RR DONNELLEY

Retiree Medical Benefit and Drug Benefit Programs

Summary Plan Description

October 1, 2016

Contents

Introduction

Effective October 1, 2016, retiree medical, prescription drug and retiree life insurance benefits were eliminated for all active employees of a Participating Employer who retire on or after October 1, 2016. This Summary Plan Description ("SPD") describes the medical and prescription drug benefits available to an eligible former employee of R.R. Donnelley & Sons Company ("RR Donnelley") and its subsidiaries who retired prior to October 1, 2016 (a "Retiree"), and his or her eligible dependent(s). The R.R. Donnelley & Sons Company Retiree Welfare Benefits Plan (the "Plan") provides benefits to eligible Retirees through two programs, the:

- "Medical Benefit Program"; and
- "Drug Benefit Program".

When the term "Program" is used in this SPD, it refers collectively to the Medical Benefit Program and the Drug Benefit Program.

This SPD explains Retiree coverage for you and your spouse if you retired from a Participating Employer prior to October 1, 2016 (unless used otherwise in the context, "you" or "your" when used in this SPD is intended to refer to the Retiree, unless deceased, in which case it refers to the eligible spouse of the Retiree). It details who is eligible for coverage, when coverage begins and ends, and which expenses are and are not covered under the Program. It also describes how to file a claim and your rights under the Program. Please read this information to familiarize yourself with the Program.

Claims Administrators

The Plan has contracted with a number of third parties to render services necessary for the operation and administration of the Plan and the Program as the claims administrator and network manager. Some of these services involve authority and discretion over the Program.

In most cases, United HealthCare Insurance Company (UHC) is the claims administrator and network manager for the self-funded portions of the Medical Benefit Program (except in the case of Esselte Retirees, in which case BlueCross BlueShield (BCBS) of Illinois is the claims administrator. In other cases, UHC is also an insurer and underwrites the Medical Benefit Program coverage (except in the case of Meredith Burda, where Wellmark BCBS is the insurer). CVS Caremark and SilverScript are the claims administrators and network managers for the Drug Benefit Program. (See the "Administrative and Contact Information" section for additional information.)

This SPD and any supplemental information incorporated by reference are intended to be a complete, accurate, and up-to-date description of your coverage under the Program. However, since treatments, protocols, and practice patterns continually change, this document cannot adequately define every potentially covered service or exclusion. In all cases, the applicable claims administrator will have the authority and

discretion to make the determination of covered services. If there is any discrepancy between this SPD and the Plan, the Plan always governs.

In addition, nothing in this SPD should be interpreted as a guarantee of continued coverage. This summary merely describes the coverages and benefits offered to eligible Retirees and their dependent(s) who retired from a Participating Employer prior to October 1, 2016. RR Donnelley reserves the right to change or terminate the Plan or Program, in whole or in part, at any time.

The Plan also provides similar Retiree coverage for certain grandfathered Retirees of acquired companies and their subsidiaries. (See the "Special Rules for Certain Participants" section for additional information.) In addition, the Plan also provides similar Retiree coverage for "access-only" eligible Retirees.

This content contains a summary in English of your rights and benefits under the 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 from 8 a.m. to 5 p.m. CT, Monday through Friday, except holidays.

Who Is Eligible

Retiree Eligibility Requirements (RRD-Subsidized)

The following eligibility requirements apply only to employees of a Participating Employer (RRD-Subsidized) as defined in the "Administrative and Contact Information" section of this SPD. See further eligibility requirements for Participating Employer (RRD-Access Only) below and see the "Special Rules for Certain Participants" section for additional information for Participating Employer (Acquisition Group – Grandfathered).

You are eligible for coverage as a Retiree under the Program if you meet all of the following requirements:

- Your employment with a (RRD-Subsidized) Participating Employer terminated prior to October 1, 2016; and
- Your employment with a (RRD-Subsidized) Participating Employer terminated on or after your 55th birthday; and
- You completed 10 or more years of service with a (RRD-Subsidized) Participating Employer in a benefits-eligible position, and this period of service must end after attaining age 55.

If You Are Involuntarily Separated

If you were involuntarily separated from employment pursuant to a workforce reduction within 12 months of the date you otherwise would have satisfied the eligibility criteria for the Program, you would have been treated, but only for purposes of the Program, as if your employment did not terminate until you would have become eligible for coverage under the Program. You became eligible for coverage effective on the date you would have become eligible for coverage if your involuntary separation had not occurred, provided you were alive on that date.

An age example: If you are age 54 and have completed 10 years of service at the time you are involuntarily separated, you are eligible for coverage on the date you attain age 55. You must still take the necessary steps to enroll and make the required payments of your premiums to the Plan in a timely manner.

A service example: If you are age 60 with nine years of service at the time you are involuntarily separated, you are eligible for coverage on the date in which your 10-year anniversary of employment would have occurred. You must enroll and make required payments of your premiums to the Plan in a timely manner.

Retiree Eligibility Requirements (RRD-Access Only)

Note: *This RRD-Access Only provision is being eliminated effective December 31, 2016.*

The following eligibility requirements apply only to employees of a (RRD-Access Only) Participating Employer as defined in the "Administrative and Contact Information" section of this SPD.

You are eligible for coverage as a Retiree under the Program if your employment with a (RRD-Access Only) Participating Employer terminated on or after March 1, 2007, and you meet all of the following requirements at the time of termination:

- Your full years* of age and full years* of service since your adjusted service date total 55 or more points;
- You are at least age 50 on your termination date;
- You have completed two or more years of continuous service in a benefits-eligible position (defined below);
- You have completed at least two or more years of continuous service with a (RRD-Access Only) Participating Employer, which ends on your termination date; and
- Your employment with a (RRD-Access Only) Participating Employer terminated on or before September 30, 2016.

*The Program uses full years when determining age and service. Therefore, if you are 49 ½, the Program considers you to be 49 years old.

If your employment terminated prior to March 1, 2007, the eligibility requirements set forth above do not apply to you. Your Retiree eligibility requirements are those in effect on the date your employment terminated.

If You Are Involuntarily Separated

If you are involuntarily separated from employment pursuant to a workforce reduction within 12 months of the date you will attain age 50, you have earned at least two full years of continuous service in a benefits-eligible position, and you have earned at least two full years of continuous service on or immediately prior to the date you separate from employment, you will be treated, but only for purposes of the Program, as if you had attained age 50. You will become eligible for coverage effective on the date you separate from employment if your age and full years of service since your adjusted service date total 55 or more points.

An age example: If you are age 49 and have completed at least 10 years of continuous service in a benefits-eligible position at the time you are involuntarily separated, you are eligible for coverage on the date you separate from employment.

You must still take the necessary steps to enroll and make the required payments of your premiums to the Plan in a timely manner.

A service example: If you are age 60 with at least one and one-half years of continuous service in a benefits-eligible position at the time you are involuntarily separated, you are **not** eligible for coverage.

If You Are on an Authorized Leave of Absence

If you were an employee on an authorized leave of absence as determined under the provisions of your employer's policies, you would have been eligible for coverage under the Program if you met the eligibility requirements for the Program as outlined above. For this purpose, service earned while on an authorized leave of absence from a benefits-eligible position counted toward satisfying the requirement that you serve two or more years of continuous service in a benefits-eligible position.

Retiree Eligibility Requirements (RRD-Subsidized and RRD-Access Only)
Notwithstanding anything to the contrary in this SPD or any other document describing eligibility for coverage under the Program, any right to coverage under the Program immediately terminated effective October 1, 2016 if you had not met the eligibility requirements above. In order to qualify as an eligible Retiree, you must have terminated/retired from RR Donnelley and all of its subsidiaries and affiliates (including but not limited to LSC Communications and Donnelley Financial Services) on or before September 30, 2016. If you retire(d) from a Participating Employer on or after October 1, 2016, you will not be eligible to enroll in the Medical Benefit Program or Drug Benefit Program.

In addition, and notwithstanding any other provision of this SPD to the contrary, if you met the above requirements and you were a union employee covered by a collective bargaining agreement, you were eligible for coverage only to the extent the collective bargaining agreement provided for your and perhaps your eligible spouse's eligibility to participate.

You are not eligible for coverage under the Program if you are currently working as an active employee (e.g., if you are rehired by RR Donnelley and return to active employment following retirement) However, when you later cease working as an active employee of RR Donnelley, you will automatically rejoin the RR Donnelley Medical Benefit Program and Drug Benefit Program if you were enrolled in the Program immediately prior to returning to active employment.

You are not eligible for coverage under the Program if you are currently covered as a spouse or dependent of an active employee under the Medical and Drug Benefit Program of the RR Donnelley Group Benefits Plan ("Active Program"). If you want to enroll in the Retiree Program, you must drop your Active Program coverage and enroll in the Retiree Program no later than the date you attain Medicare eligibility or age 65. Otherwise, coverage under the Retiree Program will no longer be available to you (or your spouse, if eligible), and you will not be permitted to join the Retiree Program in the future.

Benefits-Eligible Position

You are in a benefits-eligible position if you are an employee of a Participating Employer and you are eligible to participate in the Active Program.

Note: *You are not eligible to participate in this program if your employment with a Participating Employer terminates on or after October 1, 2016.*

Important: *Being eligible for the Program does not mean you or Eligible spouse can enroll in the Program. See the section titled "Enrolling for Coverage" for additional rules and limitations.*

If You Die

If you are eligible for coverage under the Program when you die, your eligible dependent who is eligible for coverage can commence or continue coverage under the Program. Your surviving spouse may commence or continue coverage, regardless of whether he or she remarries or becomes eligible for coverage under another employer's plan.

However, if you have not enrolled in the Program prior to your death, your surviving spouse must enroll if he or she wants coverage.

Spouse Eligibility Requirements (RRD-Subsidized and RRD-Access Only)

A "spouse" means an individual to whom a Retiree is legally married, or a Retiree's common-law spouse, in states that recognize common-law marriages, in the state of the Retiree's primary residence.

A Retiree's spouse is eligible for coverage under the Program only if the Retiree, and if applicable, the Retiree's spouse, meet all of these requirements at all times:

- If the Retiree is alive, the Retiree must be enrolled for coverage under the Program. The Retiree's spouse cannot elect coverage under the Program on his or her own. However, if the Retiree's spouse is also a Retiree and has met the eligibility requirements for coverage under the Program, he or she may elect his or her own coverage as a Retiree.
- The Retiree must be married to the Retiree's spouse on the date the Retiree terminates employment with, or dies while employed by, a Participating Employer. No coverage will be provided for a spouse a Retiree marries after the date the Retiree's employment terminates.
- The Retiree's spouse may not be legally separated from the Retiree or on active duty with any military forces.
- The Retiree's spouse may not be covered as an active employee under the Active Program or under the Program as a Retiree.

A Retiree's spouse who continues coverage as a surviving spouse who later remarries cannot enroll his or her new spouse in the Program.

Dependent children of a Retiree or a Retiree's spouse are not eligible for coverage under the Program (unless the Retiree is an access-only Retiree – see dependent child eligibility requirements below).

Dependent Child Eligibility Requirements (RRD-Access Only)

Note: *RRD-Access Only Provision will terminate on December 31, 2016.*

Effective March 1, 2007, and until December 31, 2016, a dependent child of an access-only Retiree or of the surviving spouse of such Retiree is an "eligible child" who can be covered under the Program only if and for so long as the access-only Retiree and/or the surviving spouse of such Retiree and the eligible child meet all of these requirements:

- If the access-only Retiree or the surviving spouse of such Retiree is alive, the access-only Retiree or the surviving spouse of such Retiree must be enrolled for coverage under the Program.
- If neither the access-only Retiree nor the surviving spouse of such Retiree is living, a dependent child of such Retiree or such spouse is not eligible for coverage.
- The eligible child must be a dependent child of the access-only Retiree on the date the Retiree terminates employment with, or dies while employed by, RR Donnelley or a Participating Employer and otherwise be eligible for coverage under the Program. No coverage will be provided for a dependent child who becomes a dependent child of the access-only Retiree or the surviving spouse of such Retiree after the date the Retiree's employment terminates.
- The eligible child may not be on active duty with any military forces.
- The eligible child may not be covered as an active employee or dependent under the Active Program.
- The eligible child cannot elect coverage under the Program on his or her own.
- The child must qualify as a dependent child of the Retiree or surviving spouse within the meaning of Section 105 of the Internal Revenue Code of 1986, as amended,
  and be:
  - An unmarried child under age 19; or
  - An unmarried child age 19, and up to age 23, who is a full-time student enrolled in a recognized accredited school, college, or university.

A child, for purposes of the Program, is defined below.

Child – the "child" of an individual is:

- Such individual's natural child;
- Such individual's legally adopted child;
- A child placed with such individual for adoption;
- Such individual's stepchild;
- Such individual's grandchild who lives with him or her and for whom such individual is the sole legal guardian due to death or severed parental rights; or
- Any other child who lives with such individual and for whom such individual is the sole legal guardian.

Extended Coverage for Full-Time Students Age 19 and Older

Note: *RRD-Access Only Provision will terminate on December 31, 2016.*

You must verify student status of your covered eligible child from age 19 until age 23 to continue coverage for such child. If you fail to provide verification of student status when requested by the administrator, your child will no longer be an eligible child as of the day he or she attains age 19 and will be removed from coverage under the Program for the remainder of the calendar year.

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

If your covered eligible child is no longer a student, contact the administrator to have the child removed from coverage. Eligibility ends upon such notification, or earlier as described above. If your child again becomes an eligible child, you may enroll the child for coverage during the next Annual Enrollment period provided the child continues to be an eligible child at that time, or possibly sooner if you report a Qualified Status Change.

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

Extended Coverage for Disabled Children

Note: *RRD-Access Only Provision will terminate on December 31, 2016.*

If your covered eligible child is mentally or physically disabled and unable to support himself or herself, you can continue coverage for that child after age 19 (or after age 23 if a student). To be eligible for continued coverage, your child must be covered under the Program immediately before the coverage would otherwise end, and the disability must begin while his or her eligible child coverage under the Program is in effect. To continue coverage, 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 your disabled child to your coverage based on his or her disability status.

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

- Be unmarried; and
- Be 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 medical vendor (i.e., UHC) at the address and by the deadline indicated, your child will cease to be an eligible child and will lose extended coverage.

Qualified Medical Child Support Order (QMCSO)

Note: *RRD-Access Only Provision will terminate on December 31, 2016.*

The Program can also provide coverage for your child pursuant to the terms of a Qualified Medical Child Support Order (QMCSO). You are responsible for 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 RR Donnelley 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 "qualified" and therefore valid. The Plan follows certain procedures to determine if a medical child support order 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 Program pursuant to the terms of a valid QMCSO. If you do not elect a coverage 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.

Please note that if you are subject to a QMCSO, your "child" is defined as:

- Your natural child;
- Your legally adopted child; or
- A child 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 Program's service area; or
- Is receiving benefits or is eligible to receive benefits under a state Medicaid program.

Your parents, grandparents, brothers, and sisters are not eligible for coverage.

Enrolling for Coverage

General Information

If you are enrolled or eligible to enroll in the Program each year you will receive Annual Enrollment materials. Here is a brief look at how enrolling for coverage works.

If you want to enroll, you can:

Log on to the Your Benefits Resources™ website via *My Benefits Directory* at **www.resources.hewitt.com/rrd**; or

- Call the Benefits Center at 1-877-RRD-4BEN (1-877-773-4236).

You will receive a confirmation of your enrollment or disenrollment based on your method of enrollment. If you enroll via the website, print a confirmation page (a paper statement will not be mailed to you). If you enroll by phone, you will receive a written confirmation in the mail.

If, on December 31, 2013, a subsidy-eligible former employee is under age 65 (and not enrolled in the Program): The subsidy-eligible Retiree must enroll the earlier of attaining Medicare eligibility or age 65. Otherwise, coverage under the Program will no longer be available to the subsidy-eligible Retiree or his or her spouse, if eligible. **This means the subsidy-eligible former employee's last chance to opt in to the Program is when he or she becomes Medicare-eligible.** In addition, once enrolled in the Program, even if prior to age 65 or Medicare-attainment, if a subsidy-eligible former employee decides to opt out of coverage, such individual and his or her eligible spouse cannot opt back in.

Note: Medicare is effective the first of the month in which you turn 65, but it can take 60 days for coverage under the Program to take effect, since your election must first be accepted by the Centers for Medicare and Medicaid Services (CMS). Thus, if you want coverage to take effect at the same time as Medicare, you will need to contact the Benefits Center 60 days prior to that date. Otherwise, you may have a lapse in coverage and need to pay a penalty. Visit http://www.medicare.gov for more information about enrollment and potential penalties.

The rules above apply based on your (the Retiree's) Medicare eligibility. For example, if you are under age 65, but your spouse is over 65, you have until **your** Medicare attainment age to enroll both you and your spouse in coverage.

If, on December 31, 2013, a subsidy-eligible former employee is age 65 or over (or otherwise Medicare-eligible) and has not previously enrolled in the Program: The subsidy-eligible former employee only has until December 31, 2013 to elect coverage under the Program. His or her coverage will take effect either January 1, 2014, or 60 days after he or she contacts the Benefits Center to enroll, whichever is later. If a subsidy-eligible former employee does not opt in by December 31, 2013, coverage under the Program will no longer be available to the subsidy-eligible former employee or his or her spouse, if eligible. In addition, once enrolled in the Program, if a subsidy-

eligible former employee decides to opt out of coverage, such individual and his or her eligible spouse cannot opt back in.

If, on December 31, 2013, a subsidy-eligible former employee regardless of age continued enrollment in the Program: The subsidy-eligible former employee will continue his or her coverage under the Program. However, if a subsidy-eligible former employee later decides to opt out of coverage after December 31, 2013, such individual and his or her eligible spouse cannot opt back in.

NOTE: IF YOU ENROLL IN COVERAGE UNDER THE PROGRAM AND LATER DECIDE TO OPT OUT, YOU CANNOT REENROLL YOURSELF OR YOUR ELIGIBLE SPOUSE.

Program Premium Cost

Determining an Annual Premium for You and your Eligible Spouse

Program Premium Cost – Determining an Annual Premium for You and Your Eligible Spouse – Total Cost of Coverage

Each calendar year, the Plan's actuaries determine the projected total cost of coverage for the Program based on each Medical Benefit Program option available to a Retiree and his or her spouse. The "total cost of coverage" includes all Program claims incurred by the Plan and operating expenses.

How much you and your eligible spouse must pay to the Plan to be enrolled for coverage (called your "premium") will depend upon:

- Which Medical Benefit Program you are enrolled in;
- Whether you cover eligible spouse; and
- Whether you are eligible for a subsidy, as described below, from your former employer, and if so, the amount of such subsidy.

You will know the premium for the next calendar year when you receive your Annual Enrollment materials.

If you are an ***RRD-Access Only Retiree*** participating in the Program, you are not eligible for any subsidy. You pay the full premium.

Note: *The RRD-Access Only provision will terminate on December 31, 2016.*

If you are a grandfathered Retiree of an acquired company, you may be eligible for a subsidy as outlined in your grandfathered coverage. (See the "Special Rules for Certain Participants" section for additional information.)

Annual Subsidy Cap Amount

On January 1, 1997, RR Donnelley implemented a cap (the "annual subsidy cap amount") on how much a Participating Employer will pay, on and after January 1, 1997, to the Plan for coverage of a Retiree and his or her spouse in the Program, based on the Medical Benefit Program in which the Retiree and his or her spouse are enrolled, if the Retiree satisfies an age and continuous service requirement. When the total cost of coverage (e.g., without a subsidy) exceeds the annual subsidy cap amount, the Retiree and his or her spouse, if eligible for the annual subsidy cap amount, are responsible for the total cost of coverage in excess of their annual subsidy cap amount. As a result, if you and your spouse are eligible for an annual subsidy cap amount, the premiums you and your spouse are charged for participating in the Program will be equal to the total cost of coverage you and your spouse would otherwise have to pay, based on the Medical Benefit Program in which you and your spouse are enrolled (without the

subsidy), minus the annual subsidy cap amount for you and your spouse for that Medical Benefit Program.

You and your spouse are eligible, on and after January 1, 1997, for an annual subsidy cap amount only if all of the following criteria are met:

- You have 10 years of “continuous service”;
- Your employment with a Participating Employer (RRD-Subsidized) terminated:
  - on or after your 55th birthday, and
  - on or before September 30, 2016; and
- Your 10 years of continuous service must end on or after you attain age 55 while you are employed in a benefits-eligible position.

On and after January 1, 2002:

- RR Donnelley eliminated any subsidy amount if you were hired on or after January 1, 2002 by a Participating Employer (RRD-Subsidized), or
- You were hired prior to January 1, 2002 but did not work prior to January 1, 2002 for a Participating Employer (RRD-Subsidized) in a benefits-eligible position.

On and after January 1, 2005:

- RR Donnelley froze the group of Retirees and their spouses who were, or could have become, eligible for the annual subsidy cap amount.
- To be eligible, or to become eligible, for the annual subsidy cap amount, you must satisfy the eligibility criteria created effective on and after January 1, 1997 and January 1, 2002, plus you either (1) must have terminated employment from a Participating Employer (RRD-Subsidized), or died while employed by a Participating Employer (RRD-Subsidized), prior to January 1, 2005, or (2) must have a combination of your age and continuous service as of December 31, 2004 equal to at least 65.
- If you could have become eligible for the annual subsidy cap amount but your combined age and continuous service, on December 31, 2004, was less than 65, you and your spouse will become eligible for a reduced annual subsidy cap amount when you satisfy the eligibility criteria created effective January 1, 1997 and January 1, 2002.

If you and your spouse are eligible for an annual subsidy cap, the following charts outline the current amount of an annual subsidy cap based on the Medical Benefit Program in which you and your spouse are enrolled.

You satisfy the eligibility criteria created effective on and after January 1, 1997 and January 1, 2002, and you:	Annual subsidy cap amount per individual if you or your spouse is under age 65 and you or your spouse is enrolled in the UHCPre 65 Option
• Terminate employment or die before January 1, 2005.	$5,180
• Terminate employment or die on or after January 1, 2005 and your age and continuous service, when combined, equal at least 65 as of December 31, 2004.	$5,180
• Terminate employment or die on or after January 1, 2005 and your age and continuous service, when combined, is less than 65 as of December 31, 2004.	$2,590
You satisfy the eligibility criteria created effective on and after January 1, 1997 and January 1, 2002, and you:	**Annual subsidy cap amount per individual if you or your spouse is age 65 or older and is enrolled in the UHC Post-65 Medical Option**
• Terminate employment or die before January 1, 2005.	$1,458
• Terminate employment or die on or after January 1, 2005 and your age and continuous service, when combined, equal at least 65 as of December 31, 2004.	$1,458
• Terminate employment or die on or after January 1, 2005 and your age and continuous service, when combined, is less than 65 as of December 31, 2004.	$500

The annual subsidy cap does not affect the $2 million lifetime maximum benefit and is not associated with health care claims of individual Retirees or their spouses.

Continuous Service

Continuous service, for eligibility purposes, means that you were continuously employed in a benefits-eligible position, or if you terminated employment, you were reemployed in a benefits-eligible position within 30 days of your termination date.

Special Rules for Certain Participants

For purposes of the Program, some Retirees currently have grandfathered rights under the Program. This most likely occurred when RR Donnelley acquired a business, sold a business or when there was a significant workforce reduction.

Who Is Eligible – Closed Eligibility Group

If you are in a Retiree group described below ("Retiree Group"), your eligibility and benefits are subject to the additional rules described below for your group.

Moore Pre-1979 Retiree Group

Coverage under the Program is available if you:

- Are a former employee of a participating division of Moore North America, Inc. (formerly Moore U.S.A. Inc.);
- Meet the requirements of an early, normal, deferred, or certain disability retirement under the Moore Retirement Income Plan; and
- Retired prior to January 1, 1979.

Participating divisions include all U.S. Moore divisions as of December 31, 1978, except for collective bargaining units of the Minneapolis plant of Moore Data Management Services.

Moore 1979 – 1986 Retiree Group

Coverage under the Program is available if you:

- Are a former employee of a participating division of Moore North America, Inc. (formerly Moore U.S.A. Inc.);
- Meet the requirements of an early, normal, deferred, or certain disability retirement under the Moore Retirement Income Plan; and
- Retired between January 1, 1979 and June 30, 1986.

Participating divisions include all U.S. Moore divisions as of June 30, 1986, except for collective bargaining units of the Minneapolis plant of Moore Data Management Services.

Special Rules for Certain Participants

Moore 1986 – 1994 Retiree Group

Coverage under the Program is available if you:

- Are a former employee of a participating division of Moore North America, Inc. (formerly Moore U.S.A. Inc.);
- Meet the requirements of an early, normal, deferred, or certain disability retirement under the Moore Retirement Income Plan; and
- Retired between July 1, 1986 and March 31, 1994.

Participating divisions include all U.S. Moore divisions as of March 31, 1994, except for collective bargaining units of the Minneapolis plant of Moore Data Management Services.

Moore Post-4/1/1994 Retiree Group

Coverage under the Program is available if you:

- Are a former employee of a participating division of Moore North America, Inc. (formerly Moore U.S.A. Inc.);
- Meet the requirements of an early, normal, deferred, or certain disability retirement under the Moore Retirement Income Plan; and
- Retired between April 1, 1994 and June 30, 1997; or
- Retired on or after July 1, 1997 and were “grandfathered.”

You are considered “grandfathered” if you fall into one of the following categories:

- As of June 30, 1997, you were age 65 or older; or
- As of June 30, 1997, you were age 50 or older with 10 or more years of service; or
- As of June 30, 1997, you were age 45 with 20 or more years of service and you were employed by Moore on December 31, 1997.

General Rules Applicable to Moore Retiree Groups

Generally, all divisions and units of Moore are eligible for the Moore Retirement Income Plan, except collective bargaining units of the Data Management Services Division or any divisions, units, or subsidiaries formed, reorganized, or acquired after January 1, 1992 – unless Moore designates it in writing as a participating division or unit. In addition, most expatriate employees are ineligible.

Wallace Subsidized Retiree Group

Coverage under the Program is available if you:

- Retired before 1997 and were age 55 or older with five or more years of service at retirement; or
- Were a Retiree covered by the Program as of January 1, 1994; or
- Were an employee at least age 55 and had 20 or more years of service by December 31, 1993; or
- Were an employee between ages 50 and 54 who had 20 years of service by December 31, 1993 and elected on or prior to December 31, 1998 to elect early retirement and was 55 years of age or older at the time of the special election; or
- Were an employee who was at least 60 years of age with less than 20 years of service by December 31, 1993 who elected to take early retirement by the end of 1993.

Wallace, Litho, Nielsen Unsubsidized Retiree Group

Coverage under the Program is available if you:

- Were actively at work on December 31, 2003;
- Were age 55 or older with 10 or more years of service at retirement; and
- Had 75 points (age and service) as of December 31, 2003.

Wallace, Litho, Nielsen Unsubsidized Retiree Group (retired on or after January 1, 2004)

Coverage under the Program is available if you:

- Were a former employee of Wallace Computers, Litho Industries, or The Nielsen Company; and
- Were age 55 or older with 10 or more years of service at retirement.

Program Premium Cost

See the table below for information on the premium for you and your spouse/domestic partner for the Program. Refer to the "Who Is Eligible" section for a detailed description of who qualifies for each of the Retiree Groups.

Retiree Group	Retiree Medical Coverage Cost
Moore Pre-1979 Retirees	The company pays the entire cost of your coverage.
Moore 1979 – 1986 Retirees	The company subsidizes a portion of your coverage.
Moore 1986 – 1994 Retirees	The company subsidizes a portion of your coverage.
Moore Post-4/1/1994 Retirees	You are responsible for the full cost of your coverage.
Wallace Subsidized Retirees	The company subsidizes a portion of your coverage.
Wallace, Litho, Nielsen Unsubsidized Retirees	You are responsible for the full cost of your coverage.
Wallace, Litho, Nielsen Retirees Who Retired on or After January 1, 2004	You are responsible for the full cost of your coverage.

Thus, all eligible Retirees and their spouses/domestic partners, except Moore pre-1979 Retirees, must pay premiums to be covered under the Program.

"Domestic partner" means the person of the same- or opposite-sex with whom the eligible Retiree has 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 Program. If the eligible Retiree's domestic partnership is not registered with a state or local governmental entity, it must satisfy the following criteria for the eligible Retiree's domestic partner to be eligible for coverage:

- Neither the eligible Retiree nor his or her domestic partner are legally married to or are the legal domestic partner of anyone else;
- the eligible Retiree and his or her domestic partner intend to remain each other's sole domestic partner indefinitely;
- the eligible Retiree and his or her domestic partner are committed to each other and share joint responsibilities for their common welfare and financial obligations; and
- the eligible Retiree and his or her domestic partner are not related by blood, closer than would prohibit marriage in the state in which they live.

Cap on Company Subsidies

On January 1, 2005, RR Donnelley implemented a subsidy cap on future Moore Wallace Retiree and spouse/domestic partner health care costs. When future Program costs exceed the subsidy cap amount, participating Retirees and their spouses/domestic partners are responsible for all additional costs. As a result, the contributions you and your spouse/domestic partner are charged for participating in the Program reflect the excess costs.

The cap on the Retiree medical subsidy applies to members of the Moore 1986 – 1994 Retiree Group and the Wallace Subsidized Retiree Group.

The following chart summarizes the amount of the subsidy cap.

Retiree Group	Annual subsidy cap amount per individual if you or your spouse/domestic partner are under age 65 and you or your spouse/domestic partner are enrolled in the Program
If You Are Under Age 65	
Moore Pre-1979 Retirees	No cap
Moore 1979 – 1986 Retirees	No cap
Moore 1986 – 1994 Retirees	$5,000
Moore Post-4/1/1994 Retirees	Not applicable (subsidy based on Retiree Medical Allowance if you retired before July 1, 1997; if not, you are not subsidized)
Wallace Subsidized Retirees	$5,000
Wallace, Litho, Nielsen Unsubsidized Retirees	Not subsidized
Wallace, Litho, Nielsen Retirees Who Retired on or After January 1, 2004	Not subsidized
Retiree Group	Annual subsidy cap amount per individual if you or your spouse/dependent partner are age 65 or older and you or your spouse/dependent partner are enrolled in the Program
If You Are Age 65 and Over	
Moore Pre-1979 Retirees	No cap
Moore 1979 – 1986 Retirees	No cap
Moore 1986 – 1994 Retirees	$2,000
Moore Post-4/1/1994 Retirees	Not applicable (subsidy based on Retiree Medical Allowance if you retired before July 1, 1997; if not, you are not subsidized)
Wallace Subsidized Retirees	$2,000
Wallace, Litho, Nielsen Unsubsidized Retirees	Not subsidized
Wallace, Litho, Nielsen Retirees Unsubsidized Who Retired on or After January 1, 2004	Not subsidized

The cap does not affect the $2 million lifetime maximum benefit and is not associated with health care claims of individual Retirees or their spouses/domestic partners.

Retiree Waive Credit Program

The Retiree Waive Credit Program (RWCP) is available to eligible Retirees and their spouses/domestic partners who seek medical coverage through another source.

You're eligible for the RWCP if you are a:

- Moore North America Retiree who retired between January 1, 1979 and March 31, 1994; or
- Wallace Subsidized Retiree who retired before 1997, at age 55 or older with five or more years of service at retirement.

If you and/or your spouse/domestic partner choose to opt out of coverage under the Program, each of you who elect to opt out will be eligible to receive up to a $1,200 reimbursement. This is to cover medical premiums you pay for an alternative plan during this period, on an after-tax basis. You must first incur a premium cost for coverage outside of this program; then you can submit the claim for premium reimbursement.

If you choose to participate in the RWCP, you will need to choose "No Coverage" under this Program. For your spouse/domestic partner to be eligible for the RWCP, you must ensure that your spouse/domestic partner is on the "Your Benefits Resources" system as an eligible dependent. If the RWCP coverage is for the Retiree and the spouse/domestic partner, then the spouse/domestic partner will be eligible to continue a $1,200 opt out reimbursement after the Retiree's death. The surviving spouse/domestic partner will also be eligible to continue the RWCP as long as the Retiree selected two $1200 opt out reimbursements at the time of the enrollment in the Program. If the Retiree selected only one reimbursement, then the benefit stops with the Retiree's death (i.e., the spouse will no longer receive a reimbursement).

Note: If you are dropped from RR Donnelley coverage during the coverage period due to non-payment, you are not treated as having elected an opt-out and are not eligible to receive the RWCP reimbursement for the remainder of the year. The RWCP is only offered during the benefits enrollment period, unless you have a qualifying status change.

Your Spending Account will handle all administrative and customer service issues for reimbursements related to premiums paid on or after January 1, 2005. Once you incur a premium charge after this date, you will be able to mail your claim form, along with receipts or copies of receipts, to the following address:

Your Spending Account
P.O. Box 64030
The Woodlands, TX 77387-4030
1-877-RRD-4BEN (1-877-773-4236)

Retiree Health Care Account (RHCA)

Here is some important information regarding the RHCA Plan, including eligibility requirements and how the RHCA Plan operates.

If You Retired From Moore Prior to July 1, 1997

During your active employment, the Company allocated a certain amount on your behalf to the Retiree Health Care Account (RHCA) for each year of service with Moore. When you retired, your Retiree Medical Allowance was determined, based on the value of your account and your age, and whether or not you chose a separate medical allowance for your spouse***/***domestic partner, and if so, your spouse's/domestic partner's age.

If You Retired From Moore on or After July 1, 1997

If you were an active regular full-time employee of Moore as of June 30, 1997, your RHCA balance was frozen as of that date, provided you were (as of June 30, 1997):

- Age 65 or older; or
- Age 50 or older with 10 or more years of service; or
- Age 45 with 20 or more years of service and employed with Moore as of December 31, 1997.

Following that date, contributions were no longer made to your account. However, your account may have continued to earn interest until you retired.

Note: Interest adjustments ended after January 1, 2004.

If you retired after June 30, 1997 and did not meet the criteria above, you are not eligible for the RHCA. Moore Wallace does not subsidize the cost of your medical coverage.

Using Your RHCA to Reimburse the Cost of Coverage

Throughout retirement, you can use your Retiree Medical Allowance to reimburse premiums you pay for medical, vision, or Medicare insurance. You cannot use your Medical Allowance to reimburse services received under these or other benefit programs. If you or your spouse/domestic partner is under age 65 (and not Medicare-eligible), your Medical Allowance can be used to purchase coverage through this Program or through an individual policy of your choice. Once Medicare becomes the primary payer of benefits for you or your spouse/domestic partner, that person can no longer be covered by the Program. However, your RHCA will still be available to you.

Once you reach age 65, your plan year Medical Allowance is adjusted to approximately one-third of the Medical Allowance in effect immediately prior to your 65th birthday. This adjustment is made because Medicare will be your primary coverage. You can use your Medical Allowance to pay your Medicare Part B premiums, premiums for supplemental Medigap insurance, and premiums for Medicare Part D.

For employees retiring after January 1, 2005 who are eligible to receive the RHCA, the allowance conversion factors have been updated to reflect more recent mortality and current interest rates that are subject to change. Additionally, beginning in January of 2006, post-65 allowances will be reduced by 20% to reflect the availability of Medicare Part D prescription drug benefits.

To receive a calculation of your estimated benefits under the RHCA Program, call the RR Donnelley Benefits Center at 1-877-RRD-4BEN (1-877-773-4236). You will receive your estimate within 10 business days from the date of your request.

If you purchase medical coverage for yourself or your spouse/domestic partner during retirement, you will be reimbursed each plan year – up to the amount of your plan year Medical Allowance – for the cost of that coverage.

Your Medical Allowance reimburses you for premiums only. You do not receive cash reimbursements for actual medical services received under the coverage you elect.

Your Medical Allowance may not cover the entire cost of your medical coverage during retirement. For example:

- If the cost of your medical coverage is greater than your Medical Allowance for any plan year, you will be responsible for the difference.
- If the cost of your coverage is less than your Medical Allowance, the amount of your unused Medical Allowance will be carried forward and added to your next plan year's Medical Allowance.

If you die after you start receiving your allowance

If you die after you begin receiving your allowance and you have a spouse who is also receiving an allowance, the remaining balance of your allowance for the year in which you die is allocated to your spouse. As of the first of the next plan year, your spouse only receives their own allowance and your allowance has ended.

Filing for Reimbursement Under the RHCA Plan

Alight/Your Spending Account (YSA) is the claims administrator for the RHCA Plan.

You must submit proof of coverage, a premium reimbursement form, and proof of payment with each request to YSA. You can use your Medical Allowance to reimburse premiums paid for medical, vision, and Medicare. In general, a copy of a premium statement or bill, or a notice of enrollment from the insurer, which indicates the person(s) covered and the premium costs, can be used as proof of coverage. A reimbursement form is available by calling YSA.

Your Spending Account
P.O. Box 64030
The Woodlands, TX 77387-4030
1-877-RRD-4BEN (1-877-773-4236)

You cannot use your Medical Allowance to pay COBRA premiums, for extended coverage during a severance period, or for before-tax contributions for coverage under another employer's medical plan.

Deadline to Submit Claims

You must submit your request for reimbursement no later than three months after the end of the plan year in which you incurred the coverage cost.

Special Disqualification Rule Regarding Competition

If you are a sales manager or sales representative of Moore Wallace or any of its participating subsidiaries and/or a Participating Employer who is included in the grandfathered group otherwise eligible for the Retiree Health Care Account ("RHCA") and you engage in competition with Moore Wallace or any of its participating subsidiaries and/or participating affiliates, you will cease to be eligible as a grandfathered participant for the RHCA.

Medical Benefit Program Summary

This section summarizes Medical Benefit Program options available to the different Retiree Groups. Not every Retiree Group is eligible for every option. Certain options are available only for those grandfathered Retiree Groups who were covered by a specific labor agreement and/or acquisition agreement, as follows:

Retiree Group	Coverage Option
Moore Pre-1979 Retirees	UnitedHealthcare Medicare Advantage $200 Deductible Plan
Moore 1979 – 1986 Retirees	UnitedHealthcare Medicare Advantage $275 Deductible Plan
Moore 1986 – 1994 Retirees	UHC Medicare Advantage PPO$400 Deductible Plan
Moore Post-4/1/1994 Retirees	UHC Medicare Advantage PPO $400 Deductible Plan
Wallace Subsidized Retirees	UHC Medicare Advantage PPO $400 Deductible Plan
Wallace, Litho, Nielsen Unsubsidized Retirees	UHC Medicare Advantage PPO $400 Deductible Plan
Wallace, Litho, Nielsen Retirees Who Retired on or After January 1, 2004	UHC Medicare Advantage PPO $400 Deductible Plan
Meredith Burda Post 65 Retired by 12/31/1991	Wellmark BCBS of IA Plan
Esselte Boorum & Pease – enrolled in the Esselte Retiree medical plan as of March 25, 2014	BCBSIL Retiree Hospital Brooklyn & Syracuse PPO Plan

You receive information regarding the coverage option available to you when you are first eligible for Retiree coverage and during each Annual Enrollment period thereafter.

In addition to the UHC Medical Benefit Program, you have prescription drug coverage through the Drug Benefit Program.

Banta Subsidized Retiree Group

If you are a Retiree of Banta as of April 1, 2007, or its subsidiaries, and you currently receive a subsidy because you met the age and service requirements on the day you retired, you continue to receive a subsidy for Retiree coverage. Effective April 1, 2007, you will receive a flat 20% employer subsidy.

If you were an active nonunion employee of Banta as of April 1, 2007, you are eligible for a subsidy if your employment with a Participating Employer (RRD-Access Only) terminated on or before September 30, 2016 and:

- You were employed by Banta on December 31, 2002 and you are age 60 or older with at least 15 continuous years of service on the day you retire; or
- As of December 31, 2007 you are age 57 or older and you have at least 10 continuous years of service, or you are age 65 or older and you have at least five continuous years of service; or
- You become totally and permanently disabled at age 57 or older and you have at least 10 continuous years of service on the date of disability leave.

Esselte Subsidized Retiree Group

If you were enrolled in the Esselte Corporation, Boorum & Pease Division, retiree medical plan as of the date of March 25, 2014, the acquisition by R.R. Donnelley & Sons Company, you are eligible to receive a subsidy.

Meredith Burda Subsidized Retiree Group

If you are a Post 65 Retiree who was retired from Meredith Burda by 12/31/1991, from one of the following Divisions you are eligible for Retiree only subsidized coverage:

- Des Moines
- Lynchburg
- Newton
- Casa Grande

How Your Monthly Contributions Change When You or Your Spouse Becomes Eligible for Medicare

When you or your spouse becomes eligible for Medicare, coverage in the Medical Benefit Program for you or your spouse automatically will be changed to the Post65 Retiree Medicare option and your monthly premium cost for coverage for you or your spouse, whichever is applicable, will be adjusted. When you or your spouse attains age 65, your monthly premium cost will be adjusted beginning in the month you or your spouse attains age 65. If you or your spouse becomes Medicare-eligible before age 65 due to a disability, the monthly premium cost for you or your spouse will be adjusted beginning in the month you notify the eligibility administrator of Medicare eligibility for you or your spouse. Refer to the "Administrative and Contact Information" section for details on whom to contact regarding Medicare eligibility.

Making Required Premium Payments

How you pay premiums to the Plan depends on whether or not you receive a monthly pension from the Pension Plan maintained by a Participating Employer and, if you do, your monthly pension amount. If you receive a pension from another employer's plan, premiums are not deducted from the other pension. Premiums can be paid in the following manner:

- If at the time you enrolled for coverage, your monthly pension benefit from your Participating Employer's Pension Plan (after taxes are withheld) is more than the monthly premiums for coverage under the Program, premiums for coverage automatically are deducted from your pension each month.
- If you do not want monthly premiums for coverage under this Program automatically deducted from your pension each month, you may at any time elect to receive a monthly invoice. You may pay the monthly invoice for coverage with a personal check, or you may elect to have the required

premium deducted from a bank account of your choice. Contact the Benefits Center if you want to arrange this payment option.

- If your monthly pension benefit from your Participating Employer's Pension Plan is less than the monthly premiums for coverage under the Program, or if you are not receiving a pension payment, you will receive an invoice by mail each month.
- The first payment for coverage is due on or before the effective date of coverage, which is the first of the month. If payment is not received within 30 days of the effective date of coverage, your coverage will be terminated.
- For ongoing premium payments, payment for you and your spouse is due the first of the month, and you have a 30-day grace period for payment. If you are more than 30 days late with your payment, coverage will be terminated.

Your Rights and Responsibilities

General Information

If you are enrolled in the 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 Program, and any charges 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 through your coverage option under the Medical Benefit 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 benefit reviewed by the claims administrator under ERISA's claim procedure rules. See the "ERISA Claims and Appeals Procedures" section for details.

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

Under federal law, the 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 mother's 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 Program may not, under federal law, require that a provider obtain authorization from the 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 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 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 eligible spouse 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 Medical Benefit Program Works

General Information

The Medical Benefit Program offers the following Medical Benefit Program options through UHC:

- The **UHC Pre65 Retiree Value** option covers you and your eligible spouse who are under age 65 (or not Medicare-eligible). This option is an HSA-eligible option in which you can contribute to a Health Savings Account (HSA).
- The **UHC Pre65 Retiree PPO** option covers you and your eligible spouse who are under age 65 (or not Medicare-eligible).
- The **UHC Post65 Retiree Medicare Advantage PPO $400 Deductible Plan** option covers you and your spouse who are age 65 or older or who are otherwise eligible for Medicare due to disability.*

If either you or your spouse is age 65 or older (or otherwise Medicare-eligible due to disability) and the other is under age 65 (and not Medicare-eligible), you will be covered by different plans. In this case, the not Medicare-eligible individual will be eligible for one of the Pre65 options. The individual who is age 65 (or otherwise Medicare-eligible due to disability) is eligible only for the Post65 Retiree Medicare option.

You receive information regarding the Medical Benefit Program coverage options available to you and your eligible spouse when you are first eligible for coverage under the Program and during each Annual Enrollment period thereafter.

Once you and your eligible spouse are enrolled in a Medical Benefit Program, you and your spouse automatically are enrolled in the Drug Benefit Program.

The Medical Benefit Program covers most charges for illness and injury (up to the maximum reimbursable charge), provided the claims administrator considers the expense to be a covered expense.

The amount the Medical Benefit Program pays is based on the plan design.

Note: The UHC Post65 Retiree Medicare Advantage Plans are fully-insured options and you must refer to the insurance certificate provided by United HealthCare for all terms and coverages. You will receive an Annual Notice of Change each with any Plan updates.

Plan Design Charts

The Medical Benefit Program offers several plan designs, depending on whether the Retiree is Pre-65 or Post-65, and whether the Retiree is a member of a closed Retiree Group. The plan design charts that follow provide a high-level summary of the coverage for each Program option. Where the option is fully-insured, additional details can be found in the insurance certificate booklet, which is provided to you separately.

Additional information about the Post-65 Prescription Drug Plan administered by SilverScript can be found in the mailings you receive from SilverScript, including the:

- Annual Notice of Change
- Evidence of Coverage
- Pharmacy Directory
- Abridged Formulary (list of preferred drugs)

You can also visit http://myrrdbenefits.com/documents/UHCSoB.pdf for a copy of the SilverScript Summary of Benefits.

UHC SELF-FUNDED PLAN OPTIONS PLAN DESIGN SUMMARY

PROGRAM/BENEFIT	UHC POST65 RETIREE MEDICARE	UHC PRE65 RETIREE VALUE		UHC PRE65 RETIREE PPO	
Medical	UHC Member Services 1-866-868-0286 UHCRetiree.com	UHC Member Services 1-877-442-5999 uhc.com			
Annual Deductible*	$400	*In-Network*	*Out-of-Network*	*In-Network*	*Out-of-Network*
		$2,000/individual $4,000/family Combined Medical & Pharmacy		$500/individual $1,000/family	$1,000/individual $2,000/family
Annual Out-of-Pocket Maximum*	$2,000/individual	$4,500/individual $9,000/family Combined Medical & Pharmacy		$2,500/individual $5,000/family	$3,000/individual $6,000/family
Lifetime Maximum	NA	$2,000,000 combined with Out-of-Network		$2,000,000 combined with Out-of-Network	
Coinsurance Percentage	80% or 90%, varies by service	80%	60%	80%	60%
Preventive Care	$0 copay	100% covered with no deductible	60% covered after deductible	100% covered with no deductible	60% covered after deductible
Physician Office Visits	• PCP: $10 copay • Specialist: $20 copay	80% covered after deductible	60% covered after deductible	80% covered after deductible	60% covered after deductible
Inpatient Hospital Services	$150 copay	80% covered after deductible	60% covered after deductible	80% covered after deductible	60% covered after deductible
Inpatient/ Outpatient Professional Services	80% covered after deductible	80% covered after deductible	60% covered after deductible	80% covered after deductible	60% covered after deductible
Outpatient Lab/X-ray	80% covered after deductible	80% covered after deductible	60% covered after deductible	80% covered after deductible	60% covered after deductible
Outpatient Surgery	90% covered after deductible	80% covered after deductible	60% covered after deductible	80% covered after deductible	60% covered after deductible
Emergency Room/ Urgent Care Facility	• Emergency Room: $65 copay • Urgent Care Facility: $35 copay	80% covered after deductible	80% covered after deductible, if claims administrator determines true emergency; otherwise, 60% covered after deductible	80% covered after deductible	80% covered after deductible, if claims administrator determines true emergency; otherwise, 60% covered after deductible

*** Pre65 Retiree Value option:** If you cover dependents, the Plan starts paying benefits for an individual's claims only after the *total* family deductible has been met, even if those expenses are incurred by only one individual. Similarly, the Plan starts paying 100% only after the *total* family out-of-pocket maximum has been met, even if those expenses are incurred by only one individual.

<table>
<tr><th rowspan="2">PROGRAM/BENEFIT</th><th rowspan="2">UHC POST65 RETIREE MEDICARE</th><th colspan="2">UHC PRE65 RETIREE VALUE</th><th colspan="2">UHC PRE65 RETIREE PPO</th></tr>
<tr><th>In-Network</th><th>Out-of-Network</th><th>In-Network</th><th>Out-of-Network</th></tr>
<tr><td>Outpatient Rehabilitation Services
Limited to a maximum of 90 visits per year combined with Physical, Occupational, Pulmonary, Cognitive and Speech Therapies</td><td>• PT/OT/ST: 90% covered after deductible
• Cardiac/Pulmonary: 90% covered after deductible
• Chiropractic: $20 copay</td><td>80% covered after deductible</td><td>60% covered after deductible</td><td>80% covered after deductible</td><td>60% covered after deductible</td></tr>
<tr><td>Mental Health and Substance Abuse</td><td>• Inpatient: $150 copay
• Outpatient: $20 copay</td><td>80% covered after deductible</td><td>60% covered after deductible</td><td>80% covered after deductible</td><td>60% covered after deductible</td></tr>
<tr><td>Prescription Drug</td><td>SilverScript
1-855-313-9445
caremark.com</td><td colspan="4">CVS Caremark
1-866-273-8402
caremark.com</td></tr>
<tr><td>Retail
30-day supply</td><td rowspan="8">If you are currently enrolled, you will receive the following from SilverScript prior to Annual Enrollment: Annual Notice of Change, Evidence of Coverage, Pharmacy Directory, Abridged Formulary
If you are newly enrolling, you will receive the following once you are enrolled: Summary of Medicare Part D Benefits; Opt Out Notice (do not opt out of SilverScript if you wish to retain retiree medical coverage through RRD); Evidence of Coverage; Pharmacy Directory; Abridged Formulary</td><td>In-Network</td><td>Out-of-Network</td><td colspan="2"></td></tr>
<tr><td>• Generic</td><td>80% covered after deductible</td><td>60% covered after deductible</td><td colspan="2">80% covered; $10 minimum copay</td></tr>
<tr><td>• Brand formulary</td><td>80% covered after deductible</td><td>60% covered after deductible</td><td colspan="2">60% covered; $10 minimum copay</td></tr>
<tr><td>• Brand non-formulary</td><td>80% covered after deductible</td><td>60% covered after deductible</td><td colspan="2">50% covered; $10 minimum copay</td></tr>
<tr><td>Mail-order
90-day supply</td><td colspan="2"></td><td colspan="2"></td></tr>
<tr><td>• Generic</td><td colspan="2">80% covered after deductible</td><td colspan="2">80% covered; $30 minimum copay</td></tr>
<tr><td>• Brand formulary</td><td colspan="2">80% covered after deductible</td><td colspan="2">60% covered; $30 minimum copay</td></tr>
<tr><td>• Brand non-formulary</td><td colspan="2">80% covered after deductible</td><td colspan="2">50% covered; $30 minimum copay</td></tr>
<tr><td>Annual Prescription Out-of-Pocket Maximum</td><td>$2,500/individual
$4,500/family</td><td colspan="2">Combined with Medical</td><td colspan="2">$2,500/individual
$4,500/family</td></tr>
<tr><td colspan="6">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.</td></tr>
</table>

UHC 200 POST-65 RETIREE MEDICARE OPTION PLAN DESIGN SUMMARY
Available to Moore Pre-1979 Retirees Only

This chart provides only highlights of the benefit plans(s). After enrollment, members will receive an insurance certificate booklet that more fully describes the terms of coverage.

PROGRAM/BENEFIT	COVERAGE
Annual Deductible	$200
Annual Out-of-Pocket Maximum	$6,700/individual
Coinsurance Percentage	80% or 90%, varies by service (see certificate)
Preventive Care	$0 copay
Physician Office Visits	• PCP: $5 copay • Specialist: $15 copay
Inpatient Hospital Services	$0 copay
Inpatient/Outpatient Professional Services	80% covered after deductible
Outpatient Lab/X-ray	80% covered after deductible
Outpatient Surgery	80% covered after deductible
Urgent Care Facility	$35 copay
Emergency Room	$65 copay
Outpatient Rehabilitation Services Limited to a maximum of 90 visits per year combined with Physical, Occupational, Pulmonary, Cognitive and Speech Therapies	• *PT/OT/ST:* 90% covered after deductible • *Cardiac/Pulmonary:* 80% covered after deductible • *Chiropractic:* $20 copay
Mental Health and Substance Abuse	• Inpatient: $0 copay • Outpatient: $15 copay
Prescription Drug	SilverScript 1-855-313-9445 | caremark.com
If you are currently enrolled, you will receive these materials from SilverScript prior to Annual Enrollment, which further describe the terms of the Plan:	• Annual Notice of Change • Evidence of Coverage • Pharmacy Directory • Abridged Formulary (list of preferred drugs)

Charges above usual and customary (U&C) limits are member's responsibility. Amounts above U&C don't count toward the annual deductible or the out-of-pocket maximum.

UHC 275 POST-65 RETIREE MEDICARE OPTION PLAN DESIGN SUMMARY
Available to Moore 1979 – 1986 Retirees Only

This chart provides only highlights of the benefit plans(s). After enrollment, members will receive an insurance certificate booklet that more fully describes the terms of coverage.

PROGRAM/BENEFIT	COVERAGE
Annual Deductible	$275
Annual Out-of-Pocket Maximum	$6,700/individual
Coinsurance Percentage	80% or 90%, varies by service (see certificate)
Preventive Care	$0 copay
Physician Office Visits	• PCP: $5 copay • Specialist: $15 copay
Inpatient Hospital Services	$0 copay
Inpatient/Outpatient Professional Services	80% covered after deductible
Outpatient Lab/X-ray	80% covered after deductible
Outpatient Surgery	80% covered after deductible
Urgent Care Facility	$35 copay
Emergency Room	$65 copay
Outpatient Rehabilitation Services Limited to a maximum of 90 visits per year combined with Physical, Occupational, Pulmonary, Cognitive and Speech Therapies	• *PT/OT/ST:* 90% covered after deductible • *Cardiac/Pulmonary:* 80% covered after deductible • *Chiropractic:* $20 copay
Mental Health and Substance Abuse	• Inpatient: $0 copay • Outpatient: $15 copay
Prescription Drug	SilverScript 1-855-313-9445 | caremark.com
If you are currently enrolled, you will receive these materials from SilverScript prior to Annual Enrollment, which further describe the terms of the Plan:	• Annual Notice of Change • Evidence of Coverage • Pharmacy Directory • Abridged Formulary (list of preferred drugs)

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.

BCBSIL SELF-FUNDED PLAN OPTION PLAN DESIGN SUMMARY *Available to Esselte Corporation, Boorum & Pease Division Retirees from Brooklyn Only*

PROGRAM/BENEFIT	COVERAGE
Lifetime Comprehensive Major Medical Coverage	Unlimited
Deductible Out-of-Pocket Expense Limit	Not applicable Not applicable
Hospital Services	*maxes are per calendar year
Inpatient Hospital Services Coverage includes services received in a hospital, skilled nursing facility and hospice, including mental health and substance abuse services. Room allowances based on the hospital's most common semi-private room rates.	100% 365 day max - Hospice, 210 day max - Skilled Nursing, 210 day max
Hospital Ambulatory Surgical Facility Services	100%
Ambulance	100%
Inpatient Mental Health and Substance Abuse	Inpatient Services - 100%, 30 day max Outpatient Services – 80%, $30 max per visit, up to $1,500 per calendar year
Outpatient Surgery and Diagnostic Tests Including X-rays, blood tests, CAT scans, MRIs, annual routine mammograms and PSA tests performed at a hospital.	100% - Facility Services 80% - Professional Services
Outpatient Hospital Services	100% - Facility Services only
Including Radiation, Chemotherapy and Renal Dialysis.	
Hospital Emergency Medical/Accident Care Initial treatment in hospital of accidental injuries or sudden and unexpected medical conditions with severe acute symptoms. If an inpatient admission occurs, MSA must be contacted within two business days.	100% - Facility Services 100% - Professional Services
Professional Services	
Outpatient Physician Services	80%
Preventive Care Routine annual physicals, well-baby exam, immunizations, and other preventive health services as determined by the USPSTF.	Not Covered
Additional Services	*maxes are per calendar year
Coordinated Home Health	100% 200 visit max
Private Duty Nursing	100% 120 visit max
Medical Supplies, Durable Medical Equipment and Appliances	100%, only if billed by a Hospital or Surgicenter
Kidney and Cornea Transplant Services	100%
Muscle Manipulation Services	80%
Outpatient Therapy Services – Speech, Occupational and Physical	100% - Facility Services 80% - Professional Services
Prescription Drug	*specific maxes listed below
Retail and Home Delivery	100%, up to 10,000 max per calendar year and up to an overall $25,000 lifetime max

Schedule of Maximum Allowances (SMA): The Schedule of Maximum Allowances (SMA) is not the same as a Usual and Customary fee (U&C). Blue Cross and Blue Shield of Illinois' SMA is the maximum allowable charge for professional services, including but not limited to those listed under Medical/Surgical and Other Covered Services above. The SMA is the amount that professional PPO providers have agreed to accept as payment in full. When members use PPO providers, they avoid any balance billing other than applicable deductible, coinsurance and/or copayment.

BCBSIL SELF-FUNDED PLAN OPTION PLAN DESIGN SUMMARY *Available to Esselte Corporation, Boorum & Pease Division Retirees from Syracuse Only*

PROGRAM/BENEFIT	COVERAGE
Lifetime Comprehensive Major Medical Coverage	$1,000,000
Deductible (per calendar year) Program deductible does not apply to services that have a copayment.	Individual: $150 Family: $450 (aggregate)
Out-of-Pocket Expense Limit The amount of money that any individual will have to pay toward covered health care expenses during any one calendar year. The following items will not be applied to the out-of-pocket expense limit: • Reductions in benefits due to non-compliance with utilization management program requirements • Charges that exceed the eligible charge or the Schedule of Maximum Allowances (SMA) • Transplant expenses	Individual: $2000 Family: Not Applicable
Hospital Services	*maxes are per calendar year
Inpatient Hospital Services Coverage includes services received in a hospital, skilled nursing facility and hospice, including mental health and substance abuse services.. Room allowances based on the hospital's most common semi-private room rates.	100% 365 day max - Hospice, 210 day max - Skilled Nursing, 120 day max
Hospital Ambulatory Surgical Facility Services	80%, after deductible
Ambulance	80%, after deductible
Inpatient Mental Health and Substance Abuse	Inpatient Services - 100%, 30 day max Outpatient Services – 80%, $30 max per visit, up to $1,500 max per calendar year
Outpatient Surgery and Diagnostic Tests	80%, after deductible - Facility Services
Including X-rays, blood tests, CAT scans, MRIs, annual routine and diagnostic mammograms and PSA tests performed at a hospital.	80%, after deductible - Professional Services
Outpatient Hospital Services	80%, after deductible
Including Radiation, Chemotherapy and Renal Dialysis.	
Hospital Emergency Medical/Accident Care Initial treatment in hospital of accidental injuries or sudden and unexpected medical conditions with severe acute symptoms. If an inpatient admission occurs, MSA must be contacted within two business days.	80%, after deductible – Facility Services 80%, after deductible – Professional Services
Professional Services	
Outpatient Physician Services	80%, after deductible
Preventive Care Routine annual physicals, well-baby exam, immunizations, and other preventive health services as determined by the USPSTF.	Not Covered
Additional Services	*maxes are per calendar year
Coordinated Home Health	80%, after deductible 200 visit max
Private Duty Nursing	80%, after deductible -120 visit max
Medical Supplies, Durable Medical Equipment and Appliances	100%, only if billed by a Hospital or Surgicenter
Muscle Manipulation Services	80%, after deductible
Outpatient Therapy Services – Speech, Occupational and Physical	80%, after deductible - Facility Services 80%, after deductible - Professional Services
Prescription Drug	*specific maxes listed below
Retail and Home Delivery	100%, up to 10,000 max per calendar year and up to an overall $25,000 lifetime max

Schedule of Maximum Allowances (SMA): The Schedule of Maximum Allowances (SMA) is not the same as a Usual and Customary fee (U&C). Blue Cross and Blue Shield of Illinois' SMA is the maximum allowable charge for professional services, including but not limited to those listed under Medical/Surgical and Other Covered Services above. The SMA is the amount that professional PPO providers have agreed to accept as payment in full. When members use PPO providers, they avoid any balance billing other than applicable deductible, coinsurance and/or copayment.

WELLMARK BCBS OF IA POST-65 RETIREE MEDICARE

Available to Meredith Burda Post 65 Retirees by 12/31/1991 Only

This chart provides only highlights of the benefit plans(s). After enrollment, members will receive an insurance certificate booklet that more fully describes the terms of coverage.

Medicare Part A Hospital Services (Per Benefit Period)

PROGRAM/BENEFIT	COVERAGE		
Services	Medicare Pays	Wellmark Pays	You Pay
Hospitalization [1] Semi-private room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $1,288	$1,288 (Part A deductible)	$0
61st thru 90th day	All but $322 a day	$322 a day	$0
91st day and after:			
- While using 60 lifetime reserve days	All but $644 a day	$644 a day	$0
- Once lifetime reserve days are used:			
Additional 365 days	$0	100% of Medicare eligible expenses	$0 [2]
Beyond the additional 365 days	$0	$0	All costs
Skilled Nursing Facility Care [1] You must meet Medicare's requirements, including having been in a hospital for at least three days and entered a Medicare-approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but $161 a day	Up to $161 a day	$0
101st thru 130th day	$0	All approved amounts	$0
131st day and after	$0	$0	All costs
Blood			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
Hospice Care Available as long as your doctor certifies you are terminally ill and you elect to receive these services	All but very limited coinsurance for outpatient drugs and inpatient respite care	$0	Balance

1 A benefit period begins on the first day you receive services as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

2 NOTICE: When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Basic Benefits."

Note: Medicare benefits are subject to change and are typically adjusted annually. The numbers in this chart reflect the Medicare benefits in effect in 2016. For complete details of Medicare benefits and exclusions, you may obtain a copy of Medicare & You from the Social Security Administration, or visit *www.medicare.gov*.

Medicare Part B Medical Services (Per Calendar Year)

PROGRAM/BENEFIT	COVERAGE		
Services	Medicare Pays	Wellmark Pays	You Pay
Medical Expenses IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment			
First $166 of Medicare-Approved Amounts [3]	$0	$166 (Part B deductible)	$0
Remainder of Medicare-Approved Amounts	Generally 80%	Generally 20%	$0
Part B Excess Charges (Above Medicare-Approved Amounts)	$0	$0	All Part B excess charges
Blood			
First 3 pints	$0	All costs	$0
Next $166 of Medicare-Approved Amounts [3]	$0	$166 (Part B deductible)	$0
Remainder of Medicare-Approved Amounts	80%	20%	$0
Clinical Laboratory Services BLOOD TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0
Home Health Care MEDICARE-APPROVED SERVICES			
Medically necessary skilled care services and medical supplies	100%	$0	$0
Durable Medical Equipment: - First $166 of Medicare-Approved Amounts [3]	$0	$166 (Part B deductible)	$0
- Remainder of Medicare-Approved Amounts	80%	20%	$0

3 Once you have been billed $166 of Medicare-approved amounts for covered services, your Part B deductible will have been met for the calendar year. $166 is the Part B deductible for 2016. It is adjusted by Medicare each year.

Other Benefits Not Covered By Medicare

PROGRAM/BENEFIT	COVERAGE		
Services	Medicare Pays	Wellmark Pays	You Pay
Foreign Travel Emergency Care NOT COVERED BY MEDICARE Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA			
Charges	$0	75% of approved charges	25% of approved charges
Preventive Medical Care Benefit [4] NOT COVERED BY MEDICARE Some annual physical and preventive tests and services administered or ordered by your doctor when not covered by Medicare			
Routine mammography screening per calendar year	After $135 (Part B deductible), 80% of Medicare-approved amount for one screening every year for women 65 and older	One mammography screening per year for women 65 or older up to maximum allowable fee amount, less any amount paid by Medicare	$0

Glossary of Key Terms

Certain terms have special meaning under the Medical Benefit Program. The definitions provided in this section apply to services you and your eligible spouse receive while covered under the Medical Benefit Program. The claims administrator may have additional definitions that may apply to the health care services you and your eligible spouse receive, and will always have the discretionary authority to interpret the meaning of these terms and the benefits payable under the Medical Benefit Program.

Note: For the fully insured Medicare Advantage Options (UHC 200, UHC 275, UHC 400, and Wellmark), please refer to the Certificate of Coverage for complete details of terms and coverage.

Allowable Charge – the amount of covered expense prior to any reductions due to coinsurance or deductible amounts.

Charges – the actual billed charges, except when the provider contracts directly or indirectly for a different amount.

Coinsurance – Coinsurance is the percentage of covered expenses you are responsible for paying after the Medical Benefit Program has paid a percentage of the covered expense. Percentages apply after any applicable deductible or copayment requirement has been met.

The percentage you and your eligible spouse and the Medical Benefit Program pay depends on the coverage option you elect, the type of service you receive, and whether you receive in- or out-of-network care (if applicable). You pay coinsurance amounts until you reach the annual out-of-pocket limit. Once you reach the out-of-pocket limit, the Medical Benefit Program starts to pay benefits for covered expenses at 100%.

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

Covered Expenses – the expenses that the Medical Benefit Program covers. To be considered a covered expense, an expense must qualify in each of the following ways:

- The claims administrator must determine that the expense meets the definition of “medically necessary” 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 charge for the service as determined by the claims administrator.
- The expense is not excluded from being a Covered Expense.

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 is the fixed-dollar amount that you pay out of your pocket each calendar year before the Program begins to pay benefits. You can apply only 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.

Durable Medical Equipment – equipment that can withstand repeated use, is primarily and customarily used to serve a medical purpose, is not implantable in the body, is generally not useful for a person in the absence of a sickness or an 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 eligible spouse 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 eligible spouse goes 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 eligible spouse receives emergency care at an out-of-network facility and the Group Health Care 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 six 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).

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 registered bed patient and treated as such by the facility.

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

Lifetime Maximum Benefit – The Medical Benefit Program applies a lifetime maximum benefit of $2 million for each covered person. Covered expenses paid under the Drug Benefit Program do not count toward the lifetime $2 million maximum benefit.

If you would like to know how your covered expenses are "tallying up" in regard to your lifetime maximum, you should be aware that:

- You can contact the claims administrator to find out your lifetime maximum.

Maximum Reimbursable Charge – the maximum billed amount that is recognized for a covered service or supply, 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 or your spouse receives care from a participating provider, the reimbursable rates are already negotiated at a rate that does not exceed the maximum reimbursable

charge(s). If, however, you or your spouse receives care from a non-participating provider (or if you or your spouse participates in the UHC Indemnity coverage option), you are responsible for paying any amount over the maximum reimbursable charge(s).

Any amount in excess of the maximum reimbursable charge does not count toward your annual deductible or your annual out-of-pocket limit.

Medically Necessary – the determination of whether a particular service or supply is medically necessary is based on whether the:

- Service or supply is for the treatment, diagnosis, or symptoms of an injury, disease, or condition (including pregnancy);
- Service or supply 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 research-related or not generally regarded as experimental or investigational in nature.

The claims administrator makes a final determination as to whether a service or supply is medically necessary.

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 coverage option in which you or your spouse is enrolled.

Nurse – a registered 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 this Program.

Out-of-Network Benefit Level – the benefit level that is payable when services are provided by non-participating providers or when unauthorized by the claims administrator.

Out-of-Pocket Limits – The annual out-of-pocket limit is the most you have to pay out-of-pocket (inclusive of deductible and coinsurance) for covered expenses in any calendar year. Once you reach the out-of-pocket limit, the Medical Benefit Program pays 100% of your additional covered expenses for the remainder of that calendar year.

Certain charges do not apply toward the out-of-pocket limit. These include:

- Any amount you pay above the maximum reimbursable charge when seeking care outside the claims administrator's 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 Medical Benefit Program limits.

Outpatient Surgical Facility – an institution that has a staff of physicians, nurses, and licensed anesthesiologists and 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 who has a contractual relationship with the claims administrator for the coverage option in which you or your spouse is 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 for UHC is http://www.uhc.com/find-a-physician. The phone number to call is 1-877-442-5999 for pre-65 members, and 1-866-868-0286 for post-65 members. 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 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 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 Medical Benefit Program.

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

A complete list of participating providers can be provided to you or your spouse 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 or your spouse can call the claims administrator and a member services representative can assist you or your spouse. You or your spouse also can confirm with your provider directly as to whether he or she is a participating provider.

Private-Duty Nursing – skilled nursing services that are rendered by a registered nurse, a licensed practical nurse, or a licensed vocational nurse on a per-shift, part-time, or intermittent basis. Such services are part of a treatment plan that is supervised by a licensed physician. Private-duty nursing services may be provided as part of a confinement or as part of a home health plan.

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 Medical Benefit 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 for which benefits are provided under this Medical Benefit Program when provided by a psychologist.

Room and Board – all charges made by a hospital on its own behalf for room and meals, and for all general services 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 Program still pays the benefits at the in-network level (provided an in-network specialist provides the care).

Urgent Care Services – medical, surgical, hospital, and related health care services and testing that are not emergency services. Instead, a prudent layperson with average knowledge of medical science determines such services to be necessary to treat a condition 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. Urgent care services can include severe sore throat, sprains and strains, ear or eye infections, or fever.

Medical Benefit Program – Other Services Available

If you enroll in one of the Medical Benefit Programs, the following services are also available to you.

Disease Management Services

The Medical Benefit Program's Disease Management Services apply for covered individuals who are younger than age 65 (or otherwise not Medicare-eligible). If you or your spouse is younger than age 65 (or otherwise not Medicare-eligible) and diagnosed with or at risk for developing certain chronic medical conditions, you or your spouse may be eligible to participate in a condition management program at no cost. The heart failure, coronary artery disease, diabetes, asthma, and chronic obstructive pulmonary disease programs are designed to support you or your spouse. This means you or your spouse will receive free educational information through the mail and may even be called by a health advocate who will be a resource to advise and help you or your spouse manage your condition.

The Disease Management Services offer:

- Education and guidance on managing your condition, as well as proper nutrition, medication management, exercise, how to quit smoking, and other healthy lifestyle options; and
- One-on-one support from a registered nurse 24 hours a day, seven days a week, through a toll-free number, a website, and educational booklets.

Participation is completely voluntary and is provided to you or your spouse at no charge. If you or your spouse thinks you or your spouse may be eligible to participate or would like additional information regarding the Disease Management Services, call the claims administrator at the phone number listed on your medical ID card. UHC will contact you or your spouse if you or your spouse is identified as having one of the conditions listed above to ask if you or your spouse wants to participate in the condition management program.

House Calls

Retirees enrolled in a UHC Medicare Advantage plan option are eligible for the House Calls program, which provides one 45- to 60-minute at-home visit from a health care practitioner each year, including a head-to-toe exam, health screenings and plenty of time to talk about your health questions. For more information, call toll-free1-866-447-7868, TTY711, Monday– Friday, 8 a.m.– 8:30 p.m. ET

Silver Sneakers

Retirees enrolled in a UHC Medical Benefit Program option are eligible for the Silver Sneakers program, which provides free fitness memberships at participating locations. For more information, visit silversneakers.com/StartHere or call SilverSneakers

Customer Service toll-free at 1-888-423-4632, TTY 711, Monday – Friday, 8 a.m. – 8 p.m. ET.

Preadmission Certification

The Medical Benefit Program covers charges, up to the maximum reimbursable charge for eligible expenses. To help ensure that you or your spouse receives appropriate care, you or your spouse must precertify any hospital admission if you or your spouse is under age 65.

How to Precertify Your Hospital Admission

If you or your spouse is younger than age 65, you or your spouse must call the claims administrator to precertify a scheduled hospital admission at least 24 hours before you or your spouse is admitted. When you or your spouse calls, be prepared to provide information regarding your upcoming hospitalization, including the full name, address, and phone number of your provider.

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

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

If You Do Not Precertify a Hospital Admission

If you or your spouse is younger than age 65 and you or your spouse fails to precertify a hospital admission, the Program reduces benefits by $500. This means that you are responsible for paying $500 more than you would have paid if you or your spouse had precertified the admission (this does not apply to emergency admissions). The $500 precertification penalty is not a covered expense. Therefore, it does not apply to your annual deductible requirement or your out-of-pocket limit. In addition, any other covered expense for a hospitalization, surgery, or an unauthorized day may be denied. This means that your share of out-of-pocket costs could be significantly higher.

Emergency Notification

In the case of an emergency, go directly to the nearest emergency facility or call 911. If you or your spouse is younger than age 65 and you or your spouse is admitted, you, your spouse, a family member, or your provider must call the claims administrator within 24 hours of the admission. If you, your spouse, a family member, or your provider does not call, the level at which the Program pays benefits may be impacted.

To learn more about any of the services listed above, call the toll-free number listed on your medical ID card or visit the UHC HealthCare website.

What Is an Expense That May Be a Covered Expense – Medical Benefit Program

Expenses under the Medical Benefit Program that may qualify as covered expenses are described on the following pages, provided they are not excluded as an expense that is not covered. Certain limits may differ by Medical Benefit Program.

Professional Services

ABA therapy – Applied Behavior Analysis and other Early Intensive Behavioral Intervention (EIBI) programs (examples of EIBI include, but are not limited to, Lovaas discrete trial training, LEAP (Learning Experiences and Alternative Programs), TEACCH (Treatment and Education of Autistic and Related Communication of Handicapped Children), the Denver program, the Rutgers program, etc.). You or an eligible dependent must meet claims administrator-specific criteria for the in-network therapy to be approved and covered by the Medical Benefit Program. Please work with the claims administrator to confirm the preapproval process and criteria surrounding coverage of ABA therapy.

Allergy treatment – services provided in a physician's office for the diagnosis and treatment of allergies.

Bariatric surgery – covered on an in-network basis only. You or your eligible spouse must meet claims administrator-specific criteria for the in-network surgery to be approved and covered by the Medical Benefit Program. These criteria generally include, but are not limited to, a minimum BMI, physician approval, unsuccessful attempts at weight loss via a physician-supervised established weight loss program(s), and other health side effects. Please work with the claims administrator to confirm the preapproval process and criteria surrounding coverage of bariatric surgery.

Cognitive therapy – you or an eligible dependent must meet claims administrator-specific criteria for the in-network therapy to be approved and covered by the Medical Benefit Program. Please work with the claims administrator to confirm the preapproval process and criteria surrounding coverage of cognitive therapy.

Hearing exams – services provided to determine hearing status. Hearing exams and aids are covered when due to an injury or illness, up to $1,000 per 36-month period.

Inpatient hospital professional services – services that are provided by an appropriately licensed physician during an inpatient confinement and in conjunction with an inpatient admission.

Multiple surgeries – surgical procedures during one operating session that are secondary or incidental to the primary surgery. The maximum amount that the Medical Benefit Program pays is the amount otherwise payable for the most expensive procedure, and half of the amount otherwise payable for all other procedures. The

Medical Benefit Program pays benefits for any charge that is made by an assistant or co-surgeon, up to 20% of the primary surgeon's allowable charge. (For purposes of this covered expense, "allowable charge" means the covered amount payable to the surgeon prior to any reductions due to coinsurance or deductible amounts.)

Outpatient professional services – services that are provided by an appropriately licensed physician in conjunction with outpatient services that are provided at a hospital or a licensed outpatient surgical facility. Such services may include those services provided by a pathologist, radiologist, anesthesiologist, emergency medicine physician, oncologist, or nephrologist, and includes inpatient facility and outpatient setting.

Physician office visits – services that are provided in a physician's office, including routine preventive care and the diagnosis and treatment of an illness and injury. Such services may also include emergency care services. Lab/X-rays that are sent to and billed by an independent lab/X-ray facility will be paid under the independent lab/X-ray facility benefit.

Preventive care – services include well-woman exams, annual routine physicals to detect illness, and early cancer detection screenings. The components that make up a preventive care examination are determined by your age, gender, and health status.

Under the UHC options, the Medical Benefit Program may pay benefits for preventive care only if you or your eligible spouse goes to a participating provider. In addition, gynecological exams are covered only if you or your eligible spouse receives care from a participating OB/GYN. If you or your spouse receives preventive care services from a provider or at a hospital that is outside the network, the Medical Benefit Program does not pay benefits.

Women's breast health services – such services include all medically necessary, non-experimental surgery and supplies. In addition, the Medical Benefit Program also pays benefits for certain breast reconstruction services in connection with a mastectomy. This coverage includes:

- Reconstruction of the breast on which the mastectomy was performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance;
- Prosthesis and physical complications for all stages of the mastectomy, including lymphedema; and
- Charges for brassieres purchased incidental to mastectomy or reconstructive breast surgery.

Reproductive Services

Family planning – **office visits** – services for testing and counseling.

Home delivery services – provided in conjunction with the delivery of a child or children in the home setting. Such services must be provided by an appropriately

licensed and certified midwife and must be provided under the direct supervision of a physician who is acting within the scope of his or her license (as permitted by law).

Hospital facility or birthing center services – covered charges include:

- Charges for hospital room and board and ancillary supplies for the covered individual who would have been eligible had the confinement been for a sickness or injury;
- Physician fees for prenatal care, for the delivery of the child(ren), or for dilation and curettage (in the case of a miscarriage); and
- Physician fees to administer an anesthetic.
- Expenses for hospital nursery or room accommodations for the newborn child(ren) during the period that both the mother and newborn child(ren) are confined to the hospital.
- Services for newborn child(ren) who remain in the hospital after the mother is released, or services that start on the date the child(ren) requires special care (such as an incubator or medical treatment because of a diagnosed sickness or injury). Such services are considered a separate claim.
- Physician fees for circumcision of a newborn child(ren).

Infertility diagnosis – services provided to diagnose conditions related to fertility, including:

- Testing and treatment services performed in connection with an underlying medical condition that may restore fertility may also be covered (e.g., endometriosis diagnosis, which can cause infertility, treatment of endometriosis may be covered); and
- Treatment and/or procedures performed specifically to restore fertility (e.g., procedures to correct an infertility condition).

Prenatal physician office visits, delivery, and postnatal visits – diagnostic services, pre- and postnatal visits, and delivery services. Such services may include those provided by a licensed and certified midwife who is working under the direct supervision of a physician (as permitted by state law).

Surgical sterilization procedures for vasectomy/tubal ligations – sterilization surgeries for men or women.

Voluntary pregnancy termination – services provided by an appropriately licensed physician to terminate a pregnancy.

Outpatient Hospital/Facility and Emergency Room Services

Emergency care, including hospital emergency room, outpatient facility, or other urgent care facility – includes professional, technical, and supply fees for facilities,

and supplies used in conjunction with emergency care. The Medical Benefit Program covers emergencies and urgent care services 24 hours a day, worldwide.

Outpatient preadmission testing – services provided for testing required prior to admission.

Outpatient surgical facility services – includes technical fees for facilities and supplies used in conjunction with an outpatient surgical procedure. The surgical procedure must be performed in an appropriately licensed surgical facility or hospital.

Inpatient Hospital Services

Inpatient hospital facility services – covered charges include:

- Hospital room and board for a semiprivate room, isolation unit, or coronary care unit. Private room charges are covered when medically necessary as determined by the claims administrator.
- Hospital services and supplies, including the use of an operating and recovery room, surgical dressings, X-ray exams, lab tests, drugs and medicines consumed during a hospital confinement, anesthetics and their administration, oxygen and its administration, and blood and blood plasma in excess of credits for blood replaced by individual blood donors. Private-duty nursing services inside the hospital are covered only as approved by the claims administrator.

Inpatient surgery – includes all medically necessary, non-experimental surgery and supplies.

Organ transplants – all medically necessary, non-experimental transplants, including cadaver or live donor match testing, and inpatient facility and physician services. The Medical Benefit Program also pays benefits for immunosuppressive medication. Certain transplants are not covered based on the Office of Medical Applications of Research of the National Institute of Health's ruling. Contact the claims administrator before you incur any related costs.

Miscellaneous Services

Ambulance transport – appropriately licensed ambulance services to or from the nearest hospital that can provide medical care and treatment when medically necessary. This includes air ambulance when medically necessary. The claims administrator determines if the air ambulance service qualifies as medically necessary.

Cardiac and pulmonary rehabilitation (Phases I and II) – includes inpatient and outpatient treatment. Phase I rehabilitation is covered in conjunction with an inpatient confinement. Phase II rehabilitation is covered on an ambulatory basis and is limited to 90 days per calendar year (combined with outpatient short-term rehabilitation services).

Chiropractic therapy – limited for medically necessary treatment of injury or illness.

Contact lenses and eyeglasses – limited to the first pair following cataract surgery, for the initial replacement of natural lenses. The Medical Benefit Program does not pay benefits for the purchase of contacts or eyeglasses, unless they are necessary to treat an illness or injury.

Dental care – limited to the treatment of a fractured jaw or the repair of an accidental injury to sound, natural teeth that is sustained while covered under the Medical Benefit Program. Treatment must begin within six months following the accident or injury. Appliances necessary to stabilize the joint and for necessary surgery for treatment of temporomandibular joint (TMJ) dysfunction syndrome are covered. Hospital facility charges and anesthesia may be covered subject to medical necessity. Services for orthognathic surgery may be covered subject to medical necessity.

Durable medical equipment – equipment that is provided for use in the home, including (but not limited to) external insulin pumps, oxygen, and ostomy supplies. This also includes equipment rental charges such as wheelchairs, hospital beds, and any device that provides mechanical ventilatory support.

External prosthetic appliances – any appliance that is provided to replace or substitute a missing body part, and that is necessary to alleviate or correct sickness, injury, or a congenital defect. This includes the initial fitting and purchase of an external prosthetic device, including:

- Artificial lenses;
- Artificial limbs;
- Terminal devices (such as a hand or hook); and
- External breast prostheses.

The Program pays benefits for the replacement only if it is needed due to normal body growth. The Program does not pay benefits for charges related to wear and tear.

Home health care – includes short-term rehabilitative home health care services that are ordered by a physician and provided by an appropriately licensed home health care agency. Care must be provided in conjunction with an approved treatment program. Covered charges include:

- Part-time or intermittent nursing care provided by or under the supervision of a registered graduate nurse or home health aide (the claims administrator must approve private-duty nursing care).
- Physical, occupational, and speech therapies.
- Consumable medical supplies, drugs, and medicines lawfully dispensed only on the written prescription of a physician, including (but not limited to):
  - Oxygen;
  - Ostomy supplies;

  - Consumable medical supplies as part of authorized inpatient or outpatient facility services;
  - Consumable medical supplies as part of home care when used directly by an authorized, skilled professional; or
  - Authorized consumable medical supplies used in conjunction with authorized durable medical equipment as determined by the claims administrator.
- Laboratory services, but only to the extent that the charges would have been considered covered expenses if the covered individual had required confinement in the hospital as a registered bed patient or confinement in a skilled nursing facility.
- Dietary supplements and nutritional formula for PKU or other protein absorption deficiencies. The Medical Benefit Program also covers nutritional supplements for life-sustaining nutrition that you or your spouse may receive via a gastrointestinal tube or intravenously in a home setting if you or your spouse is no longer capable of swallowing.

Home health visit – services provided by a registered professional employed by a certified home health care agency in conjunction with a written treatment program. A two-hour visit provided by a home health aide employed by a certified home health agency may be substituted for one visit.

Hospice – services provided in an inpatient facility or outpatient setting if you or your covered spouse is diagnosed as having an incurable disease with a life expectancy of six months or less. Covered charges, if determined to be medically necessary by the claims administrator, include:

- Precertified hospice facility room and board for a semiprivate room (private room charges are covered up to the cost of the facility's highest daily rate for a semiprivate room at the time of the covered individual's confinement);
- Hospice facility services and supplies during the precertified confinement;
- Outpatient services provided by a hospice facility;
- Professional services of a licensed physician;
- Pain relief treatment, including drugs, medicines, and medical supplies;
- Part-time or intermittent nursing care provided in the home by or under a nurse's supervision;
- Part-time or intermittent services provided in the home by a home health aide;
- Consumable medical supplies, drugs, and medicines that are lawfully dispensed only on the physician's written prescription, and laboratory services (only to the extent that such charges would have been payable if the person had remained or been confined in a hospital or hospice facility); and

- Other covered charges or services that are determined to be medically necessary and are authorized by the claims administrator.

Inpatient skilled nursing and rehabilitation – requires precertification if you or your spouse is under age 65, but no prior hospitalization is required. Covered charges include:

- Regular daily services and supplies provided by the skilled nursing facility (including routine nursing care, prescription drugs, and physical and speech therapy), and covered at the specified percentage of covered charges; and
- Private-duty professional nursing services provided by a registered graduate nurse or an appropriately licensed practical nurse (other than a close relative of the covered individual). The services must be provided in conjunction with an approved stay in a skilled nursing or rehabilitation facility.

Orthopedic shoes and orthotic appliances – charges related to foot care treatment, if medically necessary, for orthotics or corrective shoes.

Outpatient short-term rehabilitation therapies – includes short-term physical, speech, and occupational therapy of a restorative nature to treat an injury or illness. Such services must be provided by an appropriately licensed physical, occupational, or speech therapist. Speech loss or impairment due to a mental or nervous disorder is not covered. Outpatient short-term rehabilitation therapy is limited to a maximum of 90 days per calendar year (combined with cardiac and pulmonary rehabilitation therapy). No prior hospitalization is required.

Reconstructive surgery – charges for surgery required when an individual sustains an illness or injury that results in bodily damage that requires restoration of a prior functional status, provided it:

- Qualifies as reconstructive surgery following medically necessary surgery for the specific illness or injury; or
- Is required to provide or restore a normal bodily function.

Surgical support hose and Jobst® stockings – limited to three pairs per calendar year, when determined medically necessary and authorized by the claims administrator.

What Expense Is Excluded From Being a Covered Expense – Medical Benefit Program

The Medical Benefit Program, administered by UHC, does not cover the following expenses (except where indicated otherwise). The claims administrator makes a final determination as to whether an expense is excluded from coverage.

- Charges incurred before your coverage effective date.
- Services, treatments, and supplies that are not reasonably necessary for medical care or to treat an illness or injury, as determined by the claims administrator (except as specifically outlined under preventive care).

- Medicine, supplies, or services that are not ordered by a properly licensed physician (or another properly licensed practitioner of the healing arts) who is acting within the scope of his or her license.
- Testing or checkup procedures that are not necessary to diagnose or treat an illness or injury (except as specifically outlined under preventive care).
- Educational or experimental treatments, procedures, devices, drugs, or medicines for which one or more of the following are true:
  - The service or supply is not approved for marketing by the Food and Drug Administration at the time the device, drug, or medicine is furnished;
  - The treatment method is not approved by the American Medical Association or the appropriate medical specialty society, or published in authoritative medical and scientific material; or
  - The treatment, procedure, device, or drug is the subject of ongoing trials to determine tolerated dose, toxicity, safety, or efficacy.
- Routine physicals or mental health or substance abuse examinations and administrative documentation that are not required for health reasons but are required for (but not limited to):
  - Employment, insurance, school, or athletic exams;
  - Government licenses; or
  - Court-ordered, forensic, foreign travel, or custodial evaluations (except if the physical examination would have been performed as part of a routine exam and is within the scope of regular preventive care services covered under the Medical Benefit Program).
- Routine physical exams received under the UHC Open Access Plus Pre-65 option by out-of-network providers.
- Vaccinations and inoculations for any purpose, including non-employment-related foreign travel (except as specifically outlined under preventive care).
- Eyeglass lenses, frames, and contact lenses (except for the first pair of contact lenses or eyeglasses to treat keratoconus or post-cataract surgery).
- Routine hearing aids or the fitting thereof.
- Charges associated with the replacement of an external prosthetic appliance due to loss, theft, or destruction; or for any biomechanical external prosthetic appliance.
- Tests and treatments that are directly related to the actual or attempted impregnation or fertilization that involves the covered individual as a surrogate, donor, or recipient, including (but not limited to):
  - Artificial insemination;
  - In vitro fertilization;
  - Infertility surgical treatment;

  - Gamete intrafallopian transfer (GIFT);
  - Zygote intrafallopian transfer (ZIFT); and
  - Depo-Provera when administered in the office of a provider who does not participate in the network (except as part of adjunctive therapy and palliative treatment of inoperable, recurrent, and metastatic endometrial or renal carcinoma).
- Services or supplies that are related to penile prostheses, except appliances such as semi-rigid internal or erectoid vacuum external prosthetics used to correct a neurogenic bladder of organic etiology.
- Services or supplies that are related to gender reassignment surgery, including hormonal therapy.
- Services or supplies that are related to the reversal of voluntary sterilization.
- Cosmetic surgery, unless:
  - While covered under the Medical Benefit Program, you are injured and your injury results in bodily damage that requires reconstructive surgery; or
  - It qualifies as reconstructive surgery following medically necessary surgery for the specific illness or injury;
  - It is required to provide or restore a normal bodily function; or
- Services or supplies that are related to breast augmentation (except as outlined immediately above).
- Nursing care and speech, occupational, or physical therapy provided by you, your spouse, or you or your spouse's child, sibling, or parent.
- Expenses associated with maintenance care or any service that you may receive to maintain a level of function at which no demonstrable and/or measurable improvement of condition will occur.
- Exercise and maintenance therapies designed to improve general physical condition, including (but not limited to) Phase III cardiac and pulmonary rehabilitation.
- Outpatient rehabilitative therapy provided by a licensed physical, occupational, or speech therapist that is neither short-term nor restorative in nature, or that is in excess of the stated benefit level.
- Routine chiropractic adjustments and manipulation, except for the treatment of a subluxation of the vertebrae.
- Custodial care that helps with functions of daily living and personal needs.
- Educational services or supplies, when the primary purpose is one of the following:

- Training in the activities of daily living (except training that is directly related to an illness or injury that results in a loss of a previously demonstrated ability);
- Scholastic instruction;
- Vocational training;
- Treatment of a learning disability; or
- Prenatal instruction and exercise classes.

Educational services or supplies also include any service or supply that is designed to promote development beyond any level of function previously demonstrated.

- Charges made by a provider, to the extent they result from scholastic, educational, or vocational training (as determined by the claims administrator).
- Consumable medical supplies, except as noted in the "What Is an Expense That May Be a Covered Expense – Medical Benefit Program" section.
- Non-medical services and supplies, such as:
  - Air conditioners;
  - Air filters or non-allergenic blankets; and
  - Modifications made to a home, property, or automobile (such as ramps, elevators, spas, air conditioners, and car hand controls).
- Artificial aids, including (but not limited to) corrective orthotic devices and orthotic shoes (except if medically necessary), dentures, garter belts, corsets, and wigs.
- Hygienic or self-help items, environmental control items, and institutional or athletic items.
- Charges made by a physician for, or in connection with, a surgery that exceeds the following maximum (only applies if you or your spouse receives care from a non-participating provider): When two or more surgical procedures are performed at one time, the maximum amount covered is the amount that otherwise would be covered for the most expensive procedure, and one-half of the amount that would otherwise be covered for all surgical procedures.
- Charges made by an assistant or co-surgeon in excess of 20% of the primary surgeon's allowable charge. These charges apply only if you or your spouse receives care from a non-participating provider.
- Any charge that is made for or in connection with tired, weak, or strained feet for which treatment consists of routine foot care, including (but not limited to) the removal of calluses and corns, or the trimming of nails (unless medically necessary for orthotics or corrective shoes).

- Nutritional supplements provided in the home setting for a condition such as diabetes mellitus, anorexia, bulimia, and amino acid deficiency.
- Transportation expenses via an air ambulance, unless medically necessary for the specific illness or injury (the claims administrator determines the medical necessity for an air ambulance).
- Non-covered services and penalties associated with the failure to precertify a hospital admission.
- Charges related to an injury or disease that is covered by Workers' Compensation or similar law.
- Charges for or in connection with an injury that arises out of or in the course of any employment for wage or profit.
- Services and supplies you or your spouse receives:
  - By or from the U.S. government, or any other government unless payment of the charge is required by law; or
  - By any law or government plan under which you, or your spouse is or could be covered.
- Charges related to a sickness or injury due to a declared or undeclared act of war. Charges in connection with injuries that result from acts of armed aggression by covered individuals who commit such acts while covered under the Program.
- Court-ordered treatments, unless deemed medically necessary for the specific illness or injury.
- Charges for you or your spouse that would in any way be paid or be entitled to payment by or through a public program (other than Medicaid).
- Charges for which payment is unlawful where you or your spouse resides when the expense is incurred.
- Charges that you or your spouse is not legally required to pay.
- Charges that would not have been paid if you had no coverage.
- Charges for late or missed appointments.
- Charges related to the transfer of medical records.
- Charges incurred as a result of an accident for which, in the opinion of the claims administrator, third-party liability exists.
- Expenses under the mandatory part of any auto insurance policy written to comply with:
  - A "no-fault" insurance law; or
  - An uninsured motorist insurance law.

- Elective medical care that is received outside the United States (only emergency care, as determined by the claims administrator, is covered).
- Organ transplant travel services associated with cornea transplants, costs incurred due to travel within 60 miles of the home, laundry bills, telephone bills, alcohol and tobacco products, and transportation charges that exceed coach class rates. The Program does not pay benefits if you or your covered spouse is a donor. Dental services, other than those listed under the "What Is an Expense That May Be a Covered Expense – Medical Benefit Program" section, or for oral surgery to remove impacted teeth, or to operate on gums or mouth as long as the operation is not performed for routine extractions or repairing of teeth.
- Dental services rendered in a case of temporomandibular joint (TMJ) dysfunction syndrome that affects the jaw but not the teeth.
- Charges in excess of the maximum reimbursable charges.
- Charges that a third party is obligated to cover, such as under another plan or insurance policy, or a tort recovery or Workers' Compensation recovery by you or your spouse.
- Enteral nutrition, including infant formula available over the counter, unless it is the only source of nutrition.

How the Drug Benefit Program Works

General Information

The Drug Benefit Program described throughout this SPD is available to you and your eligible spouse, provided you enroll for coverage under the Medical Benefit Program. If you are enrolled in one of the Pre65 options, CVS Caremark is the claims administrator and pharmacy network manager for your prescription drug coverage. If you are enrolled in the Post65 Retiree Medicare option, SilverScript as part of the company-sponsored group Medicare Part D program is the claims administrator and pharmacy network manager for your prescription drug coverage.

Glossary of Key Terms – Pre65 Coverage

Certain terms have special meaning under the Drug Benefit Program. The definitions provided in this section apply to services you receive while covered under the Drug Benefit Program. These are in addition to the key terms already defined in prior sections (which also apply). 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 the Drug Benefit Program.

Charges – the actual billed charges, except when the provider has contracted directly or indirectly for a different amount.

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

Copayment – the minimum fixed-dollar amount that you or your spouse is required to pay for a prescription (if any) in addition to your coinsurance.

Covered Expenses – the expenses that the Drug Benefit Program will cover. To be considered a covered expense, an expense must qualify in each of the following ways:

- Must be determined by the appropriate claims administrator to meet the definition of “medically necessary” for the specific illness or injury;
- Cannot exceed the usual and customary limit for the service as determined by the appropriate claims administrator; and
- Is not excluded from being a Covered Expense.

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

Maintenance Medications – a list, as the claims administrator designates, of prescription drug products that are commonly prescribed for long-term use. This list is subject to periodic review and modification by the claims administrator. Contact the claims administrator to obtain a copy of the list of maintenance medications.

Medically Necessary – the determination of whether a particular service or supply is medically necessary is based on whether the:

- Service or supply is for the treatment, diagnosis, or symptoms of an injury, disease, or condition (including pregnancy);
- Service or supply 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 research-related or not generally regarded as experimental or investigational in nature.

The claims administrator makes the final determination of whether a service or supply is medically necessary.

National Drug Code Number (NDC#) – the national classification system used to identify drugs. This code is an 11-digit number. This number is required on the claim form you complete to receive reimbursement for costs you incur through the use of a retail non-participating pharmacy.

Non-Participating Provider – a provider who does not have a contractual relationship with the claims administrator.

Out-of-Network Benefit Level – the benefit level payable when services are provided by non-participating providers or when not authorized by the claims administrator.

Participating Pharmacy – a pharmacy that is part of the claims administrator's network and contracts to provide services for the Drug Benefit Program. Contact the claims administrator for a free listing of participating pharmacies, or view the current listing on the claims administrator's website.

Participating Provider – a provider who has a contractual relationship with the claims administrator.

Prescription Order – a physician's lawful authorization for a prescription drug or related supply. The physician must be duly licensed to make such authorization within the course of his or her professional practice for each authorized refill thereof.

Primary/Preferred Drug List – a clinically based drug list that contains Food and Drug Administration-approved brand-name and generic medications for a broad range of medical conditions or diseases. While physicians are encouraged to prescribe medications that are on the Primary/Preferred Drug List, it is still the physician's responsibility to determine the most appropriate medication for each patient. Using a primary/preferred drug, where available and medically appropriate, can reduce your out-of-pocket expenses.

Drug Benefit Program Design

Your coverage under the Drug Benefit Program pays benefits using three different cost-sharing levels, or "tiers." Each tier then refers to a drug's classification on the Primary/Preferred Drug List. As a result, the amount you pay depends on all of the following:

- Which tier of drug classification you select on the Primary/Preferred Drug List, including:
  - Generic;
  - Brand-name preferred drug (on the claims administrator's approved list, except as noted in the "What Expense Is Excluded From Being a Covered Expense – Drug Benefit Program" section); or
  - Brand-name non-preferred drug (not on the claims administrator's approved list, and as noted in the "What Expense Is Excluded From Being a Covered Expense – Drug Benefit Program" section).
- Whether you or your spouse obtains your prescription drug service from a participating or non-participating retail pharmacy.
- Whether you or your spouse receives your prescription through the mail service.

Quantity Limits

Certain drugs will have a quantity limit in place. This means only a certain number of pills or days' worth of medication will be available over a 30 day period. This is done to ensure appropriate, safe usage. Please contact the claims administrator to confirm whether your drug has any quantity limits in place.

What Is an Expense That May Be a Covered Expense – Drug Benefit Program – Pre65 Coverage

Outpatient prescription drugs (including injectables) that are approved for use by the Food and Drug Administration (FDA), prescribed by a properly licensed physician, and dispensed by a licensed pharmacy may qualify as a covered expense provided the drug is not excluded from coverage.

The claims administrator makes a determination as to whether a benefit will be provided.

For a complete listing of the current-year Primary/Preferred Drug List, and to confirm whether a drug listed on the Primary/Preferred Drug List is covered by the Drug Benefit Program, contact the claims administrator online or at the phone number listed on your prescription drug ID card. Refer to the "What Expense Is Excluded From Being a Covered Expense – Drug Benefit Program" section for specific information about medications that may be listed on the formulary provided by the claims administrator but that are not covered under the Drug Benefit Program.

What Expense Is Excluded From Being a Covered Expense – Drug Benefit Program – Pre65 Coverage

Charges for the following drugs or medicines by way of example, but not of limitation, are not covered under the Drug Benefit Program. The claims administrator will make a final determination as to whether an expense is excluded from being a covered expense.

- Drugs prescribed for cosmetic purposes only (e.g., topical minoxidil, Rogaine®, etc.).
- Brand name proton pump inhibitor ("PPI") drugs used to treat gastrointestinal disorders.
- Drugs available without a prescription, except insulin.
- Prescription drugs, when there is an over-the-counter equivalent available without a prescription.
- Prescription drugs that are not prescribed by a properly licensed physician who is acting within the scope of his or her license.
- Over-the-counter smoking cessation products, including nicotine gum and patches. (Prescription smoking cessation products are covered up to a dollar limitation. Once the dollar limitation is met, these services are no longer covered.)
- Infertility medications.
- Appetite suppressants (excluding Dexedrine® and Desoxyn®, which are covered with a prior authorization issued by the claims administrator).
- Weight loss medication, unless prior authorization is issued by the claims administrator.
- Nail fungal treatment, unless prior authorization is issued by the claims administrator.
- Medical supplies and equipment (except syringes and needles for the administration of insulin, alcohol swabs, lancets, and devices).
- Experimental, investigational, or unproven drugs or therapies as defined by the FDA.
- Replacement prescription drugs that result from loss or theft.
- Medications with no approved FDA indications.
- Compound prescription medications that do not contain at least one covered legend drug.
- Charges to the extent that you or your spouse is in any way paid or entitled to payment for those expenses by or through a public program (other than Medicaid).

- Charges to the extent that payment is unlawful where you or your spouse resides.
- Charges you or your spouse incurs related to an injury or disease that is covered by Workers' Compensation or similar law.
- Charges that you or your spouse is not legally required to pay.
- Charges you or your spouse incurs before the coverage effective date.
- Charges in connection with a mental illness or injury that is due to a declared or undeclared act of war, including armed aggression.
- Any "service" charge.

Prior Authorization – Pre65 Coverage

Certain drugs require the claims administrator's authorization before they are covered under the Drug Benefit Program. Please contact your claims administrator to confirm whether your drug requires prior authorization.

If your prescription requires prior authorization, begin the prior authorization process by taking your prescription to a participating retail pharmacy or submitting it to the claims administrator's mail service pharmacy. The claims administrator then works with the pharmacist and your physician to obtain the necessary information to make an appropriate coverage decision. This process can take up to two business days to complete. Once the claims administrator makes a decision, the claims administrator processes your mail service prescription or contacts the retail pharmacy to communicate whether or not the coverage was approved. If your medication is not approved, you can appeal by calling the claims administrator at the phone number listed on your prescription drug ID card.

How to Fill Your Prescriptions at a Retail Pharmacy – Pre65 Coverage

The claims administrator selects a network of retail pharmacies that offer reduced prices to covered individuals. You are not required to file a claim, provided you or your spouse receives benefits from a participating retail pharmacy, you or your spouse shows your prescription drug ID card, or the claims administrator verifies your eligibility at the point at which you or your spouse fills a prescription for you or your spouse. Your prescription drug ID card is generally separate from your medical ID card.

You or your [eligible dependent] can obtain a list of participating retail pharmacies by calling the claims administrator at the phone number listed on your prescription drug ID card or by visiting the claims administrator's website.

You or your spouse also can purchase prescription drugs at a non-participating pharmacy. However, if you or your spouse is required to pay the prescription's full cost at the time of your purchase, you and your spouse must submit a claim form to the claims administrator for reimbursement.

How to Fill Your Prescriptions Through the Mail Service Pharmacy – Pre65 Coverage

If you or your spouse needs to take a prescription drug for an extended period of time, you can purchase such prescriptions through the mail (maximum 90-day supply). Your medications are delivered to your home. Purchasing prescription drugs through the mail service pharmacy enables you to minimize your out-of-pocket costs for long-term maintenance prescriptions.

To fill your prescriptions through the mail service pharmacy:

- Complete a confidential Mail Service Order Form when you your spouse submits the first prescription by mail. It is important to complete the form for all individuals for whom you or your spouse is requesting a prescription. If you or your spouse changes or adds medications, or you or your spouse has a medical condition that you or your spouse did not previously report, you or your spouse must update your profile.
- Ask your provider to write a prescription for a 90-day supply, plus the appropriate refills for up to a maximum of one year. (After the one-year period, a new prescription is required.) Submit the original prescriptions with the covered individual's name and ID number clearly marked on the back. Also include the completed Mail Service Order Form (you may want to keep a copy for your records).
- Submit your copayment (by either check or credit card number). If you pay by credit card, you your spouse can order refills by phone or online (provided your original prescription is valid). After you or your spouse uses all of the refills noted on the original prescription, you or your spouse needs to submit a new prescription as outlined above.

Coverage under the Program ends when any of the following conditions occur:

- A covered individual has received the maximum $2 million in benefits under the Medical Benefit Program for all illnesses. If coverage for a Retiree ends because the maximum $2 million in benefits has been paid, coverage for his or her spouse continues until termination of the spouse's coverage because the spouse has received $2 million in benefits under the Medical Benefit Program or for any of the other reasons listed below.
- A covered individual dies. However, if a Retiree has coverage under the Program and dies, the Retiree's spouse can continue his or her coverage under the Program, regardless of whether he or she remarries or becomes eligible under another employer's plan.
- You do not pay the required premiums for coverage. Payment is due on or before the effective date of coverage, which is the first of each month. If payment is not received within 30 days of the effective date of coverage, coverage for you and your spouse is terminated retroactively as of the date

through which full payment was received. Coverage under the Program can be reelected only during Annual Enrollment.

- In the event of a legal separation or divorce, coverage for a spouse is automatically terminated as of the date the legal separation or divorce occurs.
- The Program or Plan (in whole or in part) can be discontinued for any reason.
- If you are reemployed by RR Donnelley in a benefits-eligible position 30 or more days after your termination date, and you have already enrolled in this Program, your coverage under the Program will be suspended. As an active employee, you must select from the available options offered under the Active Program if you want coverage. Because you cannot be simultaneously covered under both the Active Program and this Program, you will not be able to remain covered under this Program. When you next terminate employment, you will again be eligible for coverage under this Program.

Drug Rebates

The Drug Benefit Program and/or claims administrator may receive rebates or other discounts in connection with your prescriptions. The amount you are required to pay is based on the price of the prescription before the application of any rebate or other discount. The rebates will be held in the R.R. Donnelley & Sons Company Post-Retirement Medical Benefit Trust and used to pay Program claims and expenses.

Your Legal Right to Continuation Coverage

In some cases, you or your spouse may continue coverage under COBRA if his or her coverage under this Program ends.

General Information

A federal law called the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended (COBRA), requires that most employers, including a Participating Employer, that sponsor medical benefit plans (including HMOs) offer employees and certain members of their families the opportunity to extend coverage temporarily at group rates after coverage under the medical benefits plan would otherwise end due to specific events. The extension of coverage to employees and their eligible spouses is called "continuation coverage."

In general, the coverage that may be continued is the same as the coverage in which you and your spouse were enrolled under the Program on the day before the qualifying event (as listed below). For example, if you are enrolled in the Program with Retiree and spouse coverage, you and your spouse can continue this same coverage under COBRA. In addition, if you elected the "No Coverage" option as a retired employee, you would not be eligible for any continuation coverage.

To be eligible for continuation coverage, a qualifying event must take place. After the qualifying event, continuation coverage must be offered to each person who is a continuation coverage beneficiary. You and your spouse could become continuation coverage beneficiaries if coverage under the Program is lost because of a qualifying event. The following are qualifying events:

Who Can Continue Coverage	In What Situations	For How Long
Retiree and spouse	Loss of coverage or increases in cost due to, or significant reduction in coverage within one year before or after, the commencement of bankruptcy proceedings under Title 11 of the United States Code with respect to RR Donnelley or its subsidiaries from whose employment you retired	Until death; however, in the case of the covered surviving spouse, no later than 36 months after the death of the covered former employee
Retiree's spouse	Divorce or legal separation or death of Retiree	36 months

If you or your spouse becomes eligible to participate in Medicare but does not elect to participate therein, you or your spouse may become entitled to certain COBRA rights. You should contact the COBRA administrator within 60 days of not electing Medicare to receive more information.

Notification

In the case of a proceeding in bankruptcy under Title 11 of the United States Code with respect to RR Donnelley or its subsidiary from whose employment you retired, you or

your spouse who is a continuation coverage beneficiary will automatically be advised of the right to continuation 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.

Under the law, the former employee or spouse who is a continuation coverage beneficiary has the responsibility to inform the COBRA administrator of the Retiree's death, a divorce or legal separation, within 60 days after the qualifying event occurs. Upon such notification, coverage will be terminated retroactive to the date of the qualifying event. Failure to provide this notification results in the loss of continuation coverage rights. When the COBRA administrator is notified that one of these qualifying events has happened, you and your spouse will in turn be notified within 14 days of the right to choose continuation coverage.

Election Procedure

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

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

If you and your spouse does not choose continuation coverage within this 60-day period, your and your spouse's coverage under the Program will end.

You and your spouse do not have to show that you and your spouse is insurable to choose continuation coverage. However, continuation coverage under the law is provided subject to your eligibility for coverage under the Program. The Program reserves the right to terminate your continuation coverage retroactively if you your spouse is determined to be ineligible. Once your continuation coverage ends for any reason, it cannot be reinstated.

Payment

Generally, you and your spouse must pay a premium to the Program of 102% of the applicable unsubsidized premium during the 36-month (or, in the case of bankruptcy, longer) period of continuation coverage. The initial 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 and your spouse is buying coverage, subject to a 30-day grace period. If you and your spouse do not make payment on or before the first day of the month, claims by you and your spouse will not be paid by the Program until payment is received within the 30-day grace period.

When Continuation Coverage Ends

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

- The end of the 36-month continuation period or in the case of bankruptcy, the time periods indicated in the chart above;
- The date RR Donnelley and its subsidiaries no longer provide coverage to any of their employees;
- The date you and your spouse fail to pay the required premium by the specified deadline; or
- The date you and your spouse first become covered after the date of his or her continuation coverage election under another group health care program that does not contain a pre-existing exclusion that affects his or her benefits. If continuation coverage is rejected in favor of an alternate coverage under the Program, continuation coverage will not be offered at the end of that period.

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

Coordinating Benefits With Other Programs

General Information

The Program has a coordination of benefits (COB) provision, which coordinates benefit payments from your coverage and your spouse's coverage. For example, if your spouse also has coverage through his or her employment, the COB provision coordinates payments from the Medical Benefit Program and your spouse's plan. This provision is intended to prevent duplicate payments for the same covered expense.

Coordination of benefits takes into account benefits available for the same expenses under another employer plan, a government program such as Medicare, or benefits required by law, such as no-fault automobile insurance benefits. It does not apply to Medicaid or individual medical policies.

COB issues will be coordinated by the claims administrator.

How to File a Claim

General Information

In some situations, you or your spouse may need to submit a completed claim form before the Program pays benefits. In other situations, you or your spouse do not need to file a claim.

Claims for benefits (including prescription drugs) must be submitted within one year of the date of service. Claims submitted after the deadline will not be reimbursed.

Medical Benefit Program Claims

In situations when you or your spouse need to file a claim, you or your spouse should follow these general instructions:

- Participating providers in the claims administrator's network have agreed to submit claims on your behalf. Show the provider your ID card or have him or her confirm your eligibility.
- If you or your spouse receives care from a non-participating provider, you or your spouse needs to submit a claim. You or your spouse needs to submit a claim form each time you or your spouse receives treatment. Processing is faster when you or your spouse include a claim form with your bill.
- Fill out the applicable sections of the form completely. If your provider's bill includes the services provided and the diagnosis, the back page of the form does not require completion.
- Make sure that all bills and receipts are original and include the following information:
  - The patient's name, age, and relationship to the Retiree;
  - The Retiree's name, address, and member number;
  - The name, address, telephone number, and tax identification number of the provider, hospital, laboratory, or pharmacy that provided the service or supply;
  - The date the service or supply was received;
  - A description of the service or a CPT (Current Procedural Terminology) code;
  - The patient's diagnosis; and
  - The amount charged.
- If you or your spouse wants the claims administrator to pay the provider of services directly, sign your name to the payment authorization box on the claim form. The check will be sent to the provider instead of to you or your spouse.

- Mail the completed claim form and any attachments to the address on the form.
- Keep a copy of the claim for your records.

If you or your spouse has coverage under the Program and another group plan or program or Medicare, you or your spouse should submit a claim to the primary plan or program first. When the primary plan or program pays your claim, it will provide you or your spouse with an Explanation of Benefits (EOB) statement. Send the EOB statement, together with a copy of the bill, to the secondary plan or program to claim benefits from that plan or program.

Medicare Electronic Claim Submission (Medicare Crossover)

The claims administrator can accept Medicare Part B claims electronically from Medicare for dates of service in 2002 and beyond. However, the claims administrator must first receive your Medicare health insurance claim (HIC) number, which is listed on your Medicare EOB statement. You or your spouse will need to call the claims administrator's member services number and provide your HIC number, or you or your spouse can submit your first Medicare Part B EOB statement along with a claim form to the claims administrator. When the claims administrator receives the Medicare EOB statement, it will record your HIC number in your member record so all future Medicare Part B claims can be sent to the claims administrator electronically by Medicare.

Filling Prescriptions at Non-Participating Retail Pharmacies

CVS Caremark (Pre65) and SilverScript (Post65) are the claims administrators and network managers for the Drug Benefit Program.

You or your spouse are responsible for paying the full cost at the time you or your spouse has your prescription filled. You or your spouse must complete a Prescription Drug Claim Form, which is available by calling the claims administrator at the phone number listed on your prescription ID card.

Complete the form (you or your spouse may want to keep a copy for your records) and send it, with the original receipts attached, to the claims administrator at the address on the form. It is important that you or your spouse fill out the claim form completely, including:

- The name of the drug received (when filing a claim for prescriptions outside the United States);
- The name of the pharmacy dispensing the drug, and the seven-digit NCPDP (National Council for Drug Benefit Programs) number of the pharmacy;
- The date you or your spouse purchased the drug;
- The prescription number, name, NDC# (National Drug Code number) supply (number of days), and quantity of the drug; and
- Your signature.

You or your spouse must also include an itemized receipt that shows the amount you or your spouse paid for each prescription. When your claim is processed and approved, you or your spouse may receive a partial reimbursement of the retail cost depending on the Medical Benefit Program you choose.

ERISA Claims and Appeals Procedures

General Information

The following claim review and claim appeal procedures apply to all benefit and eligibility claims of any nature related to the 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 or your spouse is filing a benefit claim, you or your spouse needs 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 or your spouse is filing an eligibility claim, you or your spouse needs to contact the Benefits Center.

Procedure for Filing a Claim

A communication from you or your spouse ("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 Plan, he or she will be considered not to have exhausted all administrative remedies under the Plan, and this will result in his or her inability to bring a legal action for that benefit. Claims and appeals of denied 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 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 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 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 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 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 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.

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 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 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 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 Plan. This failure will result in the claimant's inability to bring a legal action to recover a benefit under the Plan. A 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 review that takes into account all comments, documents, records, and other information the claimant submits, without regard to whether such information was submitted or considered in the initial benefit determination.
- The claimant will have the opportunity to submit written comments, documents, records, and other information relating to the claim.
- The claimant will be provided, upon request and free of charge, reasonable access to and copies of all relevant documents.
- The review of a denial does not defer to the initial determination made by the claims administrator.
- The individual who conducts the review process is neither the individual who made the initial denial nor the subordinate of such individual.
- In deciding an appeal of any denial that is based in whole or in part on a medical judgment, including determinations as to whether a particular treatment, drug, or other item is experimental, investigational, or not medically necessary or appropriate, the individual conducting the review process will consult with a health care professional who has appropriate training and

experience in the field of medicine involved in the medical judgment. The health care professional will be neither the individual who was consulted in connection with the denial that is the subject of the review nor the subordinate of such individual.

- The claims administrator will identify any medical or vocational experts whose advice was obtained on behalf of the 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 Plan's benefit determination on review, must be transmitted between the Plan and the claimant by telephone, facsimile, or other available similarly expeditious method.

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 Plan's benefit determination on review, accordance with applicable U.S. Department of Labor regulations. If the claimant's appeal is denied, the notification will include:

- The specific reason or reasons for the denial;
- Reference to the specific Plan provision(s) on which the determination is based;
- A statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to and copies of all relevant documents;
- If an internal rule, guideline, protocol, or other similar criterion was relied upon in making the denial, the specific rule, guideline, protocol, or other similar criterion that was relied upon, or a statement that such rule, guideline, protocol, or similar criterion was relied upon and that a copy will be provided free of charge to the claimant upon request;

- and
- If the denial is based on medical necessity or 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.

Legal Action

A claimant cannot bring legal action to recover any benefit under, or for eligibility in, the Plan if he or she does not file a valid claim and seek timely review of a denial of that claim. In addition, no legal action may be brought:

- More than two years after the claims administrator first received the claimant's claim; or
- If the claimant received a denial on appeal of such a claim more than two years after such receipt.

ACA 1557 Grievance Procedures

It is the policy of the Plan not to discriminate on the basis of race, color, national origin, sex, age or disability. The Plan has adopted an internal grievance procedure providing for prompt and equitable resolution of complaints alleging any action prohibited by Section 1557 of the Affordable Care Act (42 U.S.C. 18116) and its implementing regulations at 45 CFR part 92, issued by the U.S. Department of Health and Human Services.

Section 1557 prohibits discrimination on the basis of race, color, national origin, sex, age or disability in certain health programs and activities. Section 1557 and its implementing regulations may be examined in the office of the Section 1557 Coordinator:

R.R. Donnelley & Sons Company Retiree Welfare Benefits Plan
c/o Vice President, Benefits
4101 Winfield Rd, Warrenville IL 60555
Phone: 312-326-8000
Email: corporatehealthwelfare@rrd.com

The Section 1557 Coordinator has been designated to coordinate the efforts of the Plan to comply with Section 1557. Any person who believes someone has been subjected to discrimination on the basis of race, color, national origin, sex, age or disability may file a grievance under this procedure. It is against the law for the Plan to retaliate against anyone who opposes discrimination, files a grievance, or participates in the investigation of a grievance.

Procedure:

- Grievances must be submitted to the Section 1557 Coordinator within (60 days) of the date the person filing the grievance becomes aware of the alleged discriminatory action.
- A complaint must be in writing, containing the name and address of the person filing it. The complaint must state the problem or action alleged to be discriminatory and the remedy or relief sought.
- The Section 1557 Coordinator (or her/his designee) shall conduct an investigation of the complaint. This investigation may be informal, but it will be thorough, affording all interested persons an opportunity to submit evidence relevant to the complaint.
- The Section 1557 Coordinator will maintain the files and records relating to such grievances. To the extent possible, and in accordance with applicable law, the Section 1557 Coordinator will take appropriate steps to preserve the confidentiality of files and records relating to grievances and will share them only with those who have a need to know.

- The Section 1557 Coordinator will issue a written decision on the grievance, based on a preponderance of the evidence, no later than 30 days after its filing, including a notice to the complainant of their right to pursue further administrative or legal remedies.
- The person filing the grievance may appeal the decision of the Nondiscrimination Grievance Coordinator by writing to the Benefits Committee within 15 days of receiving the Section 1557 Coordinator's decision. The Benefits Committee shall issue a written decision in response to the appeal no later than 30 days after its filing. The availability and use of this grievance procedure does not prevent a person from pursuing other legal or administrative remedies, including filing a complaint of discrimination on the basis of race, color, national origin, sex, age or disability in court or with the U.S. Department of Health and Human Services, Office for Civil Rights.
- A person can file a complaint of discrimination electronically through the Office for Civil Rights Complaint Portal, which is available at:
  - https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or
  - by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue SW., Room 509F, HHH Building, Washington, DC 20201.
  - Complaint forms are available at: http://www.hhs.gov/ocr/office/file/index.html.

Such complaints must be filed within 180 days of the date of the alleged discrimination. Section 1557 Coordinator will make appropriate arrangements to ensure that individuals with disabilities and individuals with limited English proficiency are provided auxiliary aids and services or language assistance services, respectively, if needed to participate in this grievance process. Such arrangements may include, but are not limited to, providing qualified interpreters, providing taped cassettes of material for individuals with low vision, or assuring a barrier-free location for the proceedings. The Section 1557 Coordinator will be responsible for such arrangements.

Situations Affecting Your Benefits

General Information

The Program is designed to help you pay the cost of medical care services for you and your spouse. However, some situations could cause the delay, loss, or reduction of your benefits under this Program. A few of these situations are highlighted below. The Program:

- Pays benefits only for covered expenses – those listed in this SPD or the Plan document – approved by the claims administrator.
- Pays benefits up to the contracted amount for in-network covered expenses and the maximum reimbursable charge for out-of-network covered expenses, but only to the extent that the covered expense is medically necessary as determined by the claims administrator.
- May reduce benefits if you or your spouse does not follow the approval procedures before admission to a hospital or other treatment facility (as explained, for example, in the "Preadmission Certification – UHC" section of this SPD). If amended, any change in benefit levels applies as of the date the amendment occurs.
- Pays no benefit for you or your spouse if you or your spouse is enrolled in Medicare Part D (this pertains to the Drug Benefit Program).
- Pays no benefit for you or your spouse if you or your spouse is enrolled in Medicare Part C (this pertains to the Medical Benefit Program).

Right of Recovery

If for any reason the Plan pays a benefit for any individual who is not eligible for coverage under the Program, or that is larger than the amount allowed, the Plan has the right to recover the excess amount from the person or agency that received it. The recipient must produce any instruments or papers necessary to ensure this right of recovery.

Right to Reimbursement, Assignment of Rights, and Duty to Notify

As a condition to receiving Plan benefits, each participant, former participant, or other person who has an interest in the Plan ("Recipient") shall provide the Plan with a Right to Reimbursement and an Assignment of Rights (as both are described below). These rights enable the Plan to recover the amount it has expended to provide benefits to the Recipient from any proceeds the Recipient receives from a third party in connection with an illness, accident, or injury. The Plan's rights to recover are reduced by its share of the attorneys' fees incurred in obtaining the proceeds from the third party.

Right to Reimbursement

As a condition to receiving Plan benefits, the Recipient grants the Plan the right to recover from any proceeds (including any form of consideration whatsoever) that the Recipient receives from a third party (via judgment, settlement, or otherwise) in connection with the accident, injury, or other event that resulted in the Plan's expenditures, dollar for dollar beginning with the first dollar received by the Recipient from the third party, regardless of how those proceeds are characterized or labeled (e.g., payment of medical expenses, pain and suffering damages, punitive damages, or any other type of non-economic or economic damages), in an amount equal to the expenditure made by the Plan in providing benefits to the Recipient.

Without in any way limiting the Plan's rights, and as illustrative examples, it is the intent of the parties that the Plan will be entitled to recover from any proceeds (including any form of consideration whatsoever) that the Recipient receives from a third party, regardless of how those proceeds are characterized or labeled:

- In the case of a judgment, by a court or jury;
- In the case of an arbitration, mediation, or any other form of dispute resolution, by the deciding person or persons or by the parties to that process;
- In the case of settlement or other form of payment, by the parties to that transaction; and
- In any of the above situations or in any other situation, in accordance with any legal principle or applicable provision of statutory or common law that would purport to characterize the proceeds or attribute to them any particular purpose, in an amount equal to the expenditure made by the Plan in providing benefits to the Recipient.

It is an additional condition to receiving benefits from the Plan that the Recipient grant the Plan a first lien with respect to any proceeds (including any form of consideration whatsoever) that the Recipient receives from a third party in connection with the accident, injury, or other event that gave rise to the Plan's expenditures, so that every such dollar of any such proceeds will be paid to the Plan, beginning with the first dollar and continuing until the Plan has been paid the amount it expended to provide benefits to the Recipient, regardless of how that payment is labeled or characterized, and regardless of the injury or loss ostensibly redressed by the payment or the apparent cause or inducement for such payment. The parties hereby disavow and waive the "make whole" doctrine or any other principle of law that would require that the Recipient be fully compensated before payment is made to the Plan under its Right to Reimbursement or any of its other rights to recovery, whether contractual, legal, or equitable.

In the event the Recipient fails to reimburse the Plan under this provision within a reasonable time of receiving any proceeds (including any form of consideration) from any third party, the Plan shall have the right to set off the amounts it has expended to provide benefits to the Recipient against any other obligations to make expenditures to

or on behalf of the Recipient, and to withhold payment of any such expenditures until it has been fully reimbursed for the expenditures it has made.

In the event that a court of competent jurisdiction determines that any part of the foregoing Right to Reimbursement is unenforceable for any reason, it is the intent of the parties that the Plan shall retain all the rights provided for in those parts that remain enforceable, including without limitation the Plan's right to recover the expenditures it has made (or will make) to provide benefits to the Recipient, to the extent that any portion of the proceeds paid to the Recipient by any third party is designated as compensation for medical expenses or for other expenses paid by the Plan to or on behalf of the Recipient, or which are intended as, or can reasonably be attributed to, compensation for medical expenses or other expenses paid by the Plan, though not expressly designated as such, which determination shall be made in the sole discretion of the claims administrator or recovery vendor acting on behalf of the claims administrator.

Assignment of Rights

In addition to providing the Right to Reimbursement described above, and as an additional condition to receiving benefits from the Plan, the Recipient assigns to the Plan any and all rights to pursue an action or claim against any third party in connection with the accident, injury, or other event that gave rise to the Plan's expenditures. If the Plan pursues any such action or claim, the Recipient shall cooperate and assist the Plan and shall be prohibited from taking any action that would prejudice the Plan's rights or in any way diminish its prospects for a recovery.

Duty to Notify

The Recipient agrees to promptly notify the claims administrator or the recovery vendor acting on behalf of the claims administrator as to whether the Recipient or anyone acting on his or her behalf is pursuing or intends to pursue an action against, or to seek any type of recovery from, any third party for damages, indemnity, recovery, insurance, or other payment of any kind whatsoever in connection with the accident, injury, or other event giving rise to the Plan's obligations to make expenditures to or on behalf of the Recipient, so that the Plan can protect its rights to recover.

Nothing in this section shall be deemed to waive or otherwise diminish any rights to reimbursement, subrogation, assignment, or other recovery available to the Plan under applicable common or statutory law.

If the Plan Is Modified or Ended

RR Donnelley reserves the right to amend or terminate the Plan or the Program at any time, in whole or in part. Benefits do not vest. If the Plan or the Program is ever terminated, suspended, or modified, benefits for any service you or your spouse receives before the change are paid under the Program's former conditions. The Program does not pay any benefits for services received after such action (unless specific provisions are adopted).

RR Donnelley can amend or replace the Group Insurance Contracts through which benefit claims are paid under the Plan. If the Plan or its programs are terminated, the rights of a participant covered under the plan or its Programs are limited to the payment of eligible losses that occur prior to the termination.

If the Plan Is Discriminatory

RR Donnelley reserves the right to modify or tax benefits to the extent required to ensure that the Plan does not discriminate in favor of highly compensated individuals as defined in the Internal Revenue Code.

Program Rebates

The Program may receive rebates or other proceeds, such from a settlement in litigation. The rebates or other proceeds will be held in the R.R. Donnelley & Sons Company Post-Retirement Medical Benefit Trust and used to pay Program claims and expenses.

Administrative and Contact Information

General Information

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

Type of Plan

The Program is part of a welfare benefit plan. Its objective is to reimburse non-occupational expenses of eligible retired employees and their eligible spouses in accordance with the terms of the Program.

Plan Sponsor

RR Donnelley & Sons Company
4101 Winfield Rd
Warrenville, IL 60555
(630) 964-6363

Employer Identification Number of Plan Sponsor

36-1004130

Plan Name and Number

R.R. Donnelley & Sons Company Retiree Welfare Benefits Plan – 512

Plan Year End

December 31

Agent for Service of Legal Process

Corporate Secretary
RR Donnelley & Sons Company
4101 Winfield Road
Warrenville, IL 60555

Legal process also may be served on the Benefits Committee and/or the trustee.

Benefits Committee and Plan Administrator

Benefits Committee
c/o Vice President, Benefits
RR Donnelley & Sons Company
4101 Winfield Road
Warrenville, IL 605555

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

Eligibility Administration

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

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

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

Website: **www.resources.hewitt.com/rrd**

Contact the Benefits Center to:

- Verify benefit eligibility;
- Report that you have, or your spouse has, become eligible for Medicare;
- Remove a spouse from coverage;
- Ask general benefit questions; and
- Report an address change.

If you want to enroll yourself or your spouse in the Program, you must follow the enrollment procedures described in this SPD.

Claims Administrator and Network Manager

If you or your spouse has questions about a specific benefit, contact the appropriate claims administrator as shown in the chart below.

Coverage Options	Claims Administrator
Group Health Program Medical Benefit Program Options • UHC Pre65 Retiree Value • UHC Pre65 Retiree PPO • UHC Post65 Retiree Medicare	United HealthCare Pre65 Coverage P.O. Box 30555 Salt Lake City, UT 84130-0555 1-888-651-7312 www.myuhc.com United HealthCare Post65 Coverage P.O. Box 31362 Salt Lake City, UT 84131-0362 84131-0362 1-866-868-0286 www.UHCRetiree.com
The Drug Benefit Program Pre65: CVS Caremark Drug Benefit Program	CVS Caremark, Attn: Claims Department P.O. Box 686005 San Antonio, TX 78268-6005 1-866-273-8402 www.caremark.com
Post65: SilverScript Prescription Drug Plan	CVS Caremark, Attn: Claims Department P.O. Box 52066 Phoenix, AZ 85072-2066 1-855-313-9445 www.caremark.com
Appeals Pre65: CVS Caremark Drug Benefit Program	Caremark, Inc., Attn: Appeals Department P.O. Box 52084 Phoenix, Arizona 85072-2084 Fax for Specialty Guideline Management appeals – 855.230.5548 Fax for all other appeals – 866.443.1172
Post65: SilverScript Prescription Drug Plan	CVS Caremark, Attn: Part D Appeals and Exceptions P.O. Box 52000, MC 109 Phoenix, AZ 85072-2000 Phone: 1-866-425-5922 TTY: 711

Each of the claims administrators is also a network manager over the health care providers it makes available through its provider network.

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 Continuation Coverage

The COBRA administrator is Alight If you or your spouse has questions about your continuation coverage rights, contact the COBRA administrator at the following address and phone number:

RR Donnelley Benefits Center

4 Overlook Point
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 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 investment-named fiduciary some authority to control or manage assets held in the R.R. Donnelley & Sons Company Post-Retirement Medical Benefit Trust ("Trust"), or to an applicable administrative-named fiduciary some authority and control over the operation and administration of the Plan, references in this SPD to the Benefits Committee are intended to refer to any such applicable investment-named fiduciary or applicable administrative-named fiduciary. The Plan also provides a procedure for the Benefits Committee, acting as the Plan's sponsor, to identify persons, such as the claims administrator, to be a named fiduciary. Typically, the Benefits Committee has identified each third-party administrator as a named fiduciary with respect to the authority and control or discretion it possesses or has exercised in connection with the Plan or Trust.

Trust and Insurance

RR Donnelley sponsors the R.R. Donnelley & Sons Company Post-Retirement Medical Benefit Trust to be used for funding benefits, holding insurance contracts, and contracting with claims administrators. The trustee is:

The Northern Trust Company
50 S. LaSalle Street
Chicago, IL 60675
(312) 630-6000

Funding

Wellmark and UHC Medicare Advantage Program are provided through contracts of insurance and benefits are paid by the carriers. All other options are self-funded.

All of the benefits under the Program are funded by the Trust. The Trust is maintained by RR Donnelley, and its assets are managed by investment managers selected by the Benefits Committee or The Prudential Insurance Company of America. The benefits funded solely by the Trust are not guaranteed by the claims administrators or network managers. The claims administrators' role is to provide services to the Program.

The Trust is the policyholder for the funding of the insurance policies. These policies are contracts of insurance which are guaranteed by the issuer and not the Plan or the Trust. The Prudential Insurance Company of America has issued a contract of insurance to the Trust. Under the terms of the insurance contract, The Prudential Insurance Company of America is the named fiduciary over the control and management of the Trust's assets held under that contract.

Participating Employers

The Program described in this document applies to retired employees of Participating Employers to whom benefits have been extended. The Plan Administrator and eligibility administrator maintain records regarding Participating Employers, including which Participating Employers are or were RRD-Subsidized versus RRD-Access Only.

If you have questions concerning your eligibility to participate in this Program, call the RRD Benefits Center, which is the Program's eligibility administrator.

You or your spouse may receive from the eligibility administrator, upon written request, information as to whether a particular employer is a Participating Employer and, if the employer is a Participating Employer, the Participating Employer's address.

Your ERISA Rights

General Information

As a participant in the Plan, you and your covered spouse 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 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 or your covered spouse if there is a loss of coverage under the 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 Program, if you have creditable coverage from another plan. You should be provided a certificate of creditable coverage, free of charge, from your Program or health insurance issuer when you lose coverage under the 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 for 12 months (18 months for late enrollees) after your enrollment date in your coverage. ***NOTE**: These provisions were eliminated by the Affordable Care Act effective in 2015.*

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 benefits 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, of 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.

Discrimination is Against the Law

R.R. Donnelley & Sons Company Retiree Welfare Benefits Plan complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. R.R. Donnelley & Sons Company Retiree Welfare Benefits Plan does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

R.R. Donnelley & Sons Company Retiree Welfare Benefits Plan:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, contact the R.R. Donnelley Benefits Center at 1-877-RRD-4BEN (1-877-773-4236).

If you believe that R.R. Donnelley & Sons Company Retiree Welfare Benefits Plan has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with: Vice President, Benefits, 4101 Winfield Road, Warrenville, IL 60555, 630-963-9494. You can file a grievance in person or by mail, or email. If you need help filing a grievance, Vice President, Benefits, is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
1-800-368-1019, 800-537-7697 (TDD)
Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-877-773-4236.

注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-877-773-4236.

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-877-773-4236.

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-877-773-4236 번으로 전화해 주십시오.

PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-877-773-4236.

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-877-773-4236.

ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-877-773-4236.

ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele 1-877-773-4236.

ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-877-773-4236.

UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1-877-773-4236.

ATENÇÃO: Se fala português, encontram-se disponíveis serviços linguísticos, grátis. Ligue para 1-877-773-4236.

ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 1-877-773-4236.

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-877-773-4236.

注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。1-877-773-4236 まで、お電話にてご連絡ください。

توجه: اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می باشد. با 1-877-773-4236 تماس بگیرید.