SUMMARY PLAN DESCRIPTION

Health Care Spending Program, Dependent Care Spending Program and Health Savings Account Program

Effective January 1, 2019
Introduction

The Flexible Benefits Plan (the “Plan”), offered by Donnelley Financial, LLC and its participating subsidiaries or Participating Employers (referred to herein as “Donnelley Financial”), provides a before-tax opportunity to help you save on eligible health and dependent care-related expenses by contributing to the:

- Health Care Spending Program (Health Care Flexible Spending Account or “Health Care FSA”), which offers two types of accounts:
  - A General Purpose Health Care FSA, for all medical expenses that would be eligible for Health Care FSA reimbursements in accordance with applicable law; and
  - A Limited-Use Health Care FSA, for dental, vision, and post-deductible medical expenses that would be eligible for Health Care FSA reimbursements in accordance with applicable law (i.e., until the employee has met the deductible under the HSA Value Medical Program option (or the HSA Advantage option for 2018), the account can be used for dental and vision expenses only);

- Dependent Care Spending Program (Dependent Care Flexible Spending Account or “Dependent Care FSA”); collectively, the Health Care FSAs and the Dependent Care FSA may be referred to as the “FSAs”;

- Health Savings Account Program (“HSA Program”); and

- Participant Premium Program to pay for your share of medical, dental, and/or vision insurance premiums under the Group Benefits Plan on a pre-tax basis.

Details about the Participant Premium Program are contained in the Summary Plan Descriptions (“SPDs”) for the respective benefit Programs that make up the Group Benefits Plan, and the related portions of the “Qualified Status Changes SPD.” Details about the FSAs and the HSA Program follow.

With the Health Care FSA, you can set aside money from your paycheck before taxes to be used to reimburse eligible health care expenses not covered by a medical, prescription drug, dental, or vision program. If you participate in the Group Health Program and elect the HSA Value Medical Program option (or the HSA Advantage option in 2018), you are only permitted to participate in the Limited-Use Health Care FSA. This is because the HSA Value option offers a contribution to a Health Savings Account (“HSA”), and under Internal Revenue Service (“IRS”) regulations you cannot contribute to an HSA if you also have a General Purpose Health Care FSA. Until you meet the deductible for the HSA Value Medical Program option (or HSA Advantage in 2018), your Limited-Use Health Care FSA will be available only for dental and vision expenses.
With the Dependent Care FSA, you can set aside money before it is taxed to be used to reimburse eligible dependent care expenses.

With the HSA Program, you can make contributions to your own HSA on a pre-tax basis through payroll.

You decide how much tax-free income you want to contribute to each account:

- Between $200 and $2,650\(^1\) annually for the Health Care FSAs;
- Between $200 and $5,000\(^2\) annually for the Dependent Care FSA;
- Up to $3,500 to the HSA Program if you have single coverage under the HSA Value Medical Program option (or the HSA Advantage option in 2018), and up to $7,000 if you have higher levels of coverage;
- Up to the amount of your share of premiums for medical, dental, and vision benefits under the Group Benefits Plan, under the Participant Premium Program.

For the FSAs, you may either pay an eligible expense out of your own pocket and submit a claim for reimbursement after-the-fact, or use a FSA-provided debit card to pay an eligible health care expense directly. With the exception of a limited carryover option for your Health Care FSA for plan years beginning on and after January 1, 2018 (described in more detail below), the IRS requires that you forfeit any money that you do not use for the year in which you participate (“use it or lose it”). Keep this in mind when you decide how much to contribute.

Effective with the 2018 plan year, you are permitted to carry over a maximum of $500 remaining in your Health Care FSA at the end of the plan year to the following plan year. This carryover does not affect your annual limit on new contributions described above. Additional details and limitations regarding this new carryover feature are detailed under “How the Health Care FSA Works.” Carryover is not permitted for the Dependent Care FSA.

This SPD summarizes the terms of each FSA and of the HSA Program as of January 1, 2019 (except as noted otherwise for certain changes in effect for 2018). It details who is eligible to participate, how to enroll, when participation begins and ends, and which expenses are and are not eligible for reimbursement.

This SPD, and the related portions of the “Qualified Status Changes SPD,” explain how you can make or change contributions to an FSA, HSA, and the Participant Premium Program. It also describes the Health Care FSA debit card option, how to submit a FSA claim for reimbursement, as well as your rights under the FSAs. Please read this information to

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\(^1\) For the Health Care FSA, this number is indexed annually for inflation. New limits may be announced each year with the enrollment materials.

\(^2\) Limited to $2,500 annually if your federal tax filing status is married filing separately. See “How the Dependent Care FSA Works” for additional rules that can affect your maximum annual contribution limit.
familiarize yourself with the FSAs.

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 participation, and contribution amounts described in this SPD. In the case of a conflict between this SPD and your collective bargaining agreement, your collective bargaining agreement will control.

The Plan has contracted with a third party to render services necessary to the operation and administration of the FSAs. Your Spending Account, Alight, LLC is the eligibility administrator and claims administrator for the FSAs.

You are eligible to participate in the Plan only if you are an employee of a Participating Employer or subsidiary who satisfies the plan’s eligibility criteria described on the next page. If you are an employee of an employer or subsidiary that is not a Participating Employer or subsidiary, 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 the Plan. However, since laws and regulations change periodically, this document cannot adequately define every potentially reimbursable expense or exclusion or the frequently-changing contribution limits. In each case, the claims administrator will have the authority or discretion to make the determination of whether a contribution is permitted, or an expense incurred is a reimbursable expense in accordance with applicable law. If there is any discrepancy between this SPD and the Plan document, the Plan document always governs.

In addition, nothing in this SPD should be interpreted as an employment contract. This summary merely describes the Plan and benefits offered to eligible employees as of January 1, 2019. Donnelley Financial reserves the right to amend, change, or terminate the Plan in whole or in part, at any time.

This content contains a summary in English of your rights and benefits under the Plan. 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

General Information

You are eligible to participate in the Plan if you are classified as a:

- Full-time benefits-eligible employee of a Participating Employer regularly scheduled to work 30 or more hours per week;
- Part-time “A” employee of a Participating Employer working at least 1,040 hours during the 12-month period preceding the date on which benefits eligibility is determined; or
- Union employee of a Participating Employer who is covered by a collective bargaining agreement and such agreement provides for your FSA participation.

You are not eligible to participate in the Plan if you are currently classified as:

- An employee of a non-Participating Employer;
- A part-time “B” employee;
- Hired for seasonal or vacation relief work (and not classified as Part-Time “A”);
- 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 FSAs.

Once you become a participant, your participation 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 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 benefit elections and annual contribution election will automatically resume. In order to still meet your annual contribution amount, your per pay period contribution will be recalculated based on the remaining pay periods. If you previously participated in the Plan and are re-employed within 30 days of your termination date, your participation will resume effective immediately with the same elections you had prior to the termination. Your participation will be 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 a new opportunity to enroll for Plan coverage. Generally, you will need to meet the applicable eligibility requirements, including the applicable eligibility waiting period, unless the Participating Employer’s look-back measurement and stability periods policy under the Patient Protection and Affordable Care Act requires that you be reinstated to benefit plan coverage at an earlier date. Any additional amounts you elect to contribute must be within the IRS limits.
Enrolling to Participate

General Information

If you meet the eligibility requirements, you can enroll in Plan benefits. When you enroll in a Plan benefit, your contributions are before tax.

You must enroll each year to participate in the FSA or HSA for that year. Your Participant Premium Program election is automatic when you enroll in medical, dental or vision coverage under the Group Benefits Plan. That election will generally rollover from year-to-year (except as otherwise described in the enrollment materials), and will be adjusted to reflect any changes in medical, dental or vision premiums.

If you and your spouse are both Donnelley Financial employees eligible to participate, each of you may elect to contribute to the Health Care FSA, the Dependent Care FSA, and an HSA (if eligible). However, certain limits apply, and the elections that each of you make may affect the elections the other can make, as further described throughout this booklet.

Your Contributions

When you enroll in the Health Care and/or Dependent Care FSAs, the HSA Program, or medical, dental or vision insurance benefits under the Group Benefits Plan, you authorize the deduction of the required contributions from your paycheck on a pre-tax basis.

Your elections for the FSAs and the medical, dental and vision insurance under the Group Benefits Plan are binding for the remainder of the calendar year for which the elections were made, unless a Qualified Status Change occurs during the calendar year. Your elections are subject to changes in the provisions of the FSAs and compliance with applicable state and federal laws. Provisions of the FSAs or the Participant Premium Program limiting your election to one calendar year will not apply if Donnelley Financial has advanced contributions for you which are unpaid at the end of the calendar year.

If you experience a Qualified Status Change, you may not reduce your contribution election below an amount that will result in your total contributions for the calendar year being less than the total amount of premiums paid and FSA reimbursements you will receive for claims incurred in the same calendar year prior to the date of the change. And, if you experience a Qualified Status Change and timely elect to increase your contribution election, the increased contribution amount can only be used to reimburse eligible expenses incurred on or after the date of the Qualified Status Change.

HSA Program elections are not subject to the rules for Qualified Status Changes. You may change your HSA Program election at any time.

“Before-tax” means that your contribution is taken from your paycheck before federal and Social Security/Medicare (FICA) taxes (and, in most cases, state and local taxes) are deducted. This reduces your taxable income (your gross pay minus contributions), so you
pay less in taxes. The IRS limits the instances when you are permitted to change your contributions to the FSAs or the Participant Premium Program to those that are considered Qualified Status Changes. See the “Qualified Status Changes SPD” for more information.

When Participation Begins

As a new benefits-eligible employee, you receive enrollment information that details Group Benefits Plan options, the FSAs, and the HSA Program. This information also includes specific instructions on how to enroll. You must enroll by the enrollment deadline set forth in your enrollment materials. As long as you enroll by the deadline, you begin participating on the first day of the month after your one-month anniversary of employment.

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

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<thead>
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<th>If You Start on the 1st of or During the Month Of:</th>
<th>Your Participation Begins On:</th>
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<tbody>
<tr>
<td>January</td>
<td>March 1</td>
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<td>February</td>
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<td>May 1</td>
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<td>September</td>
<td>November 1</td>
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<td>October</td>
<td>December 1</td>
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<tr>
<td>November</td>
<td>January 1</td>
</tr>
<tr>
<td>December</td>
<td>February 1</td>
</tr>
</tbody>
</table>

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

- Your coverage under the Health Care Spending Program and/or Dependent Care Spending 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 Health Care Spending Program and/or Dependent Care Spending 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 Health Care Spending Program and/or Dependent Care Spending Program on the date of the transfer, you will continue to participate in these programs until the end of the calendar year in which you transfer. As a result, your coverage under this Health Care Spending Program and/or Dependent Care Spending Program begins on the following January 1.

- If you transfer from a non-U.S. affiliate, your coverage under the Health Care Spending Program and/or Dependent Care Spending 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 participation is scheduled to begin, your participation still takes effect on that day. You do not need to return to active work for your participation 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 be able to do so until the next Annual Enrollment period. The only exception is if you contribute to the HSA Program, if you report a Qualified Status Change within the required time frame.

Qualified Status Changes (and the Participant Premium Program)

Because of IRS rules governing before-tax deductions, the contribution elections you make generally remain in effect until the beginning of the next calendar year (assuming you remain an employee of Donnelley Financial). 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 circumstances, 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. You must make the change within 30 days after the event has occurred (60 days to report a newborn, or in the case of certain medical plan elections relating to a Medicaid or CHIP premium subsidy). If you do not, the election change will not be allowed.

An election change due to a Qualified Status Change is effective on the date of the Qualified Status Change if you report the Qualified Status Change to the eligibility administrator within 30 days (or 60 days with respect to a newborn or certain medical plan elections relating to a Medicaid or CHIP premium subsidy).
A list of the Qualified Status Changes and other allowed changes to your contributions 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.

**Annual Enrollment**

Every fall during the Annual Enrollment period, you receive information about the FSAs and HSA Program for which you are eligible. You also receive instructions on how to make your FSA and HSA contribution elections for the upcoming calendar year. You then have the opportunity to enroll, change your contribution amounts, or choose not to participate. IRS regulations stipulate that FSA elections must be made for each plan year; they do not automatically renew from year to year. The Plan also requires that you make new HSA Program elections each plan year.

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.
A Few Words about Taxes

By contributing to an FSA or HSA, you authorize a certain amount from your pay to be set aside before taxes are withheld. This reduces your federal income taxes, most state and local income taxes, and your Social Security and Medicare (FICA) taxes (if you earn less than the Social Security wage base).

An Example of the Before-Tax Advantage

To illustrate how contributing to an FSA could affect you, assume that you earn $30,000 each year and you do not contribute to the Dependent Care FSA. You do, however, contribute $1,500 to your Health Care FSA. Here is how you may save on taxes by contributing.

<table>
<thead>
<tr>
<th></th>
<th>You Contribute</th>
<th>You Do Not Contribute</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gross Salary</td>
<td>$30,000</td>
<td>$30,000</td>
</tr>
<tr>
<td>Health Care FSA Contributions</td>
<td>– 1,500</td>
<td>– 0</td>
</tr>
<tr>
<td>Adjusted Gross Income</td>
<td>$28,500</td>
<td>$30,000</td>
</tr>
<tr>
<td>Standard Deduction &amp; Exemptions</td>
<td>$8,750</td>
<td>$8,750</td>
</tr>
<tr>
<td>Taxable Income</td>
<td>$19,750</td>
<td>$21,250</td>
</tr>
<tr>
<td>Less Federal Income and Social Security Taxes*</td>
<td>$4,755.25</td>
<td>$5,095</td>
</tr>
<tr>
<td>Take-Home Pay (excluding deductions)</td>
<td>$23,744.75</td>
<td>$24,905</td>
</tr>
<tr>
<td>Out-of-Pocket Health Expenses</td>
<td>– 0</td>
<td>– 1,500</td>
</tr>
<tr>
<td>Net Income</td>
<td>$23,744.75</td>
<td>$23,405</td>
</tr>
<tr>
<td>Tax Savings</td>
<td>$339.75</td>
<td></td>
</tr>
</tbody>
</table>

*This example assumes a single employee.

As you can see, an employee using the Health Care FSA instead of paying out-of-pocket for medical expenses saves almost $340 in federal income taxes in this example, not including any applicable state income taxes. Remember, this is only an example. Your tax savings will depend on current laws and your own personal financial and medical situation. You should consult a tax adviser for tax advice.

Keep in mind that, with the exception of the $500 carryover feature for the Health Care FSA, any contributions you make to the Health Care FSA or Dependent Care FSA and do not use by year-end are forfeited. You lose these contributions because they may not be used to reimburse you for eligible expenses incurred after that calendar year. The forfeited contributions are used only to pay the administrative costs of the FSAs.
How the Health Care FSA Works

Contribution Limits

Each plan year, you decide how much, if any, you want to contribute. You make all of your contributions on a tax-free basis. Your projected total annual contribution is divided by the number of times you are expected to be paid during the year, and that amount is deducted each pay period. For instance, if you want to contribute $360 for the year and you are paid twice a month, $15 is deducted from each of your paychecks ($360 over 24 pay periods = $15 per pay period). If you elect to participate in the Health Care FSA, your total annual contribution must be at least $200 but cannot be more than $2,650 (for 2018 and 2019; the maximum may be adjusted each year for inflation, as communicated in the enrollment materials).

Effective for plan years beginning with January 1, 2018, unused amounts of up to $500 remaining in your Health Care FSA account at the end of a plan year can be carried over and used to reimburse eligible expenses that are incurred during the next plan year, subject to the following conditions:

- No more than $500 of your unused Health Care FSA amount for a plan year can be carried over.

  - **Example:** At the end of the 2019 plan year, your unused Health Care FSA amount is $800. You may carry over up to $500 to reimburse 2020 plan year expenses. However, the entire $800 is also available to reimburse 2019 plan year expenses during the 2019 run-out period. Assume that, during the run-out period for 2019, you submit and are reimbursed for 2019 expenses of $350. This leaves you with a carryover of $450 ($800-$350), which can be used for 2020 expenses. On the other hand, if you do not submit 2019 expenses during the run-out period, you will be able to carry over the maximum permitted amount of $500.

- Carryovers may not be cashed out or converted to any other taxable or nontaxable benefit and will not count toward the maximum dollar limit on annual salary reductions under the Health Care FSA.

  - **Example:** Assume that for 2020, you elect the $2,650 maximum Health Care FSA salary reduction amount permitted under the Plan. Your election will not affect your carryover, and you can also carry over the maximum permitted amount of $500 from 2019 to 2020.

- Approved claims incurred during the current plan year will always process in a hierarchy, drawing funds first from the current year election and subsequently from the carryover balance from the preceding plan year. Carryovers that are used to reimburse a current plan year expense will reduce the amount available to pay your preceding plan year expenses during the run-out period, cannot exceed $500, and will count against the $500 maximum carryover amount.
Example: At the end of the 2019 plan year, your unused Health Care FSA amount is $800. You elect Health Care FSA salary reductions of $2,650 for 2020. In January 2020, you submit 2020 eligible medical expenses of $2,750. The entire $2,750 will be reimbursed with the $2,650 you elected for 2020 and $150 of the $800 remaining from 2019. You will then have $650 remaining to reimburse any incurred 2019 eligible medical expenses submitted during the rest of the 2019 run-out period (ending March 31st, 2020). However, $350 would remain in your 2019 Carryover ($500 maximum less the $150 already reimbursed). Thus, if you submit 2019 run-out expenses of $750 in February 2020, only $650 of these expenses can be reimbursed, and you will have no amounts remaining to reimburse 2020 expenses.

- If you were eligible for the Health Care FSA for a plan year but did not make a Health Care FSA election for that plan year, you can still use any carryovers from the preceding plan year for eligible expenses incurred in the current or preceding plan year.

- Note: you must be a participant in the Health Care FSA as of the last day of a plan year in order to carry over unused amounts to the next plan year. Termination of employment and cessation of eligibility will result in a loss of carryover eligibility unless a COBRA election is made.

- If you elect the HSA Value Medical Program option for a plan year (or the HSA Advantage plan in 2019), you will be treated as having as automatically enrolled in the Limited-Use Health Care FSA option for that plan year, and unused amounts remaining in the your General Purpose Health Care FSA at the end of the preceding plan year that are available for carryover, if any, will be automatically carried over to that Limited-Use Health Care FSA.

- Note: You may continue to submit claims for general-purpose eligible medical expenses incurred during the preceding plan year until March 31st of the following plan year, to be reimbursed from your available General Purpose Health Care FSA amounts for the preceding plan year.

Eligible Expenses

In general, you may use the amounts you contribute to the Health Care FSA to reimburse eligible medical care expenses (as defined in Code Section 213(d)) incurred by you or your eligible dependents that are not paid for by the Group Benefits Plan or other programs outside of the Group Benefits Plan. This also includes any eligible expenses that your spouse’s medical, dental, vision, or prescription drug plan does not cover. You may use the debit card option or file a claim for reimbursement of an eligible expense you have paid.

You may be asked to provide additional documentation related to your claimed expense. If you participate in the Group Health Program and select the HSA Value Medical Program option (or the HSA Advantage plan in 2018), you are not permitted to enroll in the General Purpose Health Care FSA, and you can instead use the Limited-Use Health Care FSA to reimburse eligible vision, dental, or post-deductible medical expenses (i.e., you cannot be
reimbursed for general medical expenses until after you have met the deductible under the HSA Medical Program option). See the discussion above regarding the Limited-Use Health Care FSA.

Only certain medical care expenses are eligible for reimbursement from the Health Care FSA. For a complete listing of eligible expenses, visit the Your Spending Account web site. Please note that the listing is subject to change at any time.

**Submitting Health Care FSA Claims for Children**

You can receive tax-free reimbursements from your Health Care FSA for your children who are eligible for Medical Program coverage under the Group Benefits Plan, through the end of the calendar year in which they turn age 26 (unless the child is permanently and totally disabled, then they are eligible regardless of age). Your children include biological, adopted, step, and eligible foster children (defined as a child placed with the employee by an authorized placement agency or by judgment, decree, or other order of any court of competent jurisdiction). In the case of divorced or separated parents, a child is treated as a dependent of both parents. Although Domestic Partners’ children are eligible for Medical Program benefits, they are only eligible for the Health Care FSA if they satisfy the criteria to be your tax dependent for health insurance purposes. See “Domestic Partner Tax Affidavits” for more information.

[Note: This same rule does not apply to distributions taken from your HSA. Under the HSA, you can only submit a claim for a child that is considered a tax dependent, which generally means a child under age 19 (or age 24 if a fulltime student), except that children of divorced parents are considered a child of both parents for this purpose. As with other non-qualified HSA expenses, if you submit a claim for an ineligible child, the distribution will be subject to income tax and possibly a 20% penalty tax. Adult children who are enrolled as dependents in your HSA Value Medical Program option but are not tax dependents may contribute to their own HSA.]

**Ineligible Expenses**

Certain expenses are not reimbursable through the Health Care FSA, including expenses incurred before the effective date of your Health Care FSA, or by an ineligible dependent, such as a Domestic Partner or child(ren) of a Domestic Partner who are not your tax dependents (see “Domestic Partner Tax Affidavits” for more information).

Health Care FSAs cannot be used to pay for health plan premiums, nor can they be used for long term care expenses, over-the-counter medications without a prescription, cosmetic services, or items that promote general health versus a medical condition (e.g., vitamins, nutritional supplements and weight loss programs generally are not eligible, unless prescribed to treat a medical condition). For a listing of expenses that are excluded from reimbursement, visit the Your Spending Account web site. Please note that the listing is subject to change at any time.
Domestic Partner Tax Affidavits

In most cases, Domestic Partners and their children do not qualify as the employee's tax dependent(s). If your Domestic Partner (or his or her child) does not meet the IRS definition of a tax dependent, then you cannot submit their claims for reimbursement from your Health Care FSA.

However, the IRS definition of a tax dependent for health insurance and Health Care FSA purposes is broader than the definition of who is claimed as a dependent on your income tax return or for HSA purposes, and in some cases these individuals will qualify as your tax dependent for health insurance or the Health Care FSA even if they are an eligible dependent for other tax purposes. For example, the income limits that normally apply to determine whether an individual is your tax dependent ($4,150 for 2018, indexed for inflation annually) are disregarded, and children can be considered your dependent to age 26 for health insurance and Health Care FSA purposes.

You should consult with a tax advisor to determine if your Domestic Partner or his/her child(ren) qualify as your tax dependent for health insurance and Health Care FSA purposes. You will be required to provide the Plan with a signed affidavit attesting to the dependent’s tax qualified status in order to avoid imputed income with respect to such individual’s participation in the Medical Program, and the same affidavit may be used to establish their eligibility for Health Care FSA reimbursements.

In general, the requirements for a Domestic Partner (or your partner’s child) to be your tax dependent for purposes of health insurance and the Health Care FSA are:

- The individual lives with you for the entire calendar year (and the relationship must not violate local law);
- During the calendar year, you must provide more than half of the total support (as described below) for the individual;
- The individual cannot be claimed as a qualifying child on anyone else’s federal tax return; and
- The individual must be a U.S. citizen, a U.S. national, or a resident of the U.S.

To determine whether you provide more than half of the total support for your Domestic Partner or his/her child, you must compare the amount of support you provide with the amount of support your Domestic Partner (or your partner’s child) receives from all sources, including Social Security, welfare payments, the support you provide, alimony and child support from the other parent, and the support the Domestic Partner (or the child) provides from his or her own funds. Support includes food, shelter, clothing, medical and dental care, education, and similar expenses. If you believe you might provide more than half of the support for your Domestic Partner (or child), you should complete the support worksheet in IRS Publication 501 (Exemptions, Standard Deduction, and Filing Information).
If you submit a signed affidavit certifying that your Domestic Partner or partner’s child is your tax dependent, and it is later determined that the value of those benefits should have been taxable to you, then you will be required to reimburse Donnelley Financial Solutions for any liability it may incur for failure to withhold Federal, state, or local income taxes, Social Security taxes, or other taxes related to such benefits.

**How to Access Funds or Receive Reimbursement from Your Health Care FSA Debit Card**

When you’re enrolled in the Health Care Spending Account, you have the opportunity to pay for eligible health care expenses with the YSA card. The YSA card allows you to avoid paying for eligible health expenses out of pocket. When you use your YSA card, your eligible expenses are deducted automatically from your account. You cannot request claim reimbursement for any expenses purchased with your YSA card.

- As you make payments with your YSA Card, the balance of your Health Care FSA account will be reduced to reflect the payment. Reimbursement for eligible items and services will be made up to the annual amount you have allocated to your Health Care FSA account at the time you submit the claim. The total employer contributions and/or salary redirection contributions elected for the plan year will be available in your Health Care FSA account for claim reimbursement at all times, reduced by any amount that has already been used for reimbursement. Only current plan year funds will be available for used with the YSA card.

- If you do not have sufficient funds left in your Health Care FSA to cover the entire expense at the time of purchase, then your attempt to use the YSA card will be declined. Please note that the attempted use of the YSA card to pay a provider is not considered submission of a claim under the Plan, and the administrator’s determination that an expense for which a card swipe is made is not an eligible medical expense does not constitute a claim denial under the Plan. To initiate the Plan’s claims and appeals procedure, you must submit a claim in accordance with the plan’s claims procedures.

- Understand that all YSA card transactions must be validated. As part of the validation process, Your Spending Account will notify you if itemized receipts are needed to validate your YSA card purchases. Although many transactions can be validated automatically, it’s important that you save all itemized receipts for your YSA card transactions in case supporting documentation is requested. Frequently substantiation can take place automatically, such as if your card swipe was at a qualifying provider and matches your Medical Program copay amount, where a recurring claim amount has previously been substantiated, or if the vendor where you made your card purchase utilizes an IIAS inventory system. Other times, the Administrator will require that you submit additional documentation to substantiate that you made an eligible purchase.
• If the YSA card is used to pay an expense that is not electronically substantiated at the point of sale, then you will be notified and will be required to submit acceptable documentation of the transaction, such as an Explanation of Benefits (EOB), itemized bills or receipts, or other information requested by the YSA administrator to substantiate that the amount charged was an eligible medical expense. When you used the YSA card, you should save all receipts and supporting documentation in the event you need to submit them to Alight, the YSA administrator.

• If you fail to provide information to satisfy the YSA administrator that amounts paid with the YSA card are eligible medical expenses, then the YSA administrator, Plan Administrator and/or employer may take whatever action they deem appropriate to require you to repay the unsubstantiated amount, including:
  - Requesting that you reimburse the Plan for the unsubstantiated amount;
  - Suspending your YSA card and requiring you to submit forms to obtain future reimbursements of eligible medical expenses;
  - Offsetting future Health Care FSA reimbursement claims by the unsubstantiated amount paid with the YSA card;
  - Suspending your eligibility to participate in the Plan;
  - To the extent permitted by law, having Donnelley Financial deduct from your taxable wages the amount of the unsubstantiated expense paid via with the YSA card; and
  - Where recovery is not made by the end of the taxable year, reporting the amount of the ineligible expense as taxable income to the Internal Revenue Service (IRS) on form W-2 and taking appropriate withholdings from other pay.

• If the Plan’s correction efforts prove unsuccessful, you still owe the Plan the amount of the unsubstantiated payment. In that event, and consistent with its business practices, Donnelley Financial may treat the unsubstantiated amount as it would any other business debt.

• You can use the YSA card to pay for eligible items or services at health care providers (medical, dental or vision, as appropriate) and retail merchants with an IRS-approved inventory system that sell eligible over-the-counter items and prescriptions (called “IIAS merchants’”). You can also use your card for prescription amounts that are not covered under your medical plan at merchants where 90 percent of the store’s gross receipts for the last tax year consisted of items that qualify as medical expenses under IRS guidelines (called “90 percent merchants”). If you try to use your YSA card at any other retail merchant, the YSA card will be declined and you must pay the provider by another means and request reimbursement using the claim form process described above.

• Do not use the YSA card for ineligible items or services. The YSA card cannot be used to purchase certain items and services, such over-the-counter medicines, drugs and
biologicals. Such items are only reimbursable if you submit a claim form accompanied by a physician’s prescription or other documentation of medical necessity for the item(s). You can only use your YSA card to purchase eligible health care items or services — dependent care expenses are not eligible for payment with your card. Always separate eligible health care items (e.g., prescriptions, reading glasses, contact lenses) from ineligible items (e.g., magazines, cosmetics) before using your YSA card. Ineligible items must be purchased with another form of payment.

- Choose “credit” when you swipe your card. The YSA card is a signature based debit card. This means you’ll be required to provide your signature, similar to when you use a credit card. If you choose the “debit” option, your transaction will not be processed. Each time you sign, you are affirming that the medical expense has not been reimbursed from any other source, and that you will not seek reimbursement from any other source.

- If the expense is determined to be ineligible, your YSA card may be suspended from further use until the overpayment is repaid. To the extent the overpayment is not repaid or recaptured, it will be included as wages and reported on IRS Form W-2.

- If your YSA card is suspended, you won’t be able to use the card, but you will be able to submit claims via the Web site or through postal mail. You’ll always have access to your account, regardless of the status of your YSA card. Once the overpayment is corrected, you’ll receive notification (via email or postal mail, based on whether we have an email address on file) that your YSA card was reinstated.

- The Administrator has adopted other rules to ensure that the YSA card is used only for eligible medical expenses, such as canceling the YSA card upon termination of employment, and establishing transaction limits. Please be sure to read the separate communication explaining the special rules and requirements that apply to your YSA card.

Generally, you can file a claim whenever you incur an eligible expense while you are a participant and after the service has been rendered, but no later than March 31 of the following calendar year. To file a claim, complete a claim form and submit it electronically. Or, complete a claim form and return it with the required documentation to the claims administrator at the address on the form. You must attach documentation to your claim form for it to be processed. This documentation may include:

- An Explanation of Benefits (EOB) from the health, dental, or vision program (if you, your spouse, or your dependent is covered under multiple plans or programs, submit an EOB from each plan or program, as applicable);

- An itemized bill with the patient’s name and address, the date of service, the description of service, total fees charged for services, and the name and address of the provider;

- The itemized receipt that includes the provider’s name and address, the date of service, total charges, insurance payment (or denial), and the patient’s copayment amount (if any);
A receipt from your provider for payment; or

The receipt you receive from the pharmacist that indicates the date of service, the patient’s name, the drug purchased, and the out-of-pocket cost.

After your claim is processed, you will be reimbursed by a check mailed to your home address or via direct deposit, depending on your preference. Special situations apply to submitting claims for the following two medical services:

- **LASIK**: You cannot submit a claim for the deposit that you make for LASIK before you have the procedure. However, once the LASIK procedure is performed, you can submit a claim for the entire amount, including the deposit.

- **Orthodontia**: You can submit a claim for orthodontia services before the services are provided, but only to the extent that you have actually made payments in advance of the orthodontia services in order to receive the services.

If you terminate employment during the year, you can submit claims incurred only on or before your termination date, unless you elect COBRA continuation coverage as described in the “Your Legal Right to COBRA Continuation Coverage” section.

You can submit claims postmarked by March 31 of the following calendar year, as long as you received the service and you incurred the expense prior to the end of the Plan year (and if applicable, prior to the end of your participation in the Health Care FSA). You are reimbursed for the amount of the expense, up to the total amount of your annual contribution election. Except with respect to any eligible carryover amount, you forfeit any money that remains in your Health Care FSA at the end of the calendar year, and for which you do not submit a claim by March 31 of the year after the calendar year in which you participated.

**The Heroes Earnings Assistance and Relieve Tax Act of 2008 (HEART) and Your Health Care FSA**

The HEART Act allows a Health Care FSA to offer a special distribution called a Qualified Reservist Distribution (QRD) to those who, by reason of being a member of a reserve component (as defined in the Code) are ordered or called to active duty (“reservists”).

As a reservist, you can receive all or a portion of your unused contributions in your Health Care FSA as a taxable distribution to avoid forfeiting the funds at year end, if:

- You are called or ordered to active duty for a period of 180 days or more, or for an indefinite period; and

- The distribution is made after the order/call and before the April 1st following the plan year that includes the order/call.
The maximum distribution is the amount available in the Health Care FSA (i.e., contributions minus reimbursements). Reservists who would like to request a distribution may be required to complete a Qualified Reservists Distribution form. Contact the Benefits Center for more information.

**Statutory Benefit**

Health Care FSA benefits are regulated by the Internal Revenue Code (the “Code”). You will receive only those benefits which may be provided through a Health Care FSA under the Code. For more information on what is an eligible expense payable as a benefit and for definitions of terms used in this summary, consult your tax advisor or see IRS Publication 969.
How the Dependent Care FSA Works

General Information

You can use the Dependent Care FSA to reimburse eligible expenses to care for one or more of the following qualifying individuals (as defined in section 21(b)(1) of the Code) who has the same principal residence as you for more than half the year and who is:

- Your tax dependent child under age 13;
- Your spouse who is mentally or physically incapable of self-care, lived with you for more than half of the year, and regularly spends at least 8 hours per day in your home;
- Another individual (such as a parent whom you support) who is physically or mentally incapable of self-care, lived with you for more than half of the year, regularly spends at least 8 hours per day in your home, and either: (a) is your tax dependent; or (b) could have been your tax dependent except that he or she has gross income that equals or exceeds the gross income test amount, or files a joint return, or you (or your spouse, if filing jointly) could have been claimed as a dependent on another taxpayer's return.

If you are divorced or legally separated from your spouse, you may use your Dependent Care FSA for child care expenses only if you have custody of your child during more of the year than the child’s other parent/dependent; it does not matter which parent claims the deduction for the child on their income tax return.

Contribution Limits

Each plan year, you decide how much, if any, you want to contribute. You must estimate how much you will need for the upcoming year to help pay for your eligible care expenses. You make all of your contributions on a tax-free basis. Your total annual contribution is divided by the number of times you are paid in a year, and that amount is deducted each pay period. For instance, if you want to contribute $360 for the year, and you are paid twice a month, $15 is deducted from each of your paychecks ($360 + 24 pay periods = $15 per pay period).

When you decide how much to contribute, keep in mind that the IRS requires you to forfeit any money that remains in your account at the end of the plan year. Forfeited amounts are then used to pay the administrative expenses of operating the FSA, or may be used to reduce the employer-funded contributions under a Cafeteria Benefit Program. You should carefully consider how much you want to contribute to your Dependent Care FSA.

If you choose to participate, your minimum contribution amount is $200 each year. Your annual contributions to the Dependent Care FSA are limited to:

- $5,000 if your tax filing status is single, head of household, or married filing jointly;
$2,500 if your tax filing status is married filing separately; or

$5,000 total, including your spouse’s contributions, if your spouse’s employer offers a similar program.

In addition:

- If you are not married at the end of the calendar year, your annual contributions can never be more than your earnings.

- If you are married at the end of the calendar year, your annual contributions can never be more than the lesser of:
  - Your earnings; and
  - Your spouse’s earnings.

Special rules apply if you are a “highly compensated” employee as defined by the Code. If you meet the definition, your contributions may be limited. You will be notified if you are affected by these rules.

**Eligible Expenses**

Eligible expenses are for services provided while you are a participant during the calendar year in which the service is rendered and the expense is incurred. You can use the Dependent Care FSA to reimburse payments you make to institutions or individuals, including a:

- Child care center or nursery school that provides care for six or more children;
- Family day care provider;
- Baby-sitter;
- Neighbor;
- Day camp;
- Live-in helper;
- Nanny; or
- Member of your family – other than your spouse or a dependent.

A child care provider is eligible if he or she meets state and local requirements where they apply.
To be reimbursed for an eligible expense, you must be working* during the time you incur eligible expenses for the qualifying individual, who meets the criteria above. If you are married when you incur the eligible expenses, your spouse must be:

- Working or seeking work;
- A full-time student; or
- Mentally or physically disabled and unable to care for himself/herself.

*You are still considered to be working during any period you are unemployed but actively looking for work, on active military duty, or on a short-term leave of absence (generally for less than two weeks).

**Ineligible Expenses**

Certain expenses are not considered eligible expenses and therefore you cannot use the Dependent Care FSA to reimburse them. For a complete listing of expenses that are excluded from reimbursement, visit the Your Spending Account web site. Please note that the listing is subject to change at any time.

**How to Receive Reimbursement from Your Dependent Care FSA**

You can file a claim provided the service is an eligible expense. As long as your claim satisfies the requirement for reimbursement and the funds are available in your Dependent Care FSA, you are reimbursed for the eligible expense.

You can submit claims as long as they are postmarked by March 31 of the following calendar year. You will be reimbursed up to the lesser of:

- The total amount of the eligible expense; and
- The amount that is in your Dependent Care FSA at the time you submit the claim.

To file a claim, complete a claim form and submit it electronically. Or, complete a claim form and return it with the required documentation (i.e., receipt from the provider) to the claims administrator at the address on the form. Remember, in any calendar year, you can be reimbursed only for completely rendered services and for eligible expenses you incurred for a qualified individual while you and your spouse worked, even though you may submit the expense after the year is over. You forfeit any money that remains in your Dependent Care FSA at the end of the calendar year, and for which you do not submit a claim by March 31 of the year following the calendar year in which you participated.

After your claim is processed, you will be reimbursed by a check mailed to your home address or via direct deposit, depending on your preference.
Statutory Benefit

Dependent Care FSA benefits are regulated by the Code. You will receive only those benefits which may be provided through a Dependent Care FSA under the Code. For more information on what is an eligible expense payable as a benefit and for definitions of terms used in this summary, consult your tax advisor or see IRS Publication 503.
How the HSA Program Works

If you elect to participate in the HSA Value Medical Program option (or the HSA Advantage option in 2018), you may also elect to make pre-tax contributions to a HSA, established and maintained outside the Plan by a trustee/custodian, to which Donnelley Financial can forward employer contributions and contributions deducted from your pay on a pre-tax basis.

HSA benefits cannot be elected with General Purpose Health Care FSA Plan. Employees enrolled in the HSA Value Medical Program option (or the HSA Advantage option in 2018) will only be permitted to enroll for HSA contributions and/or contributions to the Limited-Use Health Care FSA. (See above for additional discussion regarding the interaction of the Health Care FSA Plan and HSA).

Contributions for Cost of Coverage for HSA; Maximum Limits

Donnelley Financial may contribute a lump-sum contribution to your HSA based on your medical coverage level under the HSA Value Medical Program option (or the HSA Advantage option in 2018). The amount of the Donnelley Financial contribution, if any, will be communicated each year in the New Hire Benefits Guide and/or the Enrollment Highlights.

You can make contributions to your account too, up to IRS limits. The IRS limits are adjusted annually, and the Donnelley Financial contribution counts toward the IRS limit.

The IRS limits are $3,450 for single and $6,900 for higher coverage levels in 2018; $3,500 for single and $7,000 for higher coverage levels in 2019. The maximum annual contribution is prorated for the number of months in which you are an HSA-eligible individual.

The following chart illustrates how the Donnelley Financial contribution affects your maximum contribution level.

<table>
<thead>
<tr>
<th>MEDICAL COVERAGE LEVEL</th>
<th>DONNELLEY FINANCIAL CONTRIBUTION</th>
<th>YOUR MAXIMUM CONTRIBUTION</th>
<th>2019 IRS LIMIT</th>
</tr>
</thead>
<tbody>
<tr>
<td>EMPLOYEE ONLY</td>
<td>$500</td>
<td>$3,000</td>
<td>$3,500</td>
</tr>
<tr>
<td>EMPLOYEE + SPOUSE</td>
<td>$750</td>
<td>$6,250</td>
<td>$7,000</td>
</tr>
<tr>
<td>EMPLOYEE + CHILD(REN)</td>
<td>$1,000</td>
<td>$6,000</td>
<td>$7,000</td>
</tr>
<tr>
<td>EMPLOYEE + FAMILY</td>
<td>$1,250</td>
<td>$5,750</td>
<td>$7,000</td>
</tr>
</tbody>
</table>
An additional catch-up contribution of $1,000 may be made if you are (or will be) age 55 or older by the end of the calendar year.

If you are a new hire, Donnelley Financial’s contribution to your HSA will be prorated based on your benefit effective date:

<table>
<thead>
<tr>
<th>BENEFIT EFFECTIVE DATE</th>
<th>PRORATED DONNELLEY FINANCIAL CONTRIBUTION</th>
</tr>
</thead>
<tbody>
<tr>
<td>JANUARY 1 – MARCH 31</td>
<td>100% contribution</td>
</tr>
<tr>
<td>APRIL 1 – JUNE 30</td>
<td>75% contribution</td>
</tr>
<tr>
<td>JULY 1 – SEPTEMBER 30</td>
<td>50% contribution</td>
</tr>
<tr>
<td>OCTOBER 1 – DECEMBER 31</td>
<td>25% contribution</td>
</tr>
</tbody>
</table>

Trust/Custodial Agreement; HSA not an ERISA Plan

HSA Program benefits consist solely of the ability to make contributions to the HSA on a pre-tax salary reduction basis. The terms and conditions of your HSA trust or custodial account are described in the HSA trust or custodial agreement provided by the applicable trustee/custodian and are not part of this SPD. Donnelley Financial has no authority or control over the funds deposited in an HSA. Even though you are allowed to make pre-tax salary reduction contributions to an HSA, and although Donnelley Financial may make contributions as well and may restrict the HSA trustee/custodian to which it will forward contributions, the HSA is not intended to be an ERISA benefit plan sponsored or maintained by Donnelley Financial.
When Participation Ends

When Health Care FSA Benefits End

Your participation in the Health Care FSA ends when your employment ends, or if earlier, when you are no longer eligible or decline to participate. Participation also ends on December 31 if you do not re-enroll during the Annual Enrollment period (unless you have carried over an eligible portion (i.e. not more than $500) of your Health Care FSA balance).

If you do not use the amount of your projected total annual contributions minus eligible expenses paid to you by the time your participation ends, the only way you can continue submitting receipts for expenses incurred after your participation ends is to continue coverage under the Health Care FSA for a specified period of time, as described in the “Your Legal Right to COBRA Continuation Coverage” section. However, after you leave Donnelley Financial, any contributions for continuation coverage are made after taxes. As a result, the before-tax advantage of the Participant Premium Program is lost.

When Dependent Care FSA Benefits End

Your participation in the Dependent Care FSA ends when your employment ends, or if earlier, when you are no longer eligible or decline to participate. Participation also ends on December 31 if you do not re-enroll during the Annual Enrollment period.

If you have made more Dependent Care FSA contributions than eligible expenses have been paid to you at the time your participation ends, you can still receive the unspent balance by submitting claims for eligible expenses incurred prior to the end of the plan year in which your participation ended. You may submit these eligible expenses after you cease to participate and through the end of the calendar year in which your participation ends. You will not be able to make new contributions to your Dependent Care FSA account after your participation ends.

When HSA Program Benefits End

Your participation in your HSA account does not end when you terminate employment, but you will no longer receive Donnelley Financial contributions to your HSA or be eligible to make pre-tax contributions through Donnelley Financial’s payroll. You should contact your HSA custodian regarding transferring balances or maintaining the HSA account if you leave employment with Donnelley Financial.

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, or if you accept new employment, either of which can include self-employment, you will be considered to have voluntarily abandoned your job...
at Donnelley Financial. This will be treated as a voluntary separation thus ending employment with Donnelley Financial and termination of coverage under its benefit programs. For example, this termination of employment with Donnelley Financial will result in a loss of all Group Benefit Plan and Flexible Benefit Plan benefits, including the Health Care and Dependent Care FSAs. 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.

If the Plan is Modified or Ended

Donnelley Financial reserves the right to amend or terminate the Plan or the FSAs at any time, in whole or in part. If the Plan or the FSAs are ever terminated, suspended, or modified, reimbursements for any eligible expense you incur before the change are paid under the Plan’s former conditions, provided that a written notice of claims is timely given. The FSAs do not reimburse eligible expenses incurred after such action (unless specific provisions are adopted).
Special Extensions of Participation

General Information

Depending on your situation when you leave employment with your Participating Employer, you may be eligible to continue your participation in an FSA. Situations in which an extension of participation 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 (you may discontinue Dependent Care FSA only);
- Covered by the Family and Medical Leave Act of 1993 (FMLA); and
- Covered under the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA).

If you do not terminate either of your FSA contributions while you are on an unpaid leave of absence (including a military leave), Donnelley Financial will advance on your behalf the required Health Care FSA contributions until you are able to return to work, you separate from employment, or you are reclassified as benefits-ineligible, whichever is earliest. Your Dependent Care FSA contributions will go into arrears for any deductions missed during your absence, however, you will still participate in the Dependent Care FSA but only up to your account balance on the day your leave commenced. Your election to authorize Donnelley Financial to reduce your future wages on a before-tax basis for your required FSA contributions includes an authorization to withhold from your pay, in the calendar year you return to work or commence to be paid, the amount of Health Care FSA contributions advanced for you by Donnelley Financial and the arrears amount for your Dependent Care FSA contributions during the time of your leave of absence. Therefore, if Donnelley Financial advances FSA contributions for you or places your deductions in arrears in the calendar year in which you are reemployed by, or commence to be paid by, a Participating Employer, you will be deemed to have elected to:

- Participate in the Plan for each calendar year to the extent required to repay advanced contributions made on your behalf or contributions placed in arrears 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; and
- Repay Donnelley Financial for the advanced contributions.
The FSA contributions will be recovered 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 Donnelley Financial with an outstanding balance due, the remaining balance will be recovered from your final pay as permitted by law.

Donnelley Financial will not advance your HSA contributions.
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 health care flexible spending programs offer employees the opportunity to extend participation temporarily after participation under the health care spending program would otherwise end. COBRA does not require employers to offer such extended coverage to Domestic Partners of employees or children of such Domestic Partners. However, the Group Health Program does voluntarily offer to covered Domestic Partners and the covered children of Domestic Partners (i.e., those who are eligible tax 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 is called “COBRA continuation coverage.”

In general, the Health Care FSA coverage that may be continued is the same as the coverage that was in effect under the Plan on the day before the qualifying event (as listed below). However, if you elected not to participate in the Health Care FSA as an active employee, you would not be eligible for any COBRA continuation coverage. If coverage under the plan is changed for active Employees, the same changes will apply to individuals on COBRA continuation coverage.

To be eligible for COBRA continuation coverage, a qualifying event must take place and the maximum amount payable to you under the Health Care FSA during the period of COBRA continuation coverage must equal or exceed the maximum contributions made to the Health Care FSA during the period of COBRA continuation coverage (i.e., your Health Care FSA account must not be “overspent”).

You, your enrolled spouse/tax-dependent Domestic Partner, your enrolled children, and your Domestic Partner’s enrolled children who are your tax dependents could become COBRA continuation coverage beneficiaries if coverage under the Group Health Program is lost because of a qualifying event.
The following are qualifying events:

<table>
<thead>
<tr>
<th>Who Can Continue Coverage</th>
<th>In What Situations</th>
<th>For How Long</th>
</tr>
</thead>
</table>
| Employee                                                      | ● A reduction in work hours that would cause the employee to be classified as a benefits-ineligible employee  
● Termination of the employee's employment (other than for gross misconduct) | From the date of the qualifying event, until the end of the plan year in which the qualifying event occurs |
| 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 or end of Domestic Partnership  
● Loss of status as dependent child  
● Employee’s entitlement to Medicare (under Part A, Part B, or both) | From the date of the qualifying event, until the end of the plan year in which the qualifying event occurs |

**Notification**

In the case of the employee’s death while employed, termination of employment (other than for gross misconduct), reduction in hours that would cause you to be classified as a benefits-ineligible employee, or entitlement to Medicare (under Part A, Part B, or both) that results in a loss of coverage, you 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 certain qualifying events. Under the law, the employee or a family member who is a COBRA continuation coverage beneficiary must notify the COBRA administrator if one of the following qualifying events occurs:

- Divorce;
- Legal separation;
- End of Domestic Partnership; or
- A Domestic Partner or child otherwise fails to meet the eligibility rules for coverage under the plan.

You will be allowed to make a COBRA election only if you notify the COBRA administrator within 60 days of the end of the month in which a qualifying event occurs. Failure to provide this notification during the 60-day notice period results in the loss of COBRA continuation coverage rights.
Upon such timely notification, coverage will be terminated retroactive to the date of the qualifying event. 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. Failure to provide this notification during the 60-day notice period results in the loss of COBRA continuation coverage rights. Contact information for the COBRA administrator can be found in the “Administrative and Contact Information” section.

**Election Procedure**

Under the law, to continue Health Care FSA coverage, you and your COBRA continuation coverage beneficiaries must make the election in accordance with the instructions on the election form no later than 60 days from the later of the:

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

If you and/or your COBRA continuation coverage beneficiaries do not choose COBRA continuation coverage within this 60-day period, Health Care FSA coverage will end.

COBRA continuation coverage under the law is provided subject to eligibility for coverage under the Health Care FSA. The Health Care FSA reserves the right to terminate your COBRA continuation coverage retroactively if you are determined to be ineligible. Once your COBRA continuation coverage terminates for any reason (e.g., non-payment of premiums), it cannot be reinstated.

Unless otherwise elected, all qualified beneficiaries who were covered under the Plan will be covered together. However, each qualified beneficiary may alternatively elect separate COBRA coverage to cover that qualified beneficiary only, with a separate deductible, out-of-pocket maximum and a separate premium for coverage.

If you reject COBRA continuation coverage before the election form due date and later change your mind, you may revoke your waiver by furnishing a completed COBRA Election Form before the original due date. However, in that case, you will begin COBRA continuation coverage on the date that you furnish the completed COBRA election form, and will not receive coverage retroactive to the date of the qualifying event.

**Payment**

Generally, you must pay to the Health Care FSA 102% of your contribution amount during the period of COBRA continuation coverage. Your initial COBRA continuation coverage payment 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 do not make payment on or before the first day of the month, your claim(s)
will not be paid by the Health Care FSA until payment is received within the 30-day grace period.

**When COBRA Continuation Coverage Ends**

Your COBRA continuation coverage continues until the earliest of:

- The end of the plan year in which the qualifying event occurs;
- The date your employer no longer provides a Health Care FSA to any of its employees;
- The date you fail to pay the required contribution by the specified deadline; or
- The date you first become covered after the date of your COBRA continuation coverage election under another group flexible spending account that does not contain a pre-existing exclusion that affects your benefits.

The Plan can terminate for cause the coverage of a qualified beneficiary on the same basis that the Plan terminates for cause the coverage of similarly situated non-COBRA beneficiaries, for example, for the submission of a fraudulent Claim.

In the event of early termination, the COBRA Administrator will provide the qualified beneficiaries with written notice as required by COBRA.

In the case of an individual who is not a qualified beneficiary and who is receiving coverage under the Plan solely because of the individual’s relationship to a qualified beneficiary, if the Plan’s obligation to make COBRA continuation coverage available to the qualified beneficiary ceases, the Plan is not obligated to make coverage available to the individual who is not a qualified beneficiary.

Remember to notify the COBRA administrator of any address or telephone number change.
Claims and Appeal Procedures

General Information

The following claim review and claim appeal procedures apply to all benefit claims and eligibility claims of any nature related to the Health Care FSA and Dependent Care FSA.

A “benefit claim” is a claim for a particular benefit under the Plan. It will typically include your initial request for benefits. An example of a benefit claim is a claim to receive reimbursement for a particular expense. 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 eligibility claim also includes any rescissions of coverage (i.e., a retroactive cancellation of coverage). An example of an eligibility claim is a claim to clarify a dependent’s eligibility or to change contributions midyear. If you are filing an eligibility claim, you need to contact the Benefits Center.

A “disability claim” is a benefit claim or eligibility claim that also requires a determination as to whether an individual is disabled. For example, if you are filing an eligibility claim on the basis that a dependent is disabled, then the additional procedures applicable to disability claims will also apply to your eligibility claim.

Authorized Representatives

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.

The claims administrator may establish standards for an individual to act as an authorized representative. For claims and appeals where the Benefits Committee acts as the claims administrator (e.g., in the case of eligibility claims), the following procedures generally apply to determine whether an individual is an authorized representative:

- **Specific Written Designation.** The claimant may provide in writing the name, address, and phone number of his or her authorized representative and a statement that the representative is authorized to act on his or her behalf in the claims and appeals process.

- **Other Legal Representative Status.** In the event a claimant is deceased or incapacitated, an individual may demonstrate that he or she is the claimant’s authorized representative by submitting certified letters of testamentary, letters of administration, or valid documentation of power of attorney, as applicable.

- **Employee as Authorized Representative of Dependents.** An employee may act as the authorized representative of his or her covered dependents, or other individuals
asserting an eligibility claim to become his or her covered dependents, without written authorization.

- **Additional Authorization Required for Claims and Appeals Involving PHI.**
  However, if the authorized representative is requesting access to HIPAA protected health information (“PHI”) in conjunction with the claims and appeals process, a valid HIPAA authorization form must also be submitted before PHI will be shared with the authorized representative.

**Procedure for Filing a Claim**

A communication from you, your eligible dependent, or your authorized representative (“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 under the Plan, he or she will be considered not to have exhausted all administrative remedies under the Plan, and this will result in his or her inability to bring a legal action for that benefit or eligibility.

Claims and appeals of denied claims may be pursued by a claimant, or, if approved by the claims administrator, his or her authorized representative. See the “Administrative and Contact Information” section for the appropriate claims administrator.

**Defective Claims**

If a claimant fails to follow the Plan’s procedures for filing a valid benefit claim or eligibility 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 and the specific treatment, service, or product for which reimbursement is requested (as applicable). The notice will be provided 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 30 days after receipt of the claim for a benefit under the Health Care FSA and within 60 days after receipt of the claim for a benefit under the Dependent Care FSA or eligibility claim. The claims administrator may extend the period for making the benefit determination by 15 days if it determines that such an extension is necessary due to matters beyond the Plan’s control. The claims administrator will notify the claimant, prior to the expiration of the initial 30-day or 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.

**Disability Claim**

In the case of a claim that is filed regarding a disability determination (including, but not limited to, whether a dependent is disabled for purposes of eligibility for a claim reimbursement), the claims administrator will notify the claimant of the denial within 45 days after receipt of the claim. The claims administrator may extend the period for making the benefit determination by 30 days if it determines that such extension is necessary due to matters outside the Group Benefit Plan’s control. The claims administrator will notify the claimant, prior to the expiration of the 45-day period, of circumstances requiring the extension of time and the date by which the claims administrator expect to render a decision. The claims administrator may extend the period for making the benefit determination by an additional 30 days if it determines that such additional extension is necessary due to matters outside the Group Benefit Plan’s control. The claims administrator will notify the claimant, prior to the expiration of the first 30-day extension period, of circumstances requiring the additional extension of time and the date by which the claims administrator expects to render a decision. All notices of extension will specifically explain the standards on which entitlement to a benefit is based, the unresolved issue that prevent a decision on the claim, and the additional information needed to resolve those issues, and you will have at least 45 days from receipt of the notice within which to provide the specified information.

If an extension is necessary due to the claimant’s failure to submit the information necessary to decide the claim, 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. If the Claimant provides additional information in response to such a request, a decision will be rendered within 30 days of when the information is received by the Plan.

**Manner and Content of Notification of Denied Claim**

If the benefit claim is denied, 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 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;

• In the case of a denial involving a benefit claim under the Health Care FSA, it will also include:

  – 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, applying the terms of the Plan to the claimant’s medical circumstances, or a statement that such explanation will be provided free of charge upon request;

  – Identification of any medical or vocational experts whose advice was obtained in connection with the denial, regardless of whether the advice was relied upon in making the determination;

• In the case of a denial involving a disability claim, it will also include:

  – A discussion of the decision, including an explanation of the basis for disagreeing with or not following:

    ▪ The views presented by the claimant to the Plan of health care professionals treating the claimant and vocational professionals who evaluated the claimant;

    ▪ The views of medical or vocational experts whose advice was obtained on behalf of the Plan in connection with a claimant’s denial, without regard to whether the advice was relied upon in the claim denial; and

    ▪ A disability determination regarding the claimant presented by the claimant to the Plan made by the Social Security Administration;
Either:

- The specific internal rules, guidelines, protocols, standards, or other similar criteria of the Plan that was relied upon in the claim denial; or
- A statement that such rules, guidelines, protocols, standards, or other similar criteria of the Plan do not exist;

- If the denial was based on medical necessity or experimental treatment or similar exclusion or limit, the denial will provide either:
  - An explanation of the scientific or clinical judgment relied upon for the claim denial, applying the terms of the Plan to the claimant’s medical circumstances; or
  - A statement that such explanation will be provided free of charge upon request; and

- A statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claimant’s disability claim;

- Such denial must be provided in a culturally and linguistically appropriate manner, in accordance with applicable DOL regulations.

- A description of the Plan’s review procedures, the time limits applicable to such procedures, and the claimant’s right to bring a civil action under Section 502(a) of ERISA following a claim denial on review (see below).

Review of Initial Benefit Denial

Procedure for Filing an Appeal of a Denial

A claimant must bring any appeal of a denial to the claims administrator within 180 days after he or she receives notice of the denial. If the claimant fails to appeal within the 180-day period, he or she will not be permitted to seek an appeal with the claims administrator and he or she will have failed to have exhausted all administrative remedies under the Plan. This failure will result in the claimant’s inability to bring a legal action to recover a benefit under the Plan. 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 review of a denial does not defer to the initial determination made by the claims administrator.
- The individual who conducts the review process is neither the individual who made the initial denial nor the subordinate of such individual.
- In deciding an appeal of any denial that is based in whole or in part on a medical judgment, including determinations as to whether a particular treatment, drug, or other item is experimental, investigational, or not medically necessary or appropriate, the individual conducting the review process will consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment. The health care professional will be neither the individual who was consulted in connection with the denial that is the subject of the review nor the subordinate of such individual.
- The claims administrator will identify any medical or vocational experts whose advice was obtained on behalf of the Plan in connection with the claimant’s denial, without regard as to whether the advice was relied upon in making the benefit determination.
- In the case of disability claims, the claims administrator must provide the claimant, free of charge, with any new or additional evidence considered, relied upon, or generated by the claims administrator (or at the direction of the claims administrator) in connection with the claim and any new or additional rationale for a claim determination. Such evidence or rational, as applicable, must be provided as soon as possible and sufficiently in advance of the date on which the notice of final internal adverse benefit determination is required to be provided to give the claimant a reasonable opportunity to respond prior to that date. If new or additional rationale is received close to the date on which the claims administrator must provide notice of the claim determination on review, the Plan may
extend the time to respond where the claims administrator determines that special circumstances require an extension of time for processing the review of the claim.

**Timing of Notification of Claim Determination on Review**

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

**Manner and Content of Notification of Benefit Determination on Review**

The claims administrator will provide a written or electronic notice of the Plan’s benefit determination on review, 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;
- Reference to the specific Plan provision(s) on which the determination is based;
- A statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all relevant documents;
- In the case of a denial involving a benefit claim under the Health Care FSA, it will also include:
  - 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, applying the terms of the Plan to the claimant’s medical circumstances, or a statement that such explanation will be provided free of charge upon request;
  - Identification of any medical or vocational experts whose advice was obtained in connection with the denial, regardless of whether the advice was relied upon in making the determination;
- In the case of a disability claim, it will also include:
  - A discussion of the decision, including an explanation of the basis for disagreeing with or not following:
    - The views presented by the claimant to the Plan of health care professionals treating the claimant and vocational professionals who evaluated the claimant;
• The views of medical or vocational experts whose advice was obtained on behalf of the Plan in connection with a claimant’s denial, without regard to whether the advice was relied upon in the claim denial; and
• A disability determination regarding the claimant presented by the claimant to the Plan made by the Social Security Administration;
  – Either:
    • The specific internal rules, guidelines, protocols, standards, or other similar criteria of the Plan that was relied upon in the claim denial; or
    • A statement that such rules, guidelines, protocols, standards, or other similar criteria of the Plan do not exist;
  – If the denial was based on medical necessity or experimental treatment or similar exclusion or limit, the denial will provide either:
    • An explanation of the scientific or clinical judgment relied upon for the claim denial, applying the terms of the Plan to the claimant’s medical circumstances; or
    • A statement that such explanation will be provided free of charge upon request; and
  – A statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claimant’s disability claim;
  – Such denial must be provided in a culturally and linguistically appropriate manner, in accordance with applicable DOL regulations.

• A statement describing any voluntary appeal procedures offered by the Plan and the claimant’s right to obtain information about such procedures, including a statement of the claimant’s right to bring a civil action under Section 502(a) of ERISA following a denial on review. With respect to claims regarding disability, such statement will also include any applicable contractual limitations period that applies to the claimant’s right to bring such action, including the calendar date on which the contractual limitations period expires for the claim.

The claims administrator will ensure that all disability claims are adjudicated in a manner designed to ensure the independence and impartiality of the persons involved in making the decision. Accordingly, decisions regarding hiring, compensation, termination, promotion, or other similar matters with respect to any individual (such as a claims adjudicator, vocational or medical expert, or independent review organization) will not be made based on the likelihood that such individual will support a denial of a claim for benefits or determination of disability.
Legal Action
A claimant cannot bring legal action to recover any benefit under, or for eligibility in, the Plan if he or she does not first exhaust the Plan’s internal claims and appeals procedures by timely filing a valid claim and seeking timely review of all denials of that claim. In addition, no legal action may be brought:

- More than two years after the claims administrator first received the claimant’s claim;
- If you received a denial on appeal of such claim, more than two years after such receipt;
- After such other date that is provided in an applicable insurance certificate; 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.

In the case of disability claims, then notwithstanding the previous paragraph, if the Plan fails to adhere to all of the requirements of the procedures set forth above for disability claims, then to the extent required by law, the claimant may bring an action in an appropriate court under state law or section 502(a) of ERISA, but only if the action is commenced no later than the earlier of (1) the applicable statute of limitations, or (2) the first anniversary of the claim administrator’s decision on appeal. However, the claimant cannot bring an action in an appropriate court under state law or section 502(a) of ERISA without first exhausting the claims procedures set forth above if the violation:

1. Was de minimis;
2. Does not cause, and is not likely to cause, prejudice or harm to the claimant;
3. Was attributable to good cause or matters beyond the Plan’s control;
4. Was in the context of an ongoing good-faith exchange of information between the claimant and the claims administrator; and
5. Was not reflective of a pattern or practice of non-compliance by the Plan.

Within 10 days of the Plan’s receipt of a written request by the claimant, a claimant is entitled to an explanation of the Plan’s basis for asserting that it meets the above exception that includes a specific description of its bases, if any, for asserting the violation should not cause the internal claims and appeals process to be deemed exhausted. If an external reviewer or a court reject the claimant’s request for immediate review on the basis that the Plan met the requirements for the exception, then the Plan will provide the claimant with notice of the opportunity to resubmit and pursue the internal appeal of the claim within a reasonable time after the external reviewer or court rejected the claim for immediate review (but not to exceed 10 days). Time periods for re-filing the claim will begin to run upon claimant’s receipt of such notice.
The Plan requires that any legal action involving or related to the Plan, including but not limited to any legal action to recover any benefit under the 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 Plan, the person bringing such action is not entitled to recover any legal fees or expenses from the Plan, LSC, other participating employers, the Benefits Committee, the claims 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 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.

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

- Two or more years after the claims administrator first received your claim; or
- If you received a denial on appeal of such claim, two or more 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 the Medical and Prescription Drug Program SPD.
Administrative and Contact Information

General Information

This section provides you with information about how the Flexible Benefits Plan is administered.

Type of Plan
The Program is a welfare benefits plan. Its objective is to reimburse eligible expenses of covered employees and their spouse and eligible dependents in accordance with the terms of the Program.

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

Employer Identification Number of Plan Sponsor
13-2618477

Plan Number
For federal income tax purposes, the following Programs are treated as separate, written plans:

- Health Care FSA – 502
- Dependent Care FSA – 502

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 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 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 Program, call the eligibility administrator listed under “Eligibility Administrator” below.

**Eligibility Administrator**

The eligibility administration is performed by Alight, 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 from 8 a.m. to 5 p.m. CT, Monday through Friday, except holidays.

Website: dfsco.benefitsnow.com

Contact the Benefits Center for:

- General questions about flexible benefits;
- Questions about Qualified Status Changes;
- Questions about expenses eligible for reimbursement;
- Instructions on how to get a claim form; or
- Instructions on filing FSA claims.

If you want to participate, 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 Your Spending Account at the following address and phone number:

Your Spending Account™
P.O. Box 64030
The Woodlands, TX 77387-4030
1-844-44-DFSCO (1-844-443-3726)
1-888-211-9900 (fax number for claim and/or receipt submission)

Website: dfsco.benefitsnow.com

Claims Administrator for Eligibility Claims and Appeals

The Benefits Committee is the claims administrator for claims related to eligibility and appeals of denied claims related to eligibility. Initial eligibility claims involving a determination of disability will be made by a subset of the Benefits Committee, and appeals of those denials will be decided by a different subset of the Benefits Committee, and no one in the second subset will report to anyone in the first subset.

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 website and phone number:

Conexis
1-866-206-5751
Website: dfsco.benefitsnow.com

Allocation and Delegation of Fiduciary Responsibilities by the Benefits Committee

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

The benefits paid from your Health Care Spending Program or your Dependent Care Spending Program are from the general assets of Donnelley Financial. The benefits provided by the Programs are not guaranteed by the claims administrator. The claims administrator’s role is to provide services to the Programs.
Your ERISA Rights

General Information

As a participant in the Health Care FSA portion of the Plan, you 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 the Health Care FSA 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 Health Care FSA, including collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the Plan for the Health Care FSA 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 Health Care FSA, including 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 for the Health Care FSA. The Plan Administrator is required by law to furnish each Health Care FSA participant with a copy of this Summary Annual Report.

Continue Group Health Plan Coverage

- Continue health care coverage for yourself if there is a loss of coverage under the Health Care FSA as a result of a qualifying event. You may have to pay for such coverage. Review this SPD and the documents governing the Health Care FSA on the rules governing your COBRA continuation coverage rights.

Prudent Actions by Plan Fiduciaries of the Health Care FSA

In addition to creating rights for participants in a Health Care FSA plan, ERISA imposes duties upon the people who are responsible for the operation of the program. The people who operate the Health Care FSA, called “fiduciaries,” have a duty to do so prudently and in the interest of you and other participants and beneficiaries under the Health Care FSA. 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 benefit available under the program or exercising your rights under ERISA.

Enforce Your Rights

If your claim for a benefit under the Health Care FSA 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 governing the Health Care FSA 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 under the Health Care FSA 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 Health Care FSA’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 the Health Care FSA, 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.