and/or Plan documents. 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.

(The following section replaces the section of the SPD titled "Extended Coverage for Disabled Children" found under the section of the SPD titled "Who Is Eligible" beginning on page 5 of the SPD.)

Extended Coverage for Disabled Children

If your enrolled eligible child is permanently and totally disabled (as defined in Code Section 22(e)(3)) and unable to support himself or herself, you can continue coverage for that child until the end of the month in in which the child reaches age 26. To be eligible for continued coverage, your child must be enrolled under the Group Health Program immediately before the coverage would otherwise end, and the disability must begin while your enrolled eligible child's coverage under the Group Health Program is in effect. To continue coverage, you must contact your claims administrator to request the form(s) to complete. You must provide proof (for example, a physician's certificate) of your child's disability within 30 days of the day the child's coverage would have otherwise ended. If you do not, coverage for your disabled child ends, and you will not have another opportunity to add or continue coverage for your disabled child based on his or her disability status.

If your permanently and totally disabled (as defined in Code Section 22(e)(3)) child has already reached age 26 when he or she first gains eligibility under the Group Health Program, you must enroll him or her for coverage immediately. To confirm eligibility, you must contact your claims administrator to request the certification form(s) to complete. You must provide proof (for example, a physician's certificate) of your child's disability within 30 days of enrollment or your child's coverage will be ended and you will not have another opportunity to add coverage for your disabled child based on his or her disability status.

Your disabled child must continue to meet the following conditions to be an eligible child under the Group Health Program:

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

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

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

(The following section replaces the section of the SPD titled "Glossary of Key Terms – General" found under the section of the SPD titled "How the Group Health Program Works - General" beginning on page 22 of the SPD.)

Glossary of Key Terms – General

Hospice – a program of care for a patient whose life expectancy is twelve months or less. The purpose of hospice care is to keep the patient as comfortable as possible and to provide support for the patient's family. Qualified hospice care may be provided at an approved hospice facility, or in the home under the direction of a recognized hospice care program.

(The following section replaces the section of the SPD titled "Professional Services" found under the section of the SPD titled "What is Covered" beginning on page 46 of the SPD.)

Professional Services

- **Hearing exams** – services provided to determine hearing status, as part of a PCP's or other provider's exam, with the intent of determining the need for a hearing evaluation or hearing aid.
- **Hearing Aids** - covered when a hearing aid is required for the correction of a hearing impairment (a reduction in the ability to perceive sound which may range from slight to complete deafness) with the written recommendation by a physician or Provider. Initial purchase is limited to $5,000 (including charges for associated fitting and testing). Replacement benefits are limited to $5,000 every 36 months.

(The following section replaces the section of the SPD titled "Miscellaneous Services" found under the section of the SPD titled "What is Covered" beginning on page 46. of the SPD.)

Miscellaneous Services

- **Hospice** – services provided in an inpatient facility or outpatient setting if you or a covered dependent is diagnosed as having an incurable disease with a life expectancy of twelve months or less. Covered expenses determined to be medically necessary by the claims administrator include:
  - Precertified hospice facility room and board for a semiprivate room (private room expenses are covered up to the cost of the facility's highest daily rate for a semiprivate room at the time of the covered individual's confinement);
  - Hospice facility services and supplies during the precertified confinement;
  - Outpatient services provided by a hospice facility;
  - Professional services of a physician;
  - Pain relief treatment, including drugs, medicines, and medical supplies;
  - Part-time or intermittent nursing care provided in the home by or under a nurse's supervision;
  - Part-time or intermittent services provided in the home by a home health aide;
  - Consumable medical supplies, drugs, and medicines that are lawfully dispensed only on the physician's written prescription, and laboratory services (only to the extent that such expenses would have been payable if the person had remained or been confined in a hospital or hospice facility); and
  - Other covered expenses or services that are determined to be medically necessary and are authorized by the claims administrator.