ERISA INFORMATION

THIS SUMMARY PLAN DESCRIPTION IS EXPRESSLY MADE PART OF THE R.R. DONNELLEY & SONS COMPANY GROUP BENEFITS PLAN ACCIDENT, HOSPITAL INDEMNITY AND CRITICAL ILLNESS INSURANCE PLAN AND IS LEGALLY ENFORCEABLE AS PART OF THE PLAN WITH RESPECT TO ITS TERMS AND CONDITIONS. IN THE EVENT THERE IS NO OTHER PLAN DOCUMENT, THIS DOCUMENT SHALL SERVE AS A SUMMARY PLAN DESCRIPTION AND SHALL ALSO CONSTITUTE THE PLAN.

This content contains a summary in English of your rights and benefits under this coverage. If you have difficulty understanding any part of this content, call the claims administrator at 1-800-GETMET8

NAME AND ADDRESS OF BENEFITS COMMITTEE AND PLAN ADMINISTRATOR:

Benefits Committee
C/O Vice President, Benefits
R.R. Donnelley & Sons Company
35 West Wacker Dr. 37th Floor, Chicago, IL 60601

EMPLOYER IDENTIFICATION NUMBER: 36-1004130

PLAN NUMBER: 504

COVERAGE: Accident, Hospital Indemnity and Critical Illness Insurance; provided under the Supplemental Benefits Program of the Plan

PLAN NAME: R. R. Donnelley & Sons Company Group Benefits Plan

CLAIMS ADMINISTRATOR: Metropolitan Life Insurance Company

TYPE OF ADMINISTRATION

The above listed benefits are insured by Metropolitan Life Insurance Company ("MetLife").

MetLife is liable for any benefits under the Plan. The group policy specifies the time when and the circumstances under which MetLife is liable for Accident, Hospital Indemnity and Critical Illness Insurance benefits.

AGENT FOR SERVICE OF LEGAL PROCESS

For disputes arising under the Plan, service of legal process may be made upon the Corporate Secretary at the above address for the Benefits Committee and Plan Sponsor. Legal process also may be served on the Benefits Committee. For disputes seeking payment of benefits, service of legal process may be made upon MetLife at 1095 Avenue of the Americas, New York NY 10036.

ELIGIBILITY FOR INSURANCE; DESCRIPTION OR SUMMARY OF BENEFITS

Your MetLife certificate describes the eligibility requirements for benefits insured by MetLife under the Plan. It also includes a detailed description of the terms of the insurance coverage provided by MetLife under the Plan and the maximum benefits that can be paid.

PLAN TERMINATION OR CHANGES

The group policy sets forth those situations in which the Employer and/or MetLife have the right to end the policy.

Your consent or the consent of your beneficiary is not required to terminate, modify, amend, or change the Plan.

In the event your insurance ends in accordance with the DATE YOUR INSURANCE ENDS subsection of your certificate, you may still be eligible to receive benefits. The circumstances under which benefits are available are described in your MetLife certificate.

CONTRIBUTIONS

You must pay the full after-tax cost of the premium of Accident, Hospital Indemnity and Critical Illness Insurance. The total premium rate for insurance provided under the Plan by MetLife is set by MetLife. When you enroll in the Plan, you authorize the deduction of your required premium payments from your paycheck.

PLAN YEAR

The Plan's fiscal records are kept on a Plan year basis beginning each January 1st and ending on the following December 31st.

QUALIFIED DOMESTIC RELATIONS ORDERS/QUALIFIED MEDICAL CHILD SUPPORT ORDERS

You and your beneficiaries can obtain, without charge, from the Plan Administrator a copy of any procedures governing Qualified Domestic Relations Orders (QDRO) and Qualified Medical Child Support Orders (QMCSO).

CLAIMS INFORMATION

Accident, Hospital Indemnity and Critical Illness Insurance Benefits Claims

Routine Questions

If there is any question about a claim payment, an explanation may be requested from MetLife which is able to provide the necessary information.

Claim Submission

For claims for Accident, Hospital Indemnity and Critical Illness Insurance benefits, the claimant must report the claim to MetLife and, if requested by MetLife, complete the appropriate claim form. Claim forms requested by MetLife must be submitted in accordance with the instructions on the claim form.

Initial Determination

After you submit a claim for Accident, Hospital Indemnity and Critical Illness Insurance benefits to MetLife, MetLife will review your claim and notify you of its decision to approve or deny your claim.

Such notification will be provided to you within a reasonable period, not to exceed 45 days from the date you submitted your claim; except for situations requiring an extension of time because of matters beyond the control of the Plan, in which case MetLife may have up to two (2) additional extensions of 30 days each to provide you such notification. If MetLife needs an extension, it will notify you prior to the expiration of the

initial 45 day period (or prior to the expiration of the first 30 day extension period if a second 30 day extension period is needed), state the reason why the extension is needed, and state when it will make its determination. If an extension is needed because you did not provide sufficient information or filed an incomplete claim, the time from the date of MetLife's notice requesting further information and an extension until MetLife receives the requested information does not count toward the time period MetLife is allowed to notify you as to its claim decision. You will have 45 days to provide the requested information from the date you receive the extension notice requesting further information from MetLife.

If MetLife denies your claim in whole or in part, the notification of the claims decision will state the reason why your claim was denied and reference the specific Plan provision(s) on which the denial is based. If the claim is denied because MetLife did not receive sufficient information, the claims decision will describe the additional information needed and explain why such information is needed. Further, if an internal rule, protocol, guideline or other criteria was relied upon in making the denial, the claims decision will state the rule, protocol, guideline or other criteria or indicate that such rule, protocol, guideline or other criteria was relied upon and that you may request a copy free of charge.

Appealing the Initial Determination

If MetLife denies your claim, you may appeal the decision. Upon your written request, MetLife will provide you free of charge with copies of documents, records and other information relevant to your claim. You must submit your appeal to MetLife at the address indicated on the claim form within 180 days of receiving MetLife's decision. Appeals must be in writing and must include at least the following information:

• Name of Employee

• Name of the Plan

• Reference to the initial decision

• An explanation why you are appealing the initial determination

As part of your appeal, you may submit any written comments, documents, records, or other information relating to your claim.

After MetLife receives your written request appealing the initial determination, MetLife will conduct a full and fair review of your claim. Deference will not be given to the initial denial, and MetLife's review will look at the claim anew. The review on appeal will take into account all comments, documents, records, and other information that you submit relating to your claim without regard to whether such information was submitted or considered in the initial determination. The person who will review your appeal will not be the same person as the person who made the initial decision to deny your claim. In addition, the person who is reviewing the appeal will not be a subordinate of the person who made the initial decision to deny your claim. If the initial denial is based in whole or in part on a medical judgment, MetLife will consult with a health care professional with appropriate training and experience in the field of medicine involved in the medical judgment. This health care professional will not have consulted on the initial determination, and will not be a subordinate of any person who was consulted on the initial determination.

MetLife will notify you in writing of its final decision within a reasonable period of time, but no later than 45 days after MetLife's receipt of your written request for review, except that under special circumstances MetLife may have up to an additional 45 days to provide written notification of the final decision. If such an extension is required, MetLife will notify you prior to the expiration of the initial 45 day period, state the reason(s) why such an extension is needed, and state when it will make its determination. If an extension is

needed because you did not provide sufficient information, the time period from MetLife's notice to you of the need for an extension to when MetLife receives the requested information does not count toward the time MetLife is allowed to notify you of its final decision. You will have 45 days to provide the requested information from the date you receive the notice from MetLife.

If MetLife denies the claim on appeal, MetLife will send you a final written decision that states the reason(s) why the claim you appealed is being denied and references any specific Plan provision(s) on which the denial is based. If an internal rule, protocol, guideline or other criteria was relied upon in denying the claim on appeal, the final written decision will state the rule, protocol, guideline or other criteria or indicate that such rule, protocol, guideline or other criteria was relied upon and that you may request a copy free of charge. Upon written request, MetLife will provide you free of charge with copies of documents, records and other information relevant to your claim.

Discretionary Authority of Plan Administrator and Other Plan Fiduciaries

In carrying out their respective responsibilities under the Plan, the Plan administrator and other Plan fiduciaries shall have discretionary authority to interpret the terms of the Plan and to determine eligibility for and entitlement to Plan benefits in accordance with the terms of the Plan. Any interpretation or determination made pursuant to such discretionary authority shall be given full force and effect, unless it can be shown that the interpretation or determination was arbitrary and capricious.

Allocation and Delegation of Fiduciary Responsibilities by the Benefits Committee

The Plan provides a procedure for the Benefits Committee, acticing 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 Plan.

ENROLLING FOR COVERAGE

If you meet the eligibility requirements as defined in the certificates of coverage, you can enroll yourself and your eligible spouse and/or child(ren) under the Supplemental Benefits Program.

You are not eligible for coverage under the Supplemental Benefits 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 full-time benefits-eligible or part-time A benefits-eligible, or
- A union employee represented by a collective bargaining agreement, except if such agreement allows for participation in the Supplemental Benefits Program.

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

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.

To participate, as a new benefits-eligible employee, you receive enrollment information that details the coverages for which you may elect. 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.

For purposes of determining your deadline review the chart below

If You Start on the 1st Of or During the Month Of:	**You Must Complete Your Enrollment Prior To:**
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 do not enroll when you are first eligible, you must wait until Annual Enrollment to apply.

ANNUAL ENROLLMENT

Every fall during the Annual Enrollment period, you receive information about the Supplemental Benefits Program for which you are eligible. You then have the opportunity to apply for coverage for yourself and your spouse and/or child(ren).

For Employees of New Participating Subsidiaries

The Supplemental Benefits Program described in this document applies to eligible employees of RR Donnelley to whom benefits have been extended. For employees of newly acquired participating subsidiaries, the effective date for a benefit generally is the date on which benefits are extended. That date will be announced in each affected location. The announced effective date generally applies to employees on or after that date who have enough service with their employer to satisfy the waiting period for the Supplemental Benefits Program.

If you have questions concerning your eligibility to participate in the Supplemental Benefits Program, contact the claims administrator.

A complete list of the employers sponsoring the Group Benefits Plan may be obtained for examination by you upon written request to the RR Donnelley Benefits Center at 877-773-4236 and hours of operation are 8am - 5pm central time (Monday – Friday).

GENERAL

You are eligible for coverage under the Supplemental Benefits Program only if you are an employee of a Participating Employer or subsidiary as identified in the certificates of coverage. As you review the certificates of coverage, be sure to check the eligibility to determine if the Supplemental Benefits Program's coverages apply to you, your spouse, and/or your child(ren). If you are an employee of an employer or subsidiary that does not participate in the Group Benefits Plan, you are not eligible for the benefits described in this SPD. To find out if you are eligible for these benefits, contact the claims administrator.

Union employees covered by a collective bargaining agreement need to refer to such agreement for any differences from the options offered, eligibility rules, and waiting periods for coverage described in this SPD. Your collective bargaining agreement will control.

This SPD and any supplemental information, including the certificates of coverage attached hereto, are intended to be a complete, accurate, and up-to-date description of your coverages under the Supplemental Benefits Program. In the event of uncertainty, the claims administrator has the authority or discretion to make a determination of whether you are paid a benefit under the Supplemental Benefits Program.

In addition, nothing in this SPD should be interpreted as an employment contract or a guarantee of employment. This summary merely describes the coverages and benefits currently offered to eligible employees as of January 1, 2015.

FUTURE OF THE PLAN

RR Donnelley reserves the right to amend or terminate the R. R. Donnelley & Sons Company Group Benefits Plan or this coverage at any time, in whole or in part In the event your insurance ends in accordance with the DATE YOUR INSURANCE ENDS subsection of your certificate, you may still be eligible to receive benefits. The circumstances under which benefits are available are described in your MetLife certificate.

STATEMENT OF ERISA RIGHTS

The following statement is required by federal law and regulation.

As a participant in the Plan, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all participants shall be entitled to:

Receive Information About Your Plan and Benefits

Examine, without charge, at the Plan administrator's office and at other specified locations, all Plan documents, including insurance contracts 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 copies of the latest annual report (Form 5500 Series) and updated summary plan descriptions. The 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.

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 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 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 administrator. If you have a claim for benefits which is 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 or a medical child support order, you may file suit in a 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 Plan administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor,

200 Constitution Avenue N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.