

RR DONNELLEY

**2007 Summary of
Material Modifications
(SMM) for the
RR Donnelley Medical
and Prescription Drug
Programs under the
R.R. Donnelley & Sons
Company Group
Benefits Plan**

September, 2006

The material that follows is a legally required notice of benefit plan changes effective January 1, 2007. It describes changes to the Medical & Prescription Drug Programs from the 2006 Summary Plan Description (SPD). To make sure you have the most up-to-date information, keep this document with your 2006 SPD.

All employees

The Summary Charts for the various Options are replaced with the following.

Health Choice Option (CIGNA, UHC/Definity, and BCBS)

Pages 32 – 34, 67 – 69, and 103 – 105

Key Feature	In-Network	Out-of-Network*
Annual Deductible	You Pay	
• You Only		\$2,000
• You + Spouse		\$3,000
• You + Child(ren)		\$3,000
• Family		\$4,000
Annual Out-of-Pocket Limit (includes deductible)	You Pay	
• You Only		\$4,500
• You + Spouse		\$6,750
• You + Child(ren)		\$6,750
• Family		\$9,000
Coinsurance	Program Pays	Program Pays
• Physician Office Visits	80% after deductible is met	60% after deductible is met
• Independent X-Ray and Lab Facility**	80% after deductible is met	60% after deductible is met
• Routine Preventive Care (adults and children)	100% with no deductible	Not covered
• Inpatient/Outpatient Hospital Facility Services	80% after deductible is met	60% after deductible is met
• Outpatient Surgery	80% after deductible is met	60% after deductible is met
• Inpatient/Outpatient Professional Services (for non-emergency/urgent services)	80% after deductible is met	60% after deductible is met

Key Feature	In-Network	Out-of-Network*
Coinsurance (cont.)	Program Pays	Program Pays
<ul style="list-style-type: none"> Inpatient/Outpatient Professional Services (for emergency/urgent services) 	80% after deductible is met	80% after deductible is met, if true emergency as determined by the claims administrator 60% after deductible is met, if not a true emergency as determined by the claims administrator
<ul style="list-style-type: none"> Emergency/Urgent Care Facility (for emergency/urgent services) 	80% after deductible is met	80% after deductible is met, if true emergency as determined by the claims administrator 60% after deductible is met, if not a true emergency as determined by the claims administrator
<ul style="list-style-type: none"> Outpatient Rehabilitation Services, Including Speech, Occupational, Physical, Pulmonary, and Cognitive Therapy (limited to 90 visits per calendar year, in- and out-of-network services combined) 	80% after deductible is met	60% after deductible is met
<ul style="list-style-type: none"> Outpatient Cardiac Rehabilitation Services Phases I and II (limited to 36 visits per calendar year, in- and out-of-network services combined) 	80% after deductible is met	60% after deductible is met
<ul style="list-style-type: none"> Chiropractic Therapy (limited to \$1,500 each calendar year, in- and out-of-network services combined) 	80% after deductible is met	60% after deductible is met
<ul style="list-style-type: none"> Inpatient Skilled Nursing/ Rehabilitation (subject to preauthorization of medical necessity), limited to 90 days per calendar year, in- and out-of-network services combined 	80% after deductible is met	60% after deductible is met
<ul style="list-style-type: none"> Home Health Care (subject to preauthorization of medical necessity), limited to 120 visits per year, in- and out-of-network services combined 	80% after deductible is met	60% after deductible is met
<ul style="list-style-type: none"> Durable Medical Equipment/ External Prosthetic Appliances 	80% after deductible is met	60% after deductible is met

Key Feature	In-Network	Out-of-Network*
Mental Health and Substance Abuse*** <ul style="list-style-type: none"> Inpatient (subject to preauthorization of medical necessity), a 90-day lifetime maximum applies for in- and out-of-network services combined Outpatient (subject to preauthorization of medical necessity), a 450-visit lifetime maximum applies for in-and out-of-network services combined 	80% after deductible is met (up to 30 days per year)	60% after deductible is met (up to 20 days per year)
Lifetime Maximum (includes benefits for mental health and substance abuse care as well as benefits from the Prescription Drug Program)	\$5 million per individual	
Prior Authorization	Please see the “Preadmission Certification – CIGNA,” “Prior Notification Requirements – UHC,” and “Preadmission Certification and the MSA Program – BCBS” sections for details.	
Prescription Drug Program <ul style="list-style-type: none"> Generic preventive medicine for hypertension and hyperlipidemia 	80% after deductible is met	60% after deductible is met
	100%	
	See “The Prescription Drug Program” section for details	

*Charges above the maximum reimbursable charge are the member’s responsibility. These amounts do not count toward the deductible or the out-of-pocket limit.

**If laboratory work and/or X-rays are done in an independent facility, claims will be processed at the applicable coinsurance levels.

***The Program limits care in an Intensive Outpatient Program (IOP) to two programs each year and four programs per lifetime.

**Health Value Option (CIGNA, UHC/Definity, and BCBS)
Pages 34 – 36, 69 – 71, and 105 – 107**

Key Feature	In-Network	Out-of-Network*
Annual Deductible <ul style="list-style-type: none"> You Only You + Spouse You + Child(ren) Family 	You Pay	
	\$2,700	
	\$4,100	
	\$4,100	
	\$5,450	
Annual Out-of-Pocket Limit (includes deductible) <ul style="list-style-type: none"> You Only You + Spouse You + Child(ren) Family 	You Pay	
	\$5,000	
	\$7,750	
	\$7,750	
	\$10,500	

Key Feature	In-Network	Out-of-Network*
Coinsurance	Program Pays	Program Pays
<ul style="list-style-type: none"> Physician Office Visits 	85% after deductible is met	65% after deductible is met
<ul style="list-style-type: none"> Independent X-Ray and Lab Facility** 	85% after deductible is met	65% after deductible is met
<ul style="list-style-type: none"> Routine Preventive Care (adults and children) 	100% with no deductible	Not covered
<ul style="list-style-type: none"> Inpatient/Outpatient Hospital Facility Services 	85% after deductible is met	65% after deductible is met
<ul style="list-style-type: none"> Outpatient Surgery 	85% after deductible is met	65% after deductible is met
<ul style="list-style-type: none"> Inpatient/Outpatient Professional Services (for non-emergency/urgent services) 	85% after deductible is met	65% after deductible is met
<ul style="list-style-type: none"> Inpatient/Outpatient Professional Services (for emergency/urgent services) 	85% after deductible is met	85% after deductible is met, if true emergency as determined by the claims administrator 65% after deductible is met, if not a true emergency as determined by the claims administrator
<ul style="list-style-type: none"> Emergency/Urgent Care Facility (for emergency/urgent services) 	85% after deductible is met	85% after deductible is met, if true emergency as determined by the claims administrator 65% after deductible is met, if not a true emergency as determined by the claims administrator
<ul style="list-style-type: none"> Outpatient Rehabilitation Services, Including Speech, Occupational, Physical, Pulmonary, and Cognitive Therapy (limited to 90 visits per calendar year, in- and out-of-network services combined) 	85% after deductible is met	65% after deductible is met
<ul style="list-style-type: none"> Outpatient Cardiac Rehabilitation Services Phases I and II (limited to 36 visits per calendar year, in- and out-of-network services combined) 	85% after deductible is met	65% after deductible is met
<ul style="list-style-type: none"> Outpatient Rehabilitation Services, Including Speech, Occupational, Physical, Pulmonary, Cognitive Therapy, and Cardiac Rehabilitation Therapy Phases I and II (limited to 90 visits per calendar year, in- and out-of-network services combined) 	85% after deductible is met	65% after deductible is met
<ul style="list-style-type: none"> Chiropractic Therapy (limited to \$1,500 each calendar year, in- and out-of-network services combined) 	85% after deductible is met	65% after deductible is met

Key Feature	In-Network	Out-of-Network*
Coinsurance (cont.)	Program Pays	Program Pays
<ul style="list-style-type: none"> Inpatient Skilled Nursing/ Rehabilitation (subject to preauthorization of medical necessity), limited to 90 days per calendar year, in- and out-of-network services combined 	85% after deductible is met	65% after deductible is met
<ul style="list-style-type: none"> Home Health Care (subject to preauthorization of medical necessity), limited to 120 visits per year, in- and out-of-network services combined 	85% after deductible is met	65% after deductible is met
<ul style="list-style-type: none"> Durable Medical Equipment/ External Prosthetic Appliances 	85% after deductible is met	65% after deductible is met
Mental Health and Substance Abuse***		
<ul style="list-style-type: none"> Inpatient (subject to preauthorization of medical necessity), a 90-day lifetime maximum applies for in- and out-of-network services combined 	85% after deductible is met (up to 30 days per year)	65% after deductible is met (up to 20 days per year)
<ul style="list-style-type: none"> Outpatient (subject to preauthorization of medical necessity), a 450-visit lifetime maximum applies for in-and out-of-network services combined 	85% after deductible is met (up to 30 visits per year)	65% after deductible is met (up to 20 visits per year)
Lifetime Maximum (includes benefits for mental health and substance abuse care as well as benefits from the Prescription Drug Program)	\$5 million per individual	
Prior Authorization	Please see the "Preadmission Certification – CIGNA," "Prior Notification Requirements – UHC," and "Preadmission Certification and the MSA Program – BCBS" sections for details.	
Prescription Drug Program <ul style="list-style-type: none"> Generic preventive medicine for hypertension and hyperlipidemia 	85% after deductible is met	65% after deductible is met 100%
	See "The Prescription Drug Program" section for details	

*Charges above the maximum reimbursable charge are the member's responsibility. These amounts do not count toward the deductible or the out-of-pocket limit.

**If laboratory work and/or X-rays are done in an independent facility, claims will be processed at the applicable coinsurance levels.

***The Program limits care in an Intensive Outpatient Program (IOP) to two programs each year and four programs per lifetime.

In-Network Only Option (CIGNA, UHC, and BCBS)
Pages 36 – 38, 71 – 73, and 107 – 109

Key Feature	In-Network
Annual Deductible <ul style="list-style-type: none"> • You Only • You + Spouse • You + Child(ren) • Family 	You Pay None None None None
Copayments <ul style="list-style-type: none"> • PCP Copayment • Emergency/Urgent Care Facility Copayment • Inpatient Hospital Copayment • Outpatient Surgery Copayment • Outpatient Rehabilitation Services Copayment • Specialist Copayment (a PCP referral is not required) 	You Pay \$25 \$75, waived if admitted; \$150 if not a true emergency \$100 per admission \$50 \$40 per therapy session per day \$40
Annual Out-of-Pocket Limit <ul style="list-style-type: none"> • You Only • You + Spouse • You + Child(ren) • Family 	You Pay \$1,000 \$2,000 \$2,000 \$2,000
Annual Out-of-Pocket Limit (Prescription Drug)* <ul style="list-style-type: none"> • You Only • You + Spouse • You + Child(ren) • Family 	You Pay \$2,500 \$4,500 \$4,500 \$4,500
Coinsurance <ul style="list-style-type: none"> • Physician Office Visits • Independent X-Ray and Lab Facility • Routine Preventive Care (adults and children) • Inpatient Hospital Facility Services • Outpatient Surgery • Inpatient/Outpatient Professional Services (for non-emergency/urgent services) • Inpatient/Outpatient Professional Services (for emergency/urgent services) 	Program Pays 100% after \$25 PCP copayment or \$40 specialist copayment 100% 100% after \$25 PCP copayment or \$40 specialist copayment 100% after \$100 inpatient hospital copayment per admission 100% after \$50 outpatient surgery copayment 100% 100%

Key Feature	In-Network
Coinsurance (cont.)	Program Pays
<ul style="list-style-type: none"> Emergency/Urgent Care Facility (for emergency/urgent services) 	100% after \$75 copayment (copayment is waived if admitted)
<ul style="list-style-type: none"> Outpatient Rehabilitation Services, Including Speech, Occupational, Physical, Pulmonary, and Cognitive Therapy (limited to 90 days per calendar year) 	100% after \$40 per therapy session copayment
<ul style="list-style-type: none"> Outpatient Cardiac Rehabilitation Therapy Phases I and II (limited to 36 visits per calendar year) 	100% after \$40 per therapy session copayment
<ul style="list-style-type: none"> Chiropractic Therapy (limited to \$1,500 each calendar year) 	100% after \$40 copayment
<ul style="list-style-type: none"> Inpatient Skilled Nursing/Rehabilitation (subject to preauthorization of medical necessity), limited to 90 days per calendar year 	100% after \$100 inpatient skilled nursing/rehabilitation copayment
<ul style="list-style-type: none"> Home Health Care (subject to preauthorization of medical necessity), limited to 120 visits per year 	100%
<ul style="list-style-type: none"> Durable Medical Equipment/External Prosthetic Appliances 	100%
Mental Health and Substance Abuse***	
<ul style="list-style-type: none"> Inpatient (a 90-day lifetime maximum applies) 	80% (up to 30 days per year)
<ul style="list-style-type: none"> Outpatient (a 450-visit lifetime maximum applies) 	80% (up to 30 visits per year)
Lifetime Maximum (includes mental health and substance benefits, as well as benefits from the Prescription Drug Program)	\$5 million per individual
Prior Authorization	Please see the "Preadmission Certification – CIGNA," "Prior Notification Requirements – UHC," and "Preadmission Certification and the MSA Program – BCBS" sections for details.

Key Feature	In-Network			
	Retail		Mail Order	
Prescription Drug Program	You Pay	Program Pays	You Pay	Program Pays
• Generic	10% (\$10 minimum)	90%	10% (\$30 minimum)	90%
• Brand Formulary	30% (\$10 minimum)	70%	30% (\$30 minimum)	70%
• Brand Non-Formulary	40% (\$10 minimum)	60%	40% (\$30 minimum)	60%
• Generic preventive medicine for hypertension and hyperlidemia	100%			
• Supply Limits	30-day supply		90-day supply	
	See "The Prescription Drug Program" section for details			

*The prescription drug out-of-pocket maximum is separate from the medical out-of-pocket maximum.

**The Program limits care in an Intensive Outpatient Program (IOP) to two programs each year and four programs per lifetime.

Indemnity Option (CIGNA) Pages 38 – 39

Key Feature	
Annual Deductible	You Pay
• Individual	\$1,000
• Family	\$2,000
Annual Out-of-Pocket Limit (includes deductible)	You Pay
• Individual	\$3,000
• Family	\$6,000
Coinsurance	Program Pays*
• Physician Office Visits	80% after deductible is met
• Independent X-Ray and Lab Facility**	80% after deductible is met
• Routine Preventive Care (adults and children)	100%, up to \$400 per covered individual per calendar year
• Inpatient Hospital Facility Services	80% after deductible is met
• Outpatient Surgery	80% after deductible is met
• Inpatient/Outpatient Professional Services (for non-emergency/urgent services)	80% after deductible is met
• Inpatient/Outpatient Professional Services (for emergency/urgent services)	80% after deductible is met
• Emergency/Urgent Care Facility (for emergency/urgent services)	80% after deductible is met

Key Feature				
Coinsurance (cont.)		Program Pays		
<ul style="list-style-type: none"> Outpatient Rehabilitation Services, Including Speech, Occupational, Physical, Pulmonary, and Cognitive Therapy (limited to 90 days per calendar year) 		80% after deductible is met		
<ul style="list-style-type: none"> Outpatient Cardiac Rehabilitation Therapy Phases I and II (limited to 36 visits per calendar year) 		80% after deductible is met		
<ul style="list-style-type: none"> Chiropractic Therapy (limited to \$1,500 each calendar year) 		80% after deductible is met		
<ul style="list-style-type: none"> Inpatient Skilled Nursing/Rehabilitation (subject to preauthorization of medical necessity), limited to 90 days per calendar year 		80% after deductible is met		
<ul style="list-style-type: none"> Home Health Care (subject to preauthorization of medical necessity), limited to 120 visits per year 		80% after deductible is met		
<ul style="list-style-type: none"> Durable Medical Equipment/External Prosthetic Appliances 		80% after deductible is met		
Mental Health and Substance Abuse***				
<ul style="list-style-type: none"> Inpatient (a 90-day lifetime maximum applies) 		80% after deductible is met (up to 30 days per year)		
<ul style="list-style-type: none"> Outpatient (a 450-visit lifetime maximum applies) 		80% after deductible is met (up to 30 visits per year)		
Lifetime Maximum (includes benefits for mental health and substance abuse care as well as benefits from the Prescription Drug Program)		\$5 million per individual		
Prior Authorization		Please see the "Preadmission Certification – CIGNA" section for details.		
Prescription Drug Program	Retail		Mail Order	
	You Pay	Program Pays	You Pay	Program Pays
<ul style="list-style-type: none"> Generic 	10% (\$10 minimum)	90%	10% (\$30 minimum)	90%
<ul style="list-style-type: none"> Brand Formulary 	30% (\$10 minimum)	70%	30% (\$30 minimum)	70%
<ul style="list-style-type: none"> Brand Non-Formulary 	40% (\$10 minimum)	60%	40% (\$30 minimum)	60%
<ul style="list-style-type: none"> Supply Limits 	30-day supply		90-day supply	
<ul style="list-style-type: none"> Generic preventive medicine for hypertension and hyperlipidemia 	100%			
See "The Prescription Drug Program" section for details				

*Charges above the maximum reimbursable charge are the member's responsibility. These amounts do not count toward the deductible or the out-of-pocket limit.

**If laboratory work and/or X-rays are done in an independent facility, claims will be processed at the applicable coinsurance levels.

***The Program limits care in an Intensive Outpatient Program (IOP) to two programs each year and four programs per lifetime.

Your Prescription Drug Coverage
Pages 134 – 135

Coverage Option	The Prescription Drug Program			
	In-Network Program Pays		Out-of-Network Program Pays	
Health Choice Options (CIGNA, UHC/Definity, and BCBS) <ul style="list-style-type: none"> Generic preventive medicine for hypertension and hyperlidemia 	80% after deductible*		60% after deductible*	
	100%			
Health Value Options (CIGNA, UHC/Definity, and BCBS) <ul style="list-style-type: none"> Generic preventive medicine for hypertension and hyperlidemia 	85% after deductible*		65% after deductible*	
	100%			
	Retail**		Mail Order Program**	
	You Pay****	Program Pays	You Pay****	Program Pays
In-Network Only Options*** (CIGNA, UHC, and BCBS) <ul style="list-style-type: none"> Generic Brand Formulary Brand Non-Formulary Generic preventive medicine for hypertension and hyperlidemia 	10% (\$10 minimum)	90%	10% (\$30 minimum)	90%
	30% (\$10 minimum)	70%	30% (\$30 minimum)	70%
	40% (\$10 minimum)	60%	40% (\$30 minimum)	60%
	100%			
	Retail**		Mail Order Program**	
	You Pay****	Program Pays	You Pay****	Program Pays
CIGNA Indemnity <ul style="list-style-type: none"> Generic Brand Formulary Brand Non-Formulary Generic preventive medicine for hypertension and hyperlidemia 	10% (\$10 minimum)	90%	10% (\$30 minimum)	90%
	30% (\$10 minimum)	70%	30% (\$30 minimum)	70%
	40% (\$10 minimum)	60%	40% (\$30 minimum)	60%
	100%			

*This is the applicable coverage option's deductible.

**A 30-day supply limit applies for retail, and a 90-day supply limit applies for mail order prescription drug services.

***A \$2,500 individual and \$4,500 family out-of-pocket limit (separate from the medical out-of-pocket limit) applies for prescription drug services under these coverage options. This means that once your eligible out-of-pocket expenses reach this limit, the Program starts paying 100% of eligible prescription drug expenses.

****If the total cost of the prescription is less than the copayment, you are still responsible for the total cost of the prescription.