SUMMARY PLAN DESCRIPTION

Employee Assistance Program

Effective July 1, 2016

dfinbenefits.com

Contents

Introduction

The Employee Assistance Program (EAP) is provided under the Donnelley Financial Group Benefits Plan (“Group Benefits Plan”).

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

This Summary Plan Description (SPD) summarizes the EAP. It explains your coverage as of July 1, 2016 (unless noted otherwise). It details who is eligible for coverage and when coverage begins and ends. It details which expenses are and are not covered under the EAP, and it describes your rights under the EAP. 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.

You are eligible for coverage under the EAP only if you are an employee of a Participating Employer. If you are an employee of an employer 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 EAP. If there is any discrepancy between this SPD and the Group Benefits Plan, the Group Benefits Plan document always governs.

This SPD only covers the EAP. For United States Department of Labor (“DOL”) filing purposes, several Donnelley Financial, LLC ("Donnelley Financial Solutions”) 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 Solutions reserves the right to amend, change, or terminate the Group Benefits Plan or EAP, in whole or in part, at any time.

This content contains a summary in English of your rights and benefits under the EAP. If you have difficulty understanding any part of this content, call the Donnelley Financial Solutions 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 EAP.

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

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

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

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

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

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

Domestic Partner – means the person of the same- or opposite-sex with whom you have a domestic partner relationship, which is registered with a state or local governmental entity or which satisfies the criteria described in the last paragraph of this definition. A domestic partner is generally eligible for all eligible spouse coverage offered under the Group Health Program.

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

- Neither you nor your domestic partner are legally married to or are the legal domestic partner of anyone else;
- You and your domestic partner intend to remain each other's sole domestic partner indefinitely;
- You and your domestic partner live together in the same principal residence and intend to do so indefinitely;

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

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

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

This reference to the word "dependent" does not carry the meaning of this word as it is used for Section 152 of the Internal Revenue Code of 1986, as amended (the "Code"). Your parents, grandparents, adult brothers, adult sisters, and other relatives are not eligible for coverage. Also, if you cover an eligible dependent who is later called to active military duty, such eligible dependent cannot be covered under the Group Health Program as an eligible dependent during such assignment. In addition, your eligible dependent who is also covered under the Group Health Program as an employee may not simultaneously be enrolled and covered under the Group Health 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.

General Information

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

- Full-time benefits-eligible employee of a Participating Employer;
- Regular Part-time "A" employee of a Participating Employer;

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

If You 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 benefits-eligible 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 EAP, 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 EAP's eligibility requirements.

Enrolling for Coverage

General Information

If you meet the eligibility requirements, you are automatically enrolled in coverage under the EAP upon your benefit effective date.

If you enroll in a medical option under the Group Benefits Plan, you have access to unlimited telephonic support as detailed in the EAP brochure, up to five no-cost in person EAP visits per incident and online support through the website detailed in the EAP brochure.

If you elect "No Coverage" for medical, you only have access to the unlimited telephonic and online support detailed in the EAP brochure.

You do not pay any paycheck deductions for the EAP.

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. Coverage under the EAP begins on the first day of the month after you complete one full calendar month of employment. For purposes of determining whether you have satisfied this waiting period, all periods of your employment with a Participating Employer before a period of more than 30 consecutive days during which you are not employed with a Participating Employer are disregarded.

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

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

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

If You Are Not Actively at Work

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

Your Rights and Responsibilities

General Information

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

Your Rights

You have the right:

- To be treated in a manner that respects your privacy and dignity as a person.
- To receive assistance in a prompt, courteous, and responsive manner.
- To be provided with information about your benefits, any exclusions and limitations associated with the EAP, and any expenses for which you will be responsible.
- To the confidential handling of all communications and medical information maintained by the claims administrator, as provided by law and professional ethics.
- To be provided automatically, without charge, a list of Participating Providers and participating pharmacies in your area.
- To express a complaint to the claims administrator about the care you have received or will not receive, and to receive a response in a timely manner.
- To initiate the grievance procedure if you are not satisfied with the decision regarding your complaint about care.
- To file a claim for a benefit with the claims administrator and to have any denial of a claim for benefits reviewed by the claims administrator under ERISA's claim procedure rules. See the "Claims and Appeals Procedures" section for details.

Your Responsibilities

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

- To fully understand the benefit communication materials you receive.
- To know how to properly use the EAP and its benefits.
- To express your opinions, concerns, or complaints in a constructive manner to the appropriate people.
- To pay all applicable fees at the time service is rendered (if applicable), plus any additional payments due, in a timely manner.

How the EAP Works – General

General Information

Review the **brochure** for contact information and details about the support available through the EAP.

When Coverage Ends

General Information

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

- Your employment with all Participating Employers terminates;
- You are no longer eligible for the EAP; or
- The EAP is terminated.

Except if COBRA continuation coverage is available and elected, the EAP 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 EAP and you received a prior authorization for such services.

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

If you leave all Participating Employers on either a voluntary or involuntary basis, coverage under the EAP stops on the last day of the month in which you stop working for your Participating Employer.

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 Solutions and its affiliates, or if you accept new employment, either of which can include self-employment, you will be considered to have voluntarily abandoned your job at your Participating Employer. This will be treated as a voluntary separation thus ending employment with all Participating Employers and termination of coverage under its benefit programs. For example, this termination of employment with your Participating Employer will result in a loss of all Group Benefits Plan benefits, including coverage under the EAP. 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 EAP. 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 Solutions' Leaves of Absence Policy, or you are laid off pursuant to the Temporary Layoffs Policy, 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).

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).

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 Solutions, who sponsor medical benefit plans to offer employees and certain members of their families the opportunity to extend coverage temporarily at group rates after coverage under the medical benefit plan would otherwise end or if costs increase due to specific events. COBRA does not require employers who sponsor group health plans to offer such extended coverage to domestic partners of employees or children of such domestic partners. However, the Group Benefits Plan 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."

If you elect to continue your medical coverage under COBRA, you can continue the EAP coverage for the same duration as your medical COBRA coverage.

If you did not enroll in medical coverage as an active employee, you are not eligible for any COBRA continuation coverage and therefore your EAP coverage will end as outlined previously.

For details regarding COBRA coverage for medical, please review the Medical and Prescription Drug Programs SPD.

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 EAP.

A “benefit claim” is a claim for a particular benefit under a plan. It will typically include your initial request for benefits.

An “eligibility claim” is a claim to participate in an option or to change an election to participate during the year. 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 EAP, he or she will be considered not to have exhausted all administrative remedies under the EAP, 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 EAP’s procedures for filing a valid claim, the claims administrator will notify him or her of the failure and the proper procedures to follow in filing a claim, provided that the communication received by the claims administrator from the claimant names the specific claimant, the specific condition or symptom, and the specific treatment, service, or product for which approval is requested. The notice will be provided within five days of receipt of the claim by the claims administrator.

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

The claims administrator will notify the claimant of the approval or denial within 60 days after receipt of the claim for a benefit under the EAP. The claims administrator may extend the period for making the benefit determination by 15 days if it determines that such an extension is necessary due to matters beyond the Plan’s control. The claims administrator will notify the claimant, prior to the expiration of the initial 60-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 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.

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.

The notification of a denial will include:

- The specific reason or reasons for the denial;
- Reference to the specific EAP 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 EAP's review procedures and the time limits applicable to such procedures.

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 EAP. This failure will result in the claimant's inability to bring a legal action to recover a benefit under the EAP. 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 Appeals of 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 an EAP, 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 EAP in connection with the claimant's denial, without regard as to whether the advice was relied upon in making the benefit determination.
- 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

The claims administrator for eligibility claims will notify the claimant of the benefit determination on review within 60 days after receipt of the request for review.

Manner and Content of Notification of Benefit Determination on Review
The claims administrator will provide a written or electronic notice of the Group Benefits Plan's benefit determination on review, in a culturally and linguistically appropriate manner, in accordance with applicable DOL regulations. If the claimant's appeal is denied, the notification will include:

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

External Review Procedures

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

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

Legal Action

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

- More than two years after the claims administrator first received your claim;
- If you received a denial on appeal of such claim, more than two years after such receipt; or
- If you forfeited a benefit based on the two-year forfeiture rule described in the "Forfeiture After Two Years" subsection of the "Situations Affecting Your Benefits" section of this SPD.

The Group Benefits Plan requires that any legal action involving or related to the Group Benefits Plan, including but not limited to any legal action to recover any benefit under the Group Benefits Plan, be brought in the United States District Court for the Northern District of Illinois, and no other federal or state court. In any legal action against a Plan Party (as defined below) in connection with any matter related to the Group Benefits Plan, the person bringing such action is not entitled to recover any legal fees or expenses from the Group Benefits Plan, Donnelley Financial Solutions, other participating employers, the Benefits Committee, the Administrator, any of their respective affiliates, or any of their respective designees, allocatees, officers, directors, employees or agents, or any other person with a right to indemnification from any of the foregoing parties (each, a "Plan Party"). This includes any legal fees or expenses incurred in connection with: (i) administrative proceedings under, or legal actions involving, the Group Benefits Plan, and (ii) actions brought under ERISA or any other law, rule, or regulation. Such prohibition on recovery applies regardless of whether or not all or any part of legal actions are decided in favor of the claimant.

Additionally, no employee, former employee, covered dependent, former covered dependent, beneficiary or other person is entitled to recover any legal fees or expenses from a Plan Party in connection with any administrative proceedings related to a claim, including if the claim is approved and no legal action is brought in connection with such claim.

Situations Affecting Your Benefits

General Information

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

- If you choose “No Coverage” for medical, you only receive telephonic and online support.
- Coverage may be stopped, changed, or delayed if you leave all Participating Employers, take a leave of absence, or experience an employment status change such that you are classified as a benefits-ineligible employee.
- 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.
- Coverage for an eligible dependent ends if he or she is no longer an eligible dependent.
- 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 Solutions reserves the right to amend or terminate the Group Benefits Plan or the EAP at any time, in whole or in part. If the Group Benefits Plan or the EAP is ever terminated, suspended, or modified, benefits for any service you receive before the change are paid under the EAP’s former conditions, provided that a written notice of claims is timely given. The EAP 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 EAP is administered.

Type of Plan
The EAP is part of a welfare benefit plan. Its objective is to provide EAP and work/life support to eligible employees and their eligible dependents in accordance with the terms of the EAP.

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

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

Participating Employers

The following employers participate in the Group Health Program of the Plan (a "Participating Employer"):

- Donnelley Financial, LLC

You have a Grandfathered Legacy Indicator ("GLI") established that notes the Participating Employer you are linked to under the Group Health Program. Your GLI is set as of your initial eligibility date for the Program or each January 1 based on your employer as of September 1 prior to the plan year, whichever is later. Even if you transfer among Participating Employers between September 1 prior to the plan year and September 1 of the plan year, your GLI and premium are based on the benefits provided by your set GLI for that plan year. The Group Health Program described in this document applies to employees of Participating Employers. If you become an employee of Donnelley Financial Solutions 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 EAP, 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 Solutions Benefits Center. Also, you or your eligible dependents may receive from the Donnelley Financial Solutions 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 Alight Solutions, at the following address and phone number:

Donnelley Financial Solutions 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 from 8 a.m. to 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.

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

Claims Administrators

If you have questions about a specific benefit, contact Beacon Health Options at 877-409-1488 or go online to www.achievesolutions.net/dfs

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

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

Website: dfsco.benefitsnow.com

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.

Self-Funded Benefits

The EAP is funded by Donnelley Financial Solutions' general assets.

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 EAP 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.

Prudent Actions by Plan Fiduciaries

In addition to creating rights for plan participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate your Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of you and other plan participants and beneficiaries. No one – including your employer, your union, or any other person – may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA.

Enforce Your Rights

If your claim for a welfare benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of Plan documents or the latest annual report from the Plan and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator.

If you have a claim for benefits that is finally denied or ignored, in whole or in part, you may file suit in a state or federal court. In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a domestic relations order, you may file suit in federal court. If it should happen that plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees; for example, if it finds your claim is frivolous.

Assistance With Your Questions

If you have any questions about your Plan, you should contact the Benefits Center or the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210. You also may obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.