HMO Program

Summary Plan Description

January 1, 2009

Contents

Introduction

Medical care is an integral part of your and your covered eligible dependents' overall wellness. That's why R.R. Donnelley & Sons Company and its participating subsidiaries or Participating Employers (referred to herein as "RR Donnelley") offers the Health Maintenance Organization (HMO) Program under the R.R. Donnelley & Sons Company Group Benefits Plan ("Group Benefits Plan").

When the term "HMO Program" is used in this SPD, it refers collectively to the:

- Medical Program administered by the HMO;
- Mental Health and Substance Abuse Program administered by the HMO; and
- Prescription Drug Program administered by the HMO or CVS Caremark (depending on the HMO option you select).

The HMO Program options for which you are eligible depend on where you live (your home ZIP code on file with RR Donnelley) and are listed in your enrollment information. As long as you are eligible, you can elect the level of coverage and cost under the HMO Program that best meet your needs.

If your home ZIP code is outside of the HMO network areas, you can elect coverage under the Group Health Program (also offered by the Group Benefits Plan), which includes the Private Medical Opt-Out option. See the Group Health Program Summary Plan Description (SPD) for details regarding the coverage options offered under the Group Health Program.

You and RR Donnelley share the cost of the HMO Program's premium for you and your enrolled eligible dependents, with RR Donnelley paying the majority of the cost. Your cost is based on:

- Your base pay* as of the September 1 prior to the plan year (or your base pay when you are first hired if you are newly hired after September 1);
- Which of the RR Donnelley participating subsidiaries or Participating Employers you work for;
- Whether you are a full- or part-time employee;
- The option you elect;
- The coverage category you choose;
- Whether or not you or any of your enrolled eligible dependents use tobacco products or agree to participate in a tobacco cessation program; and
- Your completion of certain health and wellness initiatives during Annual Enrollment and throughout the plan year, if required under the rules of your Participating Employer.

*Commissioned sales employees have a three-year average calculated. See "Enrolling for Coverage – Your Premiums" for more details.

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

This information, together with the certificate of coverage for your particular HMO option attached here, is the Summary Plan Description (SPD) for the HMO Program. It explains your coverage as of January 1, 2009 (unless noted otherwise). It details who is eligible for coverage and when coverage begins and ends. It details which expenses are and are not covered under the HMO Program, it describes how to file a claim, and it describes your rights under the HMO Program. Please read this information to familiarize yourself with your coverage.

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

The Group Benefits Plan has contracted with the following HMOs to render claims administrator and network manager services necessary to the operation and administration of the HMO Program.

The HMO Program
ConnectiCare CT/MA HMO
Health Alliance Plan IL HMO
Personal Care IL HMO
UHC River Valley POS
Geisinger PA HMO
Dean Health HMO
Network Choice
Network Co-Choice
Network POS

You are eligible for coverage under the HMO Program only if you are an employee of a Participating Employer or subsidiary. If you are an employee of an employer or subsidiary that does not participate in the Group Benefits Plan, you are not eligible for the benefits described in this SPD. To find out if you are eligible for these benefits, contact the eligibility administrator.

This SPD and any supplemental information are intended to be a complete, accurate, and up-to-date description of your coverage under the HMO Program. However, since treatments, protocols, and practices continually change, this document cannot adequately define every potentially covered service or exclusion. In each case, the claims administrator or network manager will have the authority or discretion to make the determination of whether an expense incurred is a covered benefit. If there is any

discrepancy between this SPD versus the Group Benefits Plan, the Group Benefits Plan document always governs.

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

In addition, nothing in this SPD should be interpreted as an employment contract. This summary merely describes the coverage and benefits offered to eligible employees as of January 1, 2009. RR Donnelley reserves the right to amend, change, or terminate the Group Benefits Plan or HMO Program, in whole or in part, at any time.

This content contains a summary in English of your rights and benefits under the HMO Program. If you have difficulty understanding any part of this content, call the RR Donnelley Benefits Center at 1-877-RRD-4BEN (1-877-773-4236). Benefits Center Representatives are available between the hours of 8 a.m. and 5 p.m. CT, Monday through Friday, except holidays.

Who Is Eligible

Glossary of Key Terms – Eligibility

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

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

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

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

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

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

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

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

- Banta Corporation or any of its subsidiaries that is a Participating Employer (collectively, "Banta");
- Check Printers, Inc. ("Check Printers");
- Moore Wallace North America, Inc. ("Moore Wallace"); or
- OfficeTiger, LLC, or OfficeTiger Global Real Estate Services, Inc. (collectively, "OfficeTiger"); or

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

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

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

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

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

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

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

IRS Tax Dependent – means your "dependent" within the meaning of Section 152— determined without reference to Section 152(b)(1), (b)(2), and (d)(1)(b) of the Internal Revenue Code of 1986, as amended (the "Code").

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

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

Spouse – the individual of the opposite sex to whom you are currently legally married. The HMO Program also considers an opposite-sex spouse to be your common-law spouse in states that recognize common-law marriages.

General Information

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

- Full-time benefits-eligible employee of a Participating Employer;
- Part-time A employee of a Participating Employer; or
- Union employee of a Participating Employer who is covered by a collective bargaining agreement and such agreement provides for your HMO Program participation.

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

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

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

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

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

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

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

Extended Coverage for Disabled Children

If your enrolled eligible child ispermanently and totally (as defined in Code Section 22(e)(3)) 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 enrolled under the HMO Program immediately before the coverage would otherwise end, and the disability must begin while your enrolled eligible child's coverage under the HMO Program is in effect. To continue coverage, you must contact your claims administrator to request the form(s) to complete. You must provide proof (for example, a doctor's certificate) of your child's disability within 30 days of the day the child's coverage would have otherwise ended. If you do not, coverage for your disabled child ends, and you will not have another opportunity to add 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 HMO Program:

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

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

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

Extended Coverage for Certain Dependents

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

- Your dependent's coverage will terminate the date the eligibility administrator is notified

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

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

Continued Coverage for Your Eligible Dependents Under the Certificate of Coverage

If you enroll in the HMO Program, your, your spouse's, and/or your eligible dependent's eligibility for coverage will be governed by the terms of the HMO certificate of coverage.

When your child ceases, because of their age or student status, to be an eligible dependent as defined in the "Glossary of Key Terms – Eligibility" section of this document, your child may have the right to continue coverage under the certificate of coverage due to applicable state law requirements. You will receive COBRA notification when your child ceases to be eligible under the Plan as defined above. However, you may choose to continue coverage under the certificate of coverage by notifying the Benefits Center while you are still able to make a COBRA election. Refer to the "Election Procedure" section under "Your Legal Right to COBRA Continuation Coverage".

At that time, you will have the option to continue this coverage on a pre-tax basis if your dependent qualifies as an IRS Tax Dependent, or if your dependent does not qualify as an IRS Tax Dependent, you may continue coverage by paying income taxes on the imputed income for this coverage in your paychecks. Refer to the section "Your Premiums" for details regarding how this amount is determined. It is your responsibility to notify the Benefits Center and the insurer when your dependent is no longer eligible under this state law. It is also your responsibility to notify the Benefits Center if your dependent is *not* an IRS Tax Dependent.

If you fail to notify the eligibility administrator within 30 days after your covered dependent is no longer an IRS Tax Dependent, the following significant consequences may occur:

- In addition to the before-tax premium you have paid, you will have the value of the after-tax premium for continuation coverage for this individual imputed for the period commencing with the date of the change in status, or, if later, the January 1 immediately preceding the date you notify the eligibility administrator.

- This imputed income will be in one lump sum on your next available paycheck, unless there are not sufficient funds to cover the lump sum amount in one payment, then the imputed income amount may be taken on multiple checks.

COBRA continuation coverage rights may be available once your child ceases to be an IRS Tax Dependent or ceases to be eligible for this continued coverage under the HMO.

Qualified Medical Child Support Order (QMCSO)

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

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

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

If You Are Reemployed

If you terminate employment with a Participating Employer and are reemployed by a Participating Employer within 30 days of your termination date as a full-time benefits-eligible or part-time A employee of a Participating Employer, you are not treated as a new hire. Your prior period of employment will be recognized, and your previous elections will automatically be reinstated. If you were previously covered under the HMO Program, coverage will continue effective immediately, retroactive to the date of termination and subject to any Annual Enrollment changes that became effective during your absence.

If you are reemployed by a Participating Employer more than 30 days after your termination date, you will be considered a new hire and will have to meet the HMO Program's eligibility requirements.

Enrolling for Coverage

General Information

If you meet the eligibility requirements, you can enroll yourself and your eligible dependents for coverage under the HMO Program and, at the same time, the Participant Premium Program of the R.R. Donnelley & Sons Company Flexible Benefits Plan ("Participant Premium Program"). If you elect an option under the HMO Program, you and your enrolled eligible dependents are automatically enrolled in the:

- Medical Program administered by the HMO (see the HMO certificate of coverage for details);
- Mental Health and Substance Abuse Program administered by the HMO (see the HMO certificate of coverage for details); and
- Prescription Drug Program administered by the HMO, or by CVS Caremark if you enroll in the ConnectiCare CT/MA HMO, Geisinger PA HMO, Health Alliance Plan IL HMO, or Personal Care IL HMO (see the HMO certificate of coverage or the Group Health Program SPD respectfully for additional information).

  As a ConnectiCare CT/MA HMO, Geisinger PA HMO, Health Alliance Plan IL HMO, or Personal Care IL HMO participant, your HMO does not provide prescription drug coverage. As a result, you receive prescription drug coverage through the Prescription Drug Program under the Group Health Program.

The following coverage categories generally apply:

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

If you participate in the Network Choice, Network Co-Choice, or Network POS options, only two coverage categories apply (You Only and You + Family).

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

If you and any one of your eligible dependents are both employees eligible to enroll, each of you may enroll for "You Only" coverage, or one of you may enroll and cover the other as an eligible dependent. If each of you enrolls for "You Only" coverage, neither of you can cover the other as an eligible dependent, and only one of you may enroll your children as eligible dependents.

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

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

Your Premiums

You and your Participating Employer share the cost of premiums under the HMO Program for you and your enrolled eligible dependents, with your Participating Employer paying the majority of the cost. The premium you pay is based on:

- Your base pay* as of the September 1 prior to the plan year (or your base pay when you are first hired if you are newly hired after September 1, or the three-year average of your base pay if you are a commissioned sales employee);
- Which of the Participating Employers you work for;
- Whether you are a full-time or part-time employee;
- The option you elect;
- The coverage category you choose;
- Whether or not you or any of your enrolled eligible dependents use tobacco products or agree to participate in a tobacco cessation program; and
- Your completion of certain health and wellness initiatives during Annual Enrollment and throughout the plan year.

Important Note for Commissioned Sales Employees:** Your base pay amount is your annual wage or salary as reported on your W2 form received from RR Donnelley, averaged for three full calendar years (for example, for the 2009 plan year, the three full calendar years used are 2005, 2006, and 2007). If you're not employed by RR Donnelley for three calendar years, then your base pay amount is your average annual wage or salary as reported on your W2 form for the full years employed.* ***(Note: This language is based on your most current definition of compensation for Life and Disability.)

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

When you enroll in the HMO Program, you authorize the deduction of your required premium payments from your paycheck. For you and your covered dependents, you generally pay for coverage under the HMO Program each pay period with before-tax dollars deducted from your pay under the terms of the Participant Premium Program. However, for domestic partner coverage, coverage for your domestic partner's children, and for coverage for individuals who have ceased to be an IRS Tax Dependent, you pay your premium on an after-tax basis based on your imputed income. The amount of your imputed income is determined:

- If you are covering a domestic partner and/or child of a domestic partner, by subtracting the COBRA premium for You Only coverage from the COBRA premium

for the coverage you have in effect for You + Spouse and/or You + Child(ren), as the case may be. The difference is your imputed income.

- If continued coverage is for your former spouse because you have failed to report the change of coverage, by subtracting the COBRA premium for You Only coverage from the COBRA premium for coverage of You + Spouse. The difference is your imputed income.
- If coverage is for a child for whom you have not reported their change in eligibility or for a child who is no longer an IRS Tax Dependent but eligible for coverage under the Certificate of Insurance, by subtracting the COBRA premium for You Only coverage from the COBRA premium for You + Child(ren). The difference is your imputed income.

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

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

Your elections under the HMO Program and the Participant Premium Program are binding for the remainder of the calendar year for which the elections were made, unless a Qualified Status Change or a special enrollment opportunity occurs during the calendar year.

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

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

Enrolling Yourself and Your Eligible Dependents

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

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

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

When Coverage Begins

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

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

If You Start During the Month Of:	Your Coverage Begins On:
January	March 1
February	April 1
March	May 1
April	June 1
May	July 1
June	August 1
July	September 1
August	October 1
September	November 1
October	December 1
November	January 1
December	February 1

If you are not eligible for coverage when you are first hired with a Participating Employer, you become eligible on the date you transfer from benefits-ineligible to

benefits-eligible status with that Participating Employer (provided you have at least one full calendar month of employment, as determined above, from your original hire date). If you become a new benefits eligible employee because you have transferred your employment from a non-Participating Employer which is an affiliate of RR Donnelley, the following special rules will apply:

- Your coverage under this HMO Program begins on the first day of the month following the month in which you transfer if:
  - You transfer from a U.S. affiliate and you had not satisfied the waiting period for, and therefore were not covered by, a Medical Program, Mental Health and Substance Abuse Program, and Prescription Drug Program on the date of the transfer; and
  - You have at least one full calendar month of employment with that U.S. affiliate.

  If you do not have a least one full calendar month of employment, these special rules do not apply and you are treated as a newly hired benefits eligible employee on your date of transfer.

- If you transfer from a U.S. affiliate and you were either covered by (or elected not to be covered by) a Medical Program, Mental Health and Substance Abuse Program, and Prescription Drug Program on the date of the transfer, you will continue to participate (or not participate) in these programs until the end of the calendar year in which you transfer. As a result, your coverage under this HMO Program begins on the following January 1.
- If you transfer from a non-U.S. affiliate, your coverage under the Group Health Program begins on the date you transfer.

If You Are Not Actively at Work

If you are not actively at work (due to an approved leave) on the day coverage is scheduled to begin, coverage for you and your eligible dependents still takes effect on that day. You do not need to return to active work for your coverage to take effect.

If You Do Not Enroll by the Deadline

- Unless otherwise stated in your enrollment materials, if you do not enroll by the deadline set forth in your enrollment materials either as a new hire or during the Annual Enrollment period, you will not have coverage under the HMO Program. Instead, you will have "You Only" coverage under the UHC HSA Basic coverage option (with no HSA contributions) under the Group Health Program. In addition, you will not be able to enroll your eligible dependents or make changes to your coverage until the following Annual Enrollment period. The only exception is if you report a Qualified Status Change or you meet one of the special enrollment circumstances within the required time frame. Coverage in the case of a Qualified Status Change or special enrollment circumstance starts on the date of the qualifying event and payroll deductions are taken prospectively.

Your Right and Responsibility to Change Your Coverage

Because of Internal Revenue Service (IRS) rules governing before-tax premiums, the coverage you elect, for so long as you are an employee of RR Donnelley, remains irrevocably in effect until the beginning of the next calendar year. However, you may make limited changes to your elections during the calendar year when certain circumstances in your life or family status change.

These changes in circumstance, called "Qualified Status Changes," are defined by the IRS and may change from time to time. Some examples of Qualified Status Changes include marriage, birth, adoption, divorce, and the death of your spouse or child. These events require that you must make the change within 30 days after the event has occurred. If you do not, the change will not be allowed.

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

A list of Qualified Status Changes and allowed changes to your and/or your eligible dependents' coverage in connection with such Qualified Status Changes is included in the "Qualified Status Changes" SPD. Contact the eligibility administrator if you have questions about Qualified Status Changes.

Because the Participant Premium Program is an integral part of the HMO Program, its provisions have been made a part of "Enrolling for Coverage" in this SPD and the "Qualified Status Changes" SPD.

Special Enrollment Opportunities

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

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

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

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

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

Annual Enrollment

Every fall during the Annual Enrollment period, you receive information about the HMO options for which you are eligible. You then have the opportunity to enroll yourself and your eligible dependents in any of the options available to you, switch to a different option (if available in your area), or elect "No Coverage."

The choices you make during the Annual Enrollment period take effect the following January 1 and remain in effect throughout the calendar year, unless you report a Qualified Status Change or a special enrollment opportunity.

Your Rights and Responsibilities

General Information

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

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

In any case, the HMO Program may not, under federal law, require that a provider obtain authorization from the HMO 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 HMO 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 HMO Program and its benefits.
- To select a provider or primary care physician (if applicable).
- To keep scheduled appointments and notify the provider's office promptly if you will be delayed or unable to keep the appointment.
- To follow the advice of your provider or primary care physician (if applicable) and consider the likely consequences when you refuse to comply with his or her advice.
- To make the lifestyle changes recommended by your physician (if applicable).
- To provide honest and complete information to your provider or primary care physician.
- To know what medications you and your enrolled eligible dependents take, why you are taking them, and the proper way to take them.
- To express your opinions, concerns, or complaints in a constructive manner to the appropriate people.
- To pay all applicable fees at the time service is rendered (if applicable), plus any additional payments due, in a timely manner.

How the HMO Program Works

General Information

Depending on your home ZIP code, you may be able to participate in the HMO Program. You receive information regarding the HMO options available to you when you are first hired and during each Annual Enrollment period thereafter.

There are a small number of HMO's offered in select areas. You are offered an HMO option only if an HMO option is available in your home ZIP code area. Benefits, coverages, and rules vary depending on the specific HMO offered in your area. In addition, because each state licenses and regulates the HMOs that operate in its jurisdiction, covered services may vary among states. That is why it is important to read your HMO-provided certificate of coverage and other HMO materials carefully.

This material highlights your eligibility for the HMO Program and key HMO Program features. This material, together with the HMO-provided certificate of coverage attached below, constitutes your SPD for the HMO Program.

- ConnectiCare CT/MA HMO
- Health Alliance Plan IL HMO
- Personal Care IL HMO
- UHC River Valley POS
- Geisinger PA HMO
- Dean Health HMO
- Network Choice
- Network Co-Choice
- Network POS

The certificate details your specific HMO's rules and procedures, your rights and responsibilities, and the services your HMO does and does not cover. You can also contact the HMO directly for a summary of covered services.

If your home ZIP code is outside the HMO network areas, you can elect coverage under the Group Health Program. See the Group Health Program SPD for details.

Key Features

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

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

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

Pre-Existing Conditions
Pre-existing conditions may or may not apply to a specific HMO. Check with your HMO to see how this term is defined and if any pre-existing rules apply.

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

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

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

Prescription Drug Coverage
If you enroll in the ConnectiCare CT/MA HMO, Geisinger PA HMO, Health Alliance Plan HMO, or Personal Care IL HMO option, your HMO does not provide prescription drug coverage. As a result, you receive prescription drug coverage through the Prescription Drug Program under the Group Health Program. If you enroll in one of the other available HMO options, your HMO provides prescription drug coverage. Therefore, you receive prescription drug coverage through the HMO Program.

Lifetime Maximum Benefit for the HMO Program

The lifetime maximum benefit will vary by HMO option if you are enrolled in the HMO Program.

When Coverage Ends

General Information

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

- You decline coverage;
- Your employment with all Participating Employers terminates;
- You are no longer eligible for the HMO Program;
- You participate in the R.R. Donnelley & Sons Company Retiree Welfare Benefit Plan (the "Retiree Welfare Benefit Plan"); or
- The HMO Program is terminated.

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

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

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

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

If You Die

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

If you are eligible for coverage under the R.R. Donnelley Retiree Group Health Program ("Retiree Group Health Program") and you die, your spouse may enroll for Retiree Group Health Program coverage.

If Your Collective Bargaining Unit Goes on Strike

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

Eligibility for the Retiree Group Health Program

Once you cease to be an employee of all Participating Employers, you and your enrolled eligible dependents may be eligible for coverage under the Retiree Group Health Program. For more information, refer to the SPD for the Retiree Group Health Program. Please note, collective bargaining unit participants who are covered under the Network Choice or Network Co-Choice HMO options, are eligible for retiree coverage.

If You Accept New Employment or Continue Employment While on an Approved Leave of Absence

While you are on an approved leave of absence, if you continue employment with any other employer outside of RR Donnelley and its affiliates, or if you accept new employment, either of which can include self-employment, you will be considered to have voluntarily abandoned your job at your Participating Employer. This will be treated as a voluntary separation thus ending employment with RR Donnelley and termination of coverage under its benefit programs. For example, this termination of employment with RR Donnelley will result in a loss of all Group Benefit Plan benefits, including coverage under the HMO Program. Voluntary separation will be deemed to occur in these circumstances regardless of the amount of income generated from the new or existing employment and regardless of the length of time you intend to perform the services associated with the other job or self-employment.

A Special Note About HMO Coverage

The HMO may require you to provide additional or different proof of a child's continuing disability in order to maintain coverage for such child after age 19 (or after age 23 if a full-time student). Failure to comply with the HMO's request will result in permanent loss of eligibility for such extended coverage.

If the HMO terminates coverage for you, your spouse, or your eligible dependent before coverage would otherwise end, coverage will end under the HMO Program. In such case, you may be able to change your coverage options under the Group Benefits Plan,

or have a COBRA election with the HMO or Group Benefits Plan for continuation of coverage. If you have any questions, please contact the eligibility administrator.

Special Extensions of Coverage

General Information

Depending on your situation when you leave employment with your Participating Employer, you and your enrolled eligible dependents may be eligible for continued coverage under the HMO Program. Situations in which an extension of coverage is available are described below.

During a Leave of Absence

If you are granted a leave of absence pursuant to RR Donnelley's Human Resources Core Policy 6-4, Leaves of Absence, or you are laid off pursuant to Human Resources Core Policy 6-8, Temporary Layoffs, you have the right to discontinue coverage when your unpaid leave begins. See the Qualified Status Changes SPD for additional information. This includes leaves:

- For your own personal disability; and
- Covered by the Family and Medical Leave Act of 1993 (FMLA).

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

- Participate in the HMO Program (and the Participant Premium Program) for each calendar year to the extent required to repay advanced contributions made on your behalf beginning with the calendar year in which your leave of absence or layoff begins and ending in the calendar year in which your leave of absence or layoff ends, or you return to active service; and
- Repay RR Donnelley for the advanced premiums.

The advanced premiums will be recovered by your Participating Employer by taking one past deduction plus one current deduction, beginning with your first available pay upon your return to work or when you commence being paid. Deductions from your pay will continue until you repay your outstanding balance. If you separate employment from your Participating Employer with an outstanding balance due, the remaining balance will be recovered from your final pay as permitted by law.

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

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

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

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

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

Your Legal Right to COBRA Continuation Coverage

General Information

A federal law called the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended (COBRA), requires that most employers, including RR Donnelley, who sponsor medical benefit plans (including HMOs) offer employees and certain members of their families the opportunity to extend coverage temporarily at group rates after coverage under the medical benefit plan would otherwise end or if costs increase due to specific events. COBRA does not require employers who sponsor group health care plans to offer such extended coverage to domestic partners of employees or children of such domestic partners. (The HMO may be required to extend such coverage by state law.) However, the HMO Program does offer to covered domestic partners and the covered children of domestic partners who are eligible dependents COBRA continuation coverage rights that are equivalent to those offered under COBRA to the covered spouses and enrolled children of employees, as described below. The extension of coverage to employees and their enrolled eligible dependents is called "COBRA continuation coverage."

In general, the coverage that may be continued is the same as the coverage in which you and your eligible dependents were enrolled under the HMO Program as an active employee on the day before the qualifying event (as listed below). For example, if you and your spouse are enrolled in an available coverage option before you leave all Participating Employers, you can continue this same coverage. If continued coverage is not available from your HMO, the Group Health Program will offer COBRA continuation coverage under the terms of that Program. If you elected the "No Coverage" option as an active employee, you would not be eligible for any COBRA continuation coverage.

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

Who Can Continue Coverage	In What Situations	For How Long*
Employee, employee's enrolled spouse/domestic partner, employee's enrolled child(ren), and enrolled child(ren) of employee's domestic partner	• A reduction in work hours that would cause employee to be classified as a benefits-ineligible employee • Termination of employee's employment (other than for gross misconduct) • Significant premium increase (for example, due to failure to notify the Benefits Center of a status change that resulted in a dependent's ineligibility and continued coverage on an after-tax basis)	18 months
Employee's enrolled spouse/domestic partner, employee's enrolled child(ren), and enrolled child(ren) of employee's domestic partner only	• Employee's death • Divorce or legal separation • Employee's entitlement to Medicare (under Part A, Part B, or both)**	36 months
Employee's domestic partner, employee's enrolled child(ren), and enrolled child(ren) of employee's domestic partner only	Domestic partner or children no longer meet the eligibility rules for coverage	36 months

*The duration of coverage is from the date of the qualifying event.
**The 36-month coverage begins on the day you enroll in Medicare.

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

Notification

In the case of the employee's death while employed, termination of employment (other than for gross misconduct), reduction in hours, or entitlement to Medicare (under Part A, Part B, or both), you and your COBRA continuation coverage beneficiaries will automatically be advised of the right to this continued coverage within 14 days of the date the COBRA administrator is notified by the employer of the event. The employer has 30 days after the date of the qualifying event to notify the COBRA administrator.

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

- Divorce;
- Legal separation; or

- A domestic partner or child no longer meets the eligibility rules for coverage under the HMO Program.

You will be allowed to make a COBRA election only if you notify the COBRA administrator within 60 days after the qualifying event occurs or the date on which a COBRA continuation coverage beneficiary would lose coverage under the terms of the HMO Program.

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 COBRA continuation coverage rights. When the COBRA administrator is timely notified that one of these qualifying events has happened, your COBRA continuation coverage beneficiaries will in turn be notified within 14 days of the right to choose COBRA continuation coverage. Contact information for the COBRA administrator can be found in the "Administrative and Contact Information" section.

Election Procedure

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

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

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

Disability Extension

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

the month that is 31 or more days after the Social Security determination that the disability has ended.

Other Extension

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

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

Payment

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

Your initial COBRA continuation coverage premium is due by the 45th day after coverage is elected. All other payments are due on the first day of the month for which you are buying coverage, subject to a 30-day grace period. If you or your COBRA continuation coverage beneficiaries do not make payment on or before the first day of the month, your or your COBRA continuation coverage beneficiary's claim(s) will not be paid by the HMO Program until payment is received within the 30-day grace period.

When COBRA Continuation Coverage Ends

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

- The end of the 18-month, 29-month, or 36-month continuation period;
- The date your employer no longer provides coverage to any of its employees;
- The date a COBRA continuation coverage beneficiary fails to pay the required contribution by the specified deadline;

- The date a COBRA continuation coverage beneficiary first becomes covered after the date of his or her COBRA continuation coverage election under another group health care program that does not contain a pre-existing exclusion that affects his or her benefits;
- The date a COBRA continuation coverage beneficiary first becomes entitled to Medicare after the date of his or her COBRA continuation coverage election; or
- The date that there has been a final determination by the Social Security Administration that the COBRA continuation coverage beneficiary who elected to extend coverage for up to 29 months due to disability is no longer disabled.

If COBRA continuation coverage is rejected in favor of an alternate coverage under the HMO Program, COBRA continuation coverage will not be offered at the end of that period. If an alternate coverage is offered, COBRA continuation coverage will be reduced to the extent such coverage satisfies the requirements of COBRA continuation coverage.

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

Trade Act Implications

The Trade Act of 2002 (the "Trade Act") is a law that provides trade adjustment assistance (TAA) for eligible individuals. It includes a federal tax credit that COBRA continuation coverage beneficiaries who are eligible under the law can use to offset part of the cost of COBRA continuation coverage. This special tax credit is available for workers who lose their jobs and are found eligible for TAA benefits, or are between ages 55 and 64 and receiving monthly benefits from the Pension Benefit Guaranty Corporation (PBGC).

In addition to the COBRA continuation coverage tax credit, the Trade Act adds a special 60-day COBRA continuation coverage election period for individuals who are deemed eligible for TAA benefits and the tax credit. The new election period applies to those who had not previously elected COBRA continuation coverage and are deemed eligible for the tax credit provisions, but only if the eligibility determination occurs within six months of the loss of group health coverage. Additionally, if COBRA continuation coverage is elected during this special time period, such coverage is not retroactive to the date of the qualifying event, but begins on the first day of the special new 60-day period.

The law also clarifies that the period between the loss of coverage and the beginning of the special 60-day election period does not count against the 63-day break-in-coverage rule under the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

For more information about the tax credit, you can call the Health Coverage Tax Credit Customer Contact Center toll-free at 1-866-628-4282. TDD/TTY callers

may call toll-free at 1-866-626-4282. More information may also be found at **www.doleta.gov/tradeact/2002act_index.cfm**.

Statutory Benefit

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

Claims and Appeals Procedures

General Information

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

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

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

Procedure for Filing a Claim

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

Defective Claims

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

Initial Claim Review
The claims administrator will conduct the initial claim review and consider the applicable terms, provisions, amendments, information, evidence presented, and any other information it deems relevant.

Initial Benefit Determination

Claim Involving Urgent Care
In the case of a claim that involves urgent care, the claims administrator will notify the claimant of the benefit determination (whether adverse or not) no later than 72 hours after receipt of the claim by the claims administrator. The claimant must, however, provide sufficient information to determine whether and to what extent benefits are payable under the Group Benefits Plan.

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

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

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

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

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

If an extension is necessary due to the claimant's failure to submit the information necessary to decide the claim, the notice of extension will describe the required information. The claimant will then have at least 45 days from receipt of the notice within which to provide the specified information. The period within which the claims administrator is required to make a decision is then suspended from the date on which the notification is sent to the claimant until the earlier of the date the claimant responds to the request for additional information, or the due date established by the claims administrator for furnishing the requested information.

Post-Service Claim
In the case of a claim that is filed after the claimant receives care, the claims administrator will notify the claimant of the denial within 30 days after receipt of the claim. The claims administrator may extend the period for making the benefit determination by 15 days if it determines that such an extension is necessary due to matters beyond the Group Benefits Plan's control. The claims administrator will notify the claimant, prior to the expiration of the initial 30-day period, of the circumstances that require the extension of time and the date by which the claims administrator expects to render a decision.

If an extension is necessary due to the claimant's failure to submit the information necessary to decide the claim, the notice of extension will describe the required information. The claimant will then have at least 45 days from receipt of the notice within which to provide the specified information. The period in which the claims administrator is required to make a decision is then suspended from the date on which the notification is sent to the claimant until the earlier of the date the claimant responds to the request for additional information, or the due date established by the claims administrator for furnishing the requested information.

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

The notification of a denial will include:

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

Review of Initial Benefit Denial

Procedure for Filing an Appeal of a Denial

A claimant must bring any appeal of a denial to the claims administrator within 180 days after he or she receives notice of the denial. If the claimant fails to appeal within the 180-day period, he or she will not be permitted to seek an appeal with the claims administrator and he or she will have failed to have exhausted all administrative remedies under the Group Benefits Plan. This failure will result in the claimant's inability to bring a legal action to recover a benefit under the Group Benefits Plan. The claimant's request for an appeal must be in writing utilizing the appropriate form provided by the claims administrator (or in such other manner acceptable to the claims administrator). A claimant's request for an appeal must be filed with the claims administrator in person, by messenger as evidenced by written receipt, or by first-class postage-paid mail to the address for the claims administrator.

Review Procedures for Denials

- The claims administrator will provide a review that takes into account all comments, documents, records, and other information the claimant submits, without regard to whether such information was submitted or considered in the initial benefit determination.
- The claimant will have the opportunity to submit written comments, documents, records, and other information relating to the claim.
- The claimant will be provided, upon request and free of charge, reasonable access to and copies of all relevant documents.

- The review of a denial does not defer to the initial determination made by the claims administrator.
- The individual who conducts the review process is neither the individual who made the initial denial nor the subordinate of such individual.
- In deciding an appeal of any denial that is based in whole or in part on a medical judgment, including determinations as to whether a particular treatment, drug, or other item is experimental, investigational, or not medically necessary or appropriate, the individual conducting the review process will consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment. The health care professional will be neither the individual who was consulted in connection with the denial that is the subject of the review nor the subordinate of such individual.
- The claims administrator will identify any medical or vocational experts whose advice was obtained on behalf of the Group Benefits Plan in connection with the claimant's denial, without regard as to whether the advice was relied upon in making the benefit determination.
- In the case of a claim that involves urgent care, an expedited review process will be provided. The claimant must request an expedited appeal orally or in writing, and all necessary information, including the Group Benefits Plan's benefit determination on review, must be transmitted between the Group Benefits Plan and the claimant by telephone, facsimile, or other available similarly expeditious method.

Timing of Notification of Benefit Determination on Review

- **Claim involving urgent care.** In the case of a claim that involves urgent care, the claims administrator will notify the claimant of the benefit determination on review within 72 hours after receipt of the claimant's request for review.
- **Pre-service claim.** The claims administrator will notify the claimant of the benefit determination on review within 30 days after receipt of the request for review.
- **Post-service claim.** The claims administrator will notify the claimant of the benefit determination on review within 60 days after receipt of the request for review.

Manner and Content of Notification of Benefit Determination on Review

The claims administrator will provide a written or electronic notice of the Group Benefits Plan's benefit determination on review, in accordance with applicable U.S. Department of Labor regulations. If the claimant's appeal is denied, the notification will include:

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

- If the denial is based on medical necessity or an experimental treatment or similar exclusion or limit, an explanation of the scientific or clinical judgment relied upon for the determination or a statement that such explanation will be provided free of charge upon request.

Legal Action

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

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

A Special Note About HMO Coverage

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

Situations Affecting Your Benefits

General Information

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

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

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

If the Group Benefits Plan Is Modified or Ended

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

Administrative and Contact Information

General Information

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

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

Plan Sponsor
RR Donnelley & Sons Company
111 South Wacker Drive
Chicago, IL 60606-4301
(312) 326-8000

Employer Identification Number of Plan Sponsor
36-1004130

Plan Name and Number
R.R. Donnelley & Sons Company Group Benefits Plan – 504

Plan Year End
December 31

Agent for Service of Legal Process
Corporate Secretary
RR Donnelley & Sons Company
111 South Wacker Drive
Chicago, IL 60606-4301
(312) 326-8000

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
111 South Wacker Drive
Chicago, IL 60606-4301
(312) 326-8000

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

Participating Employers

The following employers participate in the HMO Program of the Plan ("Participating Employers"). A complete list of the Plan's Participating Employers may be obtained by you upon written request to the eligibility administrator:

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

You have a Grandfathered Legacy Indicator ("GLI") established that notes the Participating Employer you are linked to under the Group Health Program. Your GLI is established either as of your initial eligibility for the Program or as of January 1, 2008, whichever is later. Even if you transfer among Participating Employers, your coverage and premium are based on the benefits provided for by your GLI. Your GLI may be subject to change, and this decision will be made by the Benefits Committee in coordination with your work location. You will be notified if for any reason your benefit coverage options change due to a change in GLI. If you transfer among Participating Employers where domestic partner coverage differs, please contact the Eligibility Administrator for additional details.

The HMO Program described in this document applies to employees of Participating Employers. If you become an employee of RR Donnelley due to an acquisition, your effective date for a benefit generally is that date on which benefits are extended. That date will be announced in each affected location.

If you have questions concerning your eligibility to participate in this HMO Program, call the eligibility administrator listed under "Eligibility Administrator" below.

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

Eligibility Administrator

The eligibility administration is performed by Hewitt Associates LLC, at the following address and phone number:

RR Donnelley Benefits Center
100 Half Day Road
P.O. Box 1496
Lincolnshire, IL 60069-1496
1-877-RRD-4BEN (1-877-773-4236)

Benefits Center Representatives are available between the hours of 8 a.m. and 5 p.m. CT, Monday through Friday, except holidays.

Website: **www.mybenefitsdirectory.com/rrd**

Contact the Benefits Center to:

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

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

Claims Administrators

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

The HMO Program

Options	Claims Administrator
Connecticut	
ConnectiCare CT/MA HMO	ConnectiCare 175 Scott Swamp Road P.O, Box 4050 Farmington, CT 06034-4050 1-800-846-8578 Website: **www.connecticare.com**
Illinois	

Options	Claims Administrator
Health Alliance Plan IL HMO	Health Alliance Medical Plans 102 E. Main Street Urbana, IL 61801 1-800-851-3379 Website: **www.healthalliance.org**
Personal Care IL HMO	PersonalCare HMO 2110 Fox Drive Champaign, IL 61820 1-800-431-1211 Website: **www.personalcare.org**
Iowa UHC River Valley POS	UnitedHealthcare of the River Valley P.O. Box 5230 Kingston, NY 12402-5230 1-800-747-1446 Website: www.uhcrivervalley.com
Pennsylvania Geisinger PA HMO	Geisinger Health Plan P.O. Box 8200 Danville, PA 17821-8200 1-800-447-4000 Website: **www.thehealthplan.com**
Wisconsin Dean Health HMO	Dean Health Insurance P.O. Box 56099 Madison, WI 53705 1-608-828-1301 Website: **www.deancare.com**
Network Choice Network Co-Choice Network POS	Network Health Plan 1570 Midway Place Menasha, WI 54952 1-800-826-0940 Website: **www.networkhealth.com**

The Prescription Drug Program	
Options	**Claims Administrator For Paper Claim Reimbursements**
CVS Caremark Prescription Drug Program	CVS Caremark Attn: Claims Department P.O. Box 686005 San Antonio, TX 78268-6005 1-866-273-8402 Caremark Customer Care Representatives are available 24 hours a day, 7 days a week. Website: **www.caremark.com**

* Please note that under the HMO Program, your specific HMO is the claims administrator and network manager for your mental health and substance abuse coverage. You do, however, receive prescription drug coverage under the Group Health Program's Prescription Drug Program if you elect coverage in any of the following HMOs: ConnectiCare CT/MA HMO, Geisinger PA HMO, Health Alliance Plan IL HMO, and Personal Care IL HMO.

Claims Administrator for Eligibility Claims

The Benefits Committee is the claims administrator for claims related to eligibility and appeals of denied claims related to eligibility.

COBRA Administrator for COBRA Continuation Coverage

The COBRA administrator is Hewitt Associates LLC. If you have questions about your COBRA continuation coverage rights, contact the COBRA administrator at the following address and phone number:

RR Donnelley Benefits Center
100 Half Day Road
P.O. Box 1496
Lincolnshire, IL 60069-1496
1-877-RRD-4BEN (1-877-773-4236)

Website: www.mybenefitsdirectory.com/rrd

Allocation and Delegation of Fiduciary Responsibilities by the Benefits Committee

The Group Benefits Plan provides a procedure for the Benefits Committee, acting as named fiduciary, to allocate or delegate fiduciary responsibilities to its members or to other persons. Where the Benefits Committee has allocated to an applicable investment named fiduciary some authority to control or manage assets held in the R.R. Donnelley & Sons Company Welfare Benefits Trust ("trust"), or to an applicable administrative named fiduciary some authority and control over the operation and administration of the Group Benefits Plan, references in this SPD to the Benefits Committee are intended to refer to any such applicable investment named fiduciary or applicable administrative named fiduciary. The Group Benefits Plan also provides a procedure for the Benefits Committee, acting as the Group Benefits Plan's sponsor, to identify persons, such as the claims administrator, to be a named fiduciary. Typically, the Benefits Committee has identified each HMO as a named fiduciary with respect to the authority and control or discretion it possesses or has exercised in connection with the Group Benefits Plan or trust.

Trust and Insurance

RR Donnelley sponsors the R.R. Donnelley & Sons Company Welfare Benefits 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

Insured Benefits

The trust is the policyholder for the funding of the HMO policies under the HMO Program. These health maintenance policies are guaranteed by the HMO issuer and not by RR Donnelley, the Group Benefits Plan, or the trust. In addition, the HMO issuer of such contract also is the claims administrator and network manager with respect to such contracts of insurance.

Your ERISA Rights

General Information

As a participant in the Plan, you and your enrolled eligible dependents are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974, as amended ("ERISA"). ERISA provides that you are entitled to the following.

Receive Information About Your HMO Program and Benefits

- Examine, without charge, at the Plan Administrator's office and at other specified locations, such as work sites and union halls, all documents governing the Plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.
- Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, including insurance contracts and collective bargaining agreements, copies of the latest annual report (Form 5500 Series), and an updated SPD. The Plan Administrator may make a reasonable charge for the copies.
- Receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of this Summary Annual Report.

Continue Group Health Plan Coverage

- Continue health care coverage for you and/or your enrolled eligible dependents if there is a loss of coverage under the HMO 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 HMO Program, if you have creditable coverage from another plan. You should be provided a certificate of creditable coverage, free of charge, from your HMO Program or health insurance issuer when you lose coverage under the HMO Program, when you become entitled to elect COBRA continuation coverage, when your COBRA continuation coverage ceases, if you request it before losing coverage, or if you request it up to 24 months after losing coverage. Without evidence of creditable coverage, you may be subject to a pre-existing condition exclusion relative to your coverage for 12 months (18 months for late enrollees) after your enrollment date.

Prudent Actions by Plan Fiduciaries

In addition to creating rights for plan participants, ERISA imposes duties upon the people who are responsible for the operation of the employee 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, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.