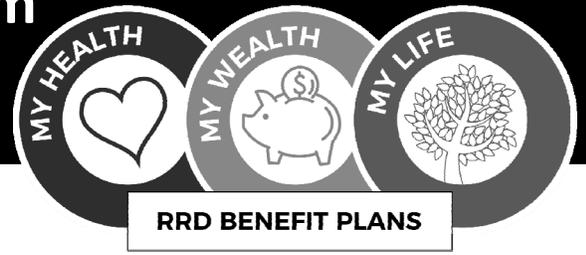


Regional Medical Options Program



Wrap Document and Summary Plan Description

Effective as of January 1, 2016

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Introduction

The options available under the Group Health Program under the RR Donnelley Group Benefits Plan (the “Group Benefits Plan”) enable you to select the level of coverage and cost that best meet your needs. In addition to the options available under the Group Health Program, the options described in this Regional Options Program SPD may be available to you based on where you live (your home zipcode) and select work locations based on legacy coverage. These options are provided under the Group Benefits Plan.

The Regional Options Program is comprised of the following Self-Funded Options:

- BCBS EGT
- BCBS Garner
- BCBS McKay

and the following Fully-Insured Options:

- BCBS HMO
- Kaiser CA HMO
- Dean HMO

All options have prescription drug coverage provided by the medical carrier.

It is important that you know how the Regional Options Program works. Become an informed consumer of services, read all of the benefits information available, and ask questions so that you can make coverage decisions that are best for you and your family.

This information is the Summary Plan Description (“SPD”) for the Self-Insured options under the Regional Options Program. This information, together with the certificate(s) of coverage for the Fully-Insured Options under the Regional Options Program (attached at the end of this booklet), constitutes the SPD for the Fully-Insured options also. This SPD explains your coverage as of January 1, 2016 (unless noted otherwise). This SPD details who is eligible for coverage and when coverage begins and ends. It details which expenses are and are not covered under the Regional Options Program, it describes how to file a claim, and it describes your rights under the Regional Options Program. Please read this information to familiarize yourself with your coverage.

Union employees covered by a collective bargaining agreement need to refer to such agreement for any differences from the option offered, eligibility rules, waiting periods for coverage, and employee premium amounts described in this SPD. If there are differences between the rules contained in this SPD and the rules contained in your applicable collective bargaining agreement, your collective bargaining agreement will control.

The Group Benefits Plan has contracted with a number of third parties to render claims administrator and network manager services necessary to the operation and administration of the Regional Options Program.

You are eligible for coverage under the Regional Options Program only if you are an employee of a Participating Employer or subsidiary. If you are an employee of an employer or subsidiary that does not participate in the Regional Options Program, 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 coverage under the Regional Options Program. However, since treatments, protocols, and practices continually change, this document cannot adequately define every potentially covered service or exclusion. 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 benefit. If there is any discrepancy between this SPD versus the Group Benefits Plan, the Group Benefits Plan document governs for the Self-Insured Options, the respective Certificate of Insurance will govern for the Fully-Insured Options.

This SPD only covers the Regional Options Program. For United States Department of Labor (“DOL”) filing purposes, several RR Donnelley welfare benefit programs, combined, make up the Group Benefits Plan. Generally, each welfare program under the Group Benefits Plan is described in a separate SPD. For example, the Group Benefits Plan may offer the Medical and Prescription Drug Programs to you as an alternative to the Regional Options Program. If you are a Global Traveler, the Group Benefits Plan offers international benefits, some of which are separate from the Regional Options Program.

In addition, nothing in this SPD should be interpreted as an employment contract. This SPD merely describes the Regional Options coverage and benefits offered to eligible employees as of January 1, 2016. RR Donnelley reserves the right to amend, change, or terminate the Group Benefits Plan or Regional Options Program, in whole or in part, at any time.

This content contains a summary in English of your rights and benefits under the Regional Options Program. 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 between the hours of 8 a.m. and 5 p.m. CT, Monday through Friday, except holidays.

Who Is Eligible

Glossary of Key Terms – Eligibility

Certain terms have special meaning as they pertain to eligibility. The definitions provided in this section apply to eligibility rules that apply under the Regional Options Program.

Child(ren) (or individually, a “child”) – means your “children” under age 26 who are:

- Natural children of you or your spouse/domestic partner (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/domestic partner and for whom you or your spouse/domestic partner are the “sole legal guardian” (as defined in this “Glossary of Key Terms – Eligibility” section).

Child (QMCSO) – please note that if you are subject to a “Qualified Medical Child Support Order,” or “QMCSO,” your “children” are defined as:

- Your natural children;
- Your legally adopted children; or
- Children placed with you for adoption.

Under a QMCSO, your child may be covered even if he or she:

- Was born out of wedlock;
- Is not claimed as a dependent on your federal income tax return;
- Does not reside with you or in the Regional Options Program’s service area; or
- Is receiving benefits or is eligible to receive benefits under a state Medicaid plan.

Domestic Partner – means 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 Regional Options Program.

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 and 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 Internal Revenue Code of 1986, as amended (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 Regional Options Program as an eligible dependent during such assignment. In addition, your eligible dependent who is also covered under the Regional Options Program as an employee may not simultaneously be enrolled and covered under the Regional Options 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.

Premiums (or Contributions) – means the amount you pay for coverage in which you have enrolled under the Regional Options Program. Sometimes the term “contribution” is used, but it has the same meaning as “premium.”

Sole Legal Guardian – as used with respect to an individual, means that such individual has been appointed by a court as “sole legal guardian” or equivalent designation, and that parental rights have been severed or have been terminated due to death.

Spouse – means the individual to whom you are currently legally married. The Regional Options Program also considers common-law spouses in states that recognize common-law marriages.

Dependent Audit

RR Donnelley and the Group Benefits Plan conduct a semi-annual audit of certain covered dependents. Dependents that have been newly added to the Group Benefits Plan since the last audit period need to be verified. A Dependent Audit Notice is mailed

to each Participant who must verify a covered dependent(s) and informs them that they must send documentation to verify the eligibility of their covered dependent(s) as indicated in the notice.

You must submit the required documentation for each of your covered dependents by the date specified in the Dependent Audit Notice, or coverage for your dependent(s) will end on the date specified in the Dependent Audit Notice (unless the Group Benefits Plan takes action to terminate coverage at an earlier date and reports imputed taxable income to the Participant). A Results Notice will be mailed out prior to any coverage termination date to advise you of the outcome of the review of the documentation provided.

If you fail to provide the required documentation by the deadline and coverage terminates for your dependent, but, prior to the next audit, you submit the required documentation and confirm your dependent's eligibility, your dependent may be allowed to be re-enrolled as follows:

- If there is no change in your coverage tier as a result of covering your dependent (i.e., you have family coverage and as a result of this dependent being added back to your coverage, you will continue to have family coverage), there will be no change in your premium amount and your dependent will be re-enrolled in coverage effective as of the 1st of the following month.
- If there is a change to coverage tier (i.e., you have single coverage and as a result of this dependent being added back to your coverage, you will now have You + Spouse (or other) coverage), your dependent will be re-enrolled in coverage on an after-tax basis for the remainder of the calendar year. Please note, however, if later in the year you experience a subsequent qualifying event which may allow for a change in elections, your premium may again be payable on a pre-tax basis. Please see section entitled "Your Premiums" for a discussion on after-tax premiums.

If a second audit commences before you take any action to certify your dependent's eligibility, you are still required to submit the required documentation. Your dependent's eligibility will be confirmed with appropriate documentation, however, you will only be allowed to re-enroll your dependent during the next Annual Enrollment period (or if you experience a qualifying event which may allow for an election change, at such time the election change is permitted). In all cases, you must provide the required documentation before your dependent(s) will be confirmed as eligible for coverage, even for a future annual enrollment.

Ineligible dependents or dependents for whom you either: (i) were unable to provide required documentation for or (ii) did not take any action for, are no longer eligible for coverage and their current coverage has been terminated. Nevertheless, such dependents may be able to continue their coverage through the Consolidated Omnibus Budget Reconciliation Act ("COBRA"). COBRA is a federal law that requires employers to offer plan participants the opportunity to continue their health care coverage in a number of situations that would otherwise ordinarily end their coverage. Any of your

dependents that were not certified during the semi-annual audit will automatically receive COBRA enrollment information. This information describes available coverage options and the cost of such options.

Required Documentation for Dependent

The documentation is needed to verify:

- Relationship of the dependent to the employee; and
- Age of the dependent.

Before submitting information, cross out the following if they appear on your documentation:

- Social Security numbers;
- Account numbers; and
- Financial information

Dependent	Documentation
Spouse	<ul style="list-style-type: none"> • Joint federal tax return from current or prior year if filing jointly (first page only), or • Both spouses' federal tax returns from current or prior year if filing separately (first page only), or • Copy of tax confirmation notice(s) from current or prior year if filed online. • Marriage certificate/license (ONLY if married within last 12 months).
Common-law spouse	<ul style="list-style-type: none"> • Joint federal tax return from current or prior year if filing jointly (first page only), or • Both spouses' federal tax returns from current or prior year if filing separately (first page only), or • Copy of tax confirmation notice(s) from current or prior year if filed online.
Domestic partner	<p>Submit 2:</p> <ul style="list-style-type: none"> • Joint federal tax return from current or prior year if filing jointly (first page only) or • Both partners' federal tax returns from current or prior year if filing separately (first page only) or • Documentation of joint ownership of residence, or • Documentation of joint tenants on lease of residence, or • Copy of both Driver's licenses or other government records reflecting the same address, or • Current bank/credit card statement (within the past 12 months) with both names, or • Current utility bill (within last 12 months) with both names.

Dependent	Documentation
Child under age 26	<ul style="list-style-type: none"> • Birth certificate for biological children showing you as parent, or • Court papers for adopted children or children placed for adoption, or • Court papers demonstrating legal guardianship or custodianship for court appointed children, or • Documentation on hospital letterhead indicating birth date of child, showing you as parent (acceptable only for children under 6 months old if documents above aren't available), <p>AND</p> <p>(Only if documents above don't include birth date) Documented proof of age, such as:</p> <ul style="list-style-type: none"> • Child's driver's license or other government records, or • Child's Visa/Passport.
Stepchild under age 26	<ul style="list-style-type: none"> • Birth certificate showing the child's parent to be your spouse, or • Documentation on hospital letterhead indicating birth date of child, listing your spouse as parent (acceptable only for children under 6 months old if birth certificate isn't available), <p>AND</p> <p>(Only if documents above don't include birth date) Documented proof of age, such as:</p> <ul style="list-style-type: none"> • Child's driver's license or other government records, or • Child's Visa/Passport, <p>AND</p> <p>Documentation showing your relationship to the stepchild's parent, such as:</p> <ul style="list-style-type: none"> • Marriage license, or • Church/justice of the peace marriage certificate, or • Documentation of joint ownership of residence (acceptable only if documents above aren't available), or • Joint tenants on lease of residence (acceptable only if documents above aren't available).
Child of domestic partner under age 26	<ul style="list-style-type: none"> • Birth certificate showing the child's parent to be your domestic partner, or • Documentation on hospital letterhead indicating the birth date of the child, listing your domestic partner as parent (acceptable only for children under 6 months old if birth certificate isn't available), <p>AND</p> <p>(Only if documents above don't include birth date) Documented proof of age, such as:</p> <ul style="list-style-type: none"> • Child's driver's license or other government records, or • Child's Visa/Passport, <p>AND</p> <ul style="list-style-type: none"> • Documentation of joint ownership of residence, or • Documentation of joint tenants on lease of residence, or • Copy of both Driver's licenses or other government records reflecting the same address, or • Current bank/credit card statement (within the past 12 months) with both names, or • Current utility bill (within last 12 months) with both names.

General Information

You are eligible for coverage under the Regional Options Program if you are classified as a:

- Full-time benefits-eligible employee of a Participating Employer;
- Part-time “A” employee of a Participating Employer;
- Part-time “B” or Contingent employee of a Participating Employer who has met the requirements with regard to full-time employment status as determined by the Patient Protection and Affordable Care Act and as a result changed to class “Z” for duration of such stability period; or
- Union employee of a Participating Employer who is covered by a collective bargaining agreement and such agreement provides for your Regional Options Program participation.

You are not eligible for coverage under the Regional Options Program if you are:

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

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

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

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 after age 26. To be eligible for continued coverage, your child must be enrolled under the Regional Options Program immediately before the coverage would otherwise end, and the disability must begin while your enrolled eligible child’s coverage under the Regional Options 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 doctor’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 Benefits Program, you must enroll him/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 doctor'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 Regional Options 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 doctor'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 and/or you do not complete and return the proof of disability to the claims administrator at the address and by the deadline indicated, your child will cease to be an eligible child and will lose extended coverage.

Extended Coverage for Certain Dependents

Except for when coverage may be continued for certain dependents under the Certificate of Coverage (as discussed in the next section "Continued Coverage for Your Eligible Dependents Under the Certificate of Coverage"), you are responsible for notifying the eligibility administrator within 30 days of when your covered dependent no longer meets the eligibility requirements for an eligible dependent as outlined above (for example, he or she is no longer your spouse). If you provide such notice within 60 days, your dependent's coverage will terminate as of the end of the month in which the qualifying event occurred unless coverage may be continued under the Certificate of Coverage. If you fail to provide such notice within 60 days, the following significant consequences may occur:

- Your dependent's coverage will terminate the date the eligibility administrator is notified.
- In addition to the before-tax premium you have paid, you will have the value of the after-tax premium for continuation coverage for this individual imputed for the period commencing with the date of the change of coverage, or if later, the January 1 immediately preceding the date you notify the eligibility administrator.
- This imputed income will be in one lump sum on your next available paycheck, unless there are not sufficient funds to cover the lump sum amount in one payment, then the imputed income amount may be taken on multiple checks.
- Your dependent will lose his or her rights to continued coverage through COBRA.

Contact the eligibility administrator or your claims administrator for questions regarding eligibility of your dependents.

Qualified Medical Child Support Order (QMCSO)

The Group Benefits Plan also makes coverage available under the Regional Options Program for your child pursuant to the terms of a Qualified Medical Child Support Order (“QMCSO”). This coverage may apply even if you do not have legal custody of the child, the child is not dependent upon you for support, and regardless of any enrollment period restrictions that might otherwise exist for dependent coverage. Your Participating Employer may withhold from your wages any contributions required for such coverage.

A QMCSO may be either a National Medical Child Support Notice that is issued by a state child support agency, or an order or a judgment from a state court or administrative body directing your Participating Employer to cover a child under the Plan. Federal law provides that a medical child support order must meet certain form and content requirements to be valid. The Regional Options Program follows certain procedures to determine if a child support notice is “qualified.” If you have any questions or would like a copy at no charge of the written procedures used to determine whether a medical child support order is valid, please contact the RR Donnelley Benefits Center.

If you are enrolled, you may enroll a child in the Regional Options Program pursuant to the terms of a valid QMCSO. If you do not elect an option, the Plan will comply with the QMCSO’s terms by providing the default coverage option for the child unless the terms of the QMCSO specify a different option.

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 elections will automatically be reinstated. If you were previously covered under the Regional Options Program, coverage will continue effective immediately, retroactive to the date of termination and 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 Regional Options Program’s eligibility requirements.

Enrolling for Coverage

General Information

If you meet the eligibility requirements, you can enroll yourself and your eligible dependents for coverage under the Regional Options Program and, at the same time, the Participant Premium Program of the RR Donnelley Flexible Benefits Plan (“Participant Premium Program”). If you elect an option under the Regional Options Program, you and your enrolled eligible dependents are automatically enrolled in the:

- Medical Program administered by the Regional Option selected (see the applicable Certificate of Coverage for the Fully-Insured Regional Option selected for details if applicable);
- Prescription Drug Program administered by the Regional Option selected); and
- Participant Premium Program.

The following coverage categories generally apply:

- No Coverage
- You Only
- You + Spouse
- You + Child(ren)
- You + Family

If you elect “No Coverage,” you are bound by that election for the remainder of the calendar year for which you elect “No Coverage,” unless you report a Qualified Status Change during the calendar year or a special enrollment opportunity occurs during the calendar year.

If you and any one of your eligible dependents are both employees eligible to enroll, each of you may enroll for “You Only” coverage, or one of you may enroll and cover the other as an eligible dependent. Neither of you can cover the other as an eligible dependent, nor double cover each other or your children as eligible dependents.

An enrolled eligible dependent who subsequently becomes an employee of a Participating Employer cannot be simultaneously covered as an employee and as an eligible dependent.

When you enroll in the Regional Options Program, you are automatically enrolling in the Participant Premium Program in order to make your premiums before tax, if available, under the IRS rules.

Your Premiums

To participate, you must pay the premiums under the Regional Options Program for you and your enrolled eligible dependents. The premium you pay is based on:

- Your base pay* as of the September 1 prior to the plan year (or your base pay when you are first hired until the next September 1). If you have a reduction in your base pay between September 1 and December 31 prior to the plan year as a result of reduced hours, relocation, or a position change resulting from current position eliminations, then your base pay as of December 31 prior to the plan year;
- Which of the Participating Employers you work for;
- Whether you are a full-time or part-time employee;
- The option you elect;
- The coverage category you choose;
- Provisions applicable to you under an applicable collective bargaining agreement;
- Whether or not you or any of your enrolled eligible dependents use tobacco products or agree to participate in a tobacco cessation program; and
- Your completion of certain health and wellness initiatives during Annual Enrollment and throughout the plan year.

***Important Note for Commissioned Sales Employees:** Your last three full calendar years of base pay and commissions will be used to calculate your base pay amount. This calculated average amount will be frozen each September 1 prior to the plan year. If you have been employed less than three calendar years, each full calendar year of employment will be used and averaged for this calculation.

If your pay changes during the calendar year, your premium payment remains the same until the next Annual enrollment period.

When you enroll in the Regional Options Program, you authorize the deduction of your required premium payments from your paycheck. For you and your covered dependents, you generally pay for coverage under the Regional Options Program each pay period with before-tax dollars deducted from your pay under the terms of the Participant Premium Program. However, for domestic partner coverage, coverage for your domestic partner's children, and for coverage for individuals who have ceased to meet the eligibility requirements for an eligible dependent (as described previously), you pay your premium on an after-tax basis based on your imputed income. The amount of your imputed income is determined:

- If you are covering a domestic partner and/or child of a domestic partner, by subtracting the COBRA premium for You Only coverage from the COBRA premium for the coverage you have in effect for You + Spouse and/or You + Child(ren), as the case may be. The difference is your imputed income.
- If continued coverage is for your former spouse because you have failed to report the change of coverage, by subtracting the COBRA premium for You Only coverage from the COBRA premium for coverage of You + Spouse. The difference is your imputed income.

- If coverage is for a child for whom you have not reported their change in eligibility, by subtracting the COBRA premium for You Only coverage from the COBRA premium for You + Child(ren). The difference is your imputed income.

COBRA coverage for this purpose is 100% of the unsubsidized cost of coverage and not 102%. When you have imputed income, it means that the premium cost of coverage determined above is added to your paycheck as taxable income and results in income tax withholdings. All of this is required to be charged as an after-tax premium because the IRS regulations governing before-tax premiums and non-taxable benefits do not apply for domestic partner coverage, coverage for your domestic partner's children, or for coverage for individuals who have ceased to meet the eligibility requirements for an eligible dependent.

RR Donnelley can create new election rights to add coverage on an after-tax basis in order to address circumstances in which RR Donnelley, in its discretion, determines to allow coverage that cannot be paid with before-tax premiums.

Your elections under the Regional Options Program 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 or a special enrollment opportunity occurs during the calendar year.

“Before-tax” means that your premium payment is taken from your paycheck before federal, Social Security and Medicare (“FICA”) taxes (and, in most cases, state and local taxes) are deducted. This reduces your taxable income (your gross pay minus premium payment), so you pay less in taxes. Because the premium payment for coverage under the Regional Options Program for yourself and your enrolled spouse or your eligible child (but not a domestic partner's child) are before-tax, the IRS limits the instances when the Participant Premium Program will allow you to change your coverage or premiums under the Regional Options Program (and the Participant Premium Program) to those that are considered Qualified Status Changes.

Using before-tax dollars to pay premiums for your coverage may affect any Social Security benefits you may eventually receive. This is because you generally do not pay FICA taxes on before-tax dollars deducted from your gross pay. For most people, the Social Security benefit reduction is only a few dollars a month. In addition, the reduction is typically more than offset by the tax savings you experience over the course of your career. If you have any questions, contact your local Social Security Administration office.

Enrolling Yourself and Your Eligible Dependents

You must enroll in the Regional Options Program to receive coverage for yourself and your eligible dependents.

If you enroll an individual who does not meet the eligibility requirements, the Regional Options Program does not pay benefits for that individual. In addition, any benefits that the Regional Options Program may have paid are subject to recovery by the Group Benefits Plan.

Once you have successfully enrolled yourself and your eligible dependents, references within this SPD will be to you, your enrolled eligible dependents, your enrolled eligible spouse, your enrolled eligible domestic partner, or enrolled eligible child, as appropriate.

When Coverage Begins

As a new benefits-eligible employee, you receive enrollment information that details the coverages for which you are eligible. This information also includes specific instructions on how to enroll. You must enroll yourself and/or your eligible dependents by the enrollment deadline set forth in your enrollment materials. As long as you enroll by the deadline, coverage under the Regional Options Program begins on the first day of the month after you complete one full calendar month of employment. For purposes of determining whether you have satisfied this waiting period, all periods of your employment with a Participating Employer before a period of more than 30 consecutive days during which you are not employed with a Participating Employer are disregarded.

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

If You Start on the 1st of or During the Month Of:	Your Coverage 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 this Regional Options 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 Medical Program, and Prescription Drug 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 Medical and Prescription Drug Programs on the date of the transfer, you will continue to participate (or not participate) in these programs until the end of the calendar year in which you transfer. As a result, your coverage under this Regional Options Program begins on the following January 1.
- If you transfer from a non-U.S. affiliate, your coverage under the Regional Options 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 coverage is scheduled to begin, coverage for you and your eligible dependents still takes effect on that day provided you enrolled by the deadline. You do not need to return to active work for your coverage 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 have coverage under the Regional Options Program. Instead, you will have “You Only” coverage under either the BCBSIL or UHC HSA Value coverage option (with no HSA contributions) under the Medical and Prescription Drug Programs. You will be enrolled with the carrier that is deemed to be the “best in market” in your geographic area. In general, either BCBSIL or UHC will have negotiated the best *overall* discounts for your area, even though individual experiences with providers and services can differ. In addition, you will not be able to enroll your eligible dependents or make changes to your coverage until the following Annual Enrollment period. The only exception is if you report a Qualified Status Change or you meet one of the special enrollment circumstances within the

required time frame. Coverage in the case of a Qualified Status Change or special enrollment circumstance starts on the date of the qualifying event and payroll deductions are taken prospectively.

Special Enrollment Opportunities

If you and/or your eligible dependents had coverage under another group health plan at the point when you elected “No Coverage” for yourself and/or your eligible dependents under the Regional Options Program, then you and/or your eligible dependents may enroll within 30 days of losing such coverage if:

- It is COBRA continuation coverage under another plan that is exhausted; or
- It is not COBRA continuation coverage that is lost, and the loss of coverage is due solely to a loss of eligibility, a termination of contributions, or a loss of coverage by its sponsor.

For special enrollment purposes, loss of eligibility for coverage does not include loss due to a failure to pay premiums or termination of coverage for reason of bad conduct.

In addition, if you later gain a new eligible dependent as a result of marriage, birth, adoption, or placement for adoption, you may enroll yourself and/or your eligible dependent as long as you notify the eligibility administrator within 30 days after the marriage, birth, adoption, or placement for adoption.

To request special enrollment or obtain more information, contact the eligibility administrator.

Your Right and Responsibility to Change Your Coverage

Because of Internal Revenue Service (“IRS”) rules governing before-tax premiums, the coverage you elect, including Default coverage, for so long as you are an employee of all Participating Employers, remains irrevocably in effect until the beginning of the next calendar year. 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 circumstance, 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. These events require that you must make the change within 30 days after the event has occurred. If you do not, the change will not be allowed.

An election change due to a Qualified Status Change is effective on the day of the qualifying event, provided you report the Qualified Status Change to the eligibility administrator within 30 days after the date of the event. After you complete the enrollment process, even though coverage takes effect on the date of the event, payroll deductions are only taken prospectively.

A list of Qualified Status Changes and allowed changes to your and/or your eligible dependents' coverage 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 the Regional Options Program, its provisions have been made a part of "Enrolling for Coverage" in this SPD and the "Qualified Status Changes" SPD.

Also, the Benefits Committee has the discretionary authority to allow for election changes as a result of certain significant changes in the cost of, or coverage under, the Regional Options Program. You will be notified if you are eligible to make this election, and election changes will be limited to those allowed by the IRS for before-tax premiums. If an election change is available, your election change will be effective on the date you give notice of the change to the eligibility administrator.

If you have individuals who are covered dependents who cease to meet the eligibility requirements of an eligible dependent (as described above), you must notify the Benefits Center of the change of coverage within 30 days of the status change. Your failure to drop coverage of an individual who is no longer an eligible dependent will result in your paying the after-tax premium for continuation coverage for this individual. The premium will be imputed taxable income to you in one lump sum on your next available paycheck. If you fail to notify the Benefits Center within 60 days of the status change, the individual also will lose his or her right to elect COBRA coverage.

Annual Enrollment

Every fall during the Annual Enrollment period, you receive information about the Options for which you are eligible. You then have the opportunity to enroll yourself and your eligible dependents in any of the options available to you, switch to a different option (if available in your area), or elect "No Coverage." If you do not enroll by the deadline set forth in your enrollment materials, you will default to coverage as outlined in the Annual Enrollment materials.

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 experience and report a Qualified Status Change or a special enrollment opportunity.

A Special Note about Regional Options Coverage

The Fully-Insured Options of the Regional Options Program may require you to provide additional or different proof of a child's continuing disability in order to maintain coverage for such child after age 26. Failure to comply with the Fully-Insured Option's request will result in permanent loss of eligibility for such extended coverage. If the Fully-Insured Regional Option terminates coverage for you, your spouse, or your eligible dependent before coverage would otherwise end, coverage will end under the Regional Options Program. In such case, you may be able to change your coverage options under the Group Benefits Plan, or have a COBRA election with the Regional Option or Group Benefits Plan for continuation of coverage. If you have any questions, please contact the eligibility administrator.

Your Rights and Responsibilities

General Information

If you are enrolled in the Regional Options Program, you assume certain rights and responsibilities. It is important that you fully understand both.

Your Rights

You have the right:

- To be treated in a manner that respects your privacy and dignity as a person.
- To receive assistance in a prompt, courteous, and responsive manner.
- To be provided with information about your benefits, any exclusions and limitations associated with the Regional Options Program, and any expenses for which you will be responsible.
- To be provided with guidance and recommendations for continuation of coverage.
- To the confidential handling of all communications and medical information maintained by the claims administrator, as provided by law and professional ethics.
- To be informed by your treating provider of your diagnosis, prognosis, and plan of treatment in terms you understand. You are encouraged to ask questions of your provider until you fully understand the care you are receiving.
- To receive prompt, courteous, and appropriate treatment.
- To be informed by your treating provider about any treatment you may receive. Your provider will request your consent for all treatment, unless there is an emergency and your life and health are in serious danger. If written consent is required for special procedures, such as surgery, be sure you understand the procedure and why it is advised.
- To refuse treatment and be advised of the probable consequences of your decision by your treating provider. You are encouraged to discuss your objections with your provider. He or she will advise you and discuss alternative treatment plans with you, but the final decision as to how to proceed is yours.
- To be provided automatically, without charge, a list of Participating Providers and participating pharmacies in your area.
- To change your provider or primary care physician (if applicable) through your option under the Regional Options Program as applicable.
- To express a complaint to the claims administrator about the care you have received or will not receive, and to receive a response in a timely manner.
- To initiate the grievance procedure if you are not satisfied with the decision regarding your complaint about care.
- To file a claim (pre-service or post-service) for a benefit with the claims administrator and to have any denial of a claim for benefits reviewed by the claims administrator under ERISA's claim procedure rules. See the "Claims and Appeals Procedures" section for details.

Statement of Rights under the Newborns' and Mothers' Health Protection Act

Under federal law, the Regional Options Program generally may not restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a delivery by cesarean section. However, federal law generally does not prohibit the mothers' or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable).

In any case, the Regional Options Program may not, under federal law, require that a provider obtain authorization from the Regional Options Program for prescribing a length of stay not in excess of 48 hours (or 96 hours). However, to use certain providers or facilities, or to reduce your out-of-pocket costs, you may be required to obtain certification. For information on certification, contact the claims administrator.

Your Responsibilities

All covered individuals are responsible for learning how the Regional Options Program works by carefully studying and referring to the SPD. You have a responsibility:

- To fully understand the benefit communication materials you receive.
- To present your ID card before receiving services.
- To know how to properly use the Regional Options Program and its benefits.
- To select a provider or primary care physician (if applicable).
- To keep scheduled appointments and notify the provider's office promptly if you will be delayed or unable to keep the appointment.
- To follow the advice of your provider or primary care physician (if applicable) and consider the likely consequences when you refuse to comply with his or her advice.
- To make the lifestyle changes recommended by your physician (if applicable).
- To provide honest and complete information to your provider or primary care physician.
- To know what medications you and your enrolled eligible dependents take, why you are taking them, and the proper way to take them.
- To express your opinions, concerns, or complaints in a constructive manner to the appropriate people.
- To pay all applicable fees at the time service is rendered (if applicable), plus any additional payments due, in a timely manner.
- To remove individuals from coverage within 30 days of when they cease to be an eligible dependent.
- To initiate the certification of a disabled dependent with your claims administrator within 30 days and each year thereafter when requested.
- To comply with any documentation requests made by the eligibility administrator or claims administrator to substantiate your claim for coverage or benefits.
- To comply with any documentation requests made by the dependent audit to substantiate your dependents under the program.

How the Fully Insured Regional Options Program Works

General Information

Depending on your home ZIP code, you may be able to participate in the Fully-Insured Regional Options Program. Information regarding the Regional Options Program is made available to you when you are first hired and during each Annual Enrollment period thereafter.

You are offered a Fully-Insured Regional Option only if a Fully-Insured Regional Option is available in your home ZIP code area. Benefits, coverages, and rules vary depending on the specific Fully-Insured Regional Option offered in your area. In addition, because each state licenses and regulates the Fully-Insured Regional Option that operates in its jurisdiction, covered services may vary among states. That is why it is important to read your Fully-Insured Regional Option provided Certificate of Coverage and other materials carefully.

This material highlights your eligibility for the Regional Options Program and key Regional Options Program features. This material, together with the Fully-Insured HMO provided Certificate of Coverage (click on the links below) constitutes your SPD for any Regional Options Fully-Insured HMO Program:

- Dean Health HMO
 - [Dean Health Plan Schedule of Benefits](#)
 - [Dean Health Plan— Prevea360 Schedule of Benefits](#)
- Kaiser California HMO
 - [Kaiser Permanente Traditional Plan for Northern California Region — Evidence of Coverage](#)
 - [Kaiser Permanente Deductible HMO Plan for Southern California Region — Evidence of Coverage](#)
- [BlueCrossBlueShield of IL HMO Certificate of Coverage](#)

Each Certificate of Coverage details your specific Regional Options' Fully-Insured HMO Program's rules and procedures, your rights and responsibilities, and the services your Fully-Insured HMO does and does not cover. You can also contact the Fully-Insured HMO directly for a summary of covered services.

If your home ZIP code is outside the Fully-Insured HMO's' network area, you may still be able to elect coverage under the Regional Options Program.

Key Features

A Fully-Insured Regional Option HMO is a structured group of local providers, hospitals, health care professionals, and administrators organized to deliver comprehensive health care to the HMO's members at pre-negotiated fees. The claims administrator and network manager vary by HMO.

Receiving Care

When you join an HMO, you generally select a primary care physician (PCP) for yourself and each of your covered dependents. Your PCP then coordinates all of your care. (In some HMOs, you select a group or site through which you receive medical care.) When you need care, you simply call or visit your PCP first. If necessary, your PCP then refers you to a specialist.

In most cases, to be eligible for benefits under the HMO's Certificate of Coverage, you must use providers and hospitals that participate in the HMO network. If you go to a provider or hospital outside the HMO for care – without prior approval from the HMO, the HMO does not pay benefits. The HMO may make an exception for a true emergency situation (regardless of whether you are in your area or traveling at the time of the emergency situation). In addition, rules and guidelines that apply for your Fully-Insured HMO under the Regional Options Program may be different from the Regional Options Program's rules and guidelines.

Pre-Existing Conditions

Pre-existing conditions may or may not apply to specific HMOs. Check with your HMO and read the Certificate of Coverage to see how this term is defined and if any pre-existing rules apply.

Your Share of Costs

You generally have to meet a copayment requirement (a flat-dollar amount) each time you visit a provider's office or an emergency room before the HMO pays the full cost of the covered expense. For most other covered expenses, the HMO generally pays 100% and you pay nothing (unless otherwise indicated in the HMO's Certificate of Coverage and/or participant materials).

Filing Claims

In most cases, you do not have to file a claim form. In addition, usual and customary limits rarely apply.

Mental Health and Substance Abuse

Each HMO offers its own mental health and substance abuse benefits. If you participate in an HMO, you receive mental health and substance abuse coverage through your HMO.

Prescription Drug Coverage

If you enroll in an HMO, your HMO provides prescription drug coverage. Therefore, you receive prescription drug coverage through the Regional Options Program.

How the Self-Insured Group Health Program Works – General

General Information

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

- Garner Option
- McKay Option
- EGT Option

Your employer legacy indicator and local bargaining agreement affiliation determines which options are available to you. You receive information regarding the options available to you when you are first hired and during each Annual Enrollment period thereafter.

The Group Health Program provides coverage through the following programs:

- Medical Program; and
- Prescription Drug Program

When you or your covered dependents incur an expense, the Group Health Program will pay that portion of the expense that you are not responsible to pay, but only if it is a covered expense (as defined below).

You (or your covered dependent who incurred the expense) are responsible for paying the following amounts of an expense:

- Any amount which is not considered part of the covered expense (for example, expenses that are not covered by the Group Health Program);
- Your Deductible (as defined below) for the calendar year;
- Any amount over what is the “Maximum Reimbursable Expense” for an out-of-network service;
- Your Coinsurance (as defined below), up to your annual Out-of-Pocket Limit (as defined below).
- Your Copay (as defined below), up to your annual Out-of Pocket Limit (as defined below).

Glossary of Key Terms – General

Certain terms have special meaning under the Group Health Program options. The definitions provided in this section apply to services you receive while covered under one of these self-insured options. The claims administrator may have additional definitions that may apply to the services you receive, and will always have the discretionary authority to interpret the meaning of these terms and the benefits payable under each option.

Coinsurance – coinsurance is the percentage of covered expenses you are responsible for paying. Percentages apply after any applicable deductible requirement has been met. The percentage you pay (for example, 10%, 20%, 30%, 40%, or 100%) depends on the option you elect, the type of service you receive, and whether you receive in- or out-of-network care. You pay coinsurance amounts until you reach the annual Out-of-Pocket Limit. Once you reach the Out-of-Pocket Limit, the Group Health Program starts to pay benefits for covered expenses at 100%.

Contract Amount – the predetermined amount to be covered or allowed for a service or procedure as outlined in the provider contract.

Copayments “copay” – a flat dollar amount that you are responsible for paying for certain covered healthcare services. Your “copays” do not apply to your deductible but do apply to your annual Out-of-Pocket Limit.

Covered Expense – the expenses that the Group Health Program covers. To be considered covered, an expense must qualify in three ways:

- The claims administrator must determine that the expense meets the definition of a medically necessary service or supply for the specific illness or injury. Generally, this means that the expense must be for treatment that follows acceptable protocols, is required to treat an illness or injury, is prescribed by a qualified professional, and is recognized as appropriate by the claims administrator in the diagnosis and/or treatment of the specific illness or injury.
- The expense cannot exceed the Maximum Reimbursable Expense for the service or supply as determined by the claims administrator.
- The expense is not included in the list of excluded expenses.

Custodial Services – any service that is not intended primarily to treat a specific injury or sickness (including mental illness, alcohol abuse, or drug abuse). Custodial services include (but are not limited to):

- Watching or protecting a person;
- Performing or assisting a person in performing any activities of daily living, such as walking, grooming, bathing, dressing, getting in or out of bed, toileting, eating, preparing foods, or taking medications that can be self-administered; and
- Services not required to be performed by trained or skilled medical or paramedical personnel.

Custodial Services do not include home health care to perform routine deep suctioning of the respiratory system when such routine care is the recommended care and treatment for an ongoing medical condition.

Deductible – the deductible amount depends on which option you choose and the coverage category you select under the Group Health Program (You Only, You + Spouse, You + Child (ren), or You + Family). The deductible is the fixed-dollar amount that you pay out of your pocket each calendar year before the Group Health Program

begins to pay benefits. You can only apply the amounts you incur for covered expenses toward your annual deductible, and any amount that you pay toward your deductible also is counted toward your annual Out-of-Pocket Limit (except for the excluded charges listed under the *Out-of-Pocket Limits* definition under this subsection).

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

Durable Medical Equipment – equipment that can withstand repeated use, is primarily and customarily used to serve a medical purpose, is not implantable within the body, is generally not useful for a person in the absence of a sickness or injury, and is appropriate for use in the home.

Emergency – medical, psychiatric, surgical, hospital, and related services and testing (including ambulance services) that a prudent layperson (with average knowledge of medical science) believes is needed to treat a sudden or unexpected onset of a bodily injury, a serious medical complication, possible loss of life, or permanent impairment to a bodily function. This is a condition that – if not treated immediately – might cause the loss of a limb or lead to a severe, permanent disability.

Examples of emergencies include:

- Seizure or loss of consciousness;
- Loss of breathing;
- Suspected overdose of medication or poisoning;
- Broken bones;
- Chest pain or a squeezing sensation in the chest;
- Severe bleeding;
- Burns or cuts;
- Shortness of breath;
- Sudden paralysis;
- Slurred speech; or
- Severe pain.

Emergency Care –in a medical emergency:

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

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

Expense – the lesser of:

- The actual billed charges; or
- When the provider contracts directly or indirectly for a different amount, the contract amount.

Experimental or Investigational Services – medical, surgical, diagnostic, psychiatric, substance abuse, or other health care services, technologies, supplies, treatments, procedures, drug therapies, medications, or devices that, at the time a determination is made regarding coverage in a particular case, are determined by the claims administrator to be any of the following:

- Not approved by the U.S. Food and Drug Administration (“FDA”) to be lawfully marketed for the proposed use and not identified in AHFS Drug Information or United States Pharmacopeia Dispensing Information as appropriate for the proposed use;
- Subject to review and approval by an institutional review board for the proposed use (devices that are FDA approved under the Humanitarian Use Device exemption are not considered to be experimental or investigational); or
- The subject of an ongoing clinical trial that meets the definition of a Phase 1, 2, or 3 Clinical Trial set forth in the FDA regulations, regardless of whether the trial is actually subject to FDA oversight.

If you have a life-threatening sickness or condition (one that is likely to cause death within one year of the request for treatment), the claims administrator, in its discretion, may consider an otherwise experimental or investigational health service to be a covered expense for that sickness or condition. Prior to such consideration, the claims administrator must determine that the procedure or treatment is:

- Provided to be safe and promising;
- Provided in a clinically controlled research setting; and
- Using a specific research protocol that meets standards equivalent to those defined by the National Institutes of Health.

Home Health Aide – a person who provides care of a medical or therapeutic nature. He or she reports to and is under the direct supervision of a home health care agency.

Home Health Care – short-term health care that is ordered by a physician and provided in the patient’s home by a licensed home health care agency. This type of care must be approved by the claims administrator.

Home Health Care Agency – a hospital, or a nonprofit or public home health care agency that:

- Primarily provides therapeutic services under the supervision of a physician or a registered graduate nurse;
- Is run according to rules established by a group of professional persons;
- Maintains clinical records on all patients; and
- Does not primarily provide custodial care, or care and treatment of the mentally ill.

A home health care agency must be licensed and run according to the laws that pertain to agencies in jurisdictions where required.

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.

Hospital – an institution that:

- Is licensed as a hospital and maintains on its premises all facilities that are necessary for acute medical and surgical treatment;
- Provides such treatment on an inpatient basis, for compensation, under the supervision of physicians; and
- Provides 24-hour service by registered graduate nurses.

A hospital may be accredited by the Joint Commission on Accreditation of Healthcare Organizations. A hospital can specialize in the treatment of mental illness, alcohol abuse, drug abuse, or other related illnesses. It can provide residential treatment programs, and it is licensed in accordance with the laws of the appropriate legally authorized authority. An institution that is primarily a place for rest, a place for the aged, or a nursing or convalescent home is not a hospital.

Hospital Confinement or Confined in a Hospital – a period of time during which a person is a registered bed patient in a hospital and is being treated upon the recommendation of a physician. In addition, a person is considered confined in a hospital if he or she is partially confined for the treatment of mental illness, alcohol abuse, drug abuse, or other related illness. “Partially confined” means that a person is continually treated for at least three hours (but not more than 12 hours in any 24-hour period).

In-Network Benefit Level – the benefit level payable when services are provided by Participating Providers and authorized by the claims administrator.

Inpatient – you are considered an inpatient if you are in an uninterrupted confinement following a formal hospital, skilled nursing facility, or inpatient rehabilitation facility admission. You must be a registered bed patient and treated as such by the facility.

Maximum Reimbursable Expense – the maximum amount that is recognized for a Covered Expense, as determined by the claims administrator. This maximum is based on (a) the amount which Participating Providers have agreed to accept as payment in full for a particular Covered Expense, (b) for Non-Participating Providers, the Maximum Reimbursable Expense will be the lesser of: (i) the Provider’s billed charges, or (ii) The Medicare reimbursement rate as determined by the Center for Medicare & Medicaid Services (“CMS”).

Note: the non-contracting Maximum Reimbursable Expense for Coordinated Home Care will be 50% of the Non-Participating Provider’s standard billed charge for such Covered Expenses.

Any change to the Medicare reimbursement amount will be implemented by the claims administrator within 145 days after the effective date that such change is implemented by CMS.

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 BCBSIL 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).”

Medically Necessary Services and Supplies – the determination made by the claims administrator of whether a particular expense will qualify as a covered expense. The determination is based on whether the:

- Service is for the treatment, diagnosis, or symptoms of an injury, disease, or condition (including pregnancy);
- Service is consistent with the diagnosis and is appropriate given the symptoms;
- Type, level, and length of care; the treatment or medical supply; and the setting are needed to provide safe and adequate care; and
- Care is not generally regarded as experimental, investigational, or research in nature.

Note: Certain determinations of “Medically Necessary Services and Supplies” may differ by coverage option. You may review the medical policies of BCBSIL by logging in to your claims administrator’s website. The addresses for these websites are listed in the “Administrative and Contact Information” section of this SPD.

Mental Illness – any disorder, other than a disorder induced by alcohol or drug abuse, that impairs an individual’s behavior, emotional reaction, or thought process, regardless of medical origin. In determining benefits, charges made for the treatment of any physiological symptoms related to a mental illness are not considered as charges made for the treatment of a mental illness.

Necessary Services and Supplies – any charges, except for room and board, made by a hospital for medical services and supplies actually used while an individual is confined in a hospital. Necessary services and supplies do not include any charges for special nursing fees, dental fees, or medical fees.

Non-Participating Provider – a provider who does not have a contractual relationship with the claims administrator for the option in which you are enrolled.

Nurse – a registered graduate nurse (R.N.), a licensed practical nurse (L.P.N.), or a licensed vocational nurse (L.V.N.).

Nurse Practitioner – a licensed medical practitioner operating within the scope of his or her license in the state in which he or she is practicing medicine and performing a service for which benefits are provided under the Group Health Program.

Out-of-Network Benefit Level – the benefit level that is payable when services or supplies are provided by Non-Participating Providers or when unauthorized by the claims administrator.

Out-of-Pocket Limit – the annual Out-of-Pocket Limit is the most you have to pay in coinsurance (including copayments) 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.

If you enroll 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 coverage category, the total coverage category 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 coverage category out-of-pocket maximum has been met.

Certain expenses, however, do not apply toward the Out-of-Pocket Limit. These include:

- 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.

Outpatient Surgical Facility – an institution that has a staff of physicians, nurses, and licensed anesthesiologists that maintains at least two operating rooms and one recovery room, a diagnostic laboratory, and X-ray facilities. It must have equipment for emergency care, it must maintain a blood supply, and it also must maintain medical records. The facility must have an agreement with hospitals for immediate acceptance of patients who need hospital confinement on an inpatient basis. It also must be licensed in accordance with the laws of the appropriate legally mandated agency.

Participating Provider – a provider that has a contractual relationship with the claims administrator for the option in which you are enrolled.

A complete list of Participating Providers can be provided to you as a separate document upon request and is free of charge. The claims administrator's website also contains the most current listing of Participating Providers in your area, or you can call the claims administrator and a member services representative can assist you. You also can confirm with your provider directly as to whether he or she is a Participating Provider.

Physician (or Provider) – a medical practitioner who practices within the scope of his or her license and who is licensed to prescribe and administer drugs or to perform surgery. A provider is any other licensed medical practitioner whose services or supplies are required to be covered by law in a certain area if he or she is operating within the scope of his or her license and is performing a service or supply for which benefits are provided under the Group Health Program.

Pre-Existing Condition – a condition for which an individual receives medical care, treatment, advice, or medication prior to the coverage effective date. Pre-existing condition limitations do not apply under the Group Health Program.

Primary Care Physicians (“PCPs”) – use of a PCP is not required to be eligible for benefits under the Group Health Program. However, this provider is still a good resource for your general health and for recommending specialists if you need them. PCPs may be general or family practitioners, OB/GYNs, internists, or pediatricians.

Private-Duty Nursing – skilled nursing services that are rendered by a registered graduate nurse, a licensed practical nurse, or a licensed vocational nurse on a per-shift, part-time, or intermittent basis. Such services or supplies are part of a treatment plan that is supervised by a licensed physician. Private-duty nursing services or supplies may be provided as part of a confinement or as part of a home health plan. If BCBSIL is the claims administrator for your option and you receive private-duty nursing services while confined, such services or supplies are considered skilled nursing services and the applicable skilled nursing services maximums would apply.

Psychologist – a person who is licensed or certified as a clinical psychologist. Where no license or certification exists, this term means a person who is considered qualified as a clinical psychologist by a recognized psychological association. The term also can include any other licensed counseling practitioner whose services are required to be

covered by law in a certain area if he or she is operating within the scope of his or her license and is performing a service for which benefits are provided under this Group Health Program when provided by a psychologist. The term also can include any psychotherapist while he or she is providing care authorized by the claims administrator if he or she is state-licensed or nationally certified by his or her professional discipline, and is performing a service or providing a supply for which benefits are paid under this Group Health Program when provided by a psychologist.

Room and Board – all expenses made by a hospital on its own behalf for room and meals, and for all general services or supplies and activities that are needed for the care of a registered bed patient.

Skilled Nursing and Rehabilitation Facility – an approved facility where an individual recovers from an illness or injury. The individual must be under the continuous care of a physician during the skilled nursing or rehabilitation facility confinement, and the physician must certify that 24-hour-a-day nursing care is essential.

Specialty Care – you do not have to get a referral from a PCP if you need to see a specialist. If you visit a specialist without a PCP referral, the Group Health Program still pays benefits at the in-network level (provided an in-network specialist provides the care).

Urgent Care – if urgent care symptoms are present, you should contact your carrier to locate your closest urgent care facility.

Urgent care symptoms can include severe sore throat, sprains and strains, ear or eye infections, or fever. A prudent layperson, with average knowledge of medical science, can determine that urgent care is necessary to treat such a symptom that requires prompt medical attention. This does not include care that could have been foreseen before leaving the immediate area where the patient would ordinarily receive and/or was scheduled to receive services. If you have questions about urgent care coverage, call the claims administrator at the phone number listed on your ID card.

Medical, surgical, hospital, and related health care services and testing that are not usually considered emergencies or that would not typically require urgent care should be handled through a scheduled office visit with your doctor. These situations include:

- Routine physicals;
- Immunizations;
- Colds or flu;
- Follow-up checks on injuries or broken bones; and
- Prescription drug needs.

Key Features

Below are some highlights of the key features of the Group Health Program. Under the medical program option, you have the flexibility to use any provider you want at any time, but you pay more for your covered services if they are performed by Non-Participating Providers.

- You do not have to fill out any claim forms, as long as you receive in-network care.
- The Program pays a higher level of benefits when you receive in-network care.
- You are responsible for paying a copay for certain services, coinsurance for other services after you have met the deductible requirement.
- Participating providers agree to a reimbursement schedule that is lower than the Maximum Reimbursable Expense. As a result, they cannot bill you for the difference between their billed expense and their reimbursement schedule.

Flexible Spending Account (“FSA”)

An FSA can help pay medical expenses you would otherwise have to pay from your own pocket. The following is an overview of the account. (Separate materials are available during Annual Enrollment that describe FSAs in detail.)

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

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

You can use the account to pay your coinsurance, unreimbursed expenses for dental care, braces, eyeglasses, contact lenses, and more. You can learn more about qualified medical expenses by reviewing Publication 502 at www.irs.gov. More information can be found in the Health Care Spending Program Summary Plan Description book.

Summary Charts of the Self-Insured Coverage Options

The charts that follow summarize coverage under the BCBS Garner, BCBS EGT, and BCBS McKay options.

BCBS IL- Garner	
Benefit – In Network ONLY	
Annual Deductible	
Employee	\$2,000
Family	\$6,000
Annual Out-of-Pocket Limit	
Employee	\$5,000
Family	\$10,000
Lifetime Maximum	Not applicable
Physician Office Visits	\$20 copay per visit
Inpatient Hospital Services	70% coinsurance after deductible
Annual Physical Exam	100% paid by plan
Immunizations (children and adults)	100% paid by plan
Independent X-ray and Lab Facility	\$20 copay per visit; 30% coinsurance for facility charge
Inpatient/Outpatient Hospital Facility Services	70% coinsurance after deductible
Outpatient Surgery	70% coinsurance after deductible
Inpatient/Outpatient Professional Services (for non-emergency/urgent services)	70% coinsurance after deductible
Emergency/Urgent Care Facility	\$200 ER facility copay plus 30% coinsurance for ER physician services
Urgent Care Copayment	70% coinsurance after deductible
Outpatient Rehabilitation Services, Including Speech, Occupational, Physical, Pulmonary, Cognitive, and ABA Therapy (limited to 90 visits per calendar year, in-and out-of-network services combined)	70% coinsurance after deductible; \$20 copay applies in office setting.
Outpatient Cardiac Rehabilitation Services – Phases I and II (limited to 36 visits per calendar year, in- and out-of-network services combined)	70% coinsurance after deductible; \$20 copay applies in office setting.
Chiropractic Therapy (limited to 20 visits each calendar year), in- and out-of-network services combined	
Inpatient Skilled Nursing/Rehabilitation, subject to preauthorization of medical necessity or covered service (limited to 90 days per calendar year), in- and out-of-network services combined	70% coinsurance after deductible, in-network only; 90 days per benefit period.
Home Health Care, subject to preauthorization of medical necessity (limited to 120 visits per calendar year), in- and out-of-network services combined.	70% coinsurance after deductible; 120 days per benefit period combined with private duty nursing.
Durable Medical Equipment/External Prosthetic Appliances	70% coinsurance after deductible; benefits are limited to items used to service a medical purpose. Benefits available for both DME to purchase and rent.

BCBS IL- Garner	
	Benefit – In Network ONLY
Substance Abuse—Detoxification Inpatient Outpatient	70% after deductible \$20 copay per visit
Substance Abuse—Rehabilitation Inpatient Outpatient	70% after deductible \$20 copay per visit
Mental/Behavioral Health - Inpatient Inpatient Outpatient	70% coinsurance after deductible \$20 copay per visit; 70% coinsurance for facility charge
Prescription Drugs	
Retail Generic Brand Formulary Non Formulary Brand/ Formulary Specialty Non Formulary Specialty	Deductible individual/ family: \$100/\$200 <i>30-day supply</i> \$8 copay \$35 copay \$50 copay \$100 copay
Mail Order Generic Brand Formulary Non Formulary Brand/ Formulary Specialty Non Formulary Specialty	<i>90-day supply</i> \$24 copay \$105 copay \$150 copay \$300 copay
Prescription Drug—Out-of-Pocket Maximum	Combined with medical out-of-pocket maximum

BCBS IL- McKay	
	Benefit – In-Network ONLY
Annual Deductible Employee Family	\$3,500 \$7,000
Annual Out-of-Pocket Limit Employee Family	\$6,350 \$12,700
Lifetime Maximum	Not applicable
Physician Office Visits	\$30 copay per visit PCP \$50 copay per visit Specialist
Annual Physical Exam	100% paid by plan
Immunizations (children and adults)	100% paid by plan
Independent X-ray and Lab Facility	\$20 copay per visit; 30% coinsurance for facility charge
Inpatient/Outpatient Hospital Facility Services	70% coinsurance after deductible
Outpatient Surgery	70% coinsurance after deductible
Inpatient/Outpatient Professional Services (for non-emergency/urgent services)	70% coinsurance after deductible
Emergency/Urgent Care Facility	\$200 ER facility copay plus 30% coinsurance for ER physician services
Urgent Care Copayment	70% coinsurance after deductible
Outpatient Rehabilitation Services, Including Speech, Occupational, Physical, Pulmonary, Cognitive, and ABA Therapy (limited to 90 visits per calendar year, in-and out-of-network services combined)	70% coinsurance after deductible; \$20 copay applies in office setting.
Outpatient Cardiac Rehabilitation Services – Phases I and II (limited to 36 visits per calendar year, in- and out-of-network services combined)	70% coinsurance after deductible; \$20 copay applies in office setting.
Chiropractic Therapy (limited to 20 visits each calendar year), in- and out-of-network services combined	
Inpatient Skilled Nursing/Rehabilitation, subject to preauthorization of medical necessity or covered service (limited to 90 days per calendar year), in- and out-of-network services combined	70% coinsurance after deductible, in-network only; 90 days per benefit period.
Home Health Care, subject to preauthorization of medical necessity (limited to 120 visits per calendar year), in- and out-of-network services combined.	70% coinsurance after deductible; 120 days per benefit period combined with private duty nursing.
Durable Medical Equipment/External Prosthetic Appliances	70% coinsurance after deductible; benefits are limited to items used to service a medical purpose. Benefits available for both DME to purchase and rent.
Outpatient Surgery	70% after deductible
Emergency Room	\$250 copay
Urgent Care Copayment	\$50 copay
Mental Health Inpatient Outpatient	70% after deductible \$30 per visit

BCBS IL- McKay	
	Benefit – In Network ONLY
Substance Abuse—Detoxification Inpatient Outpatient	70% after deductible \$30 per visit
Substance Abuse—Rehabilitation Inpatient Outpatient	70% after deductible \$30 per visit
Prescription Drugs	Provided by Prime Therapeutics
Retail Generic Brand Formulary Non Formulary Brand/ Formulary Specialty Non Formulary Specialty	<i>30-day supply</i> \$6 copay \$50 copay \$80 copay 20% coinsurance (\$200 maximum)
Mail Order Generic Brand Formulary Non Formulary Brand/ Formulary Specialty Non Formulary Specialty	<i>30-day supply</i> \$15 copay \$50 copay N/A N/A
Prescription Drug—Out-of-Pocket Maximum	Combined with medical out-of-pocket maximum

BCBS EGT		
	In-Network	Out-of-Network¹
Annual Deductible		
Employee Only	\$500	\$1,000
Employee + Spouse	\$750	\$1,500
Employee + Child(ren)	\$750	\$1,500
Family	\$1,000	\$2,000
Annual Out-of-Pocket Limit² <i>Includes deductible</i>		
Employee Only	\$2,000	\$4,000
Employee + Spouse	\$3,000	\$6,000
Employee + Child(ren)	\$3,000	\$6,000
Family	\$4,000	\$8,000
Lifetime Maximum <i>Includes prescription drugs</i>	Not applicable	
Coinsurance Percentage	80%	60%
Preventive Care	100% covered with no deductible	60% after deductible
Physician Office Visits	\$40 copayment	60% after deductible
Immunizations (children and adults)	100% paid by plan	
Independent X-ray and Lab Facility	80% coinsurance after deductible	60% after deductible
Inpatient/Outpatient Hospital Facility Services	80% coinsurance after deductible	60% after deductible
Outpatient Surgery	80% coinsurance after deductible	60% after deductible
Inpatient/Outpatient Professional Services (for non-emergency/urgent services)	80% coinsurance after deductible	60% after deductible
Emergency/Urgent Care Facility	\$100 ER facility copay. Copay waived if admitted. Non-emergent visit is not covered for out-of-network.	
Urgent Care Copayment	\$40 copayment	60% after deductible
Outpatient Rehabilitation Services, Including Speech, Occupational, Physical, Pulmonary, Cognitive, and ABA Therapy (limited to 90 visits per calendar year, in-and out-of-network services combined)	80% coinsurance after deductible; 60 visits total combined per benefit period for physical, occupational, and speech therapies. \$40 copayment applies in office setting.	60% after deductible; 60 visits total combined per benefit period for physical, occupational, and speech therapies.
Outpatient Cardiac Rehabilitation Services – Phases I and II (limited to 36 visits per calendar year, in- and out-of-network services combined)	80% coinsurance after deductible; \$40 copay applies in office setting.	60% after deductible
Chiropractic Therapy	80% coinsurance after deductible; (limited to 20 visits each calendar year), in- and out-of-network services combined	60% after deductible (limited to 20 visits each calendar year), in- and out-of-network services combined
Inpatient Skilled Nursing/Rehabilitation	80% coinsurance after deductible, 120 days per benefit period. Preauthorization required, otherwise \$500 penalty.	60% coinsurance after deductible, 120 days per benefit period. Preauthorization required, otherwise \$500 penalty.
Home Health Care	80% coinsurance after deductible	60% after deductible
Durable Medical Equipment/External Prosthetic Appliances	80% coinsurance after deductible; benefits are limited to items used to service a medical purpose.	60% after deductible; benefits are limited to items used to service a medical purpose.

BCBS EGT		
	In-Network	Out-of-Network¹
Inpatient Hospital Services	80% covered after deductible; Preauthorization Required, otherwise \$500 Penalty	60% after deductible; Preauthorization Required, otherwise \$500 Penalty
Inpatient/Outpatient Professional Services	80% covered after deductible	60% after deductible
Mental Health and Substance Abuse Inpatient Outpatient	80% covered after deductible; Preauthorization Required, otherwise \$500 Penalty	60% after deductible; Preauthorization Required, otherwise \$500 Penalty

BCBS EGT		
	In-Network	Out-of-Network ¹
Prescription Drugs		
Retail	<i>30-day supply</i>	<i>30-day supply</i>
Generic	\$15 copay	\$15 copay + 25% of balance
Brand Formulary	\$30 copay	\$30 copay + 25% of balance
Brand Non-formulary	\$60 copay	\$60 copay + 25% of balance
Specialty	Covered	Not Covered
Mail Order	<i>90-day supply</i>	Not covered
Generic	\$30 copay	
Brand Formulary	\$60 copay	
Brand Non-formulary	\$120 copay	
Specialty	Not allowed via Mail Order	
¹ Charges above usual and customary (U&C) limits are member's responsibility. Amounts above U&C do not count toward the annual deductible or the out-of-pocket maximum. ² This plan has an embedded family out of pocket maximum. If more than one family member is covered, each covered individual will have a \$500 individual deductible cap and \$2,000 individual out of pocket maximum cap.		

Special Rules Under the BCBSIL Group Health Program Options

General Information – BCBSIL Preadmission Certification, and BCBSIL 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 available through BCBSIL. BCBSIL is the claims administrator and network manager, and is responsible for selecting the providers who participate in the BCBSIL network.

A listing of in-network Participating Providers is available free of charge. Contact the claims administrator, or visit the claims administrator’s website for this information.

BCBSIL 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 (or your provider) must precertify any hospital admission. If your provider precertifies your care on your behalf, it is your responsibility to ensure that precertification requirements have in fact been met. You precertify care through the Blue Care Connection Program. Here are important details surrounding preadmission certification, as well as the role of Blue Care Connection. **Note:** Preadmission review does not guarantee benefits.

Preadmission Review

Blue Care Connection gets involved in three different types of admission reviews:

- Inpatient hospital, medical, and surgical, mental health and substance abuse preadmission review;
- Emergency admission review; and
- Maternity admission review.

Length of Stay/Service Review

A length of stay/service review does not guarantee benefits. Actual benefit availability is subject to eligibility and the other terms, conditions, limitations, and exclusions of your coverage option. Benefit availability also is subject to any waiting period that may apply.

An extension to your length of stay/service is based solely on whether Blue Care Connection determines that continued inpatient care or other health care services are medically necessary. If Blue Care Connection determines that an extension is not medically necessary, your length of stay/service will not be extended. Your case is then referred to the claims administrator's physician for review.

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, please refer to the section below entitled "Failure to Notify" for a description of penalties.

Blue Care Connection™ Procedures

You must call the claims administrator to precertify a scheduled hospital admission at least 24 hours before you are admitted. When you contact the Blue Care Connection Program, be prepared to provide the following:

- Name of the attending and/or admitting physician;
- Name of the hospital where the admission is scheduled and/or the location where the service is scheduled;
- The scheduled admission and/or service date; and
- A preliminary diagnosis or reason for the admission and/or service.

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.

When you contact Blue Care Connection, Blue Care Connection 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.

Failure to Notify

The final decision regarding your course of treatment is solely your responsibility. The Blue Care Connection Program does not interfere with your relationship with any provider. However, the claims administrator has established Blue Care Connection to help you determine the course of treatment that will maximize your benefits (as described here).

If you fail to notify Blue Care Connection as required, 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. 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.

Medicare-Eligible Members

The provisions of the Blue Care Connection Program do not apply to you if you are Medicare-eligible and have secondary coverage provided under a BCBSIL Group Health Program option.

BCBSIL Special Services Available

If you enroll in one of the BCBSIL Group Health Program options, the following special services are available to you through Blue Cross and Blue Shield of Illinois.

Blue Care Connection™ Program

The claims administrator has established the Blue Care Connection Program to review inpatient hospital covered services **before** you or your enrolled eligible dependents receive such services.

Blue Care Connection provides personalized attention, support, online resources, and health advocacy to help you find the right resources, optimize your health care benefits, and manage medical conditions.

The Blue Care Connection Program offers the following:

- **Utilization and Case Management** – These programs, also known as the Medical Services Advisory, are supported by health care professionals, including doctors and nurses who can help you understand your benefits and identify health care resources.
- **Care Advisor** – A registered nurse can assist you with questions about chronic conditions, coordinate care, and provide you with a single point of contact.
- **Personal Health Manager** – A resource of online tools and information can help you make informed health care decisions. Log in to **Blue Access® for Members** to:
 - Set up a personal health record;
 - Access online health content;
 - Receive targeted wellness information;

- Ask registered nurses your health-related questions via secured e-mail through the Ask-A-Nurse feature; or
- Request nutrition, fitness, and weight-loss advice via secured e-mail at Ask-A-Trainer.

The Blue Care Connection Program is staffed primarily by registered nurses and other personnel with clinical backgrounds. The physicians that staff the Blue Care Connection Program's Medical Department also are an essential part of the Blue Care Connection Program.

If you (or your provider) fail to contact the Blue Care Connection Program or comply with Blue Care Connection's determinations, the Medical Program may not pay the maximum level of benefit. Blue Care Connection's toll-free telephone number is on your ID card. Please read the provisions outlined in the "BCBSIL Group Health Program – Preadmission Certification" and the "Blue Care Connection Program" sections very carefully. Please note that these provisions do not apply to mental health or substance abuse treatments.

Special Beginnings® Program

The Special Beginnings Program is designed to help you better understand and manage your pregnancy. You'll receive:

- An e-mail newsletter;
- Access to a 24-hour toll-free line staffed by maternity nurses; and
- An online health information library.

Follow these steps to enroll in the Special Beginnings Program:

- Call the Medical Advisory Services number (1-800-433-3232) located on the back of your ID card as soon as you find out you are pregnant.
- Once you are precertified for coverage, you will receive a welcome packet with information about the Special Beginnings Program. The packet will include instructions on how to enroll and how to complete the initial assessment.
- Based on the information you provide, you will receive educational materials specific to your needs. With your written consent, information from your health assessment also will be shared with your contracting provider.
- If there are any significant factors that could affect your pregnancy, a maternity nurse will offer to coordinate your care.

If you precertify and complete the initial Special Beginnings health assessment within your first trimester (or first 17 weeks of pregnancy), you will receive a copy of *The Good Housekeeping Illustrated Book of Pregnancy & Baby Care*. When you complete and return the final questionnaire, you may be eligible to receive a \$50 coupon off any Toys "R" Us or Babies "R" Us purchase of \$50 or more. You can use this coupon within seven weeks of your baby's birth.

Additional resources to help you understand and manage your pregnancy are available through the Mayo Clinic on the Blue Access for Members secure site. You can track the results of your prenatal appointments, create a general guideline for labor and delivery, and much more. These tools are available exclusively to BCBSIL members.

Online Wellness Information

BCBSIL offers access to exclusive online health and wellness content and decision-making tools. You can benefit from health assessments and other self-management web-based tools available through the online portal. Such tools relate to common health care problems (for example, asthma, low back pain, headaches). You also can access information about specific diseases and treatments, including alternative medicine and interactive health/lifestyle decision-making tools.

To access the online tools, go to the website at www.bcbsil.com/rrd and use Blue Access for Members.

Blue Access for Members

Blue Access for Members offers you an electronic way to access information about your health care claims. You can check claims status, receive an electronic EOB statement, and review membership information for yourself and your family members.

You can take advantage of a number of additional online services, including downloading claim forms, ordering replacement ID cards, requesting literature on plans, and contacting BCBSIL via e-mail with any type of inquiry. Claim and other inquiries are logged in to customer service tracking systems to ensure appropriate routing and prompt response. In addition to online services, the website includes contact information and helpful phone numbers if you prefer to call or write.

When Coverage Ends

General Information

Generally, coverage under the Regional Options Program for you and your enrolled eligible dependents ends if:

- You decline coverage;
- Your employment with all Participating Employers terminates;
- You are no longer eligible for the Regional Options Program; or
- The Regional Options Program is terminated.

Except as provided in a Fully-Insured HMO Regional Options Certificate of Coverage, or if COBRA continuation is available and elected, the Regional Options Program does not extend benefits for services completed after coverage ends or pay benefits for any service that begins after coverage ends. This applies even if the services began while you were covered under the Regional Options Program and you received a prior authorization for such services.

If You Leave the Company or Are No Longer Eligible for Coverage

If you leave all Participating Employers on either a voluntary or involuntary basis, coverage under the Regional Options Program stops on the last day of the month in which you stop working for your Participating Employer. You and your enrolled eligible dependents who are COBRA continuation coverage beneficiaries may be eligible to continue coverage under the Regional Options Program for a specified period of time, as described in the “Your Legal Right to COBRA Continuation Coverage” section.

If you or any eligible dependent of yours does not elect COBRA continuation coverage, coverage under the Regional Options Program for you or such eligible dependent, as applicable, stops at the end of the month in which you or such eligible dependent, as applicable, loses coverage.

If You Die

If you die while you are an active employee, your enrolled eligible dependent’s coverage under the Regional Options Program may continue at no cost until the end of the third month after the month in which you die, provided your surviving eligible dependent is a COBRA continuation coverage beneficiary and elects COBRA continuation coverage under the Regional Options Program. The three months of subsidized coverage count toward the period of COBRA continuation coverage for which such enrolled eligible dependents are eligible, as described in the “Your Legal Right to COBRA Continuation Coverage” section.

If Your Collective Bargaining Unit Goes on Strike

If your collective bargaining unit goes on strike, your coverage under the Regional Options Program ends on the day the strike begins. You and your enrolled eligible dependents who are COBRA continuation coverage beneficiaries may be eligible to continue coverage for a specified period of time, as described in the “Your Legal Right to COBRA Continuation Coverage” section.

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 and its affiliates, or if you accept new employment, either of which can include self-employment, you will be considered to have voluntarily abandoned your job at your Participating Employer. This will be treated as a voluntary separation thus ending employment with all Participating Employers and termination of coverage under its benefit programs. For example, this termination of employment with your Participating Employer will result in a loss of all Group Benefits Plan benefits, including coverage under the Regional Options Program. 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.

Special Extensions of Coverage

General Information

Depending on your situation when you leave employment with your Participating Employer, you and your enrolled eligible dependents may be eligible for continued coverage under the Regional Options Program. Situations in which an extension of coverage 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; and
- Covered by the Family and Medical Leave Act of 1993 (FMLA).

If you do not terminate your coverage under the Regional Options Program (and the withholding of premiums from your pay through the Participant Premium Program) while you are on a leave of absence, including short-term disability (excluding a military leave), you are responsible for your premiums. If you are approved for short-term and/or long-term disability and receive disability payments from the disability vendor, your premiums will be deducted from your disability pay as available. If you are not receiving short-term and/or long-term disability payments or do not have enough disability pay to cover your total premiums, RR Donnelley will advance on your behalf the required premiums until you are able to return to work, you separate from employment, or you are reclassified as benefits-ineligible, whichever is earliest. Your election to authorize RR Donnelley to reduce your future wages on a before-tax basis for your required premiums includes an authorization to withhold from your pay, in the calendar year you return to work or commence to be paid, the amount of premiums advanced for you by RR Donnelley during the time of your leave of absence or layoff (excluding military leave). Therefore, if RR Donnelley advances premiums for you, you will be deemed to have elected to:

- Participate in the Regional Options Program (and the Participant Premium Program) for each calendar year to the extent required to repay advanced contributions made on your behalf 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, or you return to active service; and
- Repay RR Donnelley for the advanced premiums.

The advanced premiums will be recovered by your Participating Employer 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 your Participating Employer with an outstanding balance due, the remaining balance will be recovered from your final pay as permitted by law or through deductions from disability pay.

Upon your separation, you and your enrolled eligible dependents who are COBRA continuation coverage beneficiaries may be eligible for continued coverage, as described in the “Your Legal Right to COBRA Continuation Coverage” section.

Uniformed Services Employment and Reemployment Rights Act of 1994 (“USERRA”)

If you go on a military leave of absence, your Participating Employer benefit eligibility and active employment status will continue for up to 60 months, or at the completion of your military service (whichever is shorter). During this period, RR Donnelley will advance on your behalf the required premiums for coverage.

If you return to a Participating Employer as an active employee, you will not be required to repay the Company for premiums paid on your behalf while out on leave. As an active employee, you will begin to pay benefit premiums effective with your return-to-work date at the active employee rate for all benefits elected. Premiums will be based on your elections for the current plan year, and your eligibility is subject to meeting all regular enrollment requirements.

If you do not return to a Participating Employer within a 60-month period or at the completion of your military service (whichever is shorter), your employment and employee benefit eligibility will be terminated. You will not be required to repay the Company for premiums paid while out on military leave. However, you will have the opportunity to continue Regional Options Program coverage under COBRA.

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 medical benefit plans (including Regional Options) to offer employees and certain members of their families the opportunity to extend coverage temporarily at group rates after coverage under the medical benefit plan would otherwise end or if costs increase due to specific events. COBRA does not require employers who sponsor group health plans to offer such extended coverage to domestic partners of employees or children of such domestic partners. However, the Regional Options Program does offer to covered domestic partners and the covered children of domestic partners who are eligible dependents COBRA continuation coverage rights that are equivalent to those offered under COBRA to the covered spouses and enrolled children of

employees, as described below. The extension of coverage to employees and their enrolled eligible dependents is called “COBRA continuation coverage.”

In general, the coverage that may be continued is the same as the coverage in which you and your eligible dependents were enrolled under the Regional Options Program as an active employee on the day before the qualifying event (as listed below). For example, if you and your spouse are enrolled in an available coverage option before you leave all Participating Employers, you can continue this same coverage. If you elected the “No Coverage” option 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. After the qualifying event, COBRA continuation coverage must be offered to each person who is a COBRA continuation coverage beneficiary. You, your enrolled spouse/domestic partner, your enrolled children, and your domestic partner’s enrolled children could become COBRA continuation coverage beneficiaries if coverage under the Regional Options Program is lost because of a qualifying event.

The following are qualifying events:

<i>Who Can Continue Coverage</i>	<i>In What Situations</i>	<i>For How Long*</i>
Employee, employee's enrolled spouse/domestic partner, employee's enrolled child(ren), and enrolled child(ren) of employee's domestic partner only	<ul style="list-style-type: none"> • A reduction in work hours that would cause employee to be classified as a benefits-ineligible employee • Termination of employee's employment (other than for gross misconduct) • Significant premium increase (for example, due to failure to notify the Benefits Center of a status change that resulted in a dependent's ineligibility and continued coverage on an after-tax basis) 	18 months
Employee's enrolled spouse/domestic partner, employee's enrolled child(ren), and enrolled child(ren) of employee's domestic partner only	<ul style="list-style-type: none"> • Employee's death • Divorce or legal separation • Employee's entitlement to Medicare (under Part A, Part B, or both)** 	36 months
Employee's domestic partner, employee's enrolled child(ren) and enrolled child(ren) of employee's domestic partner only	Domestic partner or children no longer meet the eligibility rules for coverage	36 months

*The duration of coverage is from the date of the qualifying event.

**The 36-month coverage begins on the day you enroll in Medicare.

A child who is born to the employee or placed for adoption with the employee during a period of COBRA continuation coverage may be added to the coverage. The child will have all of the COBRA continuation coverage rights that any other enrolled eligible dependent would have otherwise.

Notification

In the case of the employee's death while employed, termination of employment (other than for gross misconduct), reduction in hours, or entitlement to Medicare (under Part A, Part B, or both), you and your COBRA continuation coverage beneficiaries 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.

You must give notice of certain qualifying events. Under the law, the employee or a family member who is a COBRA continuation coverage beneficiary must notify the COBRA administrator if one of the following qualifying events occurs:

- Divorce;
- Legal separation; or
- A domestic partner or child fails to meet the eligibility rules for coverage under the Regional Options Program.

You will be allowed to make a COBRA election only if you notify the COBRA administrator within 60 days of the end of the month in which a qualifying event occurs.

Upon such timely notification, coverage will be terminated retroactive to the date of the qualifying event. When the COBRA administrator is timely notified that one of these qualifying events has happened, your COBRA continuation coverage beneficiaries will in turn be notified within 14 days of the right to choose COBRA continuation coverage. Failure to provide this notification during the 60-day notice period results in the loss of COBRA continuation coverage rights. Contact information for the COBRA administrator can be found in the “Administrative and Contact Information” section.

Election Procedure

Under the law, to continue coverage, you and your COBRA continuation coverage beneficiary have 60 days from the later of the:

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

If you and/or your COBRA continuation coverage beneficiary does not choose COBRA continuation coverage within this 60-day period, your and/or your COBRA continuation coverage beneficiary’s coverage under the Regional Options Program will end.

Disability Extension

An 18-month period of COBRA continuation coverage may be extended for up to 11 months (for a total of up to 29 months of COBRA continuation coverage) if you, your enrolled spouse/domestic partner, your enrolled child (ren), or your domestic partner's enrolled child (ren) have been determined to be disabled (under Title II or XVI of the Social Security Act). The disability would have to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month COBRA continuation coverage period. The 11-month extension applies to all disabled and non-disabled COBRA continuation coverage beneficiaries entitled to COBRA continuation coverage as a result of the same qualifying event to which the disability extension applies, subject to the above notice requirements. If the disability ends, you (or your spouse/domestic partner, your child, or your domestic partner's child who is a COBRA continuation coverage beneficiary with respect to the qualifying event to which the disability extension relates) must notify the COBRA administrator within 30 days after the determination. COBRA continuation coverage will end on the first day of the month that is 31 or more days after the Social Security determination that the disability has ended.

Other Extension

Your spouse/domestic partner, your children, and your domestic partner's children can experience additional qualifying events while COBRA continuation coverage is in effect. Such events may extend an 18- or 29-month period of COBRA continuation coverage to a period of up to 36 months. In no event will coverage extend beyond 36 months after the initial qualifying event. You should notify the COBRA administrator immediately if a second qualifying event occurs during a COBRA continuation coverage period.

A COBRA continuation coverage beneficiary does not have to show that he or she is insurable to choose COBRA continuation coverage. However, COBRA continuation coverage under the law is provided subject to eligibility for coverage under the Regional Options Program. The Regional Options Program reserves the right to terminate a COBRA continuation coverage beneficiary's COBRA continuation coverage retroactively if such COBRA continuation coverage beneficiary is determined to be ineligible. Once a COBRA continuation coverage beneficiary's COBRA continuation coverage terminates for any reason, it cannot be reinstated.

Payment

Generally, you must pay a premium to the Regional Options Program of 102% of the applicable unsubsidized active employee premium during the 18- or 36-month period of COBRA continuation coverage. However, during the additional 11 months of COBRA continuation coverage (for disability), if the disabled individual is covered, payment of up to 150% of the applicable unsubsidized active employee premium is required.

Your initial COBRA continuation coverage premium 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 or your COBRA continuation coverage beneficiaries do not make payment on or before the first day of the month, your or your COBRA continuation coverage beneficiary's claim(s) will not be paid by the Regional Options Program until payment is received within the 30-day grace period.

When COBRA Continuation Coverage Ends

COBRA continuation coverage of a COBRA continuation coverage beneficiary continues until the earliest of:

- The end of the 18-month, 29-month, or 36-month continuation period;
- The date your employer no longer provides coverage to any of its employees;
- The date a COBRA continuation coverage beneficiary fails to pay the required contribution by the specified deadline;
- The date a COBRA continuation coverage beneficiary first becomes covered after the date of his or her COBRA continuation coverage election under another group health care program that does not contain a pre-existing exclusion that affects his or her benefits;
- The date a COBRA continuation coverage beneficiary first becomes entitled to Medicare after the date of his or her COBRA continuation coverage election;
- The date a Medicare eligible COBRA continuation coverage beneficiary becomes eligible under Medicare or 60 days; or
- The date that there has been a final determination by the Social Security Administration that the COBRA continuation coverage beneficiary who elected to extend coverage for up to 29 months due to disability is no longer disabled.

If COBRA continuation coverage is rejected in favor of an alternate coverage under the Regional Options Program, 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 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 begins 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 also may be found at http://www.doleta.gov/tradeact/2002act_summary.cfm

Statutory Benefit

COBRA continuation coverage is required by law. This summary is intended to describe your rights under law to this coverage. A COBRA continuation beneficiary will have only those rights provided by law, whether they are better than, or not as good as, they may appear in this summary.

Claims and Appeals Procedures

A Special Note about Regional Options Coverage

Your Regional Options Program Full-Insured HMO certificate of coverage will outline the claims and appeals procedures applicable to your claim with that Regional Options Program Fully-Insured HMO. Those procedures will control unless they afford you and your covered dependents less rights than those set forth below. If you have questions, you should contact the Regional Options Program Fully-Insured HMO to explain any difference.

General Information

The following claim review and claim appeal procedures apply to all benefit and eligibility claims of any nature related to the Group Benefits Plan.

A “benefit claim” is a claim for a particular benefit under a plan. It will typically include your initial request for benefits. An example of a benefit claim is a claim to receive coverage for a particular type of surgery. If you are filing a benefit claim, you need to contact the claims administrator.

An “eligibility claim” is a claim to participate in an option or to change an election to participate during the year. An example of an eligibility claim is a claim to switch from one available coverage option to another midyear. If you are filing an eligibility claim, you need to contact the Benefits Center.

Procedure for Filing a Claim

A communication from you or your enrolled eligible dependent (“claimant”) constitutes a valid claim if it is in writing on the appropriate claim form (or in such other manner acceptable to the claims administrator) and is delivered (along with any supporting comments, documents, records, and other information) 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 Group Benefits Plan, he or she will be considered not to have exhausted all administrative remedies under the Group Benefits Plan, and this will result in his or her inability to bring a legal action for that benefit. Claims and appeals of denied claims may be pursued by a claimant, or, if approved by the claims administrator, his or her authorized representative. See the “Administrative and Contact Information” section for the appropriate claims administrator.

Defective Claims

If a claimant fails to follow the Group Benefits Plan’s procedures for filing a valid claim, the claims administrator will notify him or her of the failure and the proper procedures to follow in filing a claim, provided that the communication received by the claims administrator from the claimant names the specific claimant, the specific condition or symptom, and the specific treatment, service, or product for which approval is requested. The notice will be provided within five days of receipt of the claim by the claims administrator. In the case of a failure to follow the proper procedures with respect to a claim that involves urgent care, the notice will be provided to the claimant within 24 hours of such receipt.

Initial 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

Claim Involving Urgent Care

In the case of a claim that involves urgent care, the claims administrator will notify the claimant of the benefit determination (whether adverse or not) no later than 72 hours after receipt of the claim by the claims administrator. The claimant must, however,

provide sufficient information to determine whether and to what extent benefits are payable under the Group Benefits Plan.

If the claimant fails to provide sufficient information to determine whether, and to what extent, a claim involving urgent care is covered by the Group Benefits Plan, the claims administrator will notify the claimant within 24 hours after receipt of the claim of the specific information necessary to complete the claim.

The claimant will be given a reasonable amount of time, taking into account the circumstances, but in no event less than 48 hours, to provide the specified information. The claims administrator will notify the claimant of the benefit determination no later than 48 hours following the earlier of:

- The claims administrator's receipt of the specified information; or
- The end of the period afforded to the claimant to provide the specified additional information.

Concurrent Care Decision

In the case of a denial of coverage that involves a course of treatment (other than by amendment or termination of the Group Benefits Plan) before the end of such period of time or number of treatments, the claims administrator will notify the claimant of the denial in advance of the reduction or termination. This will enable the claimant to appeal and obtain a determination on review of that denial before the benefit is reduced or terminated. If the claimant wants to extend the course of treatment beyond the period of time or number of treatments and the claim involves urgent care, the claims administrator will notify the claimant of the benefit determination (whether adverse or not) within 24 hours after receipt of the claim by the claims administrator (provided that any such claim is made to the claims administrator at least 24 hours prior to the expiration of the prescribed period of time or number of treatments).

Pre-Service Claim

In the case of a claim that involves prior authorization, the claims administrator will notify the claimant of the benefit determination (whether adverse or not) within 15 days after receipt of the claim. The claims administrator may extend the period by 15 days if it determines that such an extension is necessary due to matters beyond the Group Benefits Plan's control. The claims administrator will notify the claimant, prior to the expiration of the initial 15-day period, of the circumstances that require the extension, 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.

Post-Service Claim

In the case of a claim that is filed after the claimant receives care, the claims administrator will notify the claimant of the denial within 30 days after receipt of the claim. 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 Group Benefits Plan's control. The claims administrator will notify the claimant, prior to the expiration of the initial 30-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 in which the claims administrator is required to make a decision is then suspended from the date on which the notification is sent to the claimant until the earlier of the date the claimant responds to the request for additional information, or the due date established by the claims administrator for furnishing the requested information.

Manner and Content of Notification of Denied Claim

The claims administrator will provide the claimant with notice of any denial, in accordance with applicable U.S. Department of Labor regulations. In the case of a denial concerning a claim that involves urgent care, notice of the denial may be provided orally, provided that a written or electronic notice is furnished to the claimant within three days of the oral notice.

The notification of a denial will include:

- The specific reason or reasons for the denial;
- Reference to the specific Group Benefits Plan provision(s) on which the determination is based;
- A description of any additional material or information necessary for the claimant to perfect the claim, and an explanation of why such material or information is necessary;
- If an internal rule, guideline, protocol, or other similar criterion was relied upon in making the denial, the specific rule, guideline, protocol, or other similar criterion that was relied upon, or a statement that such rule, guideline, protocol, or similar criterion was relied upon and that a copy will be provided free of charge to the claimant upon request;
- If the denial is based on medical necessity, experimental treatment, or a similar exclusion or limit, an explanation of the scientific or clinical judgment relied upon for the determination, or a statement that such explanation will be provided free of charge upon request; and

- A description of the Group Benefits Plan's review procedures, the time limits applicable to such procedures, and the expedited review process if the claim involves urgent care.

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 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 Group Benefits Plan. This failure will result in the claimant's inability to bring a legal action to recover a benefit under the Group Benefits Plan. The claimant's request for an appeal must be in writing utilizing the appropriate form provided by the claims administrator (or in such other manner acceptable to the claims administrator). A claimant's request for an appeal must be filed with the claims administrator 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 will provide a full and fair review that takes into account all comments, documents, records, and other information the claimant submits, without regard to whether such information was submitted or considered in the initial benefit determination.
- The claimant will have the opportunity to submit written comments, documents, records, and other information relating to the claim.
- The claimant will have the opportunity to review the claim file, if any, created by the claims administrator during the initial claim.
- The claimant will have the opportunity to present evidence and testimony as part of the review of the claimant's initial benefit denial.
- The claimant will be provided, upon request and free of charge, reasonable access to and copies of all relevant documents.
- The claimant may receive, free of charge and as soon as possible, any new or additional evidence considered, relied upon, or generated by the Group Benefits Plan or an insurer, if applicable of a Regional Options Program, in connection with the claim.
- The review of a denial does not defer to the initial determination made by the claims administrator.
- The individual who conducts the review process is neither the individual who made the initial denial nor the subordinate of such individual.
- In deciding an appeal of any denial that is based in whole or in part on a medical judgment, including determinations as to whether a particular treatment, drug, or other item is experimental, investigational, or not medically necessary or appropriate, the individual conducting the review process will consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment. The health care professional will be

neither the individual who was consulted in connection with the denial that is the subject of the review nor the subordinate of such individual.

- The claims administrator will identify any medical or vocational experts whose advice was obtained on behalf of the Group Benefits Plan in connection with the claimant's denial, without regard as to whether the advice was relied upon in making the benefit determination.
- In the case of a claim that involves urgent care, an expedited review process will be provided. The claimant must request an expedited appeal orally or in writing, and all necessary information, including the Group Benefits Plan's benefit determination on review, must be transmitted between the Group Benefits Plan and the claimant by telephone, facsimile, or other available similarly expeditious method.
- The claimant may receive, prior to the issuance of the benefit determination on review, any new or additional rationale upon which the benefit determination is decided.

Timing of Notification of Benefit Determination on Review

- **Claim involving urgent care.** In the case of a claim that involves urgent care, the claims administrator will notify the claimant of the benefit determination on review within 72 hours after receipt of the claimant's request for review.
- **Pre-service claim.** The claims administrator will notify the claimant of the benefit determination on review within 30 days after receipt of the request for review.
- **Post-service claim.** The claims administrator 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 will provide a written or electronic notice of the Group Benefits Plan's benefit determination on review, in a culturally and linguistically appropriate manner, in accordance with applicable DOL 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 (along with the corresponding meaning of these codes).
- 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 will be provided free of charge to the claimant upon request;
- 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 the external review procedures.

External Review Procedures

Under the new healthcare reform law, you may have the right to have an independent group of health care professionals who have no association with the Group Benefits Plan review any denied appeal. Your request for an external review must be filed within four months after the date you receive a denied appeal from the claims administrator. Within five days of receiving your request for external review, the Group Benefits Plan will review whether certain requirements are met, and within one day of completing this review the Group Benefits 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 Group Benefits Plan will assign an accredited independent review organization to perform the external review. The independent review organization may request additional information in order to complete its review. 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 Group Benefits Plan's denial, the Group Benefits 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 Group Benefits 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:

- More than two years after the claims administrator first received your claim;
- If you received a denial on appeal of such claim, more than two 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 this SPD.

Situations Affecting Your Benefits

General Information

Some situations could affect benefits from the Regional Options Program, as summarized here:

- If you choose “No Coverage” when you are first hired or during any Annual Enrollment period, no benefits are payable.
- Coverage may be stopped, changed, or delayed if you leave all Participating Employers, retire, take a leave of absence, or experience an employment status change such that you are classified as a benefits-ineligible employee.
- If you do not apply for benefits (when necessary) or provide the necessary claim information, benefits may be delayed.
- You may change your coverage during the year only if you report a Qualified Status Change.
- Coverage for a spouse ends if you and such spouse are divorced or legally separated.
- Coverage for a domestic partner ends if he or she is no longer a domestic partner, as defined in the “Glossary of Key Terms – Eligibility” section.
- Coverage for an eligible dependent ends if he or she is no longer an eligible dependent as defined in the “Glossary of Key Terms – Eligibility” section.
- Coverage for you and your eligible dependents may be suspended or terminated if you are on an unauthorized leave of absence from work.

An unauthorized leave of absence includes a failure to report to work as the result of a strike or other labor action where such failure to report is not authorized by your Participating Employer.

If the Group Benefits Plan Is Modified or Ended

RR Donnelley reserves the right to amend or terminate the Group Benefits Plan or the Regional Options Program at any time, in whole or in part. If the Group Benefits Plan or the Regional Options Program is ever terminated, suspended, or modified, benefits for any service you receive before the change are paid under the Regional Options Program’s former conditions, provided that a written notice of claims is timely given. The Regional Options Program does not pay benefits for services received after such action (unless specific provisions are adopted).

Administrative and Contact Information

General Information

This section provides you with information about how the Regional Options Program is administered.

Type of Plan

The Regional Options Program is part of a welfare benefit plan. Its objective is to reimburse non-occupational expenses of eligible employees and their enrolled eligible dependents in accordance with the terms of the Regional Options 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 Name and Number

R.R. Donnelley & Sons Company Group Benefits Plan – 504

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

As of January 1, 2016, the following employers participate in the Group Health Program of the Plan (a “Participating Employer”):

- Banta Corporation
- Banta Global Turnkey LLC
- Consolidated Graphics, Inc.
- Courier Communications, LLCRR Donnelley & Sons Company
- R.R. Donnelley Printing Company
- RR Donnelley Financial, Inc.
- RRD Secaucus Financial, Inc.
- Office Tiger, LLC
- work bench co op LLC

You have a Grandfathered Legacy Indicator (“GLI”) established that notes the Participating Employer you are linked to under the Group Health Program. Your GLI is set as of your initial eligibility date for the Program or each January 1 based on your employer as of September 1 prior to the plan year, whichever is later. Even if you transfer among Participating Employers between September 1 prior to the plan year and September 1 of the plan year, your GLI and premium are based on the benefits provided by your set GLI for that plan year. The Group Health 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.

The Regional Options 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 Regional Options Program, call the eligibility administrator listed under “Eligibility Administrator” below.

A complete list of the employers sponsoring the Group Benefits Plan and your GLI may be obtained for examination by you or your eligible dependents upon written request to the RR Donnelley Benefits Center. Also, you or your eligible dependents may receive from the RR Donnelley Benefits Center, upon written request, information as to whether a particular employer is a sponsor of the Group Benefits Plan and, if the employer is a sponsor, the sponsor’s address.

Eligibility Administrator

The eligibility administration is performed by AonHewitt Associates LLC, 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 between the hours of 8 a.m. and 5 p.m. CT, Monday through Friday, except holidays.

Website: www.resources.hewitt.com/rrd

Contact the Benefits Center to:

- Enroll;
- Verify benefit eligibility;
- Remove a former eligible dependent who is no longer eligible from coverage;
- Report a Qualified Status Change;
- Ask a question about Qualified Status Changes;
- Report an address change (inactive participants only); and
- Ask general benefit questions.

If you want to enroll yourself or an eligible dependent in the Regional Options Program, you must follow the enrollment procedures provided herein and included in the Annual Enrollment materials established by the Benefits Committee.

Claims Administrators

If you have questions about a specific benefit, contact the appropriate claims administrator as shown in the chart below.

The Regional Options Program

Options	Claims Administrator
<p>Wisconsin Dean Health Special Options HMO</p>	<p>Dean Health Insurance P.O. Box 56099 Madison, WI 53705 1-608-828-1301</p> <p>Website: www.deancare.com</p>
<p>Illinois Blue Advantage HMO BCBS EGT BCBS Garner BCBS McKay</p>	<p>Blue Cross and Blue Shield of Illinois P.O. Box 805107 Chicago, IL 60680 1-800-537-9765</p> <p><u>Rx:</u> Prime Therapeutics 1-800-423-1973</p> <p>Website: www.bcbsil.com/rrd (for online provider directories and other resources)</p>
<p>California Kaiser HMO</p>	<p>Kaiser Permanente</p> <p>Southern CA: Claims Department P.O. Box 7004 Downey, CA 90242-7004 1.800.278.3296</p> <p>Northern CA: Claims Department P. O. Box 12923 Oakland, CA 94604-2923 1.800.278.3296</p> <p>Website: www.kp.org/memberservices</p>

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 AonHewitt Associates LLC. 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.resources.hewitt.com/rrd

Allocation and Delegation of Fiduciary Responsibilities by the Benefits Committee

The Group Benefits 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 Group Benefits Plan, references in this SPD to the Benefits Committee are intended to refer to any such applicable administrative-named fiduciary. The Group Benefits Plan also provides a procedure for the Benefits Committee, acting as the Group Benefits 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 Group Benefits Plan.

Insured Benefits

RR Donnelley is the policyholder for the funding of the Regional Options Program Fully-Insured HMO policies under the Regional Options Program. The insurance contract(s) is(are) guaranteed by the issuer and not by RR Donnelley or the Group Benefits Plan. The issuer of such contract is the claims administrator and network manager with respect to such contract of insurance.

Self-Funded Benefits

Options other than the HMO options under the Regional Options Program are funded by RR Donnelley's general assets. The Benefits funded by RR Donnelley's general assets are not guaranteed by the claims administrators or network managers. The claims administrators' role is to provide services to the Group Health Program.

Your ERISA Rights

General Information

As a participant in the Plan, you and your enrolled eligible dependents 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 Your Regional Options Program 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 Plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the Plan 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 Plan, including insurance contracts and 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. The Plan Administrator is required by law to furnish each participant with a copy of this Summary Annual Report.

Continue Group Health Plan Coverage

- Continue health care coverage for you and/or your enrolled eligible dependents if there is a loss of coverage under the Regional Options Program as a result of a qualifying event. You or your covered spouse may have to pay for such coverage. Review this SPD and the documents governing the Plan on the rules governing your COBRA continuation coverage rights.
- Reduce or eliminate exclusionary periods of coverage for pre-existing conditions under your Regional Options Program, if you have creditable coverage from another plan. You should be provided a certificate of creditable coverage, free of charge, from your Regional Options Program or health insurance issuer when you lose coverage under the Regional Options Program, when you become entitled to elect COBRA continuation coverage, when your COBRA continuation coverage ceases, if you request it before losing coverage, or if you request it up to 24 months after losing coverage. Without evidence of creditable coverage, you may be subject to a pre-existing condition exclusion relative to your coverage for 12 months (18 months for late enrollees) after your enrollment date.

Prudent Actions by Plan Fiduciaries

In addition to creating rights for plan participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate your Plan, called “fiduciaries” of the Plan, have a duty to do so prudently and in the interest of you and other plan participants and beneficiaries. 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 welfare benefit or exercising your rights under ERISA.

Enforce Your Rights

If your claim for a welfare benefit 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 instance, if you request a copy of Plan documents 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 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 Plan’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 your Plan, 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 also may obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

Keep as a Handy Reference

www.SPExpressRRD.com

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