LSC GROUP BENEFITS PLAN AND LSC FLEXIBLE BENEFITS PLAN

Summary Plan Description

Effective as of January 1, 2024

This document, together with the Certificate(s) and Booklet(s) for the Benefit Program(s) in which you are enrolled and your annual enrollment materials, constitutes your Summary Plan Description for the LSC Group Benefits Plan and LSC Flexible Benefits Plan.

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REAL SUPPORT.
HEALTH · MONEY · HOME · COMMUNITY

Contents

Introduction

The **LSC Group Benefits Plan** and the **LSC Flexible Benefits Plan** (collectively, the "Plan") sponsored by **LSC Communications LLC** (the "Company") are designed to help you and your covered family members by offering the types of coverage listed below. The various types of coverages available under the Plan are referred to in this Summary Plan Description (the "SPD") as "Benefit Programs."

Summary Plan Description

This SPD contains key administrative information about the Plan and the Benefit Programs as in effect on and after January 1, 2024. If you have any general questions about the information in this SPD, please contact the LSC Benefits Center at 1-888-681-2241, Monday through Friday from 8 a.m. to 5 p.m. Central Time.

This SPD supplements each certificate of insurance (or evidence of coverage) produced by the Insurer ("Certificate") and each booklet (or underlying summary plan description) ("Booklet") provided by the Company or third-party administrator for each Benefit Program, the current annual enrollment materials and any applicable Summary of Material Modifications ("SMM")—***together, these documents constitute your SPD for the Plan***. You are encouraged to carefully read all portions of the SPD together and keep the SPD with other information about your Company welfare benefits. The Certificates and Booklets are available at mylscbenefits.com.

This SPD provides details about the administration of the Plan and your rights under the Employee Retirement Income Security Act of 1974, as amended ("ERISA") and other applicable laws. In the event of any discrepancy between this SPD and the official Plan document (including administrative documents and insurance policies), the Plan document will govern.

Benefit Programs

You may not be eligible for all of the Benefit Programs available under the Plan – eligibility for a particular Benefit Program may depend on certain factors, such as your employment classification. The Benefit Programs which may be available to you under the Plan include:

- Medical Program (including Prescription Drug coverage)
- Dental Program
- Vision Program
- Employee Assistance Program
- Short Term Disability Program
- Long Term Disability Program (including Basic and Buy-up Disability benefits)
- Life Insurance Program (including Basic and Optional Insurance)
- Dependent Life Insurance Program (including Spouse** and Child Insurance)
- Optional Accidental Death and Dismemberment Insurance Program
- Supplemental Hospital Indemnity Program
- Supplemental Critical Illness and Accident Insurance Program

- Health Care Flexible Spending Accounts ("FSA") (including a General Purpose and Limited Purpose Health Care FSAs)
- Dependent Care FSA*
- Health Savings Account ("HSA")*
- Commuter Benefits*

*Indicates Benefit Programs that are not subject to ERISA and are not required to be included in this SPD.

**Please note, the elected amount of spousal life insurance cannot exceed the amount of elected optional life insurance, as further described in the applicable Certificate.

Keep in mind that you and your doctor always make the final decision regarding your health care and treatment. The Plan only determines whether benefits will be paid by the Plan, not whether care or treatment is appropriate for you or your dependents.

The Medical, Dental and Vision Benefit Programs use provider networks. Therefore, a provider listing will be furnished to you, upon request, without charge. In accordance with the No Surprise Act, the Medical Program third-party administrator is required to confirm that its list of network providers (and certain information about those providers) in its provider directory is accurate at least every 90 days. For information regarding the provider network(s) for a particular Benefit Program, refer to the applicable Certificate or Booklet and/or contact the Insurer or Plan Administrator, whose contact information appears in the "**Administrative Information**" section. If you have any general questions about your benefits, please contact the LSC Benefits Center at 1-888-681-2241, Monday through Friday from 8 a.m. to 5 p.m. Central Time.

Benefit Program Information

Complete details about each of the Benefit Programs, such as eligibility, coverage details and schedules, claims and appeals procedures, etc., can be found in the Certificates, Booklets, and the annual enrollment materials. The annual enrollment materials will also include the cost of coverage and any employee contribution or premium obligations. The Company reserves the right, in its sole discretion, to determine the amount of such obligations.

If you have any questions about a Certificate, Booklet or the Benefit Program in which you are enrolled, you should contact the applicable Insurer or the Plan Administrator, whose contact information appears in the "**Administrative Information**" section and in the applicable Certificate or Booklet.

Amendment or Termination of the Plan

The Company reserves the right to amend or terminate the Plan or any Benefit Program available under the Plan at any time. Refer to the "**Administrative Information**" section for more information.

Who Is Eligible

You

Please refer to the applicable Certificate or Booklet for specific eligibility requirements, enrollment requirements (including deadlines) and entry dates that apply for each Benefit Program under the Plan. Generally, coverage is extended to employees classified by the Company (or a Participating Employer) as either a:

- Regular full-time employee; or
- Benefit-eligible part-time employee.

Except as may be required in accordance with the Company's eligibility procedures or as required by the Affordable Care Act, you generally will not be eligible to participate in the Plan if you are:

- Not classified by the Company (or a Participating Employer) as a benefits-eligible employee;
- A temporary, FLEX or seasonal employee or an intern;
- A leased employee or an independent contractor;
- A nonresident alien who receives no earned income from the Company that constitutes income from sources within the United States; or
- A union employee represented by a collective bargained agreement, except if such agreement provides for participation in the Plan.

A person's status as an eligible employee will be determined by the Plan Administrator (or its delegate, the Eligibility Administrator) and such determination will be conclusive and binding on all persons notwithstanding any contrary determination of employee status by any court or governmental agency including, but not limited to, the Internal Revenue Service ("IRS").

Your Eligible Dependents

Eligible dependents are described in detail in the applicable Certificates and Booklets. Generally, eligible dependents include:

- Your spouse (including a same-sex spouse who is considered your spouse for Federal tax purposes pursuant to applicable IRS guidance or a common-law spouse in states that recognize common-law marriages).
- Your domestic partner (including a same- or opposite-sex domestic partner) if you provided any required documentation to the Plan Administrator and you and your domestic partner are registered with a state or local governmental entity, or you and your domestic partner satisfy the following: (i) neither of you are legally married to or are the legal domestic partner of anyone else; (ii) you both intend to remain each other's sole domestic partner indefinitely; (iii) you both live together in the same principal residence and intend to do so indefinitely; (iv) you both are committed to each other and share joint responsibilities for your common welfare and financial obligations; and (v) you and your domestic partner are not related by blood, closer than would prohibit marriage in the state in which you live.
- Your (or your spouse's or domestic partner's) dependent children until they turn age 26. Your eligible children include your natural children, legally adopted children or children who are placed with you for adoption and children who reside in your household under your legal guardianship.
- Your unmarried incapacitated dependent children (refer to the applicable Certificate or Booklet for details).

- Your dependents eligible under the applicable Certificates and Booklets or required by law.
- In addition, a court order could require you as a parent to provide for your child's group health plan coverage. If this is the case and the court order is determined by the Plan Administrator to satisfy all applicable legal requirements (and is therefore a *qualified medical child support order*, or "QMCSO"), the Company will offer coverage to the extent required by law and under the Plan. To obtain a copy of the Plan's QMCSO procedures, free of charge, contact the Plan Administrator whose contact information appears in the "**Administrative Information**" section.

Proof of Dependent Status

You are required to provide proof of your dependent's eligibility prior to enrollment in the Plan and your dependent will not be considered eligible for coverage unless and until current satisfactory proof of such current eligibility is submitted to the Plan Administrator or the Insurer. Further, the Plan Administrator reserves the right (in its sole discretion) to establish rules regarding the time, form, and manner in which such proof must be submitted and when additional dependent eligibility audits may occur. Failure to submit the required proof according to those rules may result in ineligibility. If you attempt to intentionally or fraudulently misrepresent your dependent's eligibility, the Company (and the Insurer) reserve the right to retroactively rescind your coverage and to seek to recoup any benefits that you (or your dependents) received.

Company Couples and Parent/Child Employees

Dual coverage is not permitted under the Plan. If you are married to or in a domestic partnership with another Company employee, you may enroll as an employee or a dependent under the Plan, but you cannot enroll as both a dependent and an employee. Additionally, you cannot enroll your spouse or domestic partner in spousal life insurance. Eligible dependents may be enrolled under one employee's coverage only under the Plan. In addition, your dependent child may not be covered as both an eligible employee in their own right and as your dependent. It is your responsibility as an employee to ensure you comply with this section.

Taxation of Domestic Partner Coverage

The cost of a Company subsidy (if any) associated with providing benefits to a domestic partner, where the domestic partner is not your dependent for purposes of Section 152 of the Internal Revenue Code (the "Code"), as modified by Code Section 105(b), shall be treated for withholding purposes as taxable compensation to you. You should speak with your tax advisor or legal counsel if you have questions regarding the tax implications of coverage for your domestic partner.

Responsibility for Reporting Ineligible Dependents

You are responsible for reporting your enrolled dependent's loss of eligibility within 30 days after the date your dependent is no longer eligible for coverage. Your dependent loses coverage when he or she is no longer an eligible dependent, even if you fail to report the status change within the 30-day period, unless your eligible dependent has elected COBRA continuation coverage. If you do not timely report the status change, you may be subject to imputed income for the period of time your ineligible dependent remained enrolled in coverage under the Plan, subject to the Plan Administrator's procedures.

Enrollment and Cost of Coverage

When you are first hired or first become eligible to participate in the Plan, and each year before the annual enrollment period, you will receive information about enrolling for benefits. Your enrollment materials and enrollment information, accessed through mylscbenefits.com, will inform you of the current cost of coverages and what information is needed to complete enrollment.

New Hire or Newly Eligible Employee

If eligible, you will automatically be enrolled in the non-elective Benefit Programs (*i.e.*, Company-provided Basic Life Insurance, Employee Assistance Program, Company-provided Short Term Disability and Company-provided Long Term Disability) as a new employee.

Unless provided otherwise in an applicable Certificate or Booklet, coverage generally begins on the first day of the month *after* you complete one full calendar month of employment regardless of the day of the month you started your employment. For example, if your date of hire is any day in January (including the first day of the calendar month, i.e. January 1), your coverage will begin on March 1 (see chart below).

For New Hires, when benefits coverage begins:

If you start any day, in the month of, including the 1st:	**Your benefit coverage begins on:**
January	March 1
February	April 1
March	May 1
April	June 1
May	July 1
June	August 1
July	September 1
August	October 1
September	November 1
October	December 1
November	January 1
December	February 1

For Newly Eligible employees, if you have been employed with the Company for 30 days or more prior to your status change to benefits eligible, you will be benefits eligible the date of your status change. You have 14 days from the date of your status change to complete enrollment for you and your dependents. If your status change to benefits eligible happens before you are employed for 30 days with the Company, you will be treated like a New Hire.

To elect other coverage:

- Review your enrollment information carefully. Be sure to note the deadline for making your enrollment elections.

- Decide whom you want to cover under the elective Benefit Programs of the Plan.
- Complete the Plan's enrollment process (and any other requirements by the Insurer(s)).

You have until 14 days prior to your benefits effective date to complete enrollment for you and your dependents. If you don't take action within the enrollment window, that failure will constitute an election not to participate in the elective Benefit Programs and an election to receive your full compensation in cash, except that the Plan Administrator reserves the right to select a default enrollment option and deem you have elected coverage in that default option. The default enrollment option will be communicated to you in your enrollment materials. Unless otherwise communicated, if you fail to timely enroll, you will be defaulted into HSA Value for you only with no HSA contributions and you will pay the tobacco-user rates.

You generally may not change your coverage elections until the next annual enrollment period unless you experience an event described in the "**Changing Your Coverage Elections**" section. Certain exceptions apply with respect to the Optional Employee and Dependent Life Insurance and Optional AD&D Insurance.

Actively at Work

For newly hired employees, unless provided otherwise in an applicable Certificate or Booklet, if you are not actively at work (due to an approved leave) on the day coverage is scheduled to begin, coverage (excluding Life Insurance, Disability, Supplemental Hospital Indemnity, Supplemental Critical Illness and Accident Insurance coverage) for you and your eligible dependents still takes effect on that day provided you enrolled by the deadline. You do not need to return to active work for your coverage to take effect. Please refer to the applicable Certificate or Booklet for specific actively at work requirements.

Annual Enrollment for Current Employees

You may change your coverage elections once each year during the annual enrollment period. Before the annual enrollment period begins, enrollment information will be available through mylscbenefits.com, that is designed to help you with your annual enrollment elections. The information will describe the enrollment procedures, the coverage options available for the upcoming Plan year, your cost for each option, the maximum contribution under the Health Care and Dependent Care FSAs and the HSA, and any changes to the available coverages since the last annual enrollment period. Be sure to read the information carefully. The elections you make during annual enrollment generally take effect on the following January 1, the start of the new Plan year.

Your failure to make an election during annual enrollment will constitute an election to waive any coverage under any Benefit Program under the Plan, except for any default enrollment option as communicated in your annual enrollment materials.

Mid-year Enrollment

If you previously declined coverage because you were covered under another health plan and you then lose that coverage, special enrollment rules may apply. See the "**Special Enrollment Rules**" section below for more information.

Enrollment for Dependents

You may enroll your eligible dependents at the same time you enroll yourself. Unless a longer time frame is provided, newly eligible dependents must be enrolled within 30 days of the date

they become eligible for coverage under the Plan. If you are adding a newborn child or coverage due to (a) loss of coverage under Medicaid or a state Children's Health Insurance Plan (CHIP) or (b) eligibility for premium assistance from Medicaid or CHIP toward the cost of the group health plan, you have up to 60 days to report such event to the Eligibility Administrator.

If you request coverage for your eligible dependents within 30 days of the date they become eligible, their coverage will take effect on the same date yours takes effect if you are a newly eligible employee, or on the date you acquired the new dependent, provided you request enrollment within 30 days of the date you acquired the dependent. Coverage for dependents you enroll during annual benefits enrollment is effective the following January 1.

Please note, you are required to provide proof of dependent status prior to your dependents' enrollment in the Plan. Refer to the "**Proof of Dependent Status**" section for more information.

Reemployment

If you terminate employment, you will be eligible to resume participation in the Plan on the same basis as any newly hired employee. However, if you resume employment within 30 days of your termination of employment, without any intervening event that would permit a change in Plan elections, you will be automatically reinstated in the same Plan elections that were in effect for that benefit Plan year before your termination of employment.

Cost of Coverage and Cost Sharing–*Elective Benefit Programs*

The Company may pay a portion of your elective coverages. You pay your portion of the cost through payroll deductions. Your costs for elective coverage are based on the Plan option and coverage level you select. Information regarding the applicable benefits, pricing, and whether the benefit premiums are payable on a pre-tax or after-tax basis will be available during the annual enrollment period and new hire enrollment period.

The elective Benefit Program options contain certain cost sharing features, such as deductibles and co-payments. These are the responsibility of the Plan participant or dependent, and are described in detail in the Certificates and Booklets.

Cost of Coverage and Cost Sharing–*Non-Elective Benefit Programs*

The Company pays the cost of your non-elective insurance coverages.

Tobacco-Free Credit

The Company offers a medical premium credit when you and your covered dependents make the Tobacco-free Pledge (*i.e.*, pledge that you are either tobacco-free or that you will complete the tobacco cessation program). If you and/or any covered dependents do not make the Tobacco-free Pledge, an annual surcharge is added to your medical premium (or otherwise deducted from your paycheck, as determined in accordance with the Plan Administrator's procedures) in an amount communicated in your annual enrollment materials. For newly hired employees, if you and/or any covered dependents do not make the Tobacco-free Pledge, the annual surcharge will be prorated for your applicable coverage period during your year of hire.

You may sign up for the tobacco cessation program through the Quantum Health website accessible at mylscbenefits.com or by calling Quantum Health at 1-844-460-2803. Additionally, alternate cessation recommendations by your physician will be accommodated. If you or any of your dependents declare you use tobacco, but agree to complete the tobacco cessation program, the Claims Administrators will receive confirmation when you complete the program. If you do

not complete the tobacco cessation program within the timeframe communicated in your annual enrollment materials, you will incur the surcharge retroactively the following plan year.

Changing Your Coverage Elections

The circumstances under which you may change your Benefit Program coverage elections during the year are described below. If none of these circumstances apply, you may not change your coverage elections during the year. In order to make a mid-year change to your coverage elections, you must meet the requirements of the Plan and of the applicable Benefit Program, as described in the Certificate or Booklet for that Benefit Program.

Changing Your Coverage

Under certain circumstances, you may enroll in coverage, add or remove dependents, or change coverage that is paid for on a pre-tax basis during the year. For example, you may make a prospective change to your coverage (and/or the coverage of your dependents, if applicable), if:

- You experience a "change in status" (as described below) that affects your or your dependents' eligibility for a Benefit Program;
- You qualify for a special enrollment during the year (as described below);
- The Plan Administrator or Insurer receives a QMCSO or other court order, judgment or decree requiring you to enroll a dependent child;
- You, your spouse, or your dependent becomes entitled to or loses Medicare or Medicaid coverage;
- You, your spouse, or your dependent experiences a significant, unexpected and unforeseen increase (or decrease) in the cost of coverage;
- You, your spouse, or your dependent child experience a significant reduction in coverage or a total loss of coverage;
- The Plan adds a benefit package option or significantly improves coverage under an existing option;
- You or your dependents qualify for annual or special enrollment in Health Insurance Marketplace coverage, with Marketplace coverage to begin no later than the day following the termination of your coverage under this Plan; or*
- Any other event recognized for purpose of changing Plan elections under applicable law and regulation, in the sole discretion of the Plan Administrator.

*This event only permits election changes to your medical coverage election.

Coverage election changes must be consistent with the event and generally must be made within 30 days (60 days for the birth of a child or loss of coverage under Medicaid or CHIP) after the event, or within such other timeframe provided in the applicable Certificate or Booklet. The Plan Administrator, or its delegate, will determine, in its sole discretion, if an event has occurred that permits a change under these rules.

Change in Status

You may change certain coverage elections under the Plan during the year if you experience a change in status. Depending on the event that you experience, you may change your coverage elections. You also may change your pre-tax salary reduction amount, and you may be able to add or remove dependents from coverage. Changes in status include:

- You get married, divorced, or legally separated or you have your marriage annulled;
- You form or dissolve a domestic partnership;

- Your spouse, domestic partner or dependent dies;
- Your dependent becomes eligible for coverage or ineligible for coverage (*e.g.*, he or she reaches the eligibility age limit);
- You or your spouse or your domestic partner has a baby, you adopt or you have a child placed with you for adoption;
- You, your spouse or your domestic partner, or your dependents experience a change in employment status that leads to a loss of or gain in eligibility for coverage;
- Your home residence changes and your previous coverage is no longer available or new coverage options become available; or
- You begin or return from an unpaid leave of absence.

Regardless of what type of change in status you have, any coverage election change you make under the Plan must be because of and consistent with the change in status. The Plan Administrator (or its delegate) will determine (in its sole discretion) whether a particular event constitutes a change in status. The change must also be permitted by the Insurer, if applicable. If you experience a change in status or any other event described in this section, you must notify the Plan Administrator within 30 days after the event (60 days for the birth of a child or loss of coverage under Medicaid or CHIP), or within such other timeframe provided in the applicable Certificate or Booklet, to change your Benefit Program coverage election. In addition, you may be required to provide proof of your change in status or the other event. If you do not, you cannot change your coverage until the next annual enrollment period, unless you once again experience a change in status.

Effective Date of Coverage Change

Except as otherwise provided in the applicable Certificate or Booklet (and except as described below under "Special enrollment rules"), your coverage change will generally be effective as of the date of the event once the Plan Administrator, or its delegate, or Insurer process your election. The processing will take place as soon as administratively feasible. Premium deduction changes will take effect as soon as administratively feasible after the date the election change is processed and no refunds will be issued, to the extent applicable.

Special Enrollment Rules

If you decline enrollment in the Plan for yourself or your dependents because of other health coverage and you later lose that other coverage or the employer providing other coverage stops making contributions, you may be able to enroll yourself or your dependents in the Plan, provided that you request enrollment within 30 days after your other coverage ends, or within such other timeframe provided in the applicable Certificate.

Your loss of other health coverage qualifies for special enrollment treatment only if you satisfy both of the following conditions:

- You (or your dependents) were covered under another group health plan or health insurance coverage when coverage under the Plan was originally offered to you; and
- You (or your dependents) lost your other coverage either because you exhausted your rights under COBRA continuation coverage (or you drop COBRA continuation coverage due to the loss of an employer's COBRA subsidy) or you were no longer eligible under that plan.

If you gain a dependent as a result of marriage, establishing a relationship with a domestic partner, birth, adoption, or placement for adoption, you may be able to enroll yourself and your new

dependent(s), provided that you request enrollment within 30 days (60 days in the event of the birth, adoption, or placement for adoption) after the event, or within such other timeframe provided in the applicable Certificate.

If you and/or your dependents are eligible for health coverage under the Plan but do not elect such coverage during a regular enrollment period, and either:

- Your and/or your dependent's Medicaid or State Children's Health Insurance Program ("CHIP") coverage is terminated due to a loss of eligibility; or
- You and/or your dependent becomes eligible for a premium assistance subsidy under Medicaid or CHIP,

then you may enroll yourself and/or your dependents in health care coverage under the Plan, provided you request enrollment within 60 days after the occurrence of either of these events.

Except as otherwise provided in the applicable Certificate or Booklet, coverage under the Plan will become effective on the date of the event once the Plan Administrator, or its delegate, or Insurer process your election. The processing will take place as soon as administratively feasible.

How to Change Your Coverage

Step 1 – Log on to mylscbenefits.com and click on the LSC Benefits Center link. Log into the LSC Benefits Center site and click "Change Benefits." Select the life event that applies to your current situation and follow the prompts or call the Eligibility Administrator at 1-888-681-2241 within 30 days (60 days for the birth of a child or loss of coverage under Medicaid or CHIP) after the date of the event itself. If the 30-day (or 60-day) deadline falls on a weekend or a holiday, you will need to either process your change online, or call the Eligibility Administrator during business hours prior to the 30-day (or 60-day) expiration.

You cannot request changes before the event takes place (for example, you cannot request that your spouse be added the day before you get married). If you miss the applicable deadline, you will not be able to change your benefits until the next annual enrollment period (unless you experience another permitted change in status event).

Step 2 – If you report your change via mylscbenefits.com, you can print a confirmation statement. If you call the Eligibility Administrator to report your permitted change in status event, you will receive a confirmation statement in the mail or via email, based on your elected communication preference. If there are no inaccuracies, keep the statement for your records. If something is incorrect, report the inaccuracies by the deadline specified on the statement to complete the benefit change process.

Any change in contributions for the cost of coverage under the Plan takes effect as soon as administratively possible after you report the change to the Eligibility Administrator (payroll deductions are not retroactive to the date of the change).

Circumstances Which May Affect Benefits

Your and your dependents' eligibility for Plan benefits will terminate upon the occurrence of any of the events described under the "**When Coverage Ends**" section below, or described in the applicable Certificate or Booklet.

Other circumstances may result in the termination, reduction, loss, offset, or denial of benefits including, but not limited to, exclusions for certain medical procedures, limitations on coverage for new drugs, and rights of recovery of benefits paid by a particular Benefit Program (for example, the Benefit Program's rights of reimbursement and/or subrogation). Benefits under a particular Benefit Program may also be subject to coordination of benefits if you have coverage under another plan.

Refer to the applicable Certificate or Booklet for specific information regarding the circumstances which may affect your benefits under the particular Benefit Program.

Preexisting Conditions

Some of the Benefit Programs may include limitations on preexisting conditions. Notwithstanding the foregoing, no "group health plan" (as that term is defined under the Affordable Care Act) will impose a pre-existing condition exclusion. *Refer to the applicable Certificate or Booklet for information about that Benefit Program's preexisting condition rules and how they apply to your coverage.*

When Coverage Ends

Unless otherwise determined by the Plan Administrator, your coverage ends upon the first of the following to occur:

- You decline coverage;
- The date your employment with the Company (or a Participating Employer) ends;
- The last day of the month you no longer meet the eligibility rules of the Plan or a Benefit Program;
- The date the Plan or Benefit Program terminates;
- The date you stop making any required contributions;
- The date you commit fraud against the Plan; or
- The date you go on strike or are locked out to the extent not prohibited by the applicable collective bargaining agreement.

Please note, as part of the Plan Administrator's procedures, if your termination date is timely processed, your termination date will be the date your employment ended. If there is a 61-day or greater delay in processing your termination, your termination date will be the date your termination is actually processed. Premium deduction changes will take effect as soon as administratively feasible after the date coverage terminates and no refunds will be issued.

Your dependent's coverage ends on the date your coverage ends, or on the last day of the month in which your dependent no longer meets the Plan's definition of an eligible dependent. In the case of a dependent who ceases to be a dependent due to the attainment of age 26, coverage will automatically end on the earlier of: (i) the day your coverage ends; or (ii) the last day of the month of the dependent's 26th birthday. Notwithstanding the foregoing, if you die while you are an active employee, your enrolled eligible dependent's coverage under the Plan may continue at

no cost until the end of the third month after the month in which you die, provided your surviving eligible dependent is a COBRA continuation coverage beneficiary and elects COBRA continuation coverage. The three months of subsidized coverage count toward the period of COBRA continuation coverage for which such enrolled eligible dependents are eligible.

If you are eligible to convert or port your coverage, and you do not otherwise receive a conversion kit, you must contact the applicable Insurer to request to receive a conversion kit in the mail. You have 31 days from the date coverage under the Plan ends to submit an application and pay the first premium toward your converted/ported coverage. Your coverage would become effective on the 32nd day. Please note, conversion and port information is also included on mylscbenefits.com.

Refer to the applicable Certificate or Booklet for information about when coverage under a particular Benefit Program ends. The Certificates and Booklets also contain information about converting to an individual policy when your coverage under the group program ends, if applicable.

Rights Under Federal Law

Your Rights under the Newborns' and Mothers' Health Protection Act

Group health plans and health insurance issuers generally may not, under federal law, restrict benefits for any hospital stay in connection with childbirth for the mother or newborn child to less than:

- 48 hours following a normal vaginal delivery; or
- 96 hours following a cesarean section.

However, federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under federal law, require that a provider obtain authorization from the Plan or the insurance issuer for prescribing a length of stay not in excess of 48 (or 96) hours.

The laws of your state related to hospital stays in connection with childbirth may differ from these federal requirements. *For more information and coverage details, refer to the applicable medical Certificate or Booklet.*

Your Rights under the Women's Health and Cancer Rights Act of 1998

The Women's Health and Cancer Rights Act requires that the following procedures be covered for a person who receives benefits for a medically necessary mastectomy and decides to have reconstructive surgery after the mastectomy:

- Reconstruction of the breast on which a mastectomy has been performed;
- Surgery and reconstruction of the other breast to create a symmetrical (balanced) appearance;
- Prostheses; and
- Treatment of physical complications of all stages of mastectomy, including lymphedemas.

This coverage will be provided in consultation with the attending physician and the patient, and will be subject to the same annual deductibles and coinsurance provisions that apply to the mastectomy. *For more information and coverage details, refer to the applicable medical Certificate or Booklet.*

Military Leave

If you go on a military leave of absence, your Plan eligibility and active employment status will continue for up to 60 months, or at the completion of your military service (whichever is shorter).

During this period, the Company will advance on your behalf the required premiums for coverage under the Plan. If you return to work with the Company (or a Participating Employer) as an active employee, you will not be required to repay the Company for premiums paid on your behalf while out on a military leave. As an active employee, you will begin to pay benefit premiums effective with your return-to-work date at the active employee rate for all benefits elected. Premiums will be based on your elections for the current Plan year, and your eligibility is subject to meeting all regular enrollment requirements as described above.

If you do not return to employment with the Company (or a Participating Employer) within a 60-month period or at the completion of your military service (whichever is shorter), your employment and benefit eligibility will be terminated. You will not be required to repay the Company for premiums paid while out on military leave. You may be entitled to purchase COBRA continuation. Refer to the "**Your Legal Right to Continue Coverage under COBRA**" section below for information about COBRA continuation coverage.

HIPAA Privacy

As a participant in the Plan, your "protected health information" is subject to safeguard under the privacy provisions of the Health Insurance Portability and Accountability Act ("HIPAA"). As a Benefit Program participant, you will receive or have received a "privacy notice" that describes the important uses and disclosures of protected health information and your rights under HIPAA. If you need a copy of this notice, you should contact your Insurer or the Plan Administrator.

Children's Health Insurance Program Notice

If you or your children are eligible for Medicaid or the Children's Health Insurance Program ("CHIP") but are unable to afford the premiums, your state may have a premium assistance program that can help pay for coverage. These states use funds from their Medicaid or CHIP programs to help people who are eligible for these programs but who also have access to health insurance through their employer. If you or your children are NOT eligible for Medicaid or CHIP, you will not be eligible for these premium assistance programs.

If you or your dependents are already enrolled in Medicaid or CHIP, or if you think you might be eligible for Medicaid or CHIP, you can contact your state Medicaid or CHIP office or dial 1-877-KIDS-NOW (543-7669), or go to www.insurekidsnow.gov to find out if premium assistance is available. If you qualify, you can ask the state if it has a program that might help you pay the premiums for an employer-sponsored plan. Once it is determined that you or your dependents are eligible for premium assistance under Medicaid or CHIP, your employer's health plan is required to permit you and your dependents to enroll in the plan—as long as you and your dependents are eligible, but not already enrolled in the employer's plan. This is called a "special enrollment" opportunity, and you must request coverage within 60 days of being determined eligible for premium assistance.

Mental Health Parity and Addiction Equity Act

The Plan, to the extent its Benefit Programs provide mental health or substance use disorder ("MH/SUD") benefits, may not, under federal law, impose less favorable benefit limitations on those MH/SUD benefits than on medical/surgical benefits, as required under the Mental Health Parity and Addiction Equity Act of 2008, as amended ("MHPAEA").

Continuation of Coverage During an Approved Leave

For any Company approved leave of absence, paid or unpaid, you may continue the same benefits that you were receiving immediately before the start of your leave, if permitted under the applicable insurance policies and appropriate payment arrangements are made for unpaid leaves. If your leave qualifies under the Family and Medical Leave Act of 1993, as amended ("FMLA"), you will be entitled to receive the same Medical, Vision and Dental Benefit Program benefits that you were receiving immediately before the start of your FMLA leave. The Company also intends to allow you to continue to receive all other Plan benefits during your FMLA leave, to the extent possible. For a leave of absence that does not qualify for the FMLA, you may continue to participate in the Benefit Programs you elected, if permitted in the applicable Certificate or Booklet, provided you make the appropriate benefit contributions.

- If you do not wish to receive some or all of the coverage during your leave that you were receiving just prior to your leave, you must follow the instructions in the "Changing your Coverage Elections" section within 30 days of your leave begin date. Upon return from your leave, you will be allowed an opportunity to re-elect any benefits within 30 days of your return to work date.
- If you wish to continue your participation in the Plan, you will be required to pay your contributions in accordance with the instructions provided when your leave begins. Generally, you are required to pay your premium contributions via Direct Bill during your leave. You may call COBRA and Billing Services at 1-833-874-1600 for more information. Your eligibility to continue any coverage that requires payments from you may be cancelled if you do not make the required payments in a timely fashion.
- To the extent applicable, if the Company advances money by making contributions for you during your leave, in whole or in part, it can recoup the amounts advanced to you upon the end of your leave, whether or not you return to employment following your leave. If you return to employment following your leave, the Company may recoup those amounts through payroll deductions. If you do not return from a leave of absence, you are responsible for reimbursing the Company for the entire cost to the Company (*i.e.*, the Company's contribution) for providing any benefits under this Plan during your leave, unless the leave was an FMLA qualified leave of absence, and you do not return due to the continuation of a serious health condition or circumstances beyond your control.
- If you receive insufficient pay to cover premium deductions during your leave or, to the extent Direct Bill is not utilized by the Plan Administrator, your deductions for your premiums will go into arrears. Your premiums will be repaid when you return to employment by doubling up your deduction amounts, in other words, you will pay one current and one arrears premium payment per pay period, until the balance is paid in full.

If you are on an approved disability leave from the Company, you may continue the same benefits that you were receiving immediately before the start of your leave if permitted by the applicable Certificate or Booklet.

If you are on an approved personal leave from the Company, your Long Term Disability coverage ends after 10 consecutive weeks of an approved leave of absence.

Continuation of Coverage During a Temporary Layoff

For any Company initiated temporary layoff, you may continue the same benefits that you were receiving immediately before the start of your temporary layoff, if permitted under the applicable insurance policies and appropriate payment arrangements are made for unpaid leaves.

- If you wish to continue your participation in the Plan, you will be required to pay your contributions in accordance with the instructions provided when your layoff begins with the exception of your medical contributions. The Company will cover your share of your medical contributions while on temporary layoff. Your eligibility to continue any coverage that requires payments from you may be cancelled if you do not make the required payments in a timely fashion.
- Long Term Disability benefits end after 12 consecutive weeks of temporary layoff. Short Term Disability and all Life Insurance benefits end after 16 consecutive weeks of temporary layoff.

Your Rights and Protections Against Surprise Medical Bills

When you get emergency care or are treated by an out-of-network provider at an in-network hospital or ambulatory surgical center, you are protected from balance billing. In these cases, you shouldn't be charged more than your plan's copayments, coinsurance and/or deductible.

What is "balance billing" (sometimes called "surprise billing")?
When you see a doctor or other health care provider, you may owe certain out-of-pocket costs, like a copayment, coinsurance, or deductible. You may have additional costs or have to pay the entire bill if you see a provider or visit a health care facility that isn't in your health plan's network.

"Out-of-network" means providers and facilities that haven't signed a contract with your health plan to provide services. Out-of-network providers may be allowed to bill you for the difference between what your plan pays and the full amount charged for a service. This is called "balance billing." This amount is likely more than in-network costs for the same service and might not count toward your plan's deductible or annual out-of-pocket limit.

"Surprise billing" is an unexpected balance bill. This can happen when you can't control who is involved in your care—like when you have an emergency or when you schedule a visit at an in-network facility but are unexpectedly treated by an out-of-network provider. Surprise medical bills could cost thousands of dollars depending on the procedure or service.

You're protected from balance billing for:

Emergency services
If you have an emergency medical condition and get emergency services from an out-of-network provider or facility, the most they can bill you is your plan's in-network cost-sharing amount (such as copayments, coinsurance, and deductibles). You can't be balance billed for these emergency services. This includes services you may get after you're in stable condition, unless you give written consent and give up your protections not to be balanced billed for these post-stabilization services.

Certain services at an in-network hospital or ambulatory surgical center
When you get services from an in-network hospital or ambulatory surgical center, certain providers there may be out-of-network. In these cases, the most those providers can bill you is your plan's in-network cost-sharing amount. This applies to emergency medicine, anesthesia, pathology, radiology, laboratory, neonatology, assistant surgeon, hospitalist, or intensivist services. These providers can't balance bill you and may not ask you to give up your protections not to be balance billed.

If you get other types of services at these in-network facilities, out-of-network providers can't balance bill you, unless you give written consent and give up your protections.

You're never required to give up your protections from balance billing. You also aren't required to get out-of-network care. You can choose a provider or facility in your plan's network.

When balance billing isn't allowed, you also have these protections:

- You're only responsible for paying your share of the cost (like the copayments, coinsurance, and deductible that you would pay if the provider or facility was in-network). Your health plan will pay any additional costs to out-of-network providers and facilities directly.
- Generally, your health plan must:
    - Cover emergency services without requiring you to get approval for services in advance (also known as "prior authorization").
    - Cover emergency services by out-of-network providers.

- Base what you owe the provider or facility (cost-sharing) on what it would pay an in-network provider or facility and show that amount in your explanation of benefits.
- Count any amount you pay for emergency services or out-of-network services toward your in-network deductible and out-of-pocket limit.

If you think you've been wrongly billed, contact the No Surprises Help Desk at 1-800-985-3059 to submit your question or a compliant. Visit www.cms.gov/nosurprises/consumers for more information about your rights under federal law.

Continuity of Care Upon the Expiration of Provider Network Contract

To the extent required by the Consolidated Appropriations Act, each applicable Benefit Program (e.g., the Medical Program) will provide continued transitional care to a "continuing care patient" within the meaning of, and subject to the requirements of, the Consolidated Appropriations Act (e.g., via Section 718 of ERISA and/or Section 9818 of the Code, as applicable) and the rules of the Plan.

Compliance with All Other Applicable Federal Laws

The Plan is intended to be interpreted and administered in accordance with all other applicable federal laws and requirements, including, without limitation, the requirements under the Patient Protection and Affordable Care Act, as amended ("Affordable Care Act"), MHPAEA, and the Consolidated Appropriations Act.

Filing a Claim for Benefits Under the Plan

Even though it does not happen often, occasionally disagreements about benefit eligibility or amounts arise. In most cases, they are resolved quickly. However, if you are unable to resolve the disagreement, formal appeals processes are in place to help you (or your authorized representative acting on your behalf) file a claim and appeal a denied claim.

In this section you will find the time frames for responding to initial claims, as well as the appeals process. The timeframes for responding to claims depend on the type of claim (eligibility claim or claim for benefits, described below).

To the extent that the Plan Administrator properly delegates its claims authority to a Claims Administrator, the Claims Administrator may apply alternative timeframes than those set forth below, as described in the applicable Certificate or Booklet. To the extent that an Insurer (or other Claims Administrator) administers claims under a Benefit Program, the claims procedure pertaining to such benefits may provide for review of and decision upon denied claims by such company. Insurers will determine claims related to eligibility only to the extent eligibility depends on an insurance requirement, such as evidence of insurability.

The Claims Administrators for the various benefits provided by the Plan are listed in the "**Administrative Information**" section. The Claims Administrators do not guarantee the payment of benefits under the Plan. You may obtain claim forms for the Benefit Programs offered under the Plan by contacting the applicable Claims Administrator.

Unless an applicable Certificate or Booklet provides a different timeframe, all claims must be submitted within one year after the date the claim accrues. The Plan Administrator or Claims Administrator, as applicable, will process a claim promptly after it receives complete written proof of the claim.

Claims for Insured Benefits

Certain benefits under the Plan are fully insured. The benefits provided by the Company through insurance contracts, and the insurers, are listed in the "**Administrative Information**" section under "**Claims Administrators**." Claims for benefits under these insured programs are submitted to the insurance companies and you must follow that insurer's claims procedures. The insurance companies are responsible for determining and paying claims. The insurer has the right to secure independent medical advice and to require such other evidence as it deems necessary in order to decide your claim. If the insurer denies your claim in whole or in part, you will receive a written notification setting forth the reason(s) for the denial.

If your claim is denied, you may appeal to the insurer for a review of the denied claim. The insurer will decide your appeal in accordance with its claims procedures, as required by ERISA (if ERISA applies) and other applicable law. If you do not appeal on time, you may lose your right to file suit in a state or federal court, because you will not have exhausted your internal administrative appeal rights (which generally is a prerequisite to bringing suit in state or federal court).

Note that state insurance laws may provide additional protection to claimants under insured arrangements. For more information about the claims procedure pertaining to insured arrangements, see the applicable Certificate.

Eligibility or Enrollment Claims Process

These procedures apply to claims for eligibility for coverage under a Benefit Program or enrollment in a Benefit Program under the Plan, to the extent those determinations have not been delegated to a Claims Administrator. For example, you may want to enroll your dependent for coverage or change previously elected coverage options during the year, but you did not experience a mid-year event. A claim regarding your eligibility may overlap with a claim for benefits (described below). That is, you may be denied a benefit because you are shown as not eligible to participate in the coverage that denied your benefit.

Filing a Claim

If you believe that you or your dependent is eligible for coverage under the Plan, you may file a claim in writing with the Plan Administrator or its delegate at the following address (please include your full name, employee ID and details regarding your claim for eligibility):

LSC Benefits Center
LSC Communications
Attention: Benefits Plan Administrator
4101 Winfield Rd
Warrenville, IL 60555

Initial Claim Decision

When an eligibility or enrollment claim is received, the Plan Administrator or its delegate must notify you of its benefit determination within 90 days of the receipt of the claim. An extension of 90 days will be allowed for processing the claim if special circumstances are involved. You will be given notice of any such extension. The notice will state the special circumstances involved and the date a decision is expected.

The Plan Administrator or its delegate will send you a written notice of an adverse benefit determination. A denial of a claim will include:

- The reason(s) for the denial;
- References to the specific Plan provisions on which the decision was based;
- A description of any additional material or information you should supply in support of your claim and an explanation of why it is necessary, if any;
- A description of the Plan's appeal procedures and the time limits applicable to the appeal process; and
- A statement of your right to bring a civil action under Section 502(a) of ERISA following an adverse benefit determination on appeal.

Appealing an Eligibility or Enrollment Claim Denial

If you (or your duly authorized representative) believe that a denial is incorrect, you may request a full review by the Plan Administrator or its delegate (at the address above) within 60 days after your receipt of the denial of your claim. In connection with your appeal, you or your representative may submit written comments, documents, records and other information relating to the claim. You also have the right to request copies of all relevant documents (free of charge).

The Plan Administrator or its delegate will furnish you with a written decision providing the final determination of the appeal. The decision of the Plan Administrator or its delegate on appeal usually will be made within 60 days after receiving your appeal, unless special circumstances require an extension of an additional 60 days. If the period is extended, the Plan Administrator

or its delegate will notify you in writing of the extension within 60 days of receiving your appeal. The decision of the Plan Administrator or its delegate on review will be final and binding on you, your dependents and any other interested party. Your appeal notice will include:

- The specific reason or reasons for the appeal decision;
- Reference to the specific Plan provisions on which the determination is based;
- A statement that you have the right to request access to and copies of all relevant Plan documents free of charge; and
- A statement that you have the right to bring a civil action under Section 502(a) of ERISA following an adverse benefit determination on appeal.

Procedures Regarding Adverse Medical Benefit Determinations

These procedures apply to the Plan's Medical, Dental, Vision and Wellness Program Benefit Programs, which are all referred to as "medical benefit" claims in this Section.

How Claims for Benefits Are Processed

How a claim for benefits is processed depends on the type of claim it is. There are several categories of claims:

- *Concurrent Care Claim* – A concurrent care claim is a claim for an extension of the duration or number of treatments provided through a previously-approved benefit claim. When possible, this type of claim should be filed at least 24 hours before the expiration of the course of treatment for which an extension is being sought.
- *Pre-Service Claim* – A Pre-Service Claim is a claim for a benefit with respect to which the terms of medical coverage require approval of the benefit in advance of obtaining medical care.
- *Post-Service Claim* – A Post-Service Claim is a claim for a benefit that is not a Pre-Service Claim. Most claims are Post-Service Claims.
- *Urgent Care Claim* – An Urgent Care Claim is any Pre-Service Claim for medical care or treatment with respect to which the failure to process the claim immediately could seriously jeopardize the life or health of you or your Dependent or subject you or your Dependent to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim. This type of claim generally includes those situations commonly treated as emergencies.

Submitting a Benefit Claim

You must report claims to the address appearing in "**Administrative Information**" section promptly but no later than one year after the date of the service. If you do not provide this information to us within the shorter of: (i) one year after the payment of the benefit or receipt of a notice of non-payment or (ii) two years of the date of service, benefits for that medical service will be denied or reduced, at the Claims Administrator's discretion. This time limit does not apply if you are legally incapacitated.

Required Information

When you request payment of benefits, you may be required to provide all of the following information:

- Employee's name and address.
- The patient's name, age and relationship to the employee.

- The member number stated on your ID card.
- An itemized bill from your provider that includes the following:

    - Patient diagnosis;
    - Date(s) of service;
    - Procedure code(s) and descriptions of service(s) rendered;
    - Charge for each service rendered;
    - Provider of service name, address and Tax Identification Number;
    - The date the injury or sickness began; and
    - A statement indicating either that you are, or you are not, enrolled for coverage under any other health insurance plan or program. If you re-enrolled for other coverage you must include the name of the other carrier(s).

Submit your claims to the address "**Administrative Information**" section.

Medical Benefit Determinations

The Claims Administrator will make a benefit determination as set forth below. Benefits will be paid to you unless either of the following is true:

- The provider notifies the Claims Administrator that your signature is on file, assigning benefits directly to that provider (assuming the Plan Administrator, in its sole discretion, chooses to recognize the assignment).
- You make a written request for the out-of-network provider to be paid directly at the time you submit your claim.

Pre-Service Urgent Care

Urgent Care Claims are those for medical care or treatment with respect to which the failure to process the claim immediately could seriously jeopardize: (i) the life or health of you or your dependent; (ii) the ability of your or your dependent to regain maximum function; or (iii) subject you or your dependent to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim.

This type of claim generally includes those situations commonly treated as emergencies. In these situations:

- You will receive notice of the benefit determination in writing or electronically within 72-hours after the Claims Administrator receives all necessary information, taking into account the seriousness of your condition.
- Notice of denial may be oral with a written or electronic confirmation to follow within 3 days.

If you filed an urgent claim improperly, the Claims Administrator will notify you of the improper filing and how to correct it within 24 hours after the urgent claim was received. If additional information is needed to process the claim, the Claims Administrator will notify you of the information needed within 24 hours after the claim was received. You then have 48 hours to provide the requested information.

You will be notified of a determination no later than 48 hours after:

- The Claims Administrator's receipt of the requested information; or

- The end of the 48-hour period within which you were to provide the additional information, if the information is not received within that time.

A denial notice will set forth the specific reason or reasons for the denial, refer to specific Plan provisions on which the denial is based, contain a description of any information necessary for the claim to be granted (if applicable) an explanation of why such information is necessary. This letter will also describe the process for filing a formal appeal and the time limits for filing an appeal, including your right to bring a civil action following an adverse determination upon appeal. If the denial is based on medical necessity or experimental treatment, the denial notice will contain information on the scientific or clinical judgment for the denial, applying the terms of the Plan to your medical circumstances. The denial notice will also contain information about the internal rule, guideline or protocol that was relied on, if applicable.

Concurrent Care Claims

If an on-going course of treatment was previously approved for a specific period of time or number of treatments, and your request to extend the treatment is an Urgent Care Claim as defined above, your request will be decided within 24 hours, provided your request is made at least 24 hours prior to the end of the approved treatment.

If your request for extended treatment is not made at least 24 hours prior to the end of the approved treatment, the request will be treated as an Urgent Care Claim and decided according to the timeframes described above. If an on-going course of treatment was previously approved for a specific period of time or number of treatments, and you request to extend treatment in a non-urgent circumstance, your request will be considered a new claim and decided according to post service or pre-service timeframes, whichever applies.

Pre-Service Claims

Pre-service claims are those claims that require certification or approval prior to receiving medical care. If your claim was a pre-service claim, and was submitted properly with all needed information, you will receive written notice of the claim decision from the Claims Administrator within 15 days of receipt of the claim. If you filed a pre-service claim improperly, the Claims Administrator will notify you of the improper filing and how to correct it within 5 days after the pre-service claim was received. If additional information is needed to process the pre-service claim, the Claims Administrator will notify you of the information needed within 15 days after the claim was received, and may request a one-time extension not longer than 15 days and pend your claim until all information is received. Once notified of the extension you then have 45 days to provide this information. If all of the needed information is received within the 45-day timeframe, the Claims Administrator will notify you of the determination within 15 days after the information is received. If you don't provide the needed information within the 45-day period, your claim will be denied.

A denial notice will set forth the specific reason or reasons for the denial, refer to the specific Plan provisions on which the denial is based, contain a description of any information necessary for the claim to be granted and an explanation of why such information is necessary, and describe the process and time limits for filing a formal appeal including your rights to bring a civil action following an adverse determination upon appeal. If the denial is based on the medical necessity or experimental treatment, the denial notice will contain information on the scientific or clinical judgment for the denial, applying the terms of the Plan to your medical circumstances. The denial notice will also contain information about the internal rule, guideline or protocol that was relied on, if applicable.

Post-Service Claims

Post-Service Claims are those claims that are filed for payment of benefits after medical care has been received. If your post-service claim is denied, you will receive written notice from the Claims Administrator within 30 days of receipt of the claim, as long as all needed information was provided with the claim. The Claims Administrator will notify you within this 30-day period if additional information needed to process the claim, and may request a one-time extension not longer than 15 days and pend your claim until all information is received.

Once notified of the extension you then have 45 days to provide this information. If all of the needed information is received within the 45-day timeframe and the claim is denied, the Claims Administrator will notify you of the denial within 15 days after the information is received. If you don't provide the needed information within the 45-day period, your claim will be denied.

A denial notice will set forth the specific reason or reasons for the denial, refer to the specific Plan provisions on which the denial is based, contain a description of any information necessary for the claim to be granted and an explanation of why such information is necessary, and describe the process and time limits for filing a formal appeal including your right to bring a civil action following an adverse determination upon appeal. If the denial is based on the medical necessity or experimental treatment, the denial notice will contain information on the scientific or clinical judgment for the denial, applying the terms of the Plan to your medical circumstances. The denial notice will also contain information about the internal rule, guideline or protocol that was relied on, if applicable.

Medical Benefit Appeals

If your question or concern is about a benefit determination you may informally contact the appropriate Claims Administrator before requesting a formal appeal. If the customer service representative cannot resolve the issue to your satisfaction over the phone, you may submit your question in writing. However, if you are not satisfied with a benefit determination as described in "**Submitting a Claim**" section, you may appeal it as described below, without first informally contacting Customer Service. If you first informally contact customer service and later wish to request a formal appeal in writing, you should contact customer service and request an appeal. If you request a formal appeal, a customer service representative will provide you with the appropriate address of the claims administrator.

If you are appealing an Urgent Care Claim denial, please refer to the "**Urgent Claim Appeals that Require Immediate Action**" section below and contact customer service immediately.

How to Appeal a Claim Decision

If you disagree with a pre-service or post-service claim determination after following the above steps, you can contact the Claims Administrator in writing to formally request an appeal. Your request may be required to include:

- The patient's name and the identification number from the ID card.
- The date(s) of medical service(s).
- The provider's name.
- The reason you believe the claim should be paid.
- Any documentation or other written information to support your request for claim payment.

Your first appeal request must be submitted to the Claims Administrator within 180 days after you receive the claim denial.

Appeal Process
A qualified individual who was not involved in the decision being appealed will be appointed to decide the appeal. If your appeal is related to clinical matters, the review will be done in consultation with a health care professional with appropriate expertise in the field who was not involved in the prior determination. The Claims Administrator may consult with, or seek the participation of, medical experts as part of the appeal resolution process. You consent to this referral and the sharing of pertinent medical claim information. Upon written request and free of charge you have the right to reasonable access to and copies of, all documents, records, and other information relevant to your claim for benefits.

Appeals Determinations
You will be provided notification of decision on your appeal as follows:

- For appeals of pre-service claims, the first level appeal will be conducted and you will be notified by the Claims Administrator of the decision within 30 days from the receipt of a request for appeal of a denied claim.
- For appeals of post-service claims, you will be notified by the Claims Administrator of the decision within 60 days from receipt of a request for appeal of a denied claim.
- For procedures associated with urgent claims, see "**Urgent Claim Appeals that Require Immediate Action**" below.

Notice of Decision on Appeal
If your appeal is denied, you will receive a notice explaining the following: the reason for the denial, specific references to the part of the Plan on which the denial is based, a statement that you are entitled by law to receive, upon request and free of charge, access to and copies of all documents, records and other information relevant to the benefit claim, a statement regarding any voluntary appeal procedures offered by the Plan and your right to bring a civil action after an adverse determination on appeal, information about the internal rule, guideline or protocol that was relied on, if applicable, information on the scientific or clinical judgment for the determination if the adverse decision is based on medical necessity or experimental treatment, and a description of the external review process, including how to initiate an external review and the time limits that apply.

Please note that the Claims Administrators' decision is based only on whether or not benefits are available under the Plan for the proposed treatment or procedure. The determination as to whether the pending health service is necessary or appropriate is between you and your physician.

Urgent Claim Appeals That Require Immediate Action
Your appeal may require immediate action if a delay in treatment could significantly increase the risk to your health or the ability to regain maximum function or cause severe pain. In these urgent situations:

- The appeal does not need to be submitted in writing. You or your physician should call the Claims Administrator as soon as possible. The Claims Administrator will provide you with a written or electronic determination within 72 hours following receipt by the Claims Administrator of your request for review of the determination taking into account the seriousness of your condition.

External Review Process

For purposes of any Benefit Program considered a "group health plan," if your claim involving medical judgment, experimental or investigational services or an unproven service, a rescission of coverage, or consideration of whether the Plan is complying with the surprise billing and cost-sharing protections of the No Surprises Act, or otherwise required by applicable law is denied by the Plan, you can request an external review. In the case of an urgent care claim, you can file a request for an expedited external review at the same time you file an internal appeal.

You must file your request for an external review with the Claims Administrator within four months after the date you received the final internal appeal denial.

Preliminary Review

Within five business days of receipt of your request, the Claims Administrator will complete a preliminary review to determine that:

- You were covered by the Plan at the time the service was requested or provided;
- The adverse claim determination was not related to your failure to meet the plan's eligibility requirements;
- You had exhausted the plan's internal appeals process, if required under law; and
- You had provided all of the necessary information and forms to process an external review.

Within one business day after completing the preliminary review, the Claims Administrator will contact you in writing. If your request was complete but not eligible for an external review, the notice will tell you why and provide you with the contact information for the Employee Benefits Security Administration. If your request is incomplete, the notice will describe what information is needed to perfect your review request. You have 48 hours from receipt of this notice, or up to the original four-month external appeal filing deadline, to provide the requested information.

Referral to Independent Review Organization

If your claim qualified, the Claims Administrator will assign your review request to an accredited Independent Review Organization ("IRO") that will conduct the external review. The Claims Administrator will provide the IRO with the documents and any information considered in previously denying your claim.

The IRO will notify you in writing of your eligibility and acceptance for external review. The notice will inform you of your right to submit additional information for review in writing to the IRO within 10 business days following receipt of the notice.

Within one business day of receiving any additional information from you, the IRO will forward that information to the Claims Administrator. The Claims Administrator may then reconsider its benefits denial. If the Claims Administrator decides to reverse its previous denial, the external review will be terminated, and you will receive a written notice of the Claims Administrator's decision within one business day.

The IRO will review your claim without regard to any previous decision or conclusions reached during the internal claims and appeals processes. You will receive written notice of the IRO's decision within 45 days after the IRO received your review request.

If the IRO reverses the Plan's adverse benefit decision, your claim will be immediately paid or coverage must be immediately provided (whichever applies to your claim).

The written decision of the IRO will include the following:

- A general description of the reason for the external review request, including information sufficient to identify the claim (including the date or dates of service, the health care provider, the claim amount (if applicable), notice regarding the availability of the diagnosis code and its corresponding meaning and/or the treatment code and its corresponding meaning, and the reason for the previous denial);
- The date the IRO received the assignment to conduct the external review and the date of the IRO decision;
- References to the evidence or documentation, including the specific coverage provisions and evidence-based standards, considered in reaching its decision;
- A discussion of the principal reason or reasons for its decision, including the rationale for its decision and any evidence-based standards that were relied on in making its decision;
- A statement that the determination is binding except to the extent that other remedies may be available under state or federal law to either the Claims Administrator and you;
- A statement that judicial review may be available to you; and
- Current contact information, including phone number, for any applicable office of health insurance consumer assistance or ombudsman.

For urgent care claims and appeals, there is an expedited external appeal process. In such a case, the Claims Administrator will immediately determine if the claim is eligible for an external review and provide all documents and information to the IRO electronically or by phone or fax to expedite the process. The IRO will make a decision on your claim within 72 hours of receiving it.

The decision of the IRO is binding upon all parties, however you still have the right to bring an action under Section 502(a) of ERISA.

Flexible Spending Account Claims

Appeal a Health Care FSA Claim Decision

If you or any person claiming through you, wishes to have a denied claim reviewed, a written request must be sent to the person and address identified on the notice of claim denial letter for the receipt of requests for review of denied claims within 180 days from the date the claimant received the notice of denial of the claim or within 180 days from the date the claim was deemed denied.

- You may contact the Claims Administrator in an attempt to resolve the complaint in an informal manner.
- If you are not satisfied with any attempts at informal resolution, you must submit a written request for review of a denied claim or a written notice of the complaint or dispute to the Claims Administrator's address in accordance with the time frames set out above. You may submit supporting documentation or information to be considered. You must submit any requested additional information or documents.
- A written notice of the final decision will usually be sent to you within 60 days of receipt of the written request for review of a denied claim or notice of a complaint or dispute.

If a claim for benefits is denied in whole or in part, you or your authorized representative will be given a written notice of the denial, which will include:

- The specific reason(s) for the adverse determination;
- The specific plan provisions on which the determination was based;
- A statement that you are entitled to receive, upon request and free of charge, reasonable access to, and make copies of, all records, documents and other information relevant to the claim;
- A statement that you have the right to obtain, upon request and free of charge, a copy of the internal rules or guidelines relied upon in making the determination;
- A statement describing any voluntary appeal procedures offered under the plan and your right to bring a civil action under Section 502(a) of ERISA following the denial of your appeal;
- A statement that if your claim was denied based on a medical necessity or experimental treatment exclusion, you have a right to obtain, free of charge, an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to your medical condition; and
- The following statement: "You and your plan may have other voluntary alternative dispute resolution options such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor office and your state insurance regulatory agency."

Appeal a Dependent Care FSA Claim Decision

If you or any person claiming through you, wishes to have a denied claim reviewed, a written request must be sent to the person and address identified on the notice of claim denial letter for the receipt of requests for review of denied claims within 60 days from the date the claimant received the notice of denial of the claim or within 60 days from the date the claim was deemed denied.

- You may contact the Claims Administrator in an attempt to resolve the complaint in an informal manner.
- If you are not satisfied with any attempts at informal resolution, you must submit a written request for review of a denied claim or a written notice of the complaint or dispute to the Claims Administrator's address in accordance with the time frames set out above. You may submit supporting documentation or information to be considered. You must submit any requested additional information or documents.
- A written notice of the final decision will usually be sent to you within 60 days of receipt of the written request for review of a denied claim or notice of a complaint or dispute. However, if special circumstances require an extension of time to reach a final decision, written notice of the final decision will be sent as soon as possible following the expiration of the initial 60-day period, but no later than 120 days following receipt of the request for review of a denied claim or notice of a complaint or dispute. If special circumstances require such an extension of time, written notice of the extension shall be furnished to you prior to the expiration of the initial 60-day period. The written notice of the final decision will give specific reason(s) for the decision and references to the provision(s) of the plan on which the decision is based. If the final written decision is not furnished to you within 60 days (or if an extension was required, 120 days) from the date of receipt of the request for review of a denied claim or notice of a complaint or dispute, the request for review or the complaint or dispute shall be deemed to be rejected and denied on review.

If a claim for benefits is denied in whole or in part, you or your authorized representative will be given a written notice of the denial, which will include:

- The specific reason(s) for the adverse determination;
- The specific plan provisions on which the determination was based;
- A statement that you are entitled to receive, upon request and free of charge, reasonable access to, and make copies of, all records, documents and other information relevant to the claim;
- A statement describing any voluntary appeal procedures offered under the plan and your right to bring a civil action under Section 502(a) of ERISA following the denial of your appeal; and
- The following statement: "You and your plan may have other voluntary alternative dispute resolution options such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor office and your state insurance regulatory agency."

Disability Benefit Claims

Filing a Claim

If you or any person claiming through you, wishes to have a denied claim reviewed, a written request must be sent to the person and address identified on the notice of claim denial letter for the receipt of requests for review of denied claims.

- You may contact the Claims Administrator in an attempt to resolve the complaint in an informal manner.
- If you are not satisfied with any attempts at informal resolution, you must submit a written request for review of a claim or a written notice of the complaint or dispute to the Claims Administrator's address. You may submit supporting documentation or information to be considered. You must submit any requested additional information or documents.
- A written notice of the decision on appeal will usually be sent to you within 45 days of receipt of the written request for review of a denied claim or notice of a complaint or dispute. However, if special circumstances require an extension of 30 days to reach a decision. If, before the end of the first 30-day extension period, the Claims Administrator determines that, due to matters beyond the control of the Plan, a decision cannot be rendered within that extension period, the period for making the determination may be extended for up to an additional 30 days, provided the Claims Administrator notifies you before the expiration of the first 30-day extension period of the circumstances requiring the additional extension and the date as of which the Plan expects to render a decision. The written notice of the decision on appeal will give specific reason(s) for the decision and references to the provision(s) of the Plan on which the decision is based. If the written decision on appeal is not furnished to you within the time period from the date of receipt of the request for review of a denied claim or notice of a complaint or dispute, the request for review or the complaint or dispute shall be deemed to be rejected and denied on review.
- If you have filed an STD benefit claim and you are not satisfied with the decision on appeal, you have the right to request a second level appeal from the Claims Administrator. Your second level appeal request should be submitted to the Claims Administrator in writing within 60 days from receipt of the first level appeal decision.

If a claim for benefits is denied in whole or in part, you or your authorized representative will be given a written notice of the denial.

Appeal a Disability Claim Decision

If you think that a payment calculation or denial is wrong, you may request a full review by the Claims Administrator within 180 days after you receive the notice. In connection with your appeal, you or your representative have the right to request and receive reasonable access to and copies of relevant documents, records and other information free of charge. You will also be provided with any new or additional evidence considered, relied upon, or generated by the Plan in connection with your claim, or any new or additional rationale for denying the claim as soon as possible and sufficiently in advance of the date the decision is due in order to give you a reasonable opportunity to respond prior to the decision due date. If you want to appeal a decision on disability benefits, send your appeal to the Claims Administrator.

The Claims Administrator will review your appeal. Someone other than the person who made the first decision on your claim must make this review. The Claims Administrator must disclose the identity of medical or vocational experts whom it consults in connection with your claim. If the benefit determination is based on a medical judgment, the Claims Administrator must consult with a health care professional who has the appropriate training and experience in the field of medicine involved. After the Claims Administrator makes a decision concerning your appeal, it will notify you of its findings and decision in writing within 45 days (unless special circumstances require an extension not to exceed an additional 45 days) after it receives your appeal. If you do not properly submit all the necessary information for your request for benefits, the Claims Administrator will notify you and tell you what information is missing. While the Claims Administrator is waiting on your additional information, that time period does not count towards the time frame in which the Claims Administrator must decide your claim.

The notice given to you concerning the Claims Administrator's decision on either your initial claim or your appeal (except as noted) will include:

- The specific reason or reasons for the decision;
- The specific Plan provisions upon which the benefit decision is based;
- For an initial claim, a description of any additional material or information that is necessary for you to complete your claim and an explanation of why such material or information is necessary;
- If an internal rule, guideline, protocol or similar criterion was relied on in making the decision, either a copy of that document, or a statement that such a document was relied upon and that a copy will be furnished (free of charge) upon request;
- If the decision is based on a medical limit (for example, a decision concerning whether your disability is mental or physical), either an explanation of the scientific or clinical judgment for the decision (applying the Plan's terms to your medical circumstances), or a statement that such an explanation will be provided free of charge upon request;
- For an initial claim, a description of the appeal procedures;
- A statement that you are entitled to receive, upon request and free of charge, reasonable access to, and copies of all documents, records or other information relevant to your claim;
- A discussion of the decision including an explanation of the basis for disagreeing with or not following (i) the views presented to the Plan of health care professionals treating the claimant and vocational professionals who evaluated the claimant; (ii) the views of the medical or vocational experts whose advice was obtained on behalf of the Plan, without regard to whether the advice was relied upon in making the benefit determination; and (iii) a Social Security Administration disability determination presented by the claimant to the Plan

- In the case of a denial on appeal, a statement of your right to bring a civil action under ERISA following a denial of the claim upon review and a description of any applicable Plan-imposed limitations period, including the calendar date when the limitations period will expire.
- A statement describing any additional voluntary appeal procedures and your right to bring a civil action under ERISA following a denial of the claim upon review.
- The following statement: "You and your plan may have other voluntary alternative dispute options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor office and your State insurance regulatory agency."

All Other Benefit Claims

Initial Claim

- You may contact the Claims Administrator in an attempt to resolve the complaint in an informal manner.
- If you are not satisfied with any attempts at informal resolution, you must submit a written request for review of a claim or a written notice of the complaint or dispute to the Claims Administrator's address. You may submit supporting documentation or information to be considered. You must submit any requested additional information or documents.
- A written notice of the final decision will usually be sent to you within 90 days of receipt of the written request for review of a claim or notice of a complaint or dispute. An extension of 90 days will be allowed for processing the claim if necessary due to matters beyond the Plan's control and you are notified of the extension before the expiration of the initial 90-day period.

Filing an Appeal

If you think that a payment calculation or denial is incorrect, you may request a full review by the appropriate Claims Administrator within 60 days after you received the notice. In connection with your appeal, you or your representative can review relevant documents and submit issues and comments in writing. If you want to appeal a decision, send your appeal to the appropriate Claims Administrator.

The appropriate Claims Administrator will review all disputed claims. It will notify you of its findings and decision in writing within 60 days (unless special circumstances require an extension not to exceed an additional 60 days) after it receives the appeal. The notice given to you concerning the Claims Administrator's decision on either your initial claim or your appeal (except as noted) will include:

- The specific reason or reasons for the decision;
- The specific Plan provisions upon which the benefit decision is based;
- For an initial claim, a description of any additional material or information that is necessary for you to complete your claim and an explanation of why such material or information is necessary;
- For an initial claim, a description of the appeal procedures;
- A statement that you are entitled to receive, upon request and free of charge, reasonable access to, and copies of all documents, records or other information relevant to your claim; and
- The following statement: "You and your plan may have other voluntary alternative dispute options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor office and your State insurance regulatory agency.

Exhaustion of Administrative Remedies

In no event can you (or any other person) challenge a decision in court until this claims procedure has been complied with and exhausted. If you have complied with and exhausted the appropriate claims procedures and intend to exercise your right to bring civil action under ERISA Section 502(a), you must bring civil action under Section 502(a) of ERISA within one year after the denial of your final claim decision on appeal (or voluntary appeal, if offered and a voluntary appeal was filed), whichever comes first, or if shorter, the date specified in the Benefit Program. Any other claim or action (such as a claim or action relating to an alleged interference or violation of ERISA-protected rights) must be brought within two years of the date you have actual or constructive knowledge of the acts or failures to act that are alleged to give rise to the claim or action. If you do not bring an action within such two-year (or shorter) period, you are barred from bringing an action under ERISA related to the claim. All actions arising out of or relating to the Plan must be brought in the United States District Court for the Northern District of Illinois.

Your Legal Right to Continue Coverage Under COBRA

This section contains important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan with respect to benefits under the Medical (including Prescription Drug), Dental, Vision, and EAP Programs and Health Care FSA. This notice generally explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect the right to receive it.

The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 ("COBRA"). COBRA continuation coverage can become available to you when you would otherwise lose your group health coverage. It can also become available to other members of your family who are covered under the Plan when they would otherwise lose their group health coverage. Although not required by Title X of the Consolidated Omnibus Budget Reconciliation Act of 1985, the Plan will extend continuation coverage that is similar to COBRA to domestic partners in accordance with the terms of this section. For additional information about your rights and obligations under the Plan and under federal law, you should contact the COBRA Administrator.

For purposes of any Benefit Program administered by an Insurer, you may have additional continuation rights under state law. Refer to the Certificate or contact the Insurer at the address listed at the end of this Plan for more information.

What is COBRA Continuation Coverage?

COBRA continuation coverage is a continuation of Plan coverage when coverage would otherwise end because of a life event known as a "qualifying event." Specific qualifying events are listed later in this section. After a qualifying event, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." You, your spouse, and your dependent children could become qualified beneficiaries if coverage under the Plan is lost because of the qualifying event. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

If you are a Company employee, you will become a qualified beneficiary if you lose your coverage under the Plan because either one of the following qualifying events happens:

- Your hours of employment are reduced; or
- Your employment ends for any reason other than your gross misconduct.

If you are the spouse of an employee, you will become a qualified beneficiary if you lose your coverage under the Plan because any of the following qualifying events happens:

- Your spouse dies;
- Your spouse's hours of employment are reduced;
- Your spouse's employment ends for any reason other than his or her gross misconduct;
- Your spouse becomes entitled to Medicare benefits (under Part A, Part B, or both); or
- You become divorced or legally separated from your spouse.

Your dependent children will become qualified beneficiaries if they lose coverage under the Plan because any of the following qualifying events happens:

- You die;
- Your hours of employment are reduced;
- Your employment ends for any reason other than your gross misconduct;
- You become entitled to Medicare benefits (Part A, Part B, or both);
- You and your spouse divorce or legally separate; or
- The child stops being eligible for coverage under the plan as a "dependent child."

If your qualifying event is the end of employment or reduction of your hours of employment, and you became entitled to Medicare benefits less than 18 months before the qualifying event, COBRA continuation coverage for qualified beneficiaries other than you will last until 36 months after the date of the Medicare entitlement.

Enrollment in Health Insurance Marketplace

If you experience a qualifying event that would trigger a COBRA right, you also have the option of seeking coverage through the Health Insurance Marketplace. Coverage on the marketplaces would be under a different plan than your current medical plan, but you might qualify for premium tax credits that could reduce the cost of your coverage (potentially making it cheaper than COBRA). To learn more about the Health Insurance Marketplace, visit www.healthcare.gov.

When is COBRA Continuation Coverage Available?

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the COBRA Administrator has been notified that a qualifying event has occurred. When the qualifying event is the end of employment or reduction of hours of employment, death of the employee, or the employee's becoming entitled to Medicare benefits (under Part A, Part B, or both), the Company must notify the COBRA Administrator of the qualifying event.

You Must Give Notice of Some Qualifying Events

For the other qualifying events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), you must notify the COBRA Administrator within 60 days after the qualifying event occurs. *You must provide this notice in writing to the Plan at the contact address under "**COBRA Administrator Contact Information**" below.*

How is COBRA Continuation Coverage Provided?

Once the COBRA Administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered employees may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation coverage on behalf of their children.

COBRA continuation coverage is a temporary continuation of coverage. When the qualifying event is the death of the employee, the employee's becoming entitled to Medicare benefits (under Part A, Part B, or both), your divorce or legal separation, or a dependent child's losing eligibility as a dependent child, COBRA continuation coverage lasts for up to a total of 36 months. When the qualifying event is the end of employment or reduction of the employee's hours of employment, and the employee became entitled to Medicare benefits less than 18 months before

the qualifying event, COBRA continuation coverage for qualified beneficiaries other than the employee lasts until 36 months after the date of Medicare entitlement. For example, if a covered employee becomes entitled to Medicare eight (8) months before the date on which his employment terminates, COBRA continuation coverage for his spouse and children can last up to 36 months after the date of Medicare entitlement, which is equal to 28 months after the date of the qualifying event (36 months' minus eight (8) months). Otherwise, when the qualifying event is the end of employment or reduction of the employee's hours of employment, COBRA continuation coverage generally lasts for only up to a total of 18 months.

There are two ways in which this 18-month period of COBRA continuation coverage can be extended.

Disability extension of 18-month period of continuation coverage
If you or anyone in your family covered under the Plan is determined by the Social Security Administration to be disabled and you notify the COBRA Administrator in a timely fashion, you and your entire family may be entitled to receive up to an additional 11 months of COBRA continuation coverage, for a total maximum of 29 months. The disability would have to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of continuation coverage. You must make sure that the COBRA Administrator is notified of the Social Security Administration's determination within 60 days of the date of the determination and before the end of the 18-month period of COBRA continuation coverage. *You must provide this notice in writing to the Plan at the contact address under "**COBRA Administrator Contact Information**" below.*

Second qualifying event extension of 18-month period of continuation coverage
If your family experiences another qualifying event while receiving 18 months of COBRA continuation coverage, the spouse and dependent children in your family can get up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if notice of the second qualifying event is properly given to the Plan. This extension may be available to the spouse and any dependent children receiving continuation coverage if the employee or former employee dies, becomes entitled to Medicare benefits (under Part A, Part B, or both), or gets divorced or legally separated, or if the dependent child stops being eligible under the Plan as a dependent child, but only if the event would have caused the spouse or dependent child to lose coverage under the Plan had the first qualifying event not occurred. In all of these cases, you must make sure that the COBRA Administrator is notified of the second qualifying event within 60 days of the second qualifying event. *You must provide this notice in writing to the Plan at the contact address under "**COBRA Administrator Contact Information**" below.*

Termination of COBRA Continuation Coverage

Other events will cause COBRA continuation coverage to end sooner. Coverage will end short of the maximum period on the earliest of the following:

- The Company no longer provides group health plan coverage to any of its employees;
- The premium for continuation coverage is not paid on time;
- You or your dependents become entitled to Medicare;
- With respect to the disability extension, the Social Security Administration no longer considers you or your dependent to be disabled; or
- You become covered under another group health plan (provided preexisting condition exclusions or limitations under the group health care plan do not apply).

How Much Does COBRA Continuation Coverage Cost?

Generally, qualified beneficiaries may be required to pay the entire cost of continuation coverage. The amount a qualified beneficiary may be required to pay may not exceed 102% of the cost to the group health plan (including both employer and employee contributions) for coverage of a similarly situated participant or beneficiary who is not receiving continuation coverage. You will have 45 days from the date of electing continuation coverage to start paying for that coverage. The first payment must include the cost of coverage for the entire period from the date coverage was lost because of the qualifying event at least through the date of payment. Each other payment is due by the first day of the month for which continuation coverage is provided. A 30-day grace period will apply for making each month's payment.

A qualified beneficiary who is disabled may be required to pay up to 150% of the cost of his or her COBRA continuation coverage during the disability extension.

How is COBRA Administered with Respect to the Health Care FSA?

You are permitted to elect COBRA continuation coverage for the Health Care FSA upon a qualifying event, provided you have not received reimbursement for amounts that exceed the balance in your Health Care FSA as of the date the qualifying event occurs (i.e., you have not "overspent" your Health Care FSA). In this case, you would continue contributions on an after-tax basis. The COBRA rules discussed in this section are the same, except that the maximum period for which you may continue after-tax contributions to your Health Care FSA is the remainder of the benefit plan year in which the qualifying event occurs.

Electing COBRA for the Health Care FSA gives you the benefit of extending the time period for which claims for reimbursement may be incurred. Normally, to be eligible for reimbursement, a claim must be incurred while you are covered under and contributing to the Health Care FSA. If you have not incurred enough expenses at the time of your qualifying event to recover your contributions to the Health Care FSA, then you should consider electing COBRA in order to extend the coverage period long enough to incur claims that would allow for full reimbursement of the pre-tax dollars (plus the new after-tax COBRA dollars) credited to your Health Care FSA as of the qualifying event, but not past the end of the benefit plan year. For this reason, COBRA is available to you only if the amount you could be reimbursed exceeds the amount you would have to pay into the account on an after-tax basis.

A Special Note About COBRA Continuation Coverage and Medicare

Please note, former employees who are Medicare-eligible at the time COBRA continuation coverage is elected have coverage under the Plan as their secondary coverage to Medicare.

The Plan presumes that you will enroll in Medicare Parts A and B once you separate employment. This means the Plan will not pay expenses for which Medicare would be primarily responsible under federal law, regardless of whether you have actually enrolled in Medicare. If you do not enroll in Medicare and are enrolled in COBRA continuation coverage, you will only have secondary coverage under the Plan for COBRA continuation coverage and will be left without any primary coverage.

If you don't enroll in Medicare and elect COBRA continuation coverage instead, you may have to pay a Part B late enrollment penalty and you may have a gap in coverage if you decide you want Part B later. If you elect COBRA continuation coverage and later enroll in Medicare Part A or B before the COBRA continuation coverage ends, the Plan may terminate your COBRA continuation coverage. However, if Medicare Part A or B is effective on or before the date of the

COBRA election, COBRA continuation coverage may not be discontinued on account of Medicare entitlement, even if you enroll in the other part of Medicare after the date of the election of COBRA continuation coverage. For more information visit https://www.medicare.gov/medicare-and-you.

If You Have Questions

Questions concerning the Plan or your COBRA continuation coverage rights should be addressed to the COBRA Administrator, whose contact information appears below. For more information about your rights under ERISA, including COBRA, the Health Insurance Portability and Accountability Act ("HIPAA"), and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration ("EBSA") in your area or visit the EBSA website at www.dol.gov/ebsa. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.)

Keep Your Plan Informed of Address Changes

In order to protect your family's rights, you should keep the COBRA Administrator informed of any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the COBRA Administrator.

COBRA Administrator Contact Information

If you have questions regarding COBRA continuation coverage, you may contact the COBRA Administrator at 1-833-874-1600.

Administrative Information

The Plan is governed by the Employee Retirement Income Security Act of 1974 ("ERISA"). This section provides important legal and administrative information you may need such as:

- How to contact the Plan Administrator or Eligibility Administrator;
- Information about the Insurers that insure and administer the Benefit Programs of the Plan and how to contact them; and
- Your rights under ERISA.

Plan Identification

The plans described in this SPD include the **LSC Group Benefits Plan** (plan number 501) and the **LSC Flexible Benefits Plan** (plan number 502). The plans are collectively referred to in this SPD as the "Plan."

Plan Sponsor

The Plan is sponsored by LSC Communications LLC. The Plan sponsor's address is:

LSC Communications LLC
4101 Winfield Road
Warrenville, IL 60555
1-773-272-9200

The employer identification number ("EIN") assigned to the Plan sponsor by the IRS is 85-3418344.

Participating Employers

A complete list of the Company's affiliates that participate in the Plan may be obtained by submitting a written request to the Plan Administrator. The list is also available for examination by participants and beneficiaries.

Plan Administrator

The Plan Administrator is the Benefits Committee, or other entity or individual designated by the Benefits Committee to supervise the administration of the Plan. The Plan Administrator's business address and telephone number are:

Benefits Committee
c/o Vice President, Benefits
LSC Communications LLC
4101 Winfield Road
Warrenville, IL 60555
1-773-272-9200

The Plan Administrator (or its designee) has sole discretionary authority to interpret and construe the provisions of the Plan, to grant or deny benefits, to determine eligibility for benefits under the Plan, and to resolve any disputes that arise under the Plan. Benefits under this Plan will be paid only if the Plan Administrator (or its designee) decides in its sole discretion that the applicant is entitled to them. Decisions of the Plan Administrator (or its designee) shall be final and binding.

If a Claims Administrator has the only review authority for a Benefit Program, the Claims Administrator's decision will be final and conclusive with respect to all questions, and benefits under the Plan will be paid only if the Claims Administrator decides in its sole discretion that the applicant is entitled to them.

The Plan Administrator may delegate certain of its Plan duties to other persons and may seek such expert advice as the Plan Administrator deems reasonably necessary with respect to the Plan. The Plan Administrator is entitled to rely on the information and advice furnished by such delegates and experts, unless actually knowing such information and advice to be inaccurate or unlawful. The Plan Administrator may adopt uniform rules for the administration of the Plan from time to time, as it deems necessary or appropriate.

Eligibility Administrator

The Eligibility Administrator is Empyrean Benefit Solutions, Inc., at the following address and phone number:

LSC Benefits Center
P.O. Box 158
Bellaire, TX 77402
mylscbenefits.com
1-888-681-2241

The Eligibility Administrator is your primary source of information about the Plan. Benefits Center Representatives are available between the hours of 8 a.m. and 5 p.m. CT, Monday through Friday, except holidays.

Contact the LSC Benefits Center to:

- Report a permitted change in status event within 30 days after the date of the event (or 60 days for a newborn);
- Report an inaccurate change in status event;
- Enroll;
- Verify benefit eligibility;
- Remove a former eligible dependent who is no longer eligible from coverage;
- Ask a question about permitted change in status events;
- Report an address change (inactive participants only); and
- Ask general benefit questions.

Plan Year

The Plan year is January 1 to December 31.

Plan Type, Funding, and Administration

The Plan is an ERISA welfare benefit plan. The Benefit Programs of the Plan may be fully-insured by the Insurers pursuant to group insurance contracts entered into between Company and the Insurers or self-funded by the Company. For fully-insured benefits, premiums are paid to the Insurers from Company's general assets. The Insurers are responsible for paying benefit claims incurred while the applicable group insurance contracts are in effect. For self-funded benefits, the Company is responsible for paying benefit claims from its general assets.

Insured Benefit Programs

The following Insurers insure and administer the applicable Benefit Programs under the Plan:

BENEFIT PROGRAM	CLAIMS ADMINISTRATOR	WHO PAYS FOR COVERAGE
DENTAL	MetLife P.O. Box 981282 El Paso, TX 79998-1282 1-888-447-8996 www.metlife.com/mybenefits	You pay for the cost of coverage through your pre-tax benefit contributions.
VISION	EyeMed Attn: Claims Department c/o EyeMed Legal Department 4000 Luxottica Place Mason, OH 45040 1-866-723-0514 www.eyemed.com	You pay for the cost of coverage through your pre-tax benefit contributions.
EMPLOYEE ASSISTANCE PROGRAM	Carelon 1-877-409-1488 www.carelonwellbeing.com/LSC	The Company pays for the cost of coverage.
LONG TERM DISABILITY	The Hartford P.O. Box 14869 Lexington, KY 40512-4869 1-888-437-8671 www.abilityadvantage.thehartford.com	For Basic Long Term Disability benefits, the Company pays for the cost of coverage. For Buy-Up Long Term Disability benefits, you pay for the cost of coverage with after-tax benefit contributions.
BASIC LIFE INSURANCE	MetLife P.O. Box 981282 El Paso, TX 79998-1282 1-888-447-8996 www.metlife.com/mybenefits	The Company pays for the cost of Basic Life Insurance coverage.
OPTIONAL & DEPENDENT LIFE INSURANCE	MetLife P.O. Box 981282 El Paso, TX 79998-1282 1-888-447-8996 www.metlife.com/mybenefits	You pay for the cost of Optional and Dependent Life Insurance coverage with after-tax benefit contributions.
OPTIONAL AD&D INSURANCE	MetLife P.O. Box 981282 El Paso, TX 79998-1282 1-888-447-8996 www.metlife.com/mybenefits	You pay for the cost of coverage with after-tax benefit contributions.
VOLUNTARY CRITICAL ILLNESS/ACCIDENT AND HOSPITAL INDEMNITY INSURANCE	MetLife P.O. Box 981282 El Paso, TX 79998-1282 1-888-447-8996 www.metlife.com/mybenefits	You pay for coverage with after-tax benefit contributions.

Third-Party Administrators

The following organizations administer the applicable Benefit Programs under the Plan:

BENEFIT PROGRAM	THIRD-PARTY ADMINISTRATOR/CLAIMS ADMINISTRATOR	WHO PAYS FOR COVERAGE
MEDICAL (INCLUDING CONDITION MANAGEMENT) AND PRESCRIPTION DRUG	Quantum Health 1-844-460-2803 www.mylscbenefits.com Carrier: BlueCross BlueShield of Illinois (BCBSIL) Claims Administrator: Luminare	The Company pays part of the cost for coverage. You pay the rest through your pre-tax benefit contributions.
SURGERYPLUS	1-844-460-2803 my.surgeryplus.com	N / A
HEALTH CARE FSA DEPENDENT CARE FSA AND COMMUTER	HealthEquity 1-877-924-3967 www.healthequity.com/wageworks	You may make pre-tax benefit contributions.
HSA	HealthEquity 1-844-281-0928 www.healthequity.com	You may make pre-tax benefit contributions.
SHORT TERM DISABILITY	The Hartford P.O. Box 14869 Lexington, KY 40512-4869 1-888-437-8671 www.abilityadvantage.thehartford.com	The Company pays for the cost for coverage.
HINGE HEALTH, MDLIVE, OMADA AND WONDR	Contact information listed on mylscbenefits.com.	N/A

Agent for Service of Legal Process

The agent for service of legal process on the Plan is:

Corporate Secretary
LSC Communications LLC
4101 Winfield Road
Warrenville, IL 60555
1-773-272-9200

Legal process on the Plan may also be served on the Plan Administrator.

Amendment or Termination of the Plan

This SPD does not serve as a guarantee of future benefits. The Company reserves the right to amend or terminate the Plan or any Benefit Program at any time by action of its Vice President, Benefits or any other duly authorized officer of the Company or Benefits Committee.

No Employment Rights

The Plan shall not confer employment rights upon any person. No person shall be entitled by virtue of the Plan to become or to remain in the employ of the Company and nothing in the Plan shall restrict the right of the Company to terminate the employment of any eligible employee or other person at any time.

Subrogation and Reimbursement

General Principle

When you or your eligible dependent receives benefits under the Plan which are related to medical expenses that are also payable under workers' compensation, any statute, any uninsured or underinsured motorist program, any no fault or school insurance program, any other insurance policy or any other plan of benefits, or when related medical expenses that arise through an act or omission of another person are paid by a third party, whether through legal action, settlement or for any other reason, you or your eligible dependent shall reimburse the Plan for the related benefits received out of any funds or monies you or your eligible dependent recovers from any third party.

Specific Requirements and Plan Rights

Because the Plan is entitled to reimbursement, the Plan shall be fully subrogated to any and all rights, recovery or causes of actions or claims that you or your eligible dependent may have against any third party. The Plan is granted a specific and first right of reimbursement from any payment, amount or recovery from a third party. This right to reimbursement is regardless of the manner in which the recovery is structured or worded, even if you or your eligible dependent has not been paid or fully reimbursed for all damages or expenses.

The Plan's share of the recovery shall not be reduced because the full damages or expenses claimed have not been reimbursed unless the Plan agrees in writing to such reduction. Further, the Plan's right to subrogation or reimbursement will not be affected or reduced by the "make whole" doctrine, the "fund" doctrine, the "common fund" doctrine, comparative/contributory negligence, "collateral source" rule, "attorney's fund" doctrine, regulatory diligence or any other equitable defenses that may affect the Plan's right to subrogation or reimbursement.

The Plan may enforce its subrogation or reimbursement rights by requiring you or your eligible dependent to assert a claim to any of the benefits to which you or your eligible dependent may be entitled. The Plan will not pay attorneys' fees or costs associated with the claim or lawsuit without express written authorization from Company.

If the Plan should become aware that you or your eligible dependent has received a third party payment, amount or recovery and not reported such amount, the Plan, in its sole discretion, may suspend all further benefits payments related to you or any of your eligible dependents until the reimbursable portion is returned to the Plan or offset against amounts that would otherwise be paid to or on behalf of you or your eligible dependents.

Participant Duties and Actions
By participating in the Plan you and your eligible dependents consent and agree that a constructive trust, lien or an equitable lien by agreement in favor of the Plan exists with regard to any settlement or recovery from a third person or party. In accordance with that constructive trust, lien or equitable lien by agreement, you and your eligible dependents agree to cooperate with the Plan in reimbursing it for Plan costs and expenses.

Once you or your eligible dependent has any reason to believe that you or your eligible dependent may be entitled to recovery from any third party, you or your eligible dependent must notify the Plan. At that time, you and your eligible dependent (and your or your eligible dependent's attorney, if applicable) must sign a subrogation/reimbursement agreement that confirms the prior acceptance of the Plan's subrogation rights and the Plan's right to be reimbursed for expenses arising from circumstances that entitle you or your eligible dependent to any payment, amount or recovery from a third party.

If you or your eligible dependent fails or refuses to execute the required subrogation/ reimbursement agreement, the Plan may deny payment of any benefits to you and any of your eligible dependents until the agreement is signed. Alternatively, if you or your eligible dependent fails or refuses to execute the required subrogation/reimbursement agreement and the Plan nevertheless pays benefits to or on behalf of you or your eligible dependent, your or your eligible dependent's acceptance of such benefits shall constitute agreement to the Plan's right to subrogation or reimbursement.

You and your eligible dependent consent and agree that you or your eligible dependent shall not assign your or your eligible dependent's rights to settlement or recovery against a third person or party to any other party, including your eligible dependent's attorneys, without the Plan's consent. As such, the Plan's reimbursement will not be reduced by attorneys' fees and expenses without express written authorization from the Company.

Coordination of Group Health Benefits
The Plan has a coordination of benefits feature with respect to group health benefits. This prevents duplication of benefits if you or an eligible dependent is covered by more than one group health plan. When a claim is made, the "primary" plan pays benefits first, without regard to the other plan. When the Plan is secondary, the Plan calculates what it would have paid if it were primary and reduces benefits by what the other plan has paid.

The Plan will not supplement the other plan to bring reimbursement up to 100%, but will coordinate with the other plan to bring your reimbursement up to the Plan's benefit level. Generally, the plan covering a person as an employee is the "primary" plan while the plan covering the same person as a dependent is the "secondary" plan.

Coordination of benefits rules apply whenever you or your eligible dependent is covered by more than one insurance plan. Plans include any other type of coverage for persons in a group—whether the plan is fully-insured or self-funded. No-fault auto insurance that is required by law is also included, even if it is not provided on a group basis. The level of benefits required by law will be considered when benefits are coordinated.

Coordination with Other Plans
The Plan describes the coordination of benefits rules in greater detail. Generally, primary and secondary plans are determined as follows:

- The plan covering a person as an employee is the primary plan, and the plan covering the same person as a dependent is the secondary plan.
- For dependent children, the plan of the parent whose birthday occurs earlier in the calendar year is primary (regardless of the year of birth). If both parents have the same birthday, the plan that has covered a parent for the longer period is primary. If the other plan follows a gender rule (*i.e.*, male's plan pays first) instead of the birthday rule to determine order of benefits, the other plan's provision will apply.

    - In the case of separated or divorced parents, primary and secondary plans are determined as follows:

        - If a court decree awards joint custody but does not specify which parent is responsible for health care expenses, the rules above apply.
        - If a court decree has given financial responsibility for medical care for eligible dependent children to one parent, the plan of this parent is primary.
        - If there is not a court decree establishing financial responsibility for medical care for eligible dependent children:

            - The plan that covers the parent with custody pays first;
            - If the parent with custody has remarried, the plan of the custodial parent pays first, then the plan of the stepparent and last, the plan of the parent without custody.

    - In the case of a stepchild or the child of a domestic partner the plan of the parent will be primary.

If none of these rules apply, the plan that has covered the individual for the longest period of time is primary.

Coordination with Medicare

If you are a participant or an eligible dependent and you become eligible for Medicare, the Plan will be your primary source of coverage (with Medicare secondary), unless you elect otherwise. If you choose to be covered under both plans, your Plan coverage will be primary and Medicare secondary. If you also cover your spouse (and he or she is not covered as an employee under another employer's plan), your Plan coverage is primary for your spouse as well, regardless of whether your spouse is under or over age 65.

Active employees, or their enrolled eligible spouse/domestic partner, or child(ren) who are eligible for Medicare due to age or disability (other than permanent kidney failure) have coverage under the Plan as their primary coverage for so long as they remain an enrolled active employee.

If you do not enroll in Medicare and you have end stage renal disease, you will only have secondary coverage under the Plan after 30 months and will be left without any primary coverage.

Once the Plan becomes secondary for a person that became entitled to Medicare, it will not become secondary for other enrolled eligible dependents. For example, if John and his wife both have coverage under the Plan and John later becomes eligible for Medicare because he is diagnosed with end stage renal disease, the Plan will become secondary for John after 30 months, but not his wife if she does not have end stage renal disease.

No Assignment of Benefits

You cannot assign, pledge, encumber or otherwise alienate any legal or beneficial interest in benefits under the Plan, and any attempt to do so will be void, unless otherwise agreed to, in the sole discretion of the Plan Administrator. The assignment of rights or benefits, as well as the assignment of the right to file a lawsuit, are prohibited, except that a participant may assign covered benefits to an appropriate medical service provider solely for the purpose of allowing the provider to submit a claim and allowing the Plan to pay covered benefits directly to the provider. The payment of benefits directly to a provider, if any, shall be done as a convenience to the covered person and shall not constitute an assignment of benefits under the Plan. No compensation reduction elections or other contributions under this Plan shall cause the Company to be liable for, or subject to, any manner of debt or liability of any participant. Notwithstanding the foregoing, wage garnishments under applicable state law shall be permitted to reach cash benefits reflecting deductions from the garnishee's cash account under this Plan, unless otherwise prohibited by law.

Recovery of Excess Payments

If the Plan makes an overpayment of any benefits, the Plan may recover the amounts either by requiring you to return the overpayment to the Plan, by reducing any future Plan payments to you or by any other method deemed reasonable to the Plan Administrator.

Representations Contrary to the Plan

No employee, director or officer of the Company has the authority to alter, vary or modify the terms of the Plan except by means of a duly authorized written amendment to the Plan. No verbal or written representations contrary to the terms of the Plan are binding upon the Plan, the Plan Administrator or the Company.

Rebates and Subsidies

If any rebates or subsidies are generated by the operation of the Plan, the amount of any such rebate or subsidy will be the property of the Company to use as it shall determine, and for any purpose.

Responsibility for Tax Implication of Benefits

You will be responsible for the tax implications of any determination of imputed income with respect to any benefits you elect for eligible dependents who are not entitled to tax-free benefits under current federal law.

Applicable Law

The Plan will be governed and construed in accordance with the laws of the State of Illinois to the extent not preempted by the laws of the United States.

Forfeiture After Two Years

Any check issued to pay self-funded benefits under the Plan will be void and not reissued if it is not cashed within two years after the date the original check was issued, and the self-funded benefit for which the check was issued will be forfeited. For self-funded benefits, any expense incurred will be ineligible for benefits under the Plan if a claim for the expense is not submitted to the appropriate Claims Administrator by the end of the Plan year which contains the second anniversary of the date the expense was incurred, and any claim related to such expense will be forfeited.

Keeping Your Plan Account(s) Secure

Be sure to log into your Plan account(s) regularly. Frequent monitoring of your account(s) helps to prevent fraud, cyber threats and other unauthorized activity. It is important that you protect your Plan account(s) and personal information with respect to any Plan or vendor websites. Do not share your log-in credentials with anyone and use strong passwords. You are responsible for maintaining the security of your log-in credentials. If you believe your log-in credentials have been compromised, you should immediately notify the Plan Administrator. Neither the Plan nor the Plan Administrator is responsible for any losses or costs that may be incurred or suffered as a result of security incidents involving identity theft or your failure to protect your benefits, personal information or log-in credentials.

Consent to Be Contacted Telephonically or By Electronic Mail (Email)

You expressly consent to receive emails, phone calls, faxes, text messages, and ringless voicemails made by or on behalf of LSC Communications LLC or its vendors, affiliates, agents or partners regarding any benefit programs offered by LSC Communications LLC. For electronic mail, this includes the use of any personal email address you have provided to LSC Communications LLC or its affiliates. For telephonic outreach, this includes the use of an automatic telephone dialing system or autodialer, or prerecorded or automated voice to any cellular, facsimile or residential land line number that you have provided to LSC Communications LLC or its affiliates, regardless of whether it is on a state or national Do-Not-Call registry. You also consent to receive emails, phone calls, faxes, text messages, and ringless voicemails from LSC Communications LLC for any communications sent for commercial, sales, telemarketing or advertising purposes. You understand that your email provider, or cellular, landline or facsimile line carrier may charge you for such emails, calls, faxes, text messages or ringless voicemails and you agree to accept full responsibility for any such charges.

Your ERISA Rights

As a participant in the Plan, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 ("ERISA"). ERISA provides that all plan participants shall be entitled to:

Receive Information About Your Plan and Benefits

Examine (without charge) at the Plan Administrator's office and at other specified locations—such as work sites and union halls—all documents governing the Plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 series) filed by the Plan (if applicable) with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.

- Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, including insurance contracts, and the most recent annual report (Form 5500 series) (if applicable) and an updated summary plan description. The Plan Administrator may make a reasonable charge for these copies.
- Receive a written summary of the Plan's annual financial report, if applicable. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report.

Continue Group Health Plan Coverage

- Continue health care coverage for yourself, spouse or dependents if there is a loss of coverage under the Plan as a result of a qualifying event. You or your dependents may have to pay for such coverage. Review this Summary Plan Description and the documents governing the Plan on the rules governing your COBRA continuation coverage rights.
- Reduction or elimination of exclusionary periods of coverage for preexisting conditions under the Plan, if you have creditable coverage from another plan.

Prudent Actions by Plan fiduciaries

In addition to creating rights for Plan participants, ERISA imposes duties upon the people who are responsible for the operation of the Plan. The people who operate your Plan, called "fiduciaries," have a duty to do so prudently and in the interest of you and other Plan participants and beneficiaries.

No one, including your employer, your union, and any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA.

Enforcing Your Rights

If your claim for a welfare benefit is denied or ignored, in whole or in part, you have the right to know why this was done, to obtain copies of the 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 your ERISA rights. For instance:

- If you request a copy of plan documents or the latest annual report (if applicable) 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 (indexed for inflation) 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 which is denied or ignored—in whole or in part after going through the appeals procedure—you may file suit in a state or federal court.
- If you disagree with the Plan's decision (or lack thereof) concerning the qualified status of a medical child support 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 ERISA rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court.

If you file suit against the Plan, 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 Plan, you should contact 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.

APPENDIX A
HEALTH CARE FLEXIBLE SPENDING ACCOUNTS

The Health Care FSAs may be of interest to you if you are paying for health care expenses that are not fully reimbursed or not covered by your medical or other health coverage. This Appendix A explains how the Health Care FSAs allow you to make pre-tax contributions from your salary, which can then be used to reimburse yourself for eligible health care expenses.

The Plan offers two different kinds of Health Care FSAs:

- **General Purpose Health Care FSA** – This account is an option for eligible employees who are **not** enrolled in a high deductible health plan for the Plan year. Eligible medical (including prescription drug) dental and vision costs may be reimbursed.
- **Limited Purpose Health Care FSA** – This account is an option for eligible employees who are enrolled in a high deductible health plan (*i.e.*, the HSA Core and HSA Value medical options) for the Plan year. To comply with IRS rules, only eligible dental and vision costs can be reimbursed before your annual deductible is met for the Plan year. After your annual deductible has been met, you may also use this account to reimburse eligible medical (including prescription drug) costs. If you have an HSA, other medical costs, such as coinsurance, co-payments and deductibles, are reimbursable from your HSA.

You should carefully consider the decision to enroll in a Health Care FSA for the following reasons:

- You generally cannot change the amount you set aside during the Plan year, unless you have a qualified change in status.
- Your contributions for the Plan year can be used to reimburse eligible expenses that you incur during the period beginning January 1 (or your participation date, if later) through December 31. Please note that the Health Care FSAs do not permit any extension beyond this date in which to incur eligible expenses.
- Expenses for the Plan year must be filed within 90 days of the end of that Plan year (*i.e.*, March 31 of the next Plan year). Any unused balance left in your Health Care FSA will be lost. This “use it or lose it” rule is mandated by federal income tax laws. Any balances “lost” may be used by the Company to offset the administrative costs or as otherwise permitted by law.
- Authorizing pre-tax deductions reduces your salary base for Social Security calculation purposes. In most cases, the impact to your future Social Security benefits will be minimal.
- You may not use money in your Health Care FSA to pay dependent care expenses and vice versa. You may not switch money between the Health Care FSAs and the Dependent Care FSA.

Covered Dependents

You may submit eligible health care expenses incurred by you and your tax dependents. For purposes of the Health Care FSAs, your tax dependents include:

- Your legal spouse as defined under the laws of the state or jurisdiction in which you were married;
- Your children until the end of the year in which they turn age 26, regardless of student status, whether they are married or live with you and regardless of whether you provide any support;

- Your mentally or physically disabled adult dependent children who live with you and who are primarily dependent on you for support; and
- Any other person (including a domestic partner) who meets the IRS definition of a tax dependent (without regard to the income limit), which means an individual whose primary residence is your home, who is a member of your household, for whom you provide more than one-half of their support, and who is not the qualifying child (as defined under the Code) of the employee or any other individual.

Note: You may treat another person's qualifying child as your qualifying relative if the child satisfies the other requirements listed here and if the other person is not required to file a tax return and either doesn't file a return or files one only to get a refund of withheld income taxes. For example, this could allow tax-free health coverage for the children of an employee's non-working domestic partner.

Contribution Limits

You may contribute any whole dollar amount which must be at least $200 and not more than the IRS maximum (as adjusted for inflation) per Plan year of your own money to your Health Care FSA. The maximum amount may be adjusted each year by the Company for IRS increases, and will be communicated in your annual enrollment materials.

Eligible Expenses

The Health Care FSA is an account that allows you to put money aside to reimburse yourself for "eligible health care expenses." Expenses must be incurred during the Plan year and while you are covered under the Plan. An expense is considered incurred when the care or service is provided—not when your provider issues a bill, or when you receive or pay that bill.

In general, you may use the amounts you contribute to reimburse eligible expenses incurred by you or your eligible dependents not paid for by the Plan or programs outside of the 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.

Only certain expenses are eligible for reimbursement from the Health Care FSA. Expenses incurred for over-the-counter ("OTC") drugs obtained without a doctor's prescription and menstrual care products are considered an eligible medical expense that may be reimbursed under the Health Care FSA. Additionally, personal protective equipment ("PPE"), such as masks, hand sanitizer and sanitizing wipes, for the primary purpose of preventing the spread of COVID-19 may also be reimbursed under the Health Care FSA. For a complete listing of eligible expenses, visit the www.healthequity.com/wageworks. Please note that the listing is subject to change at any time.

Ineligible Expenses

Certain expenses are not reimbursable through the Health Care FSAs. For a listing of expenses that are excluded from reimbursement, visit the www.healthequity.com/wageworks. Please note that the listing is subject to change at any time.

Filing a Claim

When you incur eligible health care expenses, you may submit a claim form along with the invoice or receipt for such expense. Reimbursement for submitted claims will be paid as soon as

administratively practicable by the Claims Administrator. If your claim is greater than the amount of money in your account, you will still be reimbursed for the total amount of your claim up to the maximum amount you elected to contribute to your account. Thereafter, you must continue making contributions on a regular basis.

All claims for a Plan year must be submitted to the Claims Administrator by March 31st after the Plan year. Any claims for reimbursement after that date will not be considered for reimbursement by the Claims Administrator. After your claim is processed and approved, you will be reimbursed by a check mailed to your home address or via direct deposit, depending on your preference.

Debit Card

Eligible expenses under your Health Care FSA may be purchased directly from the merchant or provider of services through the use of an FSA debit card. You must agree to acquire, submit to the Claims Administrator and retain sufficient documentation for any expense paid for with the debit card, including invoices and receipts where appropriate. All charges to the debit card that are not deemed to be fully substantiated at the point-of-sale are treated as conditional pending substantiation of the eligibility of the charge through your documentation.

You should verify that the Claims Administrator considers expenses substantiated. If the Claims Administrator determines that a claim has been paid that was not for an eligible expense or a claim has not been fully substantiated, you are required to refund any amount so identified. If you fail to promptly refund such amount to the Plan, by virtue of agreeing to participate in the Plan, you authorize the Plan sponsor to withhold such amount from your wages or other compensation to the extent permitted by law. In addition, the Claims Administrator reserves the right to suspend your use of the debit card and/or credit such amount against other eligible expenses that you may submit until the refund is satisfied.

Your debit card will be cancelled automatically if your employment terminates or if your participation in the Plan otherwise terminates.

Qualified Military Service Distribution

If you are called into Uniformed Service for at least 180 days (or for an indefinite period of time) you may elect to withdraw all or a portion of the balance credited in your Health Care FSA as of the date you make the request. This distribution will be reported as gross income to you on your Form W-2 as a taxable distribution. You do not need to provide proof of eligible medical expenses. The distribution will be made to you no sooner that the date you are called into Uniformed Service, and no later than the last day in which you could submit claims for reimbursements for that Plan year (*i.e.*, March 31st of the next Plan year).

Statutory Benefit

The Health Care FSAs are regulated by 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 502 available at www.irs.gov.

APPENDIX B
DEPENDENT CARE FLEXIBLE SPENDING ACCOUNT

The Dependent Care FSA may be of interest to you if you are paying for the care of a child or disabled member of your household in order for you or, if you are married, for you and your spouse to work. This Appendix B explains how the Dependent Care FSA allows you to make pre-tax contributions from your salary, which can then be used to reimburse yourself for eligible dependent care expenses.

You should carefully consider the decision to enroll in the Dependent Care FSA for the following reasons:

- You generally cannot change the amount you set aside during the Plan year, unless you have a qualified change in status.
- Your contributions for the Plan year can be used to reimburse eligible expenses that you incur during the period beginning January 1 (or your participation date, if later) through December 31. Please note that the Dependent Care FSA does not permit any extension beyond this date in which to incur eligible expenses.
- Expenses for the Plan year must be filed within 90 days of the end of that Plan year (*i.e.*, March 31 of the next Plan year). Any unused balance left in your Dependent Care FSA will be lost. This "use it or lose it" rule is mandated by federal income tax laws. Any balances "lost" may be used by the Company to offset the administrative costs or as otherwise permitted by law.
- Authorizing pre-tax deductions reduces your salary base for Social Security calculation purposes. In most cases, the impact to your future Social Security benefits will be minimal.
- You may not use money in your Dependent Care FSA to pay health care expenses and vice versa. You may not switch money between the Dependent Care FSA and the Health Care FSAs.

Qualified Dependents

Under IRS regulations, "eligible dependents" for the Dependent Care FSA include:

- Children under age 13 (or as otherwise permitted by the IRS) who are your qualifying children, as defined under the Code;
- A disabled spouse who lives with you for more than one-half of the year; and
- Any other relative or household member who receives more than one-half of his or her support from you, resides in your home, is physically or mentally unable to care for him or herself, and who is not the qualifying child of the employee or any other individual.

For purposes of the Dependent Care FSA, the term "spouse" will not include an individual who, although married to you, files a separate federal income tax return, maintains a separate principal residence during the last 6 months, and does not furnish more than one-half of the cost of maintaining the principal residence of the qualifying individual.

Contribution Limits

The IRS limits the amount you may contribute to your Dependent Care FSA. There is an overall annual maximum of $5,000 (or $2,500 each if you and your spouse file separate income tax returns). But another limitation also applies—if you or your spouse earns less than the above

amounts, the maximum contribution you can make is the lesser of your or your spouse's annual earnings. For example, assume Mary will earn $41,500 from her job during the calendar year. Her husband will earn $3,600 from his job. Mary's reimbursement from her Dependent Care FSA will be limited to $3,600.

For purposes of determining the IRS limit, your spouse will have a presumed income if your spouse is a full-time student or disabled and incapable of self-care. For each month that your spouse is a full-time student or is incapacitated, your spouse's income is presumed to be the greater of your spouse's actual income (if any) or $250. If you have two or more qualified dependents, the presumed income is the greater of your spouse's actual income (if any) or $500 a month.

Additionally, the minimum contribution amount you can make to a Dependent Care FSA each Plan year is $200.

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 for reimbursement under the Dependent Care FSA include expenses incurred for the care of your qualified dependents:

- In your home;
- In another person's home;
- At a licensed nursery school, day camp (not overnight camp) or qualified day care center; or

  Note: A day care center will qualify if it meets state and local requirements and provides care and receives payment for more than 6 people who do not reside there.

- At a specialty day camp (*e.g.*, soccer camp, computer camp).

Expenses must be incurred in order to allow you or, if you're married, you and your spouse to work or if your spouse is disabled and unable to care for him/herself or is a full-time student for at least 5 months of the year. To be eligible, expenses must have been incurred during the Plan year and while you were covered under the Dependent Care FSA. An expense is considered incurred when the care or service is provided—not when your provider issues a bill, nor when you receive or pay that bill.

If the care is provided in your home or the home of another person, the care provider must not be claimed as a dependent on your tax return and must be age 19 or older (determined as of the close of the taxable year). An adult dependent must spend at least 8 hours a day in your home in order for expenses for caring for that person to be eligible. Services must be for the physical care of the child, not for education, meals, etc., unless incidental to the cost of care.

Ineligible Expenses

You cannot use funds in your Dependent Care FSA to pay for:

- General "baby-sitting" other than during work hours;
- Care or services provided by:
  - Your children under age 19 (whether or not they are your tax dependents); or
  - Anyone you (or your spouse if you are married) can claim as a dependent for federal income tax purposes;
- Nursing home care;
- Overnight camp;
- Private school tuition;
- Expenses for education (kindergarten and above);
- Expenses that would not otherwise be eligible to be credited on your federal income tax return;
- The cost of transportation between the place where day care services are provided and your home unless such transportation is furnished by the dependent care provider;
- Expenses incurred while you are off from work for any reason. However, if you pay your dependent care provider on a weekly or longer basis, dependent care expenses incurred during a temporary absence from work for illness or vacation/PTO may be eligible; or
- Expenses for which you claim IRS child care credit when you file your tax return.

The IRS does not allow you to claim a credit for the same expenses on your income tax return for which you are reimbursed under the Dependent Care FSA.

Filing a Claim

When you incur eligible dependent care expenses, you may submit a claim form along with the invoice or receipt for such expense. Reimbursement for submitted claims will be paid as soon as administratively practicable by the Claims Administrator.

All claims for a Plan year must be submitted to the Claims Administrator by March 31st following the Plan Year. Any claims for reimbursement after that date will not be considered for reimbursement by the Claims Administrator. After your claim is processed and approved, you will be reimbursed by a check mailed to your home address or via direct deposit, depending on your preference.

Special Rules Affecting Dependent Care Accounts

Several special rules apply to Dependent Care FSAs. You should consider these rules, as they may affect the amount you choose to contribute to your Dependent Care FSA.

The IRS requires that the maximum amount you can take as a child care tax credit for dependent care expenses be reduced – dollar for dollar – by any reimbursements you receive from your Dependent Care FSA. ***Some employees will receive more tax advantages by taking the dependent care tax credit, while others will benefit more by contributing to the Dependent Care FSA. Please consult your tax advisor or carefully review your situation before making a choice.***

The money in your Dependent Care FSA must be used to pay for dependent care expenses that allow you and your spouse to work. However, this rule does not apply if your spouse is disabled and incapable of self-care or a full-time student at an accredited institution for at least 5 months each year.

If you and your spouse are divorced and you have custody of your child(ren), you may be able to be reimbursed from the Dependent Care FSA even if you do not claim the dependent on your federal income tax return.

Statutory Benefit

The Dependent Care FSA is 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 available at www.irs.gov.

APPENDIX C
SHORT TERM DISABILITY PROGRAM

This Appendix C summarizes the Short Term Disability ("STD") benefits available under the Plan. STD coverage is designed to help ensure that you continue to receive income if you are unable to work because of an Illness, Injury or pregnancy-related condition.

Disability Benefits

The Plan offers two disability coverages: (i) STD benefits; and (ii) Long Term Disability ("LTD") benefits. This Appendix only describes STD benefits. Please see the applicable Certificate for information about your LTD benefits, including how to file a claim.

Eligibility

In addition to the requirements in the "**Who Is Eligible**" section, you are eligible for STD coverage under the Plan if you are classified by the Company (or a Participating Employer) as a:

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

Once eligible (generally on the first day of the month after you complete one full calendar month of employment), you will automatically be enrolled in STD coverage.

STD Benefits

You are eligible for STD benefits if you become wholly and continuously disabled as a result of an Illness, Injury or pregnancy-related condition so that you are prevented from performing any and every duty of your occupation from the time the Illness, Injury or pregnancy-related condition occurs, as determined by the Claims Administrator, in its sole discretion. In addition, you must be under the treatment of a physician and you must file a claim and supporting evidence of your disability with the Claims Administrator within 30 days of the first day of your disability.

Summary of Benefits

Waiting Period	Illness: benefits start on the 8th calendar day for a disability period due to illness* Injury: benefits start on the 8th calendar day for a disability period due to injury or hospitalization*
Weekly Benefit	60% of your Pre-disability Earnings** calculated on a weekly basis
Maximum Weekly Benefit Period	26 weeks

* The waiting period is covered by the STD Program for exempt and salaried non-exempt employees.

Important Note: Review the definition of Pre-disability Earnings in the "Definition**" section below to understand completely how your STD benefits will be calculated, especially if you are a commissioned sales employee or a 4-crew employee.

Amount of Benefits

Your STD benefits are described in terms of a weekly benefit. Your weekly benefit is based on your Pre-disability Earnings. To calculate your weekly benefit, multiply your Pre-disability Earnings by 60% and divide by 52. Please note, your weekly benefit may be reduced as described below.

For all employees, weekly STD benefits will be reduced by "Other Income," which includes:

- The United States Social Security Act, the Civil Service Retirement System, the Railroad Retirement Act, the Jones Act, any pension or disability plan of any other nation or political subdivision thereof, or similar plan or act that you, your spouse, or your children are eligible to receive because of your disability or retirement;
- Benefits paid or payable to you under a salary continuation pay practice of the Company, including severance pay.
- Benefits paid or payable to you for the same period of disability under any workers' compensation, occupational disease or similar law (except for certain payments request by law);
- The weekly equivalent of any disability insurance benefits or retirement (old-age) insurance benefits to which you are entitled for the same period of disability under the Federal Social Security Act or any future legislation providing similar benefits (except old-age insurance benefits reduced because of the age at which received);
- Disability or Paid Family Leave benefits under any state or governmental program (other than benefits designed to compensate veterans for disabilities);
- The amount of any benefits paid under any compulsory "no-fault" automobile insurance or the portion of a settlement or judgement, minus associated costs, of a lawsuit that represents or compensates for your loss of earnings;
- Any plan or arrangement of coverage, whether insured or not, as a result of employment by or association with the Company, or as a result of membership in or association with any group, association, union or other organization; and
- Any other amounts determined by the Claims Administrator.

The Plan will not pay STD benefits (or benefits from any other ERISA-governed plan) for any period of disability during which you are retired and receiving a pension payment from a pension plan sponsored by the Company, except where the pension payment is a disability retirement benefit under a Company sponsored pension plan.

It is your responsibility to inform the Claims Administrator when you receive Other Income and/or when the amount of your Other Income changes. An increase in your Other Income benefits may reduce your STD benefit under the Plan. The Claims Administrator may require proof that you have timely and appropriately applied for all Other Income benefits that you are or may be eligible to receive because of your disability.

When Benefit Payments Begin

Once you satisfy the requirements for a disability under the Plan and the applicable waiting period is over, the Plan will begin to pay your STD benefits. The waiting period (described in the chart above) is the amount of time you must be disabled before STD benefits start. The Plan does not provide STD benefits during the waiting period.

Duration of STD Benefits

In general, STD benefits will be paid for up to 26 weeks. However, you are no longer considered disabled or eligible for STD benefits when the first of the following occurs:

- The date you last worked if your employment ends for any reason except due to a qualified separation in accordance with the LSC Communications Separation Pay Plan;
- The date you are no longer disabled, as determined by the Claims Administrator;
- The date you are no longer under the regular care of a physician;
- The date you fail to provide proof that you are disabled;
- The date you refuse to be examined by or cooperate with an independent physician or a licensed and certified health care practitioner, as requested (the Claims Administrator has the right to examine and evaluate you at any reasonable time while your claim is pending or payable. Such examination or evaluation is done at the expense of the Plan);
- The date an independent medical exam report or functional capacity evaluation does not, in the Claims Administrator's sole discretion, confirm that you are disabled;
- The date you reach the end of your maximum benefit period, as shown in the "**Summary of Benefits**" section above;
- The date you are not receiving effective treatment for alcoholism or drug abuse, if alcoholism or drug abuse are the cause of (or part of the cause of) your disability;
- The date you refuse to cooperate with or accept:
    - Changes to your work site or job process designed to suit identified medical limitations; or
    - Any adaptive equipment or devices designed to suit your identified medical limitations, which would allow you to perform your own occupation (but, only if a physician agrees that such changes, adaptive devices or equipment suit your particular medical limitations).
- The date you refuse any treatment recommended by your attending physician that, in the Claims Administrator's sole discretion, would cure, correct or limit your disability;
- The date your work condition would permit you to work, increase the hours you work, or increase the number or type of duties you perform in your own occupation, but in each case, you refuse to do so;
- The date you return to work whether part-time or full-time in any capacity;
- The 90th cumulative calendar day if you continue to work in the Transitional Duty program;
- The date you refuse a Transitional Duty assignment;
- The date of your death; or
- The day after Claims Administrator determines that you can participate in an approved rehabilitation program and you refuse to do so.

Successive Disabilities

If you become disabled again after your STD benefits have ended, the new disability will usually be treated separately (*i.e.*, you must meet a new waiting period, if applicable) and a new benefit period begins. However, the original and any subsequent disability will be treated as the same disability if they are due to the same or a related Illness, Injury or pregnancy-related condition, and are separated by less than 30 days in a row. In this case, there is no waiting period for the later disability and you do not start a new benefit period.

Rehabilitative Employment

If you partially recover from a disability, you may be able to return to work by taking an approved rehabilitative job. This could be part-time work or a different kind of work than you had before. While you are engaged in an approved rehabilitative job, only 50% of your earnings from the job will be used to offset your STD benefits. You can earn a higher income through the rehabilitative job while developing skills that will help you return to your own job, if available or a reasonable occupation on a full-time basis, if available. However, the sum of your weekly benefit and total income received under this section may not exceed 100% of your weekly Pre-disability Earnings. If this sum exceeds your weekly Pre-disability Earnings, the weekly benefit payable by the Plan will be reduced proportion

In no event will benefits be paid after the expiration of the 26-week period.

What the Plan Does Not Cover

The Plan does not cover any disability on any day that you are confined in a penal or correctional institution for conviction of a criminal act or other public offense. You are not considered disabled, and no benefits are payable.

The Plan also does not cover any disability that:

- Is due to an occupational illness or occupational injury;
- Is due to a cosmetic and/or elective procedure/surgery not covered under the Medical Program unless such procedure/surgery is directly related to a covered medical procedure or surgery under the Medical Program;
- Is due to insurrection, rebellion or taking part in a riot or civil commotion;
- Is due to intentionally self-inflicted injury (while sane or insane);
- Is due to war or any act of war (whether declared or not declared);
- Results from your commission of, or attempt to commit, a criminal act;
- Results from an accident that happens while you are operating a motor vehicle while:
    - Under the influence of alcohol at a level that meets or exceeds the level at which intoxication would be presumed under the laws of the state where the accident occurred, or
    - Under the influence of a prescription drug taken in excess of the prescribed amount, or
    - Under the influence of an over-the-counter medication taken in excess of dosage instructions, or
    - Under the influence of an illegal drug,
- Injury, illness, mental illness, substance abuse, or pregnancy not being treated by a physician or surgeon; and
- Injury sustained as a result of doing any work for pay or profit for another employer.

Reporting a Claim

To initiate your disability claim and request your leave of absence, follow the process outlined below:

- Call your supervisor (or leave coordinator if instructed to do so) each day that you are absent from work (or report your absence according to your location's attendance policy).
- Call the Claims Administrator to initiate a disability claim as soon as possible but no later than 5 days from the start of your absence. If you have a planned absence (such as surgery or pregnancy-related condition) contact the Claims Administrator no sooner than 30 days from your expected absence begins date.

The Claims Administrator will ask you to provide some basic information, including personal information, job information, Illness/Injury information, and physician information. Please note that you should contact your physician to let him or her know that your Disability Benefits Manager will be contacting him or her to discuss your condition and how it relates to your ability to perform your job. If you have not already done so, your physician may require you to sign an authorization to release medical information before discussing your condition with the Disability Benefits Manager. Please sign this authorization as soon as possible, as this will avoid delays in the evaluation of your claim. You are ultimately responsible for ensuring that your physician(s) provides the claims administrator with the needed information.

Please note:

- The Claims Administrator then requests information from your employer regarding your last day worked, your work schedule, your job duties, and any other necessary information.
- The Claims Administrator has the sole authority to approve or reject claims according to the Plan's rules.

Your Responsibilities During the Claims Process

During the claims process, you are responsible for:

- Filing the claim in a timely manner (as defined above);
- Providing a written release of information authorization to your attending physician;
- Maintaining contact with your Disability Benefits Manager and assisting the claims administrator in obtaining medical information that is necessary to evaluate your initial claim and throughout the period of your disability;
- Following through on appointments and the treatment plan that your physician recommends;
- Cooperating with transitional return-to-work plans;
- Applying for other benefits that may be available to you as a result of your disability;
- Providing the Claims Administrator with copies of other pay you may receive;
- Updating the Claims Administrator on any changes to other benefits you may be receiving while out on disability;
- Maintaining contact with your supervisor (consistent with your location's requirement) on a regular basis; and
- Providing honest and complete information to expedite the evaluation of your claim.

If you fail to comply with this process, it may result in the delay or possible denial of your disability benefits.

Filing Proper Claims

You must file a claim for STD benefits. You can obtain a claim form from the Claims Administrator by calling **1-888-437-8671**, or by going online at **www.abilityadvantage.thehartford.com**. In addition to the responsibilities outlined above, the claim form has instructions on how, when and where to file a claim.

You should file your claim for disability within 5 days of the start of your disability. The deadline for filing a STD claim is 30 days after the end of a waiting period. If, through no fault of your own, you are not able to meet the deadline for filing a claim, your claim will still be accepted if you file as soon as reasonably possible.

How Claims Are Paid

Benefits will be paid as soon as the Claims Administrator receives the necessary proof to support your claim. STD benefits are paid weekly. Weekly benefits for a period of disability less than a week are prorated, based on how many days you are disabled during the week.

Time Frames for Claim Decisions

The Claims Administrator will notify you of its decision about your claim within 15 business days after it receives your claim.

Extension of Time Frames

If the Claims Administrator needs additional time to make a decision for reasons beyond the Plan's control:

- Five (5) business days prior to the approve through date, an outreach to the employee will occur via text message, if elected, or via telephone call, if text message is not elected.
- The employee should notify The Hartford as soon as possible regarding any extension needs. If The Hartford does not hear from the employee within 10 business days, the claim will terminate for failure to provide medical information.

When The Hartford is notified for the need of the extension, The Hartford will reach out for any applicable missing medical/financial information. This information for the extension request must be received within 15 business days or the claim will close.

The Claims Administrator's notice of any extension will specifically explain:

- The standards on which entitlement to a benefit is based;
- The unresolved issues that prevent a decision on the claim; and
- The additional information needed to resolve those issues.

Definitions

Illness

A pathological condition of the body that presents a group of clinical signs and symptoms and laboratory findings peculiar to it and that sets the condition apart as an abnormal condition differing from other normal conditions or from other pathological conditions.

Injury

An accidental bodily injury that is the sole and direct result of an unexpected or reasonably unforeseen occurrence, event or voluntary act by the person.

Pre-disability Earnings
Your gross salary or wages that you were earning from a Participating Employer as of your last day actively at work before your disability began. This amount is calculated on an annual basis.

For "4-crew" employees, your actual hours worked do not determine your Pre-disability Earnings. When your leave begins, the Claims Administrator calculates your annual amount by taking an average of hours worked in a week given your annual schedule. For example: a 4-crew employee works 36 hours one week and 48 hours the next week. Their average is 42 hours per week which will be used to calculate the annual Pre-disability Earnings.

The term does not include:

- Commissions, awards and bonuses;
- Overtime pay; or
- Any other compensation from a Participating Employer.

Important Note for Commissioned Sales Employees: Your last 3 full years of base pay and commissions, excluding bonuses, will be used to calculate your base pay amount. This calculated average amount will be frozen each September 1 prior to the Plan year. If you have been employed less than 3 calendar years, each full calendar year of employment will be used and averaged for this calculation.

Transitional Duty
Any temporary, restricted return to work, approved by a Participating Employer, which occurs during a period of disability with a goal of returning you to active work. Transitional Duty may include:

- A reduction in the number of hours (minimum of 4 hours per day) or work days;
- Restriction to performing some, but not all, of your essential job functions;
- Placement by a Participating Employer to another job.

APPENDIX D
EMPLOYEE ASSISTANCE PROGRAM

The Employee Assistance Program ("EAP") provides you and immediate members of your household with counseling and referral services to help with everyday life challenges that may affect your health, family life and productivity and happiness at work. The EAP is paid for by the Company and requires no additional cost for usage by you (or immediate members of your household).

An advocate is ready to help assess your needs and develop a solution to help resolve your concerns. He or she can also direct you to an array of resources in your community and online tools.

Confidential Counseling

You have six sessions with a qualified mental health professional available to you and your household members per presenting issue, per year. Common reasons you or your household members may access privacy protected counseling services include:

- Anxiety
- Depression
- Family or martial relational issues
- Stress
- Martial relational issues
- Occupational or situation challenges
- Presence of substance misuse

Work and Life Services

A Work-Like specialist will complete a thorough assessment with each caller then provide resources and support services specific to your needs. Call for a referral to a service in your community or advice on topics such as:

- Child care resources
- Respite care resources
- Elder - memory care
- Assisted living facilities
- Resources for activities of daily living
- Pet care
- Adoption
- Educational resources
- Moving & relocation

Legal and Financial Consultation

The EAP also provides legal and financial consultation services provided by attorneys, CPA's, financial planners, credit counselors and budget specialist, as applicable. For legal consultations, you may receive a 60-minute consultation for family related issues or a 30-minute consultation for other legal issues, per issue. For financial consultations, you may receive a 60-minute

consultation per issue. Additionally, if you retain services through the EAP, discounted rates apply to those services.

Common reasons you may access consultation services include:

- Family law issues
- Divorce, child custody, child-support
- Wills, advanced directives
- Budgetary issues
- Credit recovery support
- Identify Theft
- Criminal, tax, probate and real estate law

How the EAP Works

EAP services can be accessed through a toll-free number 24 hours a day, 7 days a week. To speak with an EAP advocate, Monday through Friday, 8:00 am to 8:00 pm (EST), please call (877) 409-1488 or visit www.carelonwellbeing.com/LSC.

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