Dental Benefit Program

Wrap Document and Summary Plan Description

Effective as of July 1, 2016

MY HEALTH MY WEALTH MY LIFE

DONNELLEY FINANCIAL BENEFIT PLANS

Contents

Introduction

The options available under the Donnelley Financial Group Benefits Plan ("Group Benefits Plan") enable you to select the level of coverage and cost that best meet your needs. These options offer you and your eligible dependents coverage for a wide range of services such as routine exams, X-rays, oral surgery, and fillings.

Your Dental Benefit Program options are listed in your enrollment information. As long as you are eligible, you can elect coverage under one of the following two MetLife Dental PPO options:

- MetLife Dental PPO; or
- MetLife Dental PPO Plus.

You pay the full cost of the Dental Benefit Program's premium for you and your enrolled eligible dependents. Your cost is based on the option and coverage category you elect. Therefore, it is important that you know how the Dental Benefit Program works. Become an informed consumer of dental 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 attached here, is the Summary Plan Description ("SPD") for the Dental Benefit Program. It explains your dental coverage as of July 1, 2016 (unless noted otherwise). It details who is eligible for coverage, how to enroll for coverage, when coverage begins and ends, and which expenses are and are not covered under the Dental Benefit Program. It also describes how to file a claim and your rights under the Dental Benefit 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. If there are differences between the rules contained in this SPD and the rules contained in your applicable collective bargaining agreement, your collective bargaining agreement will control.

Claims Administrator

The Group Benefits Plan has contracted with a third party to render services necessary to the operation and administration of the Dental Benefit Program. MetLife Dental is the claims administrator and network manager for the Dental Benefit Program.

You are eligible for coverage under the Dental Benefit 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 Dental Benefit Program. However, since treatments and practices continually change, this document cannot adequately define every potentially covered service or exclusion. In each case, the claims administrator 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 Dental Benefit Program. For United States Department of Labor ("DOL") filing purposes, several Donnelley Financial 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.

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 July 1, 2016. Donnelley Financial reserves the right to amend, change, or terminate the Group Benefits Plan or Dental Benefit Program, in whole or in part, at any time.

This content contains a summary in English of your rights and benefits under the Dental Benefit Program. If you have difficulty understanding any part of this content, call the Donnelley Financial Benefits Center at 1-844-44-DFSCO (1-844-443-3726). Benefits Center Representatives are available from 8 a.m. to 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 Dental Benefit Program.

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

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

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

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

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

- Was born out of wedlock;
- Is not claimed as a dependent on your federal income tax return;
- Does not reside with you or in the Dental Benefit 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 Dental Benefit Program.

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

- Neither you nor your domestic partner are legally married to or are the legal domestic partner of anyone else;
- You and your domestic partner intend to remain each other's sole domestic partner indefinitely;

- You and your domestic partner live together in the same principal residence and intend to do so indefinitely;
- You and your domestic partner are committed to each other and share joint responsibilities for your common welfare and financial obligations; and
- You and your domestic partner are not related by blood, closer than would prohibit marriage in the state in which you live.

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

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

This reference to the word "dependent" does not carry the meaning of this word as it is used for Section 152 of the Internal Revenue Code of 1986, as amended (the "Code"). Your parents, grandparents, adult brothers, and 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 Dental Benefit Program as an eligible dependent during such assignment. In addition, your eligible dependent who is also covered under the Dental Benefit Program as an employee may not simultaneously be enrolled and covered under the Dental Benefit 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 of the Code, determined without reference to Section 152(b)(1), (b)(2), and (d)(1)(b) of the Code.

Premiums (or Contributions) – means the amount you pay for coverage in which you have enrolled under the Dental Benefit 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 to whom you are currently legally married. The Dental Benefit Program also considers common-law spouse in states that recognize common-law marriages.

Dependent Audit

Donnelley Financial and the Group Benefits Plan conduct a semi-annual audit of certain covered dependents. Dependents that have been newly added to the Group Benefits Plan since the last audit period need to be verified. A Dependent Audit Notice is mailed to each Participant who must verify a covered dependent(s) and informs them that they must send documentation to verify the eligibility of their covered dependent(s) as indicated in the notice.

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

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

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

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

Ineligible dependents or dependents for whom you either: (i) were unable to provide required documentation for or (ii) did not take any action for, are no longer eligible for coverage and their current coverage has been terminated. Nevertheless, such

dependents may be able to continue their coverage through the Consolidated Omnibus Budget Reconciliation Act ("COBRA"). COBRA is a federal law that requires employers to offer plan participants the opportunity to continue their health care coverage in a number of situations that would otherwise ordinarily end their coverage. Any of your dependents that were not certified during the semi-annual audit will automatically receive COBRA enrollment information. This information describes available coverage options and the cost of such options.

Required Documentation for Dependent
The documentation is needed to verify:

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

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

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

Dependent	Documentation
Spouse	• Joint federal tax return from current or prior year if filing jointly (first page only), or • Both spouses' federal tax returns from current or prior year if filing separately (first page only), or • Copy of tax confirmation notice(s) from current or prior year if filed online.
Common-law spouse	• Joint federal tax return from current or prior year if filing jointly (first page only), or • Both spouses' federal tax returns from current or prior year if filing separately (first page only), or • Copy of tax confirmation notice(s) from current or prior year if filed online.
Domestic partner	**Submit 2:** • Joint federal tax return from current or prior year if filing jointly (first page only) or • Both partners' federal tax returns from current or prior year if filing separately(first page only) or • Documentation of joint ownership of residence, or • Documentation of joint tenants on lease of residence, or • Copy of both Driver's licenses or other government records reflecting the same address, or • Current bank/credit card statement (within the past 12 months) with both names, or • Current utility bill (within last 12 months) with both names.

Dependent	Documentation
Child under age 26	• Birth certificate for biological children showing you as parent, or • Court papers for adopted children or children placed for adoption, or • Court papers demonstrating legal guardianship or custodianship for court appointed children, or • Documentation on hospital letterhead indicating birth date of child, showing you as parent (acceptable only for children under 6 months old if documents above aren't available), **AND** (**Only** if documents above don't include birth date) Documented proof of age, such as: • Child's driver's license or other government records, or • Child's Visa/Passport.
Stepchild under age 26	• Birth certificate showing the child's parent to be your spouse, or • Documentation on hospital letterhead indicating birth date of child, listing your spouse as parent (acceptable only for children under 6 months old if birth certificate isn't available), **AND** (**Only** if documents above don't include birth date) Documented proof of age, such as: • Child's driver's license or other government records, or • Child's Visa/Passport, **AND** Documentation showing your relationship to the stepchild's parent, such as: • Marriage license, or • Church/justice of the peace marriage certificate, or • Documentation of joint ownership of residence (acceptable only if documents above aren't available), or • Joint tenants on lease of residence (acceptable only if documents above aren't available).
Child of domestic partner under age 26	• Birth certificate showing the child's parent to be your domestic partner, or • Documentation on hospital letterhead indicating the birth date of the child, listing your domestic partner as parent (acceptable only for children under 6 months old if birth certificate isn't available), **AND** (**Only** if documents above don't include birth date) Documented proof of age, such as: • Child's driver's license or other government records, or • Child's Visa/Passport, **AND** • Documentation of joint ownership of residence, or • Documentation of joint tenants on lease of residence, or • Copy of both Driver's licenses or other government records reflecting the same address, or • Current bank/credit card statement (within the past 12 months) with both names, or • Current utility bill (within last 12 months) with both names.

General Information

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

- Full-time benefits-eligible employee of a Participating Employer; or
- 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 Dental Benefit Program participation.

If you enroll for coverage, your participation in the Dental Benefit Program takes effect the first day of the month after you complete one full calendar month of employment. For purposes of determining whether you have satisfied this waiting period, all periods of your employment with a Participating Employer before a period of more than 30 consecutive days during which you are not employed with a Participating Employer are disregarded.

You are not eligible for coverage under the Dental Benefit 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 Dental Benefit Program.

If you are not eligible for coverage when you are first hired, you become eligible on the date you transfer from benefits-ineligible to benefits-eligible status (provided you have at least one full calendar month of employment, as determined above, from your original hire date).

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

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

Extended Coverage for Disabled Children

If your enrolled eligible child is permanently and totally disabled (as defined in Code Section 22(e)(3)) and unable to support himself or herself, you can continue coverage for that child after age 26. To be eligible for continued coverage, your child must be enrolled under the Dental Benefit Program immediately before the coverage would otherwise end, and the disability must begin while your enrolled eligible child's coverage

under the Dental Benefit 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 disabled child must continue to meet the following conditions to be an eligible child under the Dental Benefit Program:

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

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

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

Extended Coverage for Certain Dependents

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

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

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

Continued Coverage for Your Eligible Dependents Under the Certificate of Coverage

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

When your child ceases 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 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 certificate of coverage.

Qualified Medical Child Support Order (QMCSO)

The Group Benefits Plan also makes coverage available under the Dental Benefit 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 Dental Benefits 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 Donnelley Financial Benefits Center.

If you are enrolled, you may enroll a child in the Dental Benefit 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 Dental Benefit 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 Dental Benefit 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 Dental Benefit Program and, at the same time, the Participant Premium Program of the Donnelley Financial, LLC Flexible Benefits Plan ("Participant Premium Program"). The following coverage categories apply:

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

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

If you and any one of your eligible dependents are both employees eligible to enroll, each of you may enroll for "You Only" coverage, or one of you may enroll and cover the other as an eligible dependent. If each of you enrolled 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 Dental Benefit 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 pay the full cost of premiums under the Dental Benefit Program for you and your enrolled eligible dependents. The premium you pay depends on the option and coverage category you choose.

When you enroll in the Dental Benefit Program, you authorize the deduction of your required premium payments from your paycheck. For you and your covered dependents, you pay for coverage under the Dental Benefit 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.

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

Your elections under the Dental Benefit 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 Dental Benefit 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 Dental Benefit 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 Dental Benefit Program to receive coverage for yourself and your eligible dependents.

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

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 Dental Benefit 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 on the 1st of or During the Month Of:	Your Coverage Begins On:
January	March 1
February	April 1
March	May 1
April	June 1
May	July 1
June	August 1
July	September 1
August	October 1
September	November 1
October	December 1
November	January 1
December	February 1

If you are not eligible for coverage when you are first hired with a Participating Employer, you become eligible on the date you transfer from benefits-ineligible to benefits-eligible status with that Participating Employer (provided you have at least one full calendar month of employment, as determined above, from your original hire date). If you become a new benefits-eligible employee because you have transferred your employment from a non-Participating Employer that is an affiliate of Donnelley Financial, the following special rules will apply:

- Your coverage under this Dental Benefit 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 Dental Benefit 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 Dental Benefit Program on the date of the transfer, you will continue to participate in that program until the end of the calendar year in which you transfer. As a result, your coverage under this Dental Benefit Program begins on the following January 1.
- If you transfer from a non-U.S. affiliate, your coverage under the Dental Benefit 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

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 Dental Benefit 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 Donnelley Financial, 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 Dental Benefit 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 Dental Benefit 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 Dental Benefit Program 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, 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.

How the Program Works

General Information

This section summarizes some key features of the Dental Benefit Program and applies to both of the following MetLife Dental options available to you:

- MetLife Dental PPO; and
- MetLife Dental PPO Plus.

When you are first hired or during the Annual Enrollment period, you can enroll yourself and your eligible dependents for coverage in either of the above options. You receive information regarding the options available to you when you are first hired and during each Annual Enrollment period thereafter. MetLife Dental is the claims administrator and network manager for both options.

Key Features

The key features of the MetLife Dental PPO options are as follows. If you receive care from a participating PPO dentist, you:

- Do not have to fill out claim forms;
- Benefit from a higher rate of reimbursement due to the discounts applied; and
- Cannot be billed for any charges above the negotiated fees the provider has already agreed to accept.

About Passive PPOs
The MetLife Dental PPO options are passive PPOs. This means that the Dental Benefit Program does not reduce benefits if you use a provider who is not part of the network. You receive the same level of coverage regardless of the provider you use. However, if you use a provider who participates in the network, you pay less for care because network providers agree to accept reimbursement based on a negotiated fee schedule for services.

If you choose a dentist who does not participate in the MetLife Dental PPO network, MetLife Dental issues payment to you and you are responsible for the difference between your dentist's submitted amount and MetLife Dental's payment. The amount MetLife Dental uses to calculate its payment (the allowed amount), is the lesser of the dentist's submitted amount and the maximum allowance for non-network dentists (as defined in the certificate of coverage). At the dentist's discretion, you may have to pay the entire bill in advance.

See the Dental Benefit Program certificate of coverage (at the end of this booklet) for details regarding the MetLife Dental PPO and PPO Plus options and the MetLifeDental network. You also can contact the claims administrator (or visit the MetLife Dental

website) to locate network providers in your area or to request a list of providers free of charge.

When Coverage Ends

General Information

Generally, coverage under the Dental Benefit 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 Dental Benefit Program; or
- The Dental Benefit Program is terminated.

Except if COBRA continuation coverage is available and elected, the Dental Benefit 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 Dental Benefit Program and you received a prior authorization for such services (such as for orthodontia services).

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

If you leave all Participating Employers on either a voluntary or involuntary basis, coverage under the Dental Benefit 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 Dental Benefit 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 Dental Benefit 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 Dental Benefit 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 Dental Benefit Program. The three months of subsidized coverage count toward the period of COBRA continuation coverage for which such enrolled eligible dependents are eligible, as described in the “Your Legal Right to COBRA Continuation Coverage” section.

If Your Collective Bargaining Unit Goes on Strike

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

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

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

Special Extensions of Coverage

General Information

Depending on your situation when you leave employment with your Participating Employer, you and your enrolled eligible dependents may be eligible for continued coverage under the Dental Benefit 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 Donnelley Financial'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 Dental Benefit 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), you are responsible for your premium while on a leave of absence. If you are approved for short-term and/or long-term disability and receive disability payments from the disability vendor, your premiums will be deducted from your disability pay as available. If you are not receiving short-term and/or long-term disability payments or do not have enough disability pay to cover your total premiums, Donnelley Financial 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 Donnelley Financial 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 Donnelley Financial during the time of your leave of absence or layoff (excluding military leave). Therefore, if Donnelley Financial advances premiums for you, you will be deemed to have elected to:

- Participate in the Dental Benefit Program (and the Participant Premium Program) for each calendar year to the extent required to repay advanced contributions made on your behalf beginning with the calendar year in which your leave of absence begins and ending in the calendar year in which your leave of absence ends, or you return to active service; and
- Repay Donnelley Financial 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, Donnelley Financial 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 Dental Benefit 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 Donnelley Financial, who sponsor dental benefit plans offer employees and certain members of their families the opportunity to extend coverage temporarily at group rates after coverage under the dental benefit plan would otherwise end or if costs increase due to specific events. COBRA does not require employers who sponsor group health plans to offer such extended coverage to domestic partners of employees or children of such domestic partners. However, the Dental Benefit 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 Dental Benefit Program as an active employee on the day before the qualifying event (as listed below). For example, if you and your spouse are enrolled in an available coverage option before you leave all Participating Employers, you can continue this same coverage. If you elected the "No Coverage" option as an active employee, you would not be eligible for any COBRA continuation coverage.

To be eligible for COBRA continuation coverage, a qualifying event must take place. After the qualifying event, COBRA continuation coverage must be offered to each person who is a COBRA continuation coverage beneficiary. You, your enrolled spouse, your enrolled domestic partner, your enrolled children, and your domestic partner's enrolled children could become COBRA continuation coverage beneficiaries if coverage under the Dental Benefit 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

Who Can Continue Coverage	In What Situations	For How Long*
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	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.

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 Dental Benefit 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 Dental Benefits 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 do not choose COBRA continuation coverage within this 60-day period, your and/or your COBRA continuation coverage beneficiary’s coverage under the Dental Benefit 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 Dental Benefit Program. The Dental Benefit 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 Dental Benefit 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 Dental Benefit 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 dental program that does not contain a pre-existing exclusion that affects his or her benefits; 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 Dental Benefit Program, COBRA continuation coverage will not be offered at the end of that period. If an alternate coverage is offered, COBRA continuation coverage will be

reduced to the extent such coverage satisfies the requirements of COBRA continuation coverage.

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

Trade Act Implications

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

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

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

For more information about the tax credit, you can call the Health Coverage Tax Credit Customer Contact Center toll-free at 1-866-628-4282. TDD/TTY callers may call toll-free at 1-866-626-4282. More information also may be found at **http://www.doleta.gov/tradeact/2002act_summary.cfm**

Statutory Benefit

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

Claims and Appeals Procedures

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 dental service. 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 full and fair review that takes into account all comments, documents, records, and other information the claimant submits, without regard to whether such information was submitted or considered in the initial benefit determination.
- The claimant will have the opportunity to submit written comments, documents, records, and other information relating to the claim.
- The claimant will have the opportunity to review the claim file, if any, created by the claims administrator during the initial claim.

- The claimant will have the opportunity to present evidence and testimony as part of the review of the claimant's initial benefit denial.
- The claimant will be provided, upon request and free of charge, reasonable access to and copies of all relevant documents.
- The claimant may receive, free of charge and as soon as possible, any new or additional evidence considered, relied upon, or generated by the Group Benefits Plan or an insurer, if applicable of a Dental Benefit Program, in connection with the claim.
- The review of a denial does not defer to the initial determination made by the claims administrator.
- The individual who conducts the review process is neither the individual who made the initial denial nor the subordinate of such individual.
- In deciding an appeal of any denial that is based in whole or in part on a medical judgment, including determinations as to whether a particular treatment, drug, or other item is experimental, investigational, or not medically necessary or appropriate, the individual conducting the review process will consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment. The health care professional will be neither the individual who was consulted in connection with the denial that is the subject of the review nor the subordinate of such individual.
- The claims administrator will identify any medical or vocational experts whose advice was obtained on behalf of the Group Benefits Plan in connection with the claimant's denial, without regard as to whether the advice was relied upon in making the benefit determination.
- In the case of a claim that involves urgent care, an expedited review process will be provided. The claimant must request an expedited appeal orally or in writing, and all necessary information, including the Group Benefits Plan's benefit determination on review, must be transmitted between the Group Benefits Plan and the claimant by telephone, facsimile, or other available similarly expeditious method.
- The claimant may receive, prior to the issuance of the benefit determination on review, any new or additional rationale upon which the benefit determination is decided.

Timing of Notification of Benefit Determination on Review

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

Manner and Content of Notification of Benefit Determination on Review

The claims administrator will provide a written or electronic notice of the Group Benefits Plan's benefit determination on review, in a culturally and linguistically appropriate

manner, in accordance with applicable DOL regulations. If the claimant's appeal is denied, the notification will include:

- The specific reason or reasons for the denial;
- Specific information to identify the claim involved, including, the date of service, the health care provider, the claim amount (if applicable), and a statement describing the availability, upon request, of the diagnosis and treatment codes (along with the corresponding meaning of these codes);
- Reference to the specific Group Benefits Plan provision(s) on which the determination is based;
- A statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to and copies of all relevant documents;
- If an internal rule, guideline, protocol, or other similar criterion was relied upon in making the denial, the specific rule, guideline, protocol, or other similar criterion that was relief upon will be provided free of charge to the claimant upon request;
- A description of available external review procedures, including on how to initiate such review; and
- A disclosure of the availability of, and contact information for, any applicable office of health insurance consumer assistance or ombudsman established under health care reform available to assist the claimant with the external review proccedures.

External Review Procedures

Under the new healthcare reform law, you may have the right to have an independent group of health care professionals who have no association with the Group Benefits Plan review any denied appeal. Your request for an external review must be filed within four months after the date you receive a denied appeal from the claims administrator. Within five days of receiving your request for external review, the Group Benefits Plan will review whether certain requirements are met, and within one day of completing this review the Group Benefits Plan will provide you with its determination of whether you are eligible for external review, or whether additional information may be needed.

If your request for external review meets the criteria for external review, the Group Benefits Plan will assign an accredited independent review organization to perform the external review. The independent review organization may request additional information in order to complete its review. Within 45 days of receiving the external review request, the assigned independent review organization will provide written notice of its final external review decision. If the independent review organization's decision is to reverse the Group Benefits Plan's denial, the Group Benefits Plan will immediately provide coverage or payment for the claim under review.

Legal Action

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

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

A Special Note About Dental Coverage

Your certificate of coverage will outline the claims and appeals procedures applicable to your claim with the claims administrator. 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 claims administrator to explain any difference.

Situations Affecting Your Benefits

General Information

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

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

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

If the Group Benefits Plan Is Modified or Ended

Donnelley Financial reserves the right to amend or terminate the Group Benefits Plan or the Dental Benefit Program at any time, in whole or in part. If the Group Benefits Plan or the Dental Benefit Program is ever terminated, suspended, or modified, benefits for any service you receive before the change are paid under the Dental Benefit Program’s former conditions, provided that a written notice of claims is timely given. The Dental Benefit 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 Dental Benefit Program is administered.

Type of Plan
The Dental Benefit 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 Dental Benefit Program.

Plan Sponsor
Donnelley Financial, LLC
35 W Wacker Drive, 35th Floor
Chicago, IL 60601

Employer Identification Number of Plan Sponsor
13-2618477

Plan Name and Number
Donnelley Financial Group Benefits Plan – 501

Plan Year End
December 31

Agent for Service of Legal Process
Corporate Secretary
Donnelley Financial, LLC
35 W Wacker Drive, 35th Floor
Chicago, IL 60601

Legal process also may be served on the Benefits Committee.

Benefits Committee and Plan Administrator
Benefits Committee
c/o Vice President, Benefits
Donnelley Financial, LLC
35 W Wacker Drive, 35th Floor
Chicago, IL 60601

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

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

- Donnelley Financial, LLC

The Dental Benefit Program described in this document applies to employees of Participating Employers. If you become an employee of Donnelley Financial 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 Dental Benefit 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 Donnelley Financial Benefits Center. Also, you or your eligible dependents may receive from the Donnelley Financial 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 Aon Hewitt, at the following address and phone number:

Donnelley Financial Benefits Center
4 Overlook Point
P.O. Box 1496
Lincolnshire, IL 60069-1496
1-844-44-DFSCO (1-844-443-3726)

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

Website: dfsco.benefitsnow.com

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.
- Request forms.

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

Claims Administrator

If you have questions about a specific benefit, contact the claims administrator at the following address and phone number:

MetLife Dental
P.O. Box 981282
El Paso, TX 79998-1282
1-800-942-0854

Website: www.metlife.com/mybenefits (for online provider directories and other resources)

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 Conexis. If you have questions about your COBRA continuation coverage rights, contact the COBRA administrator at the following address and phone number:

Conexis
1.866.206.5751

Allocation and Delegation of Fiduciary Responsibilities by the Benefits Committee

The Group Benefits Plan provides a procedure for the Benefits Committee, acting as named fiduciary, to allocate or delegate fiduciary responsibilities to its members or to other persons. Where the Benefits Committee has allocated to an applicable administrative-named fiduciary some authority and control over the operation and administration of the Group Benefits Plan, references in this SPD to the Benefits Committee are intended to refer to any such applicable administrative-named fiduciary. The Group Benefits Plan also provides a procedure for the Benefits Committee, acting as the Group Benefits Plan's sponsor, to identify persons, such as the claims administrator, to be a named fiduciary. Typically, the Benefits Committee has identified each third-party administrator as a named fiduciary with respect to the authority and control or discretion it possesses or has exercised in connection with the Group Benefits Plan.

Insured Benefits

Donnelley Financial is the policyholder for the funding of the MetLife Dental insurance contract. The insurance contract is guaranteed by the issuer, MetLife Dental, and not by Donnelley Financial or the Group Benefits Plan. MetLife Dental is the claims administrator and network manager with respect to such contract 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 Dental Benefit 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 Dental Benefit 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 Dental Benefit Program, if you have creditable coverage from another plan. You should be provided a certificate of creditable coverage, free of charge, from your Dental Benefit Program or health insurance issuer when you lose coverage under the Dental Benefit 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 example, 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.

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