A.H. Belo
Health Care & Welfare
Benefit Plan
Summary Plan Description

Effective January 1, 2020

Your Summary Plan Description

This document presents information about the health and welfare benefit programs provided by A. H. Belo Corporation (sometimes referred to as A. H. Belo or the “company” in this document) for its eligible employees. Eligible employees of A. H. Belo and its participating subsidiaries and their family members and beneficiaries are covered by these A. H. Belo plans.

This document is intended to provide easy-to-understand descriptions (Summary Plan Descriptions, or SPDs) of each benefit program provided by the A. H. Belo health and welfare benefit plans. Neither these SPDs nor updated materials are contracts or assurances of compensation, continued employment or benefits of any kind. If any summary of benefits differs from the official plan documents in any way, the official plan documents will govern.

A. H. Belo reserves the right to modify or terminate any of its plans or programs described in the SPDs or booklets at its discretion. Only A. H. Belo is authorized to change its respective plans. From time to time, you will receive updated information concerning plan changes.

The information contained here can also be accessed at life360ahbelo.com. Citations within this text referring readers to the benefits Web site are directing you to life360ahbelo.com.

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Benefits Overview

Your Benefits

Health Benefits

A. H. Belo offers medical, dental and vision plans for you and your dependents. The company shares the cost of medical and dental benefits by paying a portion of your premiums.

Disability Coverage

The company provides long-term disability coverage so you will have income if you cannot work because of an illness or injury.

Life and Accident Coverage

Eligible employees automatically receive basic life insurance and business travel accident insurance, which are paid for by the company. You may increase the level of your life insurance coverage, add personal accident insurance coverage and elect life and personal accident insurance protection for your spouse/domestic partner and children at an additional cost.

Voluntary Benefits

The company offers voluntary auto and home insurance, critical illness and a legal plan. You pay the full cost of these benefits.

Health Savings Account

If you enroll in the BlueCross BlueShield of Texas Consumer-Driven Health Plan (BCBSTX CDHP), and eligible for a Health Savings Account (HSA) you can take advantage of tax savings by making tax-free contributions to the HSA to pay for eligible medical, dental and vision care expenses. A. H. Belo also makes a company contribution to your HSA. All of the money in the account is yours to keep, even if you leave the company, and any unused balance in your account rolls over year to year. You do not owe taxes on your contributions, your qualified withdrawals or any investment earnings.

Flexible Spending Accounts

You can also take advantage of tax savings by making before-tax contributions to flexible spending accounts (FSAs) to pay for health care and dependent care expenses. If you enroll in the CDHP and are eligible for an HSA, you may only participate in the Limited-Purpose FSA, which reimburses you for eligible dental and vision expenses.

Severance Plan

A. H. Belo has also adopted a severance plan that provides benefits to eligible employees whose employment is involuntarily terminated.

Eligibility and Participation

Eligibility Summary

Here is a quick look at our benefit plans, who can be covered and when coverage begins.

Automatic Coverage		
Plan	**Who can be covered**	**Coverage begins the 1st of the month following:**
Basic Life Insurance	Eligible employees	2 months of continuous service
Business Travel Accident Insurance	Eligible employees and dependents	No waiting period (coverage automatically begins on the first day you are actively at work)
Long-Term Disability	Eligible employees	12 months of continuous full-time service
Employee Assistance Program	Eligible employees and dependents	No waiting period (coverage automatically begins on the first day you are actively at work)
Severance Plan	Eligible employees	No service period
Optional Coverage You May Choose		
Plan	**Who can be covered**	**Coverage begins the 1st of the month following:**
Medical	Eligible employees and dependents	2 months of continuous service
Dental	Eligible employees and dependents	2 months of continuous service
Vision	Eligible employees and dependents	2 months of continuous service
Health Savings Account	Eligible employees and dependents	Your enrollment
Health and Dependent Care Flexible Spending Accounts	Eligible employees and dependents	2 months of continuous service
Supplemental Life Insurance	Eligible employees	2 months of continuous service
Personal Accident Insurance	Eligible employees	2 months of continuous service
Dependent Life and Personal Accident Insurance	Eligible dependents	2 months of continuous service
Group Legal	Eligible employees and dependents	Your enrollment
Auto and Home Insurance	Eligible employees and dependents	Your enrollment
Critical Illness	Eligible employees and dependents	Your enrollment

Who Is Eligible

You are **eligible to participate** in most of the plans if you meet all of the following requirements:

- You are classified as a regular, full-time employee of a participating A. H. Belo company,
- You work at least 30 hours per week, and
- You have completed two months of continuous service.

If you are rehired to a benefits-eligible position within six months of a reduction-in-force initiative, your benefits, with the exception of long-term disability, will resume on the first of the month following your rehire date. Part-time employees are eligible to participate in the Employee Assistance Program, business travel accident insurance, auto and home insurance, group legal and Critical Illness. Group legal coverage must be paid for through payroll deduction — as a part-time employee, you must work enough hours to cover the deduction.

You are **not eligible to participate** in any of these plans if you are:

- Covered by a collective bargaining agreement that does not provide for your participation
- A nonresident alien
- A leased employee or otherwise performing services through a leasing organization or outsourcing provider
- Classified by an A. H. Belo company as an independent contractor for federal income tax purposes, even if that classification is later determined to have been incorrect
- Classified by an A. H. Belo company as a temporary or part-time employee, regardless of the nature of your duties or the length of service for any benefit plans, except as defined above
- Employed by an A. H. Belo company that does not participate in the plans

New Employees

If you are an eligible employee, you are a participant in the Basic Life Insurance Plan on the first of the month following two months of continuous service. You are a participant in the Long-Term Disability (LTD) Plan on the first of the month following 12 months of continuous full-time service. You may choose coverage for yourself and your dependents under any of the other benefit plans provided you return your enrollment form by the deadline.

If You and Your Spouse Both Work for the Company

If you and your spouse are both employed by A. H. Belo companies, you may enroll separately for benefit coverage. (You cannot be covered as both an employee and a dependent.) If you have children, only one of you may cover them as dependents.

Eligible Dependents

For most plans, an eligible dependent is an individual who is related to you in one of the following ways:

- Spouse
    - Beginning in 2016, spouses who are employed and have access to medical and/or dental coverage through their employer are not eligible to enroll in medical and/or dental under the A. H. Belo plans.
- Your dependent child who is:
    - Under age 26, regardless of student, employment or marital status, or
    - Age 26 or older and incapacitated

Summary of Benefit Plans

The following table summarizes benefit options available to eligible employees.

Plan	Your Choices	Who Pays the Cost of Coverage
Medical	▸ BlueCross BlueShield CDHP/HSA PPO (Consumer-Driven Health Plan with Health Savings Account) ▸ BlueCrossBlueShield PPO	You and the company share the cost
Dental	▸ Delta Dental PPO ▸ MetLife Dental Health Maintenance Organization (DHMO)	You and the company share the cost
Vision	▸ Vision Service Plan	You pay
Health Savings Account	▸ Employees enrolled in the CDHP medical plan and eligible to contribute to a Health Savings Account can contribute on a tax-free basis up to $3,550 for employee-only coverage or up to $7,100 for coverage that includes dependents (minus any company contribution). ▸ IRS allows a catch up contribution of up to $1000 in addition to the above contribution limit if age 55 or older in 2019 ▸ Employees earning less than $100,000 will receive a quarterly company contribution . The company contribution is based on on your earnings and coverage level (pro-rated depending on your hire date) ▸ To avoid federal income tax and penalties, the funds in the HSA account should only be used for eligible medical, dental or vision expenses	You make voluntary contributions and, if you are enrolled in the CDHP and eligible for a HSA, the company contributes
Health Care Flexible Spending Account	**Regular Health Care Flexible Spending Account** ▸ Employees in-eligible for the HSA ▸ Contribute $300 to $2,700 per year on a before-tax basis ▸ Use for eligible medical, dental and vision care expenses **Limited-Purpose Health Care Flexible Spending Account** ▸ For use with CDHP ▸ Contribute $300 to $2,700 per year on a before-tax basis ▸ Use for eligible dental and vision care expenses only	You make voluntary contributions
Dependent Care Flexible Spending Account	▸ Contribute $300 to $5,000 per year on a before-tax basis (the company match counts toward the maximum contribution) ▸ You will receive a $1 for $1 match up to $20 per week (not to exceed $1,040 annually) if you are contributing	You make voluntary contributions and the company matches a portion
Basic Life Insurance for You	For most employees, two times your basic annual earnings: ▸ Up to $1,000,000 maximum ▸ Guarantee issue limit is $750,000	The company pays
Supplemental Life Insurance	Coverage (up to $1,000,000) of: ▸ One times to five times your basic annual earnings ▸ Guarantee issue limit is $750,000 ▸ Up to $1,000,000 maximum	You pay
Life Insurance for Your Spouse/ unmarried Children	▸ Option 1 — $10,000 for spouse; $5,000 for unmarried children less than age 26 ▸ Option 2 — $5,000 for spouse; $2,500 for unmarried children less than age 26 ▸ Option 3 — $20,000 for spouse; $10,000 for unmarried children less than age 26	You pay
Personal Accident Insurance for You	▸ One times to six times your basic annual earnings, up to $500,000	You pay

Plan	Your Choices	Who Pays the Cost of Coverage
Personal Accident Insurance for Your Family	Coverage for: ▸ Spouse only — 60% of your coverage amount ▸ Children only — 20% of your coverage amount ▸ Spouse and children — 50% and 15% of your coverage amount, respectively	You pay
Business Travel Accident Insurance for You and Eligible Family Members	Coverage for: ▸ Employee — 1-1/2 times your annual earnings (minimum of $100,000, maximum of $300,000) ▸ Spouse — $50,000 ▸ Each child — $25,000	The company pays
Long-Term Disability	▸ Coverage of 60% of base monthly earnings, up to a maximum monthly benefit of $10,000	The company pays
Severance Plan	▸ Termination benefits provided to certain eligible employees whose employment is involuntarily terminated	The company pays
Legal Plan	▸ Prepaid legal services through a nationwide network of attorneys	You pay
Auto and Home Insurance	▸ Apply for auto, home and other property insurance at special group rates	You pay
Critical Illness Insurance	▸ Lump-sum payment in the event of certain major illnesses, medical conditions or major procedures to help pay costs not typically covered by other types of insurance, such as copays, out-of-network treatments, child care, mortgage payments and other expenses	You pay

Enrolling for Benefits

You may enroll in or change your benefits when you first become eligible, during the annual enrollment period each year, if you have a change in status or if you have special enrollment rights. You may also decline all health and employee paid supplemental life coverage.

If you have a choice in medical and/or dental plans, you may not enroll yourself in one plan and your family members in another.

You may not change the medical or dental plan in which you are enrolled during a calendar year. Once you elect a specific plan, that plan remains in effect for the entire calendar year.

Coverage Categories

When you enroll for coverage, you choose one of the following coverage categories:

- Employee Only
- Employee and Spouse
- Employee and Children
- Employee and Family

Your Initial Enrollment

You do not need to enroll for basic life insurance, long-term disability (LTD), or severance plan coverage because A. H. Belo provides these benefits at no cost to you.

You must submit enrollment elections to the Workday system for all other benefits prior to the end of your eligibility period. **It is important to enter your elections — even if you want to decline optional health benefits.**

If you submit you enrollment elections within 31 days of your hire date, coverage for you (and your dependents, if applicable) will take effect on the first of the month in which you become eligible, which is two full, continuous months after your hire date. If you are hired on the first of a month, that month will count as one of the two months after your hire date.

If you do not submit your enrollment elections before the 31-day enrollment period ends, you and your dependents will not be eligible for coverage until the next annual enrollment period (unless you have a change in status, described in Changing Your Coverage, that allows you to enroll earlier). For example, assume you are hired on January 2. You would have 31 days from that date, or by February 1, to enter your enrollment elections into the Workday system. Because you become eligible for benefits on the first of the month after two full, continuous months of service, you would be eligible—and able to start benefits—on April 1.

Annual Open Enrollment

The company holds an annual enrollment each year so you can review your benefit elections and make changes for the following year. You may change your medical, dental, vision and flexible spending account elections during this enrollment period. You may also increase or decrease coverage under basic life, supplemental life, dependent life, and personal accident insurance at this time, subject to plan limitations. If you choose not to make changes to your coverage during annual enrollment, your existing health plan coverage automatically remains in effect through the following plan year (January 1 through December 31), unless you have a change in status that allows you to make changes during the year. **You must annually elect to contribute to your Health Savings Account (HSA) and your Flexible Spending Account (FSA).**

Paying for Your Benefits

The company pays for some of your benefits and you pay for others. Your cost for benefits is deducted from each paycheck. Many of your benefits are paid before-tax, which reduces the total amount of your federal income and Social Security taxes. In most states, your payroll deductions also will be made on a before-tax basis for purposes of state income taxes.

How Paying Before- or After-Tax Can Affect Changes

This table shows which benefits you may pay for on a before-tax and after-tax basis, when you may change your elections and when the changes will take effect.

Description	Before-Tax Benefits	After-Tax Benefits
Benefit Options	▸ Medical ▸ Dental ▸ Vision ▸ Health Savings Account ▸ Health care flexible spending account ▸ Dependent care flexible spending account ▸ Personal accident insurance	▸ Supplemental and dependent life insurance ▸ Group legal, critical illness and auto and home insurance
Changing Your Benefits	You may enroll in or change your elections for most before-tax benefits only: ▸ During annual enrollment, ▸ When you have a change in status, or ▸ If you have special enrollment rights. You may change your contribution amount to your Health Savings Account at any time, within plan limits.	▸ You may drop or decrease your after-tax life insurance at any time. ▸ You may increase your after-tax life insurance only during annual enrollment or a change in status.

Description	Before-Tax Benefits	After-Tax Benefits
When Changes Take Effect	▸ Changes or elections made during annual enrollment take effect the following January 1. ▸ Changes you make to your flexible spending accounts as a result of a change in status take effect on the day after your change form and supporting documentation are received by your administrator. ▸ In most cases, changes to other coverage as a result of a change in status take effect on the date of the event. For marriage, a change in coverage becomes effective on the first of the following month.	▸ Changes or elections made during annual enrollment that do not require proof of good health take effect the following January 1. ▸ If you make changes to coverage as a result of a change in status (and you are not required to provide proof of good health), your new coverage takes effect on the later of the date of the event or the date you complete the request (provided it is within 31 days following the event). ▸ If you are required to provide proof of good health to the insurer (either during annual enrollment or if you have a change in status), the new coverage will take effect when the insurer approves it, but not sooner than January 1 for open enrollment changes.

Changing Your Coverage

Changes in Status

You may change the level of your elections during the year if you have any of the following changes in status:

- Change in marital status
- Termination or commencement of employment by you, your spouse, or dependent
- Certain changes in work schedule (applies to Dependent Care Flexible Spending Account only)
- Dependent satisfies (or ceases to satisfy) dependent eligibility requirements
- Change in residence or worksite of you, your spouse, or dependent
- Acquire a new dependent through birth or adoption

To change your coverage, you must submit an online **Benefits Change Request** to your benefit administrator within **31 days** of your change in status. If requested, you must provide documentation (for example, a birth certificate) that supports the change in status. The change you request must be consistent with the change in status you experience. Your change will not go into effect until the required documentation has been received and the change has been approved.

An eligible newborn child is covered under the medical plan during the first 31 days of life. However, if you do not add the child to your coverage during the first 31 days following birth, the child's coverage will not take effect and you will have to wait until the next annual enrollment to add your child to coverage. To add your newborn, complete the online Benefits Change Request within 31 days of birth.

If you are enrolled for dependent life insurance (and covering other eligible dependents) at the time of your child's birth, your child is automatically covered under this plan (subject to plan eligibility and benefit). Otherwise, if you want to elect dependent life insurance to cover your newborn child, you will need to submit an online Benefits Change Request and elect this coverage within 31 days of birth.

If you do not submit your change of status to the system within 31 days of the event, you must wait until the next annual enrollment period to make a change to your coverage. You may not change the health plan in which you are enrolled during a calendar year due to a qualifying event.

The Summary of Allowable Status Changes table describes the changes in coverage you may make when you experience a change in status. Any change must be consistent with the change in status as interpreted in the tax laws.

Special Enrollment Rights

Under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), you may be entitled to enroll in group health plans (medical, dental, vision and flexible spending account) offered by the company at times other than the annual enrollment period. If you decline A. H. Belo's health coverage because you have other coverage and you later lose that coverage or gain a dependent, you or your dependent may have special enrollment rights. The enrollment must be consistent with the change you experience. You must enroll within 31 days of the event that caused your special enrollment rights or you will lose your special enrollment rights for that event.

If the event giving rise to your special enrollment right is a loss of coverage under Medicaid or the Children's Health Insurance Program (CHIP), you may request enrollment under the A. H. Belo health plans within 60 days of the date you or your dependent(s) lose such coverage under Medicaid or CHIP. Similarly, if you or your dependent(s) become eligible for a state-granted premium subsidy toward the A. H. Belo health plans, you may request enrollment within 60 days after the date Medicaid or CHIP determine that you or the dependent(s) qualify for the subsidy.

You are entitled to enroll in a group health plan offered by A. H. Belo when:

- Other coverage ends because you or your dependent is no longer eligible (for example, as a result of legal separation, divorce, death, termination of employment or reduction in number of hours of employment)
- You or your dependent exhausts COBRA coverage under another employer's plan
- You gain a dependent (for example, you marry, have a new child by birth or adoption)
- The employer sponsoring the plan in which you are enrolled stops making contributions toward the cost of coverage
- A loss of HMO coverage occurs because the person no longer resides or works in the HMO service area and no other coverage option is available through the HMO plan sponsor
- You or your dependent loses coverage under Medicaid or the Children's Health Insurance Program (CHIP).
- You or your dependent becomes eligible for a state-granted premium subsidy toward the plan under Medicaid or CHIP.

Even if you are not then covered by any group health plan offered by A. H. Belo, you, your spouse and new dependent child may enroll because of your marriage, or the birth or adoption of your child. However, you must request enrollment within the applicable time period following the event, as described above. In the case of any dependents who lose other coverage, they must have been and remain eligible under the A. H. Belo group health plans at the time of the last annual enrollment. Losing eligibility or exhausting COBRA coverage does not include failing to pay premiums on a timely basis or having your other coverage terminated for cause.

To request special enrollment or obtain more information, please contact A. H. Belo Benefits at 214-977-7210.

Summary of Allowable Status Changes

The following table lists the changes you are allowed to make due to qualified changes in status and indicates whether the event would potentially give you special enrollment rights or allow you to make changes to current elections. Any change must be consistent with the change in status as interpreted in the tax laws.

Description of Change	Special Enrollment Rights	Medical, Dental and Vision	Health Care FSA	Dependent Care FSA	Life Insurance Plans
You marry	✓	✓	✓	✓	✓
You gain a dependent	✓	✓	✓	✓	✓
Your spouse or dependent loses eligibility under the A. H. Belo plans		✓	✓	✓	✓
You or your dependent dies or you divorce or become legally separated		✓	✓	✓	✓
You move to a new home address which is outside your current plan's service area		✓	✓	✓	

Description of Change	Special Enrollment Rights	Medical, Dental and Vision	Health Care FSA	Dependent Care FSA	Life Insurance Plans
You become eligible for benefits as a: ▸ New hire ▸ Rehire ▸ Change from part-time to full-time status		✓	✓	✓	✓
Your spouse's coverage or cost through his or her employer changes significantly		✓			
Your spouse loses eligibility at his/her employer	✓	✓	✓	✓	✓
Your spouse gains coverage through his/her employer		✓	✓	✓	✓
You, your spouse or dependent lose other health plan coverage	✓	✓	✓		
You or your spouse change work shifts				✓	
You or your dependent lose Medicaid or CHIP coverage	✓	✓	✓		
You or your dependent become eligible for a premium subsidy under Medicaid or CHIP	✓	✓	✓		

Complete your enrollment form within **31 days** of the change in status (within 60 days if the event is loss of coverage under or new eligibility for premium subsidy under Medicaid or CHIP). The new coverage for birth, adoption or Qualified Medical Child Support Order (QMCSO) is effective on the date of the event. For marriage , coverage is effective on the first day of the following month. If you do **not** submit the enrollment form within 31 days of the change, you may not change your benefit elections until the next annual enrollment.

Note: For dropping a dependent, the change is effective the end of the month in which the qualifying event occurs. If a dependent becomes ineligible and you do not notify your benefit administrator within the 31 days, the dependent will still be considered ineligible for benefits.

Mid-Year Enrollment and Re-Enrollment

If you wish to enroll at some time after you first become eligible or after you have dropped coverage, you may do so during the next annual enrollment. Coverage will take effect on January 1 of the following year if you complete the enrollment form and you do not have an allowable status change and provide proof of good health, if applicable. If you are not actively at work when you enroll, your basic, supplemental and dependent life insurance, personal accident insurance and long-term disability coverage would not take effect until you return to work and can perform the regular duties of your job for one full day. If you have an allowable status change that permits you to enroll in the coverage you want, you may enroll in such coverage after annual enrollment, provided you request to make a change in your coverage elections within 31 days of your status change event (60 days for Medicaid or CHIP eligibility) changes.

Changing Supplemental Coverages

Supplemental Life and Accident Insurance

Because the company provides basic life insurance and you pay for your supplemental life insurance and dependent life insurance coverage on an after-tax basis, plan provisions and not IRS rules dictate changes. Requests to increase or elect coverage for the first time must be submitted with 31 days of a change in status or during the annual enrollment period. Requests to decrease or drop coverage can be submitted in writing at any time and will be processed according to payroll and carrier deadlines.

Proof of good health will be required if:

- You decline supplemental and/or dependent life insurance at initial eligibility and later wish to add it.

- You increase the amount of your supplemental or dependent life insurance coverage.
- You elect more than $1,500,000 of life insurance (basic life and supplemental life combined).
- You have any subsequent increase in your life insurance coverage, if the increase exceeds the guaranteed issue amount (including an increase in coverage resulting from a salary increase).

Benefits While on Leave of Absence

Summary of Benefits While on Leave of Absence

Benefit	Family and Medical Leave	Military Leave	Extended Medical Leave	Personal Leave
Medical, Dental and Vision	You may continue your coverage by paying your share of premiums.	You may continue your coverage by paying your share of premiums for up to 12 months.	You may continue your coverage by paying your share of premiums for up to 12 months.	You may continue your coverage by paying the full cost of premiums for up to 12 months.
Health Savings Account	As long as you continue to pay your share of medical premiums, you can choose to continue your HSA contributions.	As long as you continue to pay your share of medical premiums, you can choose to continue your HSA contributions.	As long as you continue to pay your share of medical premiums, you can choose to continue your HSA contributions.	As long as you continue to pay the full cost of medical premiums, you can choose to continue your HSA contributions.
Long-Term Disability	The company continues your coverage by paying premiums.	The company continues your coverage by paying premiums through the end of the month in which your leave begins.	The company continues your coverage by paying premiums for the first six months.	The company continues your coverage by paying premiums through the end of the month in which your leave begins.
Basic Life	The company continues your coverage by paying premiums.	The company continues your coverage by paying premiums for the first 12 months.	The company continues your coverage by paying premiums for the first 12 months.	The company continues your coverage by paying premiums for the first 12 months.
Supplemental Life, Dependent Life, Personal Accident Insurance and Group Legal Insurance	You may continue coverage by paying premiums.	You may continue your coverage by paying premiums up to 12 months.	You may continue your coverage by paying premiums for the first 12 months of disability (unless premium waiver is approved under supplemental life insurance).	You may continue your coverage by paying the full cost of premiums up to 12 months.
Health Care Flexible Spending Account	You may make after-tax contributions to your account.	You may make after-tax contributions to your account.	You may make after-tax contributions to your account.	You may make after-tax contributions to your account.
Dependent Care Flexible Spending Account	Deposits are suspended because you are no longer working.	You may not make contributions.	Contributions stop because you are no longer working. You may continue to claim reimbursement for eligible expenses, up to an IRS allowable amount.	You may not make contributions.

Family and Medical Leave

Under federal Family and Medical Leave Act (FMLA), you are eligible for up to 12 weeks of unpaid family and medical leave per year after one year of service if you worked at least 1,250 hours in the 12 months before your leave. Any paid leave (such as sick pay) runs concurrently with and is counted as part of the 12-week period (applicable state FMLA laws may provide for a longer leave). If your leave is approved, you may be able to continue benefits during the leave.

You may request a family and medical leave of absence:

- After the birth or adoption of your child or if a child is placed with you for foster care
- To care for your spouse, child or parent who has a serious health condition
- If you have a serious health condition that makes you unable to work
- If you are incapacitated due to pregnancy, prenatal medical care or child birth

- Due to a qualifying circumstance arising out of your spouse, son, daughter or parent being a covered military member on active duty or being notified of an impending call or order to active duty in support of a contingency operation

FMLA also means no more than 26 weeks of leave of absence (paid or unpaid) during any single 12-month period to care for your spouse, son, daughter, parent or next of kin who is a covered service member with a serious injury or illness incurred in the line of duty while on active duty. This serious injury or illness may render the service member medically unfit to perform his or her duties and is one for which the service member is:

- Undergoing medical treatment, recuperation or therapy,
- Is in outpatient status, or
- Is on the temporary disability retired list.

Medical, Dental and Vision Plans

The company continues to share the cost of medical and dental coverage while you are on an approved family and medical leave as long as you continue to pay your share of the premiums. You continue to pay the full cost for vision coverage. Your coverage will stop if your payments are not kept current. Your coverage will resume when you return from your leave of absence provided you notify your benefit administrator within 31 days of your return.

Basic Life Insurance

Coverage for basic life insurance will continue during your leave and the company will continue to pay for your coverage.

Supplemental Life Insurance, Dependent Life, Personal Accident Insurance and Group Legal Insurance

For coverage to continue, you must pay your premiums for supplemental life, dependent life, personal accident insurance and group legal insurance coverage during your leave. Your coverage will stop if your premium payments are not kept current. If your coverage ends, you are required to provide proof of good health before you can resume the supplemental and dependent life insurance.

Long-Term Disability

Company-provided coverage for long-term disability will continue during your leave.

Health Savings Account

As long as you continue to pay your share of medical premiums, you can choose to continue your HSA contributions — or you may change them at any time.

Health Care and Dependent Care Flexible Spending Accounts

You may continue contributions to your Health Care Flexible Spending Account during your leave by making contributions on an after-tax basis. Although you will not have any tax advantages, by continuing to make contributions you can still file claims for reimbursement of covered expenses. Your contributions to your Dependent Care Flexible Spending Account will be suspended during your leave because you can only use that account for dependent care expenses incurred while you are working.

Military Leave

If you are on an approved military leave of absence that qualifies under the Uniformed Services Employment and Reemployment Rights Act (USERRA), participation in your health benefits may continue for the lesser of:

- The 18-month period beginning on the date your military leave of absence began, or
- The day after the date you fail to apply for a return to employment with an A. H. Belo company.

The company continues to share the cost of medical and dental coverage while you are on a military leave for up to one year. After one year of military leave, you may be able to continue your participation in medical and dental benefits through COBRA. More information is provided in Continuation of Coverage.

Extended Medical Leave

Your benefits will continue under the same conditions as a family and medical leave for a period of time not to exceed 12 months, depending on local laws and the custom at your location.

Medical, Dental and Vision Plans

The company continues to share the cost of medical and dental coverage while you are on an approved extended medical leave as long as you continue to pay your share of the premiums. You continue to pay the full cost for vision coverage.

Basic and Supplemental Life Insurance

Your basic life insurance will continue during the first 12 months of extended medical leave, and you can continue your supplemental life coverage by continuing to pay the premiums for the same time. If you become disabled, you may request a premium waiver through the insurance carrier as long as your disability began before you reached age 60. If the waiver is not approved, coverage will end after you have been absent from work for 12 months. If the waiver is approved, your premiums will be waived as long as you provide certification of continuous disability, as requested by the carrier.

Benefits will end on the earliest date you:

- Cease to be to totally disabled
- Fail to furnish proof of continued total disability
- Fail to submit to required examinations
- Are not under the regular continuing care of a physician providing appropriate treatment of your total disability
- Reach age 70 (unless eligible for retiree life and that amount applies)
- Reach age 70 or are deemed retired (receiving compensation from a company-sponsored retirement plan)

If the waiver is not approved, you may apply for conversion of basic life insurance and portability for supplemental life insurance.

Dependent Life, Personal Accident Insurance and Group Legal Insurance

You can continue dependent life, personal accident and group legal insurance coverage during the first 12 months of your extended medical leave by continuing to pay the premiums. Coverage will end after you have been absent from work for 12 months. At the end of the 12 months, you may apply for conversion or portability of dependent life insurance.

Long-Term Disability

Company-provided coverage for long-term disability will continue for up to six months.

Health Savings Account

As long as you continue to pay your share of medical premiums (for up to 12 months), you can choose to continue your HSA contributions — or you may change them at any time.

Health Care and Dependent Care Flexible Spending Accounts

You may continue contributions to your Health Care Flexible Spending Account during your extended medical leave by making contributions on an after-tax basis. Although you will not have any tax advantages, by continuing to make contributions you can still file claims for reimbursement of covered expenses. Your contributions to your Dependent Care Flexible Spending Account will be suspended, but you may continue to reimburse eligible day care expenses while you are disabled, up to $200 or $400 per month, depending on the number of children.

Personal Leave

Medical, Dental and Vision Plans

For up to 12 months, you may continue coverage for your medical, dental and vision plans by paying the full premium cost. Your coverage will stop if your payments are not kept current. Your coverage will resume when you return from your leave of absence provided you notify your benefit administrator within 31 days of your return.

Basic Life Insurance

For up to 12 months, coverage for basic life insurance will continue during your leave and the company will continue to pay for your coverage.

Supplemental Life Insurance, Dependent Life, Personal Accident Insurance and Group Legal Insurance

For up to 12 months, you may continue coverage for supplemental life, dependent life, personal accident insurance and group legal insurance coverage by paying the full premium cost. Your coverage will stop if your premium payments are not kept current. If your coverage ends, you are required to provide proof of good health before you can resume the supplemental and dependent life insurance.

Long-Term Disability

Company-provided coverage for long-term disability will continue for up to end of month in which leave begins.

Health Savings Account

As long as you continue to pay the full cost of your medical premiums (for up to 12 months), you can choose to continue your HSA contributions — or you may change them at any time.

Health Care and Dependent Care Flexible Spending Accounts

You may continue contributions to your Health Care Flexible Spending Account during your leave by making contributions on an after-tax basis. Although you will not have any tax advantages, by continuing to make contributions you can still file claims for reimbursement of covered expenses. Your contributions to your Dependent Care Flexible Spending Account will be suspended during your leave because you can only use that account for dependent care expenses incurred while you are working.

Medical

Important information on your medical plan benefits is provided separately:

- If you are enrolled in the **CDHP** option, please refer to the separate medical booklet supplied by BCBS.
- If you are enrolled in the **PPO** option, please refer to the separate medical booklet supplied by BCBS.

This separate booklet is available at life360ahbelo.com > Health > Medical. The separate booklet is part of this summary plan description and is incorporated into this summary plan description by reference as if it were included herein.

When Coverage Begins and Ends

When Coverage Begins

When you first join the company, your medical coverage begins on the first of the month after you have two continuous months of service with the company, provided you have enrolled within 31 days of your eligibility period.

When Coverage Ends

Generally, medical coverage under A. H. Belo's plan for you and your enrolled dependents ends when you:

- No longer meet the eligibility requirements described in Eligibility and Participation (for example, when your dependent child reaches age 26 and is not disabled)
- Terminate employment with A. H. Belo (effective at the end of the month you terminate)
- Cancel or drop coverage
- Stop making any required payments for coverage
- Die

Coverage also ends if the plan is terminated, your employer stops participating in the plan or the plan is amended to terminate coverage for a group or class of individuals that includes you.

Dental

Important information on your dental plan is provided separately:

The company offers a **Dental PPO Plan** (administered by Delta Dental) at all A. H. Belo locations. For specific dental PPO plan details, please refer to the separate Delta Dental Certificate of Coverage, which is also available at life360ahbelo.com > Health > Dental and which is incorporated herein by reference.

A **Dental HMO Plan** is offered to employees in Texas through MetLife. For specific dental HMO plan details, please refer to the separate MetLife Dental HMO booklet, which is also available at life360ahbelo.com > Health > Dental and which is incorporated herein by reference..

When Coverage Begins and Ends

When Coverage Begins

When you first join the company, your dental coverage begins on the first of the month after you have two continuous months of service with the company, provided you have enrolled within 31 days of your eligibility period.

When Coverage Ends

Generally, dental coverage under A. H. Belo's plan for you and your enrolled dependents ends when you:

- No longer meet the eligibility requirements described in Eligibility and Participation
- Terminate employment with A. H. Belo (effective at the end of the month you terminate)
- Cancel or drop coverage
- Stop making any required payments for coverage
- Die

Coverage also ends if the plan is terminated, your employer stops participating in the plan or the plan is amended to terminate coverage for a group or class of individuals that includes you.

Vision

Important information on your vision plan is provided separately:

A vision plan is offered to employees through Vision Service Plan. For specific details, please refer to the separate VSP Summary of Benefits, which is also available at life360ahbelo.com > Health > Dental and which is incorporated herein by reference. The Vision Service Plan (VSP) offers a network of doctors. When you need vision care, you may go to a doctor who is part of the network or you may use a doctor who is not part of the network. The choice is yours.

When Coverage Begins and Ends

When Coverage Begins

When you first join the company, your vision coverage begins on the first of the month after you have two continuous months of service with the company, provided you have enrolled within 31 days of your eligibility period.

When Coverage Ends

Generally, vision coverage under A. H. Belo's plan for you and your enrolled dependents ends when you:

- No longer meet the eligibility requirements described in Eligibility and Participation
- Terminate employment with A. H. Belo (effective at the end of the month you terminate)
- Cancel or drop coverage
- Stop making any required payments for coverage
- Die

Coverage also ends if the plan is terminated, your employer stops participating in the plan or the plan is amended to terminate coverage for a group or class of individuals that includes you.

How the Vision Plan Works

Contact Lenses

Your contact lens allowance applies to the cost of your contact lens exam and your contact lenses. You will receive a 15% discount off the cost of your contact lens exam (fitting and evaluation) from a VSP doctor. Your contact lens exam is performed in addition to your routine eye exam to check for eye health risks associated with improper wearing or fitting of contacts.

Annual Limit

You are limited to two pair of glasses, or one pair of glasses and a pair of contacts, or two pairs of contacts up to the plan allowance annually. This is per dependent covered.

How to Locate a VSP Doctor

To locate a VSP doctor, you may go to the VSP Web site at www.vsp.com or you may call VSP Member Services at (800) 877-7195.

Benefits at a Glance

Vision Service Plan				
Benefit	**Frequency**	**Copay**	**Coverage from a VSP Doctor**	**Out-of-Network Reimbursement**
Eye Exam	Annual	$15	Covered in full	Up to $50 allowance
Prescriptive Lenses (You choose between frames and contact lenses.)	Annual	$25 (applied to lenses and frames)	Single vision, lined bifocal and lined trifocal lenses, tints and photochromatics are covered in full	▸ Single vision up to $50 allowance ▸ Lined bifocal up to $75 allowance ▸ Lined trifocal up to $100 allowance
▸ **Frames** or	Annual	None	Covered up to $130 allowance	Up to $70 allowance
▸ **Contact Lenses and Exam**	Annual	None	Covered up to $150 allowance	Up to $150 allowance

Second-Pair Benefit

The vision plan allows for a second-pair benefit. You may elect two pairs of glasses or two pairs of contacts or one pair of glasses and one pair of contacts up to the plan allowance with an additional $25 copay applied to lenses and frame only.

Health Savings Account (HSA)

Benefits at a Glance

An HSA is a personal health care bank account that you can use to pay for qualified healthcare expenses with pre-tax dollars if you enroll in a high-deductible health plan, such as the CDHP.

The contributions are tax free, and the money in the account is yours. HSAs allow you to control your own money, year in and year out.

You are eligible to open and fund an HSA if:

- You are covered by an HSA-eligible medical plan, as described above.
- You are not covered by your spouse's health plan that is not an HSA-qualified medical plan, and not have a regular health care flexible spending account or health reimbursement account (HRA).
- You are not eligible to be claimed as a dependent on someone else's tax return.
- You are not enrolled in Medicare or TRICARE for Life and you have not received Veterans Administration Benefits three months prior.

Your HSA can be used for your qualified expenses and those of your spouse and dependents, even if they are not covered by your medical plan.

When Coverage Begins and Ends

When Coverage Begins

If you enroll in the CDHP medical option, your HSA coverage is effective upon your medical enrollment. When you first join the company, your medical coverage begins on the first of the month after you have two continuous months of service with the company, provided you have enrolled within 31 days of your eligibility period.

When Coverage Ends

If you lose coverage under your medical plan, you will lose eligibility to deposit further funds into your HSA. However, funds already in your HSA remain available for your use.

How the HSA Works

Eligible Expenses

Examples of eligible expenses include doctor's office visits, eye exams, prescription expenses and LASIK surgery. IRS Publication 502 provides a complete list of eligible expenses and can be found at www.irs.gov/pub/irs-pdf/p502.pdf.

Individually Owned Account

You own and administer your HSA. You determine how much you will contribute to your account, when to use the money to pay for qualified medical expenses and when to reimburse yourself. HSAs allow you to save and "roll over" money if you do not spend it in the calendar year.

The money in this account is always yours, even if you change health plans or jobs. There are no vesting requirements or forfeiture provisions.

How to Enroll

CDHP Participants

When you enroll in the CDHP, you will need to complete your HSA enrollment and designate the amount you wish to contribute on a pre-tax basis. You must also complete bank account enrollment information to allow A. H. Belo to establish your account in your name and send your contribution.

Once you open your HSA bank account at www.401k.com, Fidelity will issue you a debit card, giving you direct access to your account balance. Any time you have a qualified medical expense, you may use your debit card to pay. You must have funds available in your HSA to use your debit card. You do not need to submit receipts for reimbursement. However, you should keep records to validate eligible expenses in case you are audited.

Tax Savings

- Contributions to an HSA are tax-free. If you are a CDHP participant and eligible to contribute, contributions can be made through payroll deduction on a pre-tax basis when you open an account with Fidelity.
- The money in this account, including interest and investment earnings, grows tax-free.
- As long as the funds are used to pay for qualified medical expenses, they are spent tax-free.
- Refer to IRS Publications 502 and 969.

HSA Funding and Limits

The 2016 IRS maximum contributions (including the CDHP employer contribution outlined below) are:

- Employee only: **$3,500**
- Employee with dependents: **$7,000**

Annual Employer HSA Contribution for CDHP Participants

- Employee only: **From $500 to $650 (varies on earnings)**
- Employee with Dependents: **From $1,000 to $1,300 (varies on earnings)**

If you enroll in the CDHP and establish your HSA at Fidelity, A. H. Belo will provide an employer contribution that will be deposited on a quarterly basis. If your annual earnings are $100,000 or greater, you are not eligible for the company contribution. You may be able to roll over funds from another HSA, as well. For more enrollment information, contact Fidelity at 1-800-835-5098 or www.401k.com.

The maximum annual contribution limit is based on your age and coverage tier (i.e., individual or family), as well as on when you become enrolled in a HSA-eligible health plan. Normally, for eligible individuals who enroll in the HSA-eligible plan as of the first of the plan year, the HSA contribution is prorated based on the number of months during the year a person is covered by an HSA-eligible plan as of the first day of the month. Individuals enrolled in a HSA-eligible health plan after the beginning of the plan year may contribute up to the statutory maximum annual contribution amount as long as they are eligible individuals in December of that tax year and remain eligible individuals for the entire next calendar year. If an individual fails to meet these criteria, the maximum annual contribution amount must be prorated based on the number of months he or she is an eligible individual, and any amount above such prorated amount is includible in the individual's gross income and subject to a 20% tax.

Flexible Spending Accounts

Your FSA Options

- **Health Care FSA** — If you do not qualify for a Health Savings Account (HSA) or do not elect medical coverage, you may contribute from $300 to $2,700 per year to the Regular Health Care FSA to pay for eligible unreimbursed medical, dental, vision and over-the-counter medication expenses obtained with a prescription.

  If you enroll in the CDHP and eligible for a HSA, you may contribute from $300 to $5,000 per year to the Limited-Purpose Health Care FSA to pay for eligible unreimbursed dental and vision expenses only.

- **Dependent Care FSA** — You may contribute from $300 to $5,000 ($2,500 if married and filing separate tax returns) each year to help pay for eligible child- and elder-care expenses you incur to take care of your eligible child or parent while you are working. The Dependent Care FSA cannot be used to pay medical expenses.

You can participate in either a Health Care FSA or Dependent Care FSA, or you can participate in both. While you can participate in both, the amounts in your Dependent Care FSA can only be used to pay for child care or elder care expenses you incur to enable you to work. The Dependent Care FSA cannot be used to pay any health care expenses. The Health Care FSA can only be used to pay health care expenses. The Limited-Purpose Health Care FSA can only be used to pay dental and vision expenses.

When Coverage Begins and Ends

When Coverage Begins

When you first join the company as an eligible employee, participation in one or both of the flexible spending accounts begins on the first of the month after you have two continuous months of service, provided you have enrolled within 31 days of your eligibility period.

When Coverage Ends

Generally, participation in the flexible spending accounts ends when you:

- No longer meet the eligibility requirements described in the Eligibility and Participation section
- Terminate employment with A. H. Belo (effective on your last day of active employment)
- Cancel or drop coverage
- Stop making any required contributions to the accounts
- Die

Coverage also ends if the plan is terminated, your employer stops participating in the plan or the plan is amended to terminate coverage for a group or class of individuals that includes you.

You may be able to continue your participation in the Health Care FSA through COBRA. More information is provided in Continuation of Coverage.

How the Accounts Work

Save on Taxes

Federal tax laws allow employers to offer flexible spending accounts that help you save money by reducing the amount of your pay that is subject to federal (and most state) income taxes, Social Security and Medicare taxes.

The flexible spending accounts allow you to be reimbursed for eligible dependent and health care expenses using dollars deducted from your paycheck before taxes are taken out. These before-tax dollars are contributed to each account. Then, when you submit an eligible expense, you are reimbursed with dollars that are never subject to tax. This lowers your taxable income, so you pay less in tax.

Both the health care and dependent care flexible spending accounts are administered by TaxSaver Plan, an independent company, which establishes your accounts and processes your reimbursements.

You make contributions to your account through before-tax payroll deductions. When you incur an eligible health or dependent care expense, you submit a claim for reimbursement. The claims administrator then reimburses you from the appropriate account for the amount of the expense.

Process Overview

- Decide if you want to participate. Your estimated expenses and tax savings may affect your decision. You may want to consult a tax advisor before enrolling in these accounts.
- Visit www.taxsaverplan.com to use the tax benefit calculator.
- If you choose to participate, decide how much you are going to contribute to each account based on your estimated expenses for the coming year. Your annual election is divided by the number of pay periods per year and deducted from each paycheck on a before-tax basis.
- When you incur an eligible expense, obtain a receipt with a date, type of service and cost of services rendered.
- Submit a claim form for reimbursement to the claims administrator and attach your receipt. You may be required to submit documentation for proof of eligibility if you use the Flex Debit Card.
- The claims administrator reimburses you by check or electronic fund transfer with before-tax dollars from the appropriate account.

No Transfers Between Accounts

Your Health Care FSA and Dependent Care FSA are separate accounts. You cannot transfer money between them. For example, you could not use money in your Dependent Care FSA to pay for an eligible health care charge and you cannot transfer unused dollars in your Dependent Care FSA to your Health Care FSA.

Use It or Lose It Rule

The law requires that the accounts operate on a use-it-or-lose-it basis, meaning you forfeit any money remaining in your flexible spending accounts after all eligible expenses have been reimbursed. Your expenses claimed for reimbursement must be for health care or dependent care services you or your dependents received during the plan year (January 1 through December 31) or during the grace period (ending March 15 of the following year) and will be paid only with amounts you contributed to the accounts (plus any matching amounts you receive from the company).

To receive reimbursement for health care expenses, you and your dependents must incur the eligible expenses during the time period you are making contributions to your Health Care FSA. All claims for reimbursement must be postmarked by April 30 of the following year to be eligible for payment.

You will receive a statement of your account activity each time you are reimbursed, so that you can track your reimbursements. You can also access your account information on the TaxSaver Web site at http://www.taxsaverplan.com.

Changing Your Contributions

Each fall during annual open enrollment, you can make a new decision on how much you want to contribute to your accounts for the coming year. Your decision remains in effect for the rest of the calendar year. You may not change the amount of your contributions unless you have a qualified change in status.

Health Care FSA

The Health Care FSA reimburses you for health care expenses that are not reimbursed by any other plan.

Who Is Covered

You can use the Health Care FSA to pay eligible expenses for:

- You
- Your spouse
- Any child who lives with you and whom you claim as a tax exemption (a child of a divorced employee is eligible for coverage even if the employee does not claim the child as an exemption)
- Any individual who lives with you at least eight hours a day and depends on you for at least half of his or her financial support or is claimed as an eligible dependent on your federal tax return

Even if you, your spouse or children are not covered by A. H. Belo's medical, dental or vision plans, you may still make contributions to the Health Care FSA.

Your Contributions

During annual enrollment, you decide how much to contribute to the Health Care FSA for the coming year. If you elect to participate, you can contribute a minimum of $300 and a maximum of $2,700 to the account each year.

The amount you elect to contribute is divided by the number of paychecks you receive during the year and deducted from each paycheck before taxes are taken out.

Getting Reimbursed

Here is how the Health Care FSA works:

- You incur a health care expense while you are making contributions to the Health Care FSA and submit a claim to your health care plan.
- When you receive an Explanation of Benefits (EOB) from your health plan, send a copy, along with your Health Care Account claim form, to the address on the form.
- If your health care expense is not reimbursed by any health care plan, submit the receipt with your Health Care Account claim form. The receipt should show the name of the provider, the date of service, the cost of the service and a list of the different services or items you received.
- Claims are processed weekly. You may be reimbursed up to the full amount you have elected to contribute for the year (less any amounts you have already claimed). If your claim is for more than the amount in your account, your ongoing contributions will repay your account for any earlier reimbursements that you received.

You may obtain a claim form on life360ahbelo.com, from the claims administrator or from the TaxSaver Web site at www.taxsaverplan.com. Your claim must be postmarked by April 30 of the following year to receive reimbursement. Any money from the prior plan year that is left in your account after April 30 will be forfeited, as discussed in Use It or Lose It Rule.

Flex Debit Card for Health Care FSA

The Flex Debit Card allows you to pay for current year health care expenses directly from your Regular Health Care FSA (the debit card is available for Limited-Purpose Health Care FSA participants, **however can only be used for dental and vision expenses**).

You can use your Flex Debit Card at your doctor's or dentist's office, pharmacy or vision care provider. **You do not need to provide supporting documentation if:**

- The amount you are paying with your card is the amount of your company-sponsored plan's copay for medical, dental or prescription drugs (including copays for mail order prescriptions).
- You have already filed your initial monthly orthodontia claim for this plan year and the amount is the same as the previous orthodontia payment.
- The amount you are paying is for a recurring charge — such as the coinsurance amount on a prescription — for which you have previously filed a claim.

When You Must Provide Supporting Documentation

When you use the Flex Debit Card for certain expenses, you must provide supporting documentation. If required, you will receive an e-mail from TaxSaver Plan advising what is needed. Some examples are if:

- The amount you are paying with your Flex Debit Card does not equal your medical plan's copay (applicable after you meet your deductible and use card for prescriptions that have a flat copay). For example, you can use the card but will also need to provide supporting documentation if you use it to pay deductibles, coinsurance expenses, non-covered items, or copays under your spouse's or dependent's plan.
- You use the card to buy eligible non-prescription items, such as bandages, orthotic shoe inserts or contact lens solution. If you are buying prescriptions at the same time as the eligible non-prescription items, you should pay for your prescriptions as one transaction and pay for your eligible non-prescription items separately. This way, you only need to include the non-prescription items on your claim. (Remember that you may not use the card to pay for any expenses that are not eligible for reimbursement under the health care spending account.)
- You are using the card for the first time during the plan year to pay a monthly orthodontia visit or a coinsurance amount on a prescription.

If your health care provider or pharmacy does not accept credit cards or you choose not to use your card, you may submit your receipts to TaxSaver Plan and wait for a reimbursement.

Eligible Health Care Expenses

Eligible health care expenses must be:

- An expense not paid by any other benefit plan (whether sponsored by A. H. Belo or any other plan)
- Incurred while you were an eligible participant during the plan year
- For procedures that are medically necessary (an expense that could be considered cosmetic will not be eligible, for example teeth whitening)

Here are some examples of eligible expenses:

- Out-of-pocket expenses, deductibles and coinsurance not paid by your health care plan or your spouse's employer-sponsored plan
- Charges in excess of your health plan's benefits, such as orthodontia
- Other health care expenses (except insurance premiums) considered tax-deductible by the IRS — refer to IRS publication 502 for detailed information

For a complete listing of eligible expenses, refer to the TaxSaver Web site at www.taxsaverplan.com.

Ineligible Health Care Expenses with Regular Health Care FSA

You must reimburse your Health Care FSA if you use your Flex Debit Card to pay for an ineligible expense or do not provide supporting documentation when requested. TaxSaver Plan will notify you if it receives an ineligible expense. You must either verify the expense with a claim or reimburse your account. Your card will be deactivated if you do not substantiate the expense.

You may not use your debit card for eligible expenses from the prior plan year. These prior year's claims for reimbursement must be submitted directly to TaxSaver Plan.

Excluded Health Care Expenses

Expenses that the IRS does not allow you to have reimbursed through your Health Care FSA include, but are not limited to:

- Expenses reimbursed by any other benefit plan
- Expenses not considered deductible for federal tax purposes, such as teeth whitening
- Expenses claimed as deductions on a federal or state income tax return
- Expenses incurred while you were not eligible to participate in the plan
- Premiums for any type of health insurance

For a complete listing of excluded expenses, refer to the TaxSaver Web site at www.taxsaverplan.com.

Tax Considerations

The Health Care FSA is one way the government allows you to save taxes. You may also be eligible to claim the expenses on your federal income tax return as itemized expenses. However, you cannot do both.

You must determine which method is best for your situation. You may want to consult a tax advisor when making your decision. You may also want to consider the following:

- Under current tax laws, only the portion of your health care expense that is greater than 7.5% of your adjusted gross taxable income may be deducted on your federal income tax return. In addition, you must file an itemized federal income tax return to claim itemized health care expenses.
- The Health Care FSA provides a tax break on the very first dollar of expenses, but only up to the amount you choose to contribute. Expenses and reimbursements do not have to be reported on your federal income tax return.

Of course, the advantages of using before-tax dollars depend on your individual circumstances. While before-tax dollars reduce your taxes, they may slightly lower your Social Security benefits when you retire. Consult a financial advisor before participation.

Dependent Care FSA

The Dependent Care Flexible Spending Account reimburses you for eligible dependent care expenses. Eligible expenses include day care for your children under age 13 or a disabled dependent of any age when the care enables you (and your spouse, if you are married) to work. **If you participate in this account, A. H. Belo also makes a contribution on your behalf.**

Who Is Covered

You may use the Dependent Care Flexible Spending Account to pay for eligible day care or elder care expenses for dependents who depend on you for at least half of their support and whom you can claim on your federal income tax return. These must be eligible dependent care and eligible elder care expenses you incur for the care of your dependents while you are working to enable you(and your spouse, if you are married) to work.

To qualify as a dependent, the person must be:

- Under age 13
- A person over age 13 (including your child, spouse or parent) if the person meets all of the following criteria:
    - Lives with you and depends on you for more than half of his or her financial support
    - Is physically or mentally incapable of self care
    - Is claimed as a dependent on your federal income tax return

Your Contributions

Federal tax rules regarding your family and tax filing status determine the maximum amount you can contribute per calendar year. The following table illustrates the amounts you are permitted to contribute to your Dependent Care Flexible Spending Account according to your circumstances. Keep in mind that these maximums also include the company's dollar-for-dollar matching contributions.

Description	Maximum Annual Contribution
You are single or married and filing a joint income tax return	$5,000
You are married and both you and your spouse are making contributions to a dependent care account	Total of $5,000 (your contribution + your spouse's contributions)
You are married and you and your spouse file separate income tax returns	$2,700

You may not contribute more than your earned income or your spouse's earned income, whichever is less. If your spouse is a full-time student or is unable to care for himself or herself, you may calculate your contribution amounts as if your spouse had annual earned income of $3,000, if you have one qualified dependent, or $6,000, if you have two or more qualified dependents.

Company Contributions

A. H. Belo will contribute up to $20 per week on a dollar-for-dollar match if you participate in the Dependent Care Flexible Spending Account (not to exceed $1,040 annually). Take this into account when deciding how much to contribute during enrollment. To be sure your total contribution is within the $5,000 legal limit, during annual enrollment the most you can elect to contribute from your paychecks is $3,960 each year.

Getting Reimbursed

Here is how the Dependent Care Flexible Spending Account works:

- Pay your dependent care expense and submit a claim form with proof of the expense to the claims administrator. Proof of expense is an itemized bill from the provider showing:
    - The date(s) of service
    - The name(s) of the dependents who received the service
    - Cost of service provided
- You will be reimbursed up to the amount currently in your account. If your claim is more than your account balance, the unreimbursed amount will pend and will be reimbursed after your next contribution (up to your current account balance).

You may obtain a claim form on life360ahbelo.com, from the claims administrator or from the TaxSaver Web site at www.taxsaverplan.com. Your claim must be postmarked by April 30 of the following year to receive reimbursement. Any money left in your account after April 30 will be forfeited, as discussed in Use It or Lose It Rule.

Eligible Dependent Care Expenses

To qualify as an eligible dependent care expense, the expense must be necessary for you (and your spouse, if you are married) to work or be a full-time student.

Here are some examples of expenses that are eligible for reimbursement:

- Charges for a licensed day care center if it provides care for at least six people and complies with state and local laws
- Dependent care in your home or someone else's home, as long as the care provider is not your spouse or dependent child
- Day care services outside your home, as long as the dependent spends at least eight hours a day in your home, or is under age 13
- Education expenses if your child is not yet in kindergarten
- Day camp expenses for children under age 13

Other expenses that satisfy IRS guidelines are described in IRS Publication 503 and included on the TaxSaver Web site at www.taxsaverplan.com.

Ineligible Dependent Care Expenses

Here are some examples of expenses that do not qualify for reimbursement through the Dependent Care Flexible Spending Account:

- Weekend or evening baby-sitting when you or your spouse are not at work
- Overnight camp
- Schooling in kindergarten or higher
- Transportation services
- Expenses for activities or lessons when a separate fee is charged through day care or camp

Tax Considerations

The Dependent Care Flexible Spending Account is one way the government allows you to receive a tax break on your dependent care expenses. You may choose not to participate and pay dependent care expenses with after-tax dollars and take a credit on your federal income tax return instead. You may also use a combination of the two within certain limitations:

- The tax credit and the Dependent Care Flexible Spending account cannot be used for the same expenses.
- Any expenses reimbursed through the account will reduce your tax credit dollar-for-dollar. For example, if your expenses were $2,300 and you contributed $2,000 to your Dependent Care Flexible Spending Account, you would be able to claim a tax credit for $300 ($2,300 – $2,000 = $300). This example assumes you qualify for a tax credit. Some people may not qualify.

A. H. Belo cannot provide tax advice, nor suggest how much to contribute to the Dependent Care Flexible Spending Account. You must decide which tax-saving method, if any, is best for you. Of course, the advantages of using before-tax dollars depend on your individual circumstances. While before-tax dollars reduce your taxes, they may slightly lower your Social Security benefits when you retire. Consult a financial advisor before participating.

Employee Assistance Program (EAP)

Participation

Who Can Participate

You are eligible for EAP services if you are a full-time or part-time employee. Your dependents are also eligible, even if they are not enrolled in a company-sponsored medical plan. You do not need to enroll in the EAP to use its services — and A. H. Belo pays the entire cost of the program.

How to Use the EAP

The EAP is provided through Beacon Health Options and available 24 hours a day, seven days a week. You must call Beacon Health Options at (800) 435-1986.

When you call the EAP, a mental health professional will assess your situation and coordinate a meeting with a licensed counselor. You will receive up to five sessions per issue with your counselor at no cost to you. If you need additional treatment, your counselor will refer you to the appropriate medical or community resource. Treatment costs may be covered according to your medical plan for continued care outside the EAP.

How the EAP Can Help

Through counseling or referral for medical treatment, the EAP can help you and your family members with problems such as:

- Alcohol and drug abuse
- Anxiety
- Depression
- Divorce, separation or other marriage or relationship issues
- Grief over the death of a loved one
- Parenting issues
- Stress management

No matter what the problem, the EAP is your first stop for care. This program is designed to help you get the counseling and treatment you need. All services you receive are strictly confidential.

Additional EAP Services

Beacon Health Options offers additional EAP services.

Legal/Financial

Beacon Health Options also offers resources that provide you and your eligible family members with referrals to top-rated attorneys and financial professionals in your area when needs arise. Benefits include one initial 30-minute office or telephone consultation per separate matter at no cost to you. In the event you wish to retain a lawyer or financial professional after the initial consultation, you will be provided with a preferred rate reduction of 25% from the normal hourly fees. Virtually all legal/financial matters are covered, but please note that matters involving legal disputes with your employer will not be covered.

For legal or financial services, call Beacon Health Options at (800)435-1986.

Achieve Solutions

Achieve Solutions is an online self-help resource with information on a variety of issues including mind and body wellness, mental health concerns and family and relationship issues. To access Achieve Solutions, simply go to www.myachieve.com.

Continuation of Coverage

Overview

You and/or your dependents may elect to continue health coverage for the following options if you were enrolled in these health plans at the time of the qualifying event:

- Medical
- Dental
- Vision
- Health Care Flexible Spending Account (although you will make contributions on an after-tax basis)
- Employee Assistance Program

Your Eligibility for COBRA

The Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) requires that A. H. Belo offer you and your covered family members the option to extend certain coverage through the company if your benefits end because of one of the following qualifying events:

- You leave employment with A. H. Belo (for any reason other than your gross misconduct)
- You are laid off
- You have a reduction in hours and are no longer eligible for coverage

If your coverage ends for any of the above reasons, you may purchase coverage for you and your dependents through COBRA for up to 18 months. Your coverage under COBRA will be identical to the coverage offered under this plan to active employees, including any future plan changes. However, you will pay 100% of the cost of your continued coverage plus a 2% administration fee. The cost of coverage is subject to change each year. The company's COBRA Administrator, TaxSaver Plan, will notify you of your right to continue coverage through COBRA by sending you a notification letter and a COBRA enrollment form.

In case of your divorce or legal separation or a dependent reaching the limiting age for coverage, you must notify your benefit administrator that a dependent is no longer eligible for coverage within 60 days of the event. You should provide an address for the participant losing coverage so an information package explaining COBRA coverage rights can be sent to your dependent. If A. H. Belo does not receive notice within 60 days after the event, a COBRA information package will not be sent to your dependent.

If You Are Disabled

If you become disabled as defined by Social Security, you may extend your COBRA coverage an additional 11 months beyond the 18-month coverage period described above (for a total of 29 months). However, your cost for the 11-month extension period will be higher than the first 18 months of coverage. During these 11 months, your cost will be 150% of the regular premium.

To receive coverage for an additional 11 months, you must:

- Be disabled before you become eligible for COBRA coverage or become disabled during the first 60 days you have COBRA coverage
- Be determined by Social Security to be disabled before the end of the first 18 months of your COBRA coverage
- Notify the company's COBRA Administrator within 60 days after Social Security's determination of your disability
- Provide a copy of the "Notice of Award" letter from the Social Security Administration to the company's COBRA administrator

Dependents' Eligibility for COBRA

Your dependents may also purchase COBRA coverage **if their coverage under the plan ends** because of one of the following qualifying events:

- You die
- You and your spouse divorce or legally separate
- Your dependent becomes ineligible for coverage

Special Rule for Retirees Covered in Certain Circumstances- Sometimes, filing a proceeding in bankruptcy under title 11 of the United States Code can be a qualifying event. If a proceeding in bankruptcy is filed with respect to [enter name of employer sponsoring the Plan], and that bankruptcy results in the loss of coverage of any retired employee covered under the Plan, the retired employee will become a qualified beneficiary. The retired employee's spouse, surviving spouse, and dependent children will also become qualified beneficiaries if bankruptcy results in the loss of their coverage under the Plan.

If your dependents' coverage ends for any of the above reasons, they may elect coverage through COBRA for up to 36 months. Your dependents will pay 100% of the cost of their continued coverage plus a 2% administration fee. The cost of coverage is subject to change each year.

You or your dependents must notify A. H. Belo Benefits within 60 days if you and your spouse divorce or legally separate, or your dependent becomes ineligible for coverage. The company's COBRA administrator will issue you or your dependent a COBRA notification letter and an enrollment form. If you die, the company's COBRA administrator (provided they are notified of the event) will issue your dependents a COBRA notification letter and enrollment form.

If your dependents are covered under COBRA due to your termination of employment or reduction in hours and a second qualifying event occurs that would have caused a loss of coverage, your dependents may be eligible to elect up to an additional 18 months of coverage (for a total of 36 months from your date of termination). To qualify for extended coverage, you or your dependents must notify A. H. Belo Benefits or the company's COBRA administrator within 60 days of the second event.

If you became entitled to Medicare BEFORE your qualifying event, COBRA law allows you to remain eligible for up to 18 months of COBRA coverage. When the qualifying event for the employee is the end of employment or reduction of hours, and the employee became entitled to Medicare less than 18 months before the qualifying event, COBRA continuation for the employee's spouse and dependents can last up to 36 months after the employee becomes entitled to Medicare. For example, if a covered employee becomes entitled to Medicare 8 months before the date of his/her qualifying event (termination or reduction of hours), COBRA continuation for his/her spouse and children would last 28 months (example is 36 months minus 8 months). The Company's COBRA administrator, TaxSaver Plan, must be notified and provided Medicare documentation prior to the end of the original 18 months to qualify for the additional continuation.

Enrolling for COBRA

When you become eligible for COBRA, you will receive information from the company's COBRA administrator about electing continuation of coverage.

To enroll in COBRA coverage, you or your dependents must submit a COBRA enrollment form within 60 days of the date of the notice or the date coverage ends, whichever is later. You will be covered under COBRA for that 60-day period if you choose to enroll and make payment. If you do enroll, this means you will have to pay for the coverage you receive during this 60-day election period.

If you do not elect to continue coverage within the 60-day time limit, your benefits will end under this plan on the day the qualifying event took place. You or your dependent cannot later elect to continue coverage.

Paying for Coverage

If you elect continuation of coverage, you will be notified of your monthly premium amount and when your payment is due. The cost of this coverage is subject to change each year.

Your initial premium payment for COBRA coverage must be received by the COBRA administrator within 45 days after you elect coverage. This first payment must also include payment for any period of coverage before you or your dependent submitted the enrollment form.

To maintain this coverage, you must pay the full cost of continuation of coverage on time (within 30 days after the due date), including any additional administrative expenses. If payment is not received by these deadlines, coverage will terminate and cannot be reinstated. Returned checks are considered a non-payment of premium.

Making Changes to COBRA Coverage

New Dependents

If you elect COBRA continuation of coverage for yourself and later marry, give birth or adopt a child while your continuation coverage is in effect, you may elect coverage for your newly acquired dependents after the qualifying event. To add a new dependent, notify A. H. Belo Benefits or the COBRA administrator within 31 days of the marriage, birth or adoption. A new dependent is entitled to coverage for the remaining months of your continuation period.

Qualifying Family Status Change

If you elect continuation of coverage and experience a qualifying family status change, you must notify A. H. Belo Benefits or the COBRA administrator within 31 days of the event to make changes consistent with the event.

If you experience more than one qualifying event, your maximum continuation of coverage is the number of months allowed by the event that provides the longest period of continuation.

When COBRA Coverage Ends

COBRA coverage ends on the earliest of the following dates:

- The end of the maximum period for COBRA coverage (18, 29 or 36 months)
- The date for which you or your dependents fail to pay for coverage
- The date you or your dependents become covered under another group health plan
- The date the covered person becomes entitled to Medicare
- You or a dependent is receiving the additional 11 months of COBRA disability coverage and the person's disability ends
- The date A. H. Belo no longer provides health care coverage to its employees.

Are there other coverage options besides COBRA Continuation Coverage?

Yes. Instead of enrolling in COBRA continuation coverage, there may be other coverage options for you and your family through the Health Insurance Marketplace, Medicaid, or other group health plan coverage options (such as a spouse's plan) through what is called a "special enrollment period." Some of these options may cost less than COBRA continuation coverage. You can learn more about many of these options at www.healthcare.gov.

If you have questions

Questions concerning your Plan or your COBRA continuation coverage rights should be addressed to the contact or contacts identified below. For more information about your rights under the Employee Retirement Income Security Act (ERISA), including COBRA, the Patient Protection and Affordable Care Act, 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 www.dol.gov/ebsa. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.) For more information about the Marketplace, visit www.HealthCare.gov.

Keep your Plan informed of address changes

To protect your family's rights, let the Plan Administrator know about any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Plan Administrator.

Questions?

For additional information regarding COBRA continuation coverage under the A. H. Belo Health Care and Welfare Benefit Plan, contact the COBRA administrator, TaxSaver Plan at 1-888-602-6272, for information. TaxSaver Plan's address is 4131 N Central Expressway, Suite 250, Dallas, TX 75204.

Filing Health Care Claims

Medical and Dental Claims

For more information about claims and appeals refer to your separate medical and dental booklets, available at life360ahbelo.com > Health or Dental.

Vision Claims

If you are enrolled for vision coverage, all claims and appeals are handled by Vision Service Plan (VSP). Contact VSP or refer to the VSP materials for more information.

Flexible Spending Account Claims

A. H. Belo has delegated the administration authority for the health care (both regular and limited-purpose) and dependent care flexible spending accounts to TaxSaver Plan. As the claims administrator, TaxSaver is responsible for reviewing the initial benefit determinations.

The A. H. Belo Benefits Administrative Committee is the claims administrator for all appeals.

Health Care Claims

The regular Health Care FSA can be used to pay for unreimbursed medical, dental, vision and hearing expenses. The limited-purpose Health Care FSA can be used to pay for eligible unreimbursed dental and vision expenses.

When you have health care expenses that are eligible for reimbursement, complete a claim form and attach a receipt for the expense. The receipt must include the following information:

- Name of the person who received the health care service or supply
- Name of the health care provider (physician, hospital or pharmacy)
- Provider's tax ID number
- Date the care was provided (incurred)
- Itemized costs for the care
- Type of service rendered

A canceled check or a credit card receipt is not acceptable documentation of eligible expenses. If the expense is partially covered under a health care plan, submit the bill to the health care plan first. You will receive an Explanation of Benefits (EOB) from the plan. Use this EOB as proof of your expense to submit a flexible spending account claim for the unpaid portion of the bill.

If you have used your Flex Debit card for health care expenses, you may be required to submit supporting documentation to TaxSaver Plan.

Dependent Care Claims

Pay your dependent care expense and submit a claim form with proof of the expense to the claims administrator. Proof of expense is an itemized bill from the provider showing:

- The dates of service
- The names of the dependents who received the service
- Itemized costs for the care

Payment of Spending Account Claims

After your claim is approved, you will receive reimbursement by either a check or direct deposit. Claims are processed weekly and paid as soon as possible.

If you do not have enough money in your account to cover the full amount of the expense:

- Your Health Care Flexible Spending Account reimbursement will be for the full amount of the expense, up to the amount you elected to contribute to your account for the year, less any amounts previously reimbursed for other claims.
- Your Dependent Care Flexible Spending Account reimbursement will be for the amount in your account. As you contribute more to your account through payroll deductions, you will receive additional reimbursements.

If you submit a claim for an expense that is not eligible for reimbursement under either flexible spending account, you will receive a letter explaining why it is not eligible. If it is determined that an ineligible health care claim was submitted using your Flex Debit card, you will be required to repay the amount.

You must postmark your claims by April 30 of the following year to receive reimbursement. The health care and dependent care flexible spending accounts operate on a plan year that begins each January 1 and ends December 31, with a 2½-month grace period ending on March 15 of the next calendar year. You may only file claims for expenses you incur during the plan year or grace period while you are a participant in the accounts. You have until April 30 of the calendar year following the plan year to postmark your claims for expenses you incurred during the plan year. The laws that govern the accounts require that you forfeit any money you have not claimed by April 30 (postmark date) for eligible expenses you incurred between January 1 of the prior plan year and the end of the grace period on March 15.

Eligibility Claims

If there is a question as to whether you or your dependents are eligible for coverage under any benefit option provided by the plans, that question will be decided by the plan administrator. If the eligibility question is not accompanied by a claim for benefits, the decision of the plan administrator will be final and will not be subject to review. However, if the eligibility question is being decided in connection with a claim for benefits, you may appeal the decision of the plan administrator.

Denied Claims

If your claim is denied (in whole or in part) by the claims administrator, you will receive written notice from the claims administrator. The time for notifying you of a denied claim and the deadline for requesting an appeal will depend on the type of claim you have submitted.

Medical, Dental, Vision and Health Care Flexible Spending Account Claims

Post-Service Claims. If a post-service claim for benefits is denied, the claims administrator will notify you no later than 30 days after the receipt of the claim. This 30-day period may be extended for an additional 15 days if the claims administrator determines the extension is necessary due to matters beyond the control of the plan and notifies you of the extension before the end of the initial 30-day period. If you have not furnished information that is necessary for determining your claim, the claims administrator will notify you and describe the information that is needed. You will be given a reasonable period of time, but not less than 45 days, in which to supply the missing information. While the claims administrator is waiting for the missing information, the deadline for responding to your claim will automatically be extended until 15 days after you furnish the missing information or, if you do not furnish the missing information, until 15 days after the date for furnishing such information.

If a post-service claim is denied by the claims administrator, you will have 180 days to file an appeal of the denial.

Pre-Service Claims. The claims administrator will notify you of its determination with respect to a pre-service claim, whether adverse or not, no later than 15 days after the receipt of the claim. This 15-day period may be extended for an additional 15 days if the claims administrator determines the extension is necessary due to matters beyond the control of the plan and notifies you of the extension before the end of the initial 15-day period. If you have not furnished information that is necessary for determining your claim, the claims administrator will notify you no later than five days after receiving your claim and will describe the information that is needed. You will be given a reasonable period of time, but not less than 45 days, in which to supply the missing information. While the claims administrator is waiting for the missing information, the deadline for responding to your claim will automatically be extended until 15 days after you furnish the missing information or, if you do not furnish the missing information, until 15 days after the date for furnishing such information.

If a pre-service claim is denied by the claims administrator, you will have 180 days to file an appeal of the denial.

Urgent Care Claims. The claims administrator will notify you with respect to an urgent care claim, whether adverse or not, as soon as possible, but no later than 72 hours after the receipt of the claim. If you have not furnished information that is necessary for determining your claim, the claims

administrator will notify you within 24 hours of receiving your claim and will describe the information that is needed. You will be given a reasonable period of time, but not less than 48 hours, in which to supply the missing information. While the claims administrator is waiting for the missing information, the deadline for responding to your claim will automatically be extended until 48 hours after you furnish the missing information or, if you do not furnish the missing information, until 48 hours after the time for furnishing such information has expired.

If an urgent care claim is denied by the claims administrator, you will have 180 days to file an appeal of the denial.

Concurrent Care Claim. If the plan has approved a course of treatment to be provided over a period of time or a number of treatments and reduces or terminates the course of treatment before the expiration of the period of time or number of treatments that was approved, such reduction or termination will be treated as the denial of a concurrent care claim. The claims administrator will notify you of the denial of the concurrent care claim in sufficient time before the reduction or termination of treatment to allow you to appeal the denial. If you are receiving an ongoing course of treatment, you may proceed with an expedited external review at the same time the internal appeals process is in progress.

In addition, if you request the claims administrator to extend a course of treatment beyond the approved period of time or course of treatment, and your claim involves urgent care (as defined above), the claims administrator will notify you of its decision within 24 hours of receiving your claim, provided you made your claim at least 24 hours before the course of treatment was scheduled to terminate. If your claim involves urgent care and is made less than 24 hours before the course of treatment was scheduled to terminate, your claim will be treated as an urgent care claim.

Notice of Denied Claim

If a claim for benefits is denied, you will be notified in writing, and the written notice will contain the following information:

- Information sufficient to identify the claim involved (including, to the extent applicable, the date of service, the health care provider and the claim amount)
- The specific reasons for the benefit denial, including the denial code (if any) and its corresponding meaning and the plan's standard (if any) that was used in denying the claim
- Reference to the plan provisions on which the denial is based
- A description of any additional material or information necessary to perfect your claim and an explanation of why such information is necessary
- A statement describing the availability, upon request, of the diagnosis code and the treatment code (if applicable) and their corresponding meanings
- A description of the plan's appeal process and applicable time limits (including the expedited process applicable to urgent care claims) and a statement of your right to bring a civil action under ERISA following an adverse determination on appeal
- A description of the availability of, and contact information for, any applicable office of health insurance consumer assistance or ombudsman established to assist you with the claims and appeals and external review processes
- If an internal rule, guideline, protocol or other similar criterion was relied on in denying your benefit claim, a statement to that effect (also, a copy of the applicable rule, guideline, protocol or other similar criterion will be provided to you, upon request, free of charge)
- If the benefit denial was based on medical necessity or experimental treatment or a similar exclusion or limit, an explanation of such scientific or clinical judgment and its application to your medical circumstances

If your claim for benefits is denied, you may not bring a lawsuit to recover the denied benefits until you have exercised all of your appeal rights and your appeal has been denied in whole or part. The plan administrator is granted the discretion to determine all claims for eligibility for all fully insured benefits, and for all self-insured benefits, the discretion to determine all claims for eligibility, benefits and all rights under this plan in its sole discretion.

Appeal of Denied Claims

If you wish to appeal the denial of a claim for benefits (including a retroactive termination of coverage) under the plan, you or your authorized representative must file written notice of the appeal before the time for filing the appeal expires. Your appeal must be filed with the appropriate appeals administrator. The appeals administrator is:

- The claims administrator, if the appeal relates to a denied dental PPO or dental HMO claim or Vision Service Plan claim or a denied claim for life insurance, personal accident insurance, long-term disability or business travel accident claims, or a first-level (initial) appeal related to a denied claim under the A. H. Belo self-insured medical plan(s).
- The plan administrator, if the appeal relates to a second-level appeal of a denied claim under the A. H. Belo self-insured medical plan(s) or a first-level (initial) appeal of a denied claim under the flexible spending accounts.

Your written notice should state in reasonable detail all of the grounds upon which your appeal is based, including references to applicable plan provisions, and any issues or comments you feel are relevant to your claim. You should supply any documents, records or other information relating to your claim. You may also request copies of documents, records and other information relevant to your claim that are in the possession of the plan, which will be provided to you free of charge. In addition, you shall receive, free of charge, any new or additional evidence considered, relied upon or generated by the plan in connection with your claim or any new or additional rationale upon which the decision of your claim is based, as soon as possible and sufficiently

in advance of the date on which the final appeals decision is required to be provided to you so as to give you a reasonable opportunity to respond prior to that date.

The appeals administrator will review the denial of your claim without deference to the decision of the claims administrator. If the denial of your claim was based, in whole or in part, on a medical judgment, the appeals administrator will consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment and who did not participate in the denial of your claim (and is not the subordinate of a health care professional who did participate in the claim denial).

The appeals administrator will also identify the medical or vocational experts whose advice was obtained on behalf of the plan in denying your claim, without regard to whether the plan relied on such advice. Finally, if the claim that was denied was an urgent care claim, the appeals administrator will permit an expedited appeal in which the appeal may be made orally and all necessary information, including the appeals administrator decision on appeal, may be transmitted between you and the plan by telephone, facsimile or other similar expeditious method.

The applicable time limits to file an appeal of a benefit denial are set forth below:

- **Post-Service Claims:** 180 days after the benefit denial (including a retroactive termination of coverage); the appeals administrator will issue a decision with 30 days after receiving the first level appeal and, if a second level appeal is filed, within 30 days of receiving the second level appeal. A second level appeal must be filed no later than 180 days after receiving a denial of the first level appeal.
- **Pre-Service Claims:** 180 days after the benefit denial; the appeals administrator will issue a decision with 15 days after receiving the first level appeal and, if a second level appeal is filed, within 15 days of receiving the second level appeal. A second level appeal must be filed no later than 180 days after receiving a denial of the first level appeal.
- **Urgent Care Claims:** 180 days after the benefit denial; the appeals administrator will issue a decision as soon as possible, but within 72 hours, after receiving the appeal.
- **Concurrent Care Claims:** In sufficient time to permit an appeal and determination on appeal before benefits terminate; the appeals administrator will issue a decision before benefits terminate.

Notice of Appeal Decision

If your appeal is denied, you will be notified in writing, and the written notice will contain the following information:

- Information sufficient to identify the claim involved (including, to the extent applicable, the date of service, the health care provider and the claim amount)
- The specific reasons for the benefit denial, including the denial code (if any) and its corresponding meaning and the plan's standard (if any) that was used in denying the claim
- Reference to the plan provisions on which the denial is based
- A statement that you are entitled to receive, upon request and free of charge, reasonable access to and copies of all documents, records and other information relevant to your claim for benefits
- A statement describing the availability, upon request, of the diagnosis code and the treatment code (if applicable) and their corresponding meanings
- If an internal rule, guideline, protocol or other similar criterion was relied on in denying your benefit claim, a statement to that effect (also, a copy of the applicable rule, guideline, protocol or other similar criterion will be provided to you, upon request, free of charge)
- If the benefit denial was based on medical necessity or experimental treatment or a similar exclusion or limit, an explanation of such scientific or clinical judgment and its application to your medical circumstances
- A description of the availability of, and contact information for, any applicable office of health insurance consumer assistance or ombudsman established to assist you with the claims and appeals and external review processes

Other Legal Information

Consistency of Treatment

The plan administrator will take such action from time to time as may be necessary to assure that all claims for benefits under the plan are determined in accordance with the applicable plan documents and that the provisions of the applicable plan documents are applied consistently to similarly situated plan participants and their dependents.

Coordination of Benefits

If you or your covered dependents have medical or dental coverage through another plan, your A. H. Belo plan will coordinate benefit payments with payments from the other plan. This means your benefit payments from all plans will not be more than the amount your A. H. Belo plan would have paid for eligible expenses if you had no other coverage.

The plan that pays first (as explained below) determines the amount of benefits you receive without considering other health care benefits you have under another plan. When the A. H. Belo plan pays benefits after another plan, A. H. Belo's plan will reimburse you for the balance of allowable expenses not paid by the other plan, up to the amount that would have been paid if you had no other coverage.

How Coordination of Benefits Works

Let's say your children are covered under both your spouse's plan, which pays 70% of covered expenses, and A. H. Belo's PPO plan. You submit a $100 claim for your child's outpatient lab services to your spouse's plan. You would be reimbursed for $70 (70% of $100) from your spouse's plan. You could then submit a claim for the remaining balance to Blue Cross and Blue Shield (BCBS). BCBS would pay $10 (assuming you already met your deductible, the lab services were provided in-network and the full expense was considered an allowable amount) so your total reimbursement from both plans is 80% of the cost of the service ($10 + $70 = $80) — the amount the PPO plan would normally pay if you had no other coverage.

Your A. H. Belo plan coordinates benefits with the following other plans:

- Group insurance plans, HMOs, group practices and other prepaid plans
- Union welfare and employer plans
- Government plans required by law, including Medicare and TRICARE
- Plans for students enrolled at an educational institution.

Which Plan Pays First

A plan without a coordination of benefits provision is always the plan that pays first. If all the plans have a coordination of benefits provision, the plans pay according to the following rules:

1. The plan covering the person as an employee, rather than a dependent, pays first and the other pays second.
2. The plan covering a person as an active employee, (or that person's dependent), pays before a plan covering a person who is laid off or retired (or that person's dependent).
3. If a child is covered under both parents' plans, the plan of the parent whose birthday (month and date regardless of year) falls earlier in the year pays first. However, if the other plan has a different provision for this situation, the provision of the other plan determines which plan pays first.
4. If a child is covered under both parents' plans and the parents are separated or divorced with a court decree to establish financial responsibility for the child's health care expenses, the plans pay benefits according to the court decree.
5. If a child is covered under both parents' plans, the parents are divorced or separated, and there is no court decree to determine financial responsibility, their plans pay in this order:
    - First, the plan of the natural parent with physical custody,
    - Second, the plan of the spouse, if any, of the natural parent with physical custody, and
    - Last, the plan of the natural parent without physical custody.

If none of these rules apply, the plan that has covered the person the longest is the primary plan.

Medicare or TRICARE and Your Company Plan

If you work past age 65, you will be eligible for A. H. Belo medical coverage and Medicare. As long as you continue to work, the company's medical plan is the primary plan. In calculating your benefits, Medicare benefits are coordinated (see Coordination of Benefits above) with those from this plan. Contact the Social Security Administration for more information about enrolling for Medicare. If you or a family member is or has been in uniformed military services you may be eligible for A. H. Belo medical coverage and TRICARE coverage. As long as you continue to work, the company's medical plan is the primary plan. In calculating your benefits, TRICARE benefits are coordinated (see Coordination of Benefits above) with those from this plan. Contact the Defense Health Administration for more information about enrolling for TRICARE or go to www.tricare.mil which is the official website of the Defense Health Agency (DHA) a component of the Military Health System ,DHA Address: 7700 Arlington Boulevard, Suite 5101, Falls Church, VA 22042-5101.

Liability for Payment

Neither A. H. Belo nor any A. H. Belo company will have any obligation to make a benefit payment to you or your dependents under a plan or program that is fully insured. The insurer is solely responsible to make such benefit payments, and A. H. Belo and the A. H. Belo companies will have no liability to you or your dependents if the insurer fails to make any payments required under any insured plan or program.

The plans and programs that are fully insured are the following:

- Dental PPO and Dental HMO Plan
- Vision Plan
- EAP

Recovery of Overpayments

The amount of your plan benefits will be adjusted if:

- You have misstated any information in your application for plan coverage (including any statement of health)
- You do not report required information while receiving company-provided benefits
- Any error is made in calculating your benefits

If a benefit is overpaid or benefits are duplicated, you are expected to repay the plan within 60 days. If you do not, the plan may reduce, refuse or offset future benefits until the overpayment is repaid. The plan may also take additional action allowed by law.

No interest will be charged on the amount of any overpayment or duplication of benefits and, unless required by law, no interest will be paid on any underpayment of benefits or on any benefit payments that have been delayed for any reason.

Life and Accident

Important information on your life insurance benefits is provided separately:

- These separate booklets are available at life360ahbelo.com > Life & Disability > Life & Accident Insurance and are incorporated herein by reference.

When Coverage Begins and Ends

When Coverage Begins

If eligible, your basic life insurance coverage begins automatically on the first of the month following two months of continuous service.

Supplemental life, dependent life and personal accident insurance coverages begin on the first of the month following two months of continuous service, if you submit your enrollment form at least 31 days from your eligibility date. If you are not actively at work on the day your coverage would normally begin due to injury, illness, layoff or leave of absence, the coverage will become effective on the date you return to an active work status.

If you enroll your eligible dependents, their coverage begins on the same date as your own. Your dependents' coverage may also begin on a later date when they become eligible, provided you enroll them.

When Coverage Ends

Generally, your life and accident insurance coverage ends when you:

- No longer meet the eligibility requirements described in Eligibility and Participation
- Terminate employment with A. H. Belo (effective on the last day of the month you terminate employment)
- Cancel or drop coverage
- Stop paying any required premiums for coverage

- Die

Coverage also ends if the plan is terminated, your employer stops participating in the plan or the plan is amended to terminate coverage for a group or class of individuals that includes you.

Continuation, Conversion and Portability

Refer to the coverage booklet for details on provisions to continue your coverage once your employment ends.

Life Insurance for You

Basic Life Insurance

A. H. Belo automatically provides eligible employees with basic life insurance coverage at no cost. You are eligible for basic life insurance if you are a regular, full-time employee and you have completed two months of employment with an A. H. Belo company that participates in the plan.

If you are eligible, the company provides basic life insurance coverage equal to two times your basic annual earnings, up to a maximum amount of coverage of $1,000,000 (coverage is rounded to the next higher $1,000). Life insurance volume greater than $750,000 is subject to proof of good health. The minimum amount of coverage is $30,000.

Definition of Basic Annual Earnings

Basic annual earnings are defined as your current salary or wage. They do not include bonuses, overtime pay or any other extra compensation. If your job currently includes sales commission, your basic annual earnings will be averaged over the previous 12-month period, or averaged from the date of employment, whichever period is shorter. If your salary changes during the year, your coverage amounts will also change, effective on the date of your salary increase.

Supplemental Life Insurance

You may also enroll for supplemental life insurance coverage equal to one to five times your basic annual earnings, up to a maximum of $1,000,000 (rounded to the next higher $1,000). Life insurance volume greater than $750,000 is subject to proof of good health. You pay the full cost of this coverage. You pay premiums for any supplemental coverage through payroll deductions. When you or your dependents elect to increase the level of coverage, you may be required to show proof of good health by having a medical examination at the carrier's expense.

If your combined basic and supplemental life insurance coverage exceeds $50,000, you may owe taxes on the value of your coverage over $50,000 (see Tax Considerations).

Proof of Good Health

You must provide proof of good health before coverage can become effective if you:

- Enroll for supplemental life insurance more than 31 days after your eligibility date
- Increase your supplemental life insurance coverage during annual enrollment
- Re-enroll for supplemental life insurance after you have dropped it
- Elect or increase coverage to more than $750,000
- You have any subsequent increase in your basic or supplemental life insurance coverage, if the increase exceeds the guaranteed issue amount (including an increase in coverage resulting from a salary increase).

When you are required to provide proof of good health, you must complete an Evidence of Insurability (EOI) online application. Then, A. H. Belo Benefits will certify the employer portion. The insurance company will review the form and notify you of its decision.

How Benefits Are Paid

Payment to your beneficiary will be made in one lump sum. If your beneficiary is a minor or not competent, the claims administrator may pay up to $1,000 in benefits to the institution or person that appears to have assumed custody and main support, until the appointed legal representative makes a formal claim or your minor beneficiary reaches age 18.

Naming a Beneficiary

When you become eligible for life insurance coverage, you complete your beneficiary designation when you enroll in benefits. A beneficiary is the person, institution or organization you name to receive your life insurance benefits in the event of your death. You may change your beneficiary at any time by submitting a beneficiary change request. Your beneficiary will remain the same unless you complete a new request.

If a designated beneficiary dies before you, his or her share will be paid (in equal shares) to any other beneficiaries who are still living and have been named by you. If all designated primary beneficiaries die before you, the benefits will be paid to the designated secondary beneficiaries. If no beneficiary is living or if you do not name a beneficiary for your life insurance benefits, payment is made in the following order:

- Your surviving spouse
- Equal shares to your surviving children
- Equal shares to your surviving parents
- Equal shares to your surviving sisters and brothers
- Your estate

If you elect dependent life or accident insurance coverage for your spouse or children, you are automatically the beneficiary for their insurance benefits.

Assignment of Benefit

Your beneficiary may assign a portion of his or her benefit directly to the funeral home to cover the cost of the funeral.

Payment in Special Situations

If your beneficiary is declared legally incapacitated, benefits will be paid to the legal guardian or as otherwise directed by a court of law. This decision is made by the plan administrator.

If You Become Disabled

Waiver of Premium

If you become totally disabled (as determined by the life insurance carrier) before age 60 while covered under the life insurance plan, your basic and supplemental employee life insurance and your employee personal accident coverage will continue from the date of disability and premiums will be waived. You must give notice of the disability to the life insurance carrier within 12 months of the date you stop actively working. You must provide proof of the disability within 15 months, including a description of the disability, its cause and the date it occurred. If it is not possible to provide proof within 15 months, you must supply proof as soon as reasonably possible, but not later than one year after proof is otherwise required (unless you are legally incompetent).

Waiver of premium will end on the earliest date you:

- Are no longer disabled
- Fail to furnish proof of continued disability
- Fail to submit to required examinations
- Are not under the regular continuing care of a physician for treatment of your disability
- Reach age 70 (unless eligible for retiree life and that amount applies)
- Reach age 70 or are deemed retired (receiving benefits from a company-sponsored pension plan)

You must apply for the waiver of premium within the first 52 weeks of disability.

If You Die While Disabled

If you are absent from work (but have not terminated your employment with A. H. Belo), your basic and supplemental life insurance remains effective for 52 weeks from the last day you worked. Prior to the end of the 52 weeks from last day worked, you must apply for a waiver of premium. If you die, your beneficiary may be eligible to receive your basic life insurance benefits.

Your supplemental life insurance would pay a benefit only if you had continued to pay premiums during your absence from work. To receive benefits, your beneficiary must notify the claims administrator within 12 months of your death.

Benefit Limits

Your basic and supplemental life insurance coverage is limited to $1,000,000 each for a combined total of $2,000,000. Amounts of basic and supplemental coverage over $750,000 each are subject to approval by the life insurance carrier.

Tax Considerations

You do not pay taxes on the first $50,000 of basic and supplemental life insurance coverage. If the total basic and supplemental life insurance coverage for yourself is more than $50,000, you may owe taxes on the value of your coverage over $50,000. This value is called imputed income. IRS regulations require the company to report federal wages and deduct Social Security taxes (FICA) on imputed income from your paycheck and report it as taxable income on your Form W-2 each year.

Exclusions

No amount of supplemental life insurance is payable if the cause of death is suicide that occurs within 24 months after:

- Your coverage goes into effect
- You increase the amount of your coverage
- Your coverage exceeds the guaranteed issue amount

Travel Assistance Services

Who Can Use the Services

Lincoln Financial Group, the company's life insurance provider, has created a partnership with TravelConnect to provide emergency medical and language assistance while you travel. This benefit is available to all full-time employees who are covered under the A. H. Belo Basic Life Insurance Plan. This applies to travel that is:

- 100 miles or more from your place of residence,
- A foreign country, and
- For travel lasting no more than 90 consecutive days.

IMPORTANT! TravelConnect's protection automatically extends to eligible employees, their spouses and dependent children. Whether the travel is for business or pleasure, you are covered. Your spouse and dependent children are covered while traveling for pleasure (business travel for your spouse or children is not covered).

What Services Are Covered

Some of the TravelConnect's travel services include assistance with:

- Language problems
- Obtaining pre-trip information
- Medical consultations, evaluations and referrals
- Hospital admission guarantee
- Critical care monitoring
- Emergency medical evacuation (if medically necessary).

Also, when you are ready to be discharged from a hospital and need medical assistance to return home (or to a rehabilitation facility), TravelConnect will help arrange your transportation and provide an escort, if deemed necessary. In the unfortunate event of a death, return of mortal remains is provided.

This service will not replace your health coverage nor cover medical bills. In order to get reimbursed for medical bills, follow the normal procedures outlined by your health coverage plan.

How to Access Services

The TravelConnect staff is available 24 hours a day, 365 days a year to help ensure that you obtain appropriate emergency travel assistance on covered travel. You must contact Assist America prior to any services in order for them to provide help.

To access TravelConnect services:

- Call toll-free in the U.S.: (800) 527-0218
- Call collect outside of the U.S.: (410) 453-6330

Whenever you contact TravelConnect, you will need to provide the following reference number:**322541**. For more information, visit www.Lincoln4Benefits.com and use group number 000400211825. Please contact your A. H. Belo Benefits if you would like additional information or to obtain an ID card.

Dependent Life Insurance

How the Plan Works

Your Coverage Choices

You may enroll your spouse and your eligible unmarried dependent children for life insurance coverage. You pay the full cost of this coverage. The following coverage options are available:

Family Member	Option 1	Option 2	Option 3
Spouse	$10,000	$5,000	$20,000
Each unmarried dependent less than age 26	$5,000	$2,500	$10,000

Note: Children, from birth, are eligible for dependent life insurance. If you are already enrolled for dependent life insurance (and covering other eligible dependent children) at the time of your child's birth, your child is automatically covered under this plan. Also, the law limits the maximum amount of life insurance coverage for each dependent to not more than 50% of your combined basic and supplemental life insurance coverage.

Proof of Good Health

You must provide proof of your dependents' good health before coverage can become effective if you:

- Enroll for dependent life insurance more than 31 days after your eligibility date
- Increase your dependent life insurance coverage during annual enrollment

When you are required to provide proof of good health, you must complete an Evidence of Insurability (EOI) online application. Then, A. H. Belo Benefits will certify the employer portion. The life insurance carrier will review the form and notify you of its decision.

How Benefits Are Paid

If one of your covered dependents dies, you are automatically the beneficiary of any dependent life insurance benefits you have elected. To receive benefits, you must notify the claims administrator within 12 months of your covered dependent's death.

Voluntary Accidental Death and Disability (VADD) Insurance

How the Plan Works

The Voluntary Accidental Death and Disability (VADD) plan pays benefits to you or your covered dependents if you experience a loss as the result of a serious accidental injury. The plan pays your beneficiary if you die as the result of an accident, and it pays you if your covered dependent dies. Covered losses include death, paralysis or loss of a limb, and loss of sight, speech or hearing.

Coverage for You

You may elect VADD coverage for yourself of up to six times your basic annual earnings.

Definition of Basic Annual Earnings

Basic annual earnings are defined as your current salary or wage. They do not include bonuses, overtime pay or any other extra compensation. If your job currently includes sales commission, your basic annual earnings will be averaged over the previous 12-month period, or averaged from the date of employment, whichever period is shorter. If your salary changes during the year, your coverage amounts will also change, effective on the date of your salary increase.

Coverage for Your Family

You may also choose VADD coverage for your spouse and children. You have three coverage options:

- **Spouse only** — 60% of your personal accident insurance coverage amount
- **Children only** — 20% of your personal accident insurance coverage amount
- **Spouse and children** — 50% for your spouse and 15% for your children of your personal accident insurance coverage amount

How Benefits Are Paid

The plan pays a benefit if you or your covered dependents die or suffer a covered physical loss as the direct result of an accident. For the benefits to be paid, the loss or death must occur within 365 days of the accident. The following table shows the covered losses and the benefit amount for each loss.

Loss Table for VADD

Covered Loss	Percentage of Benefit Paid
Life	100%
Speech and hearing	100%
Use of both arms and legs	100%
Use of both legs	75%
Sight of one eye	50%
Use of one limb	50%
Speech or hearing	50%
Loss of use of arm and leg on one side of body	50%
Thumb and index finger of same hand	25%

In the event of an accidental injury, personal accident insurance coverage pays benefits to:

- You in the case of certain accidental injuries
- Your named beneficiary in the event of your death (see Naming a Beneficiary)
- If one of your covered dependents dies, you are automatically the beneficiary of any dependent life insurance benefits you have elected

If you have a double loss that is named together in the table above, both losses must occur in the same accident for the plan to pay 100% of the amount of coverage. If the two losses are not named together in the table, you receive benefits for the greater of the two losses. The maximum amount payable from one accident is 100% of the amount of coverage.

Exclusions

Benefits are paid only for losses caused by an accident. The plan does not pay benefits if the loss results from:

- Suicide or attempted suicide, while sane or insane
- Intentionally self-inflicted injury
- Committing or attempting to commit an assault, felony or other illegal act
- Physical or mental infirmity, disease or infection, except when caused by accidental bodily injury
- War (declared or undeclared) or active duty in any armed service during a time of war (declared or undeclared)
- Active participation in a riot, rebellion or insurrection

- Injury or death as a result of the covered person operating any motorized vehicle while intoxicated or under the influence of any controlled substance

Long-Term Disability

Important information on your long-term disability plan is provided separately:

The company offers a **Long-Term Disability** Plan (administered by MetLife for disabilities arising prior to January 1, 2015 and after January 1, 2008, and by Liberty Life Assurance Company of Boston for disabilities arising on or after January 1, 2015) at all A. H. Belo company locations. For disabilities arising prior to January 1, 2008, contact A. H. Belo Benefits to determine the administrator for any such claims. For specific long-term disability plan details for claims arising on or after January 1, 2015, please refer to the separate Liberty Life Assurance Company of Boston Long-Term Disability Certificate which is available at life360ahbelo.com > Life & Disability > Long-Term Disability. Contact A. H. Belo Benefits for the applicable certificate for disabilities arising prior to January 1, 2015. The separate long-term disability group insurance policies are available at the website mentioned above and are incorporated herein by reference.

Your Coverage

A. H. Belo automatically provides long-term disability (LTD) insurance coverage if you are a regular, full-time employee and you have completed 12 months of continuous full-time service with an A. H. Belo company that participates in the plan.

When Coverage Begins and Ends

When Coverage Begins

Your LTD coverage begins on the first day of the month after you have completed 12 months of continuous full-time service with an A. H. Belo company that participates in the plan. If you are already on a disability leave, your coverage will begin on the first day you return to work as a regular, full-time employee.

Pre-existing Conditions

The LTD Plan has a pre-existing condition restriction that applies to the first 12 months of plan coverage. You will not receive LTD benefits for a disability that is related to an injury or illness that you had during the three-month period before becoming covered and for which you:

- Received medical treatment, consultation, care or services including diagnostic tests, or
- Took prescription drugs or medicines

When Coverage Ends

Generally, LTD coverage ends when you:

- No longer meet the eligibility requirements described in Eligibility and Participation
- Terminate employment with A. H. Belo (effective on your last day of active employment)
- Cancel or drop coverage
- Stop making any required payments for coverage
- Die

Coverage also ends if the plan is terminated, your employer stops participating in the plan or the plan is amended to terminate coverage for a group or class of individuals that includes you.

If you are on an approved leave of absence, you may continue coverage for the period of time outlined in the Benefits While on Leave of Absence chart.

Conversion Privilege

When you terminate your employment with an A. H. Belo company, you may obtain individual LTD coverage without providing proof of good health if you were covered by the LTD Plan for 12 consecutive months before terminating employment.

You must apply for conversion coverage and pay the first quarterly premium within 31 days after your coverage terminates under the LTD Plan. The conversion privilege is not available to you if your LTD coverage terminates because of the following:

- The LTD Plan terminates
- You retire
- You become covered under another employer's LTD plan within 31 days after your termination from A. H. Belo
- You become disabled under the LTD Plan
- You recover from a disability and do not return to work for an A. H. Belo company
- You are on a leave of absence

  You may be able to convert your group long-term disability coverage to an individual long-term disability insurance policy. To determine if this is an option available to you, you must review the group long- term disability policy which is available at life360ahbelo.com > Life & Disability > Long-Term Disability. You must apply for any conversion policy that may be available within 31 days of the date your coverage under the A. H. Belo group long-term disability insurance terminates for one of the specified reasons. See the group long-term disability policy for more information on the requirements you must satisfy to be eligible for the conversion policy.

Business Travel Accident Insurance

When Coverage Begins and Ends

When Coverage Begins

All full-time and part-time employees are eligible for coverage on their first day of employment. Non-employee directors are eligible for coverage on their first day of service.

When Coverage Ends

Generally, your business travel accident (BTA) coverage ends when you:

- No longer meet the eligibility requirements described in Eligibility and Participation
- Terminate employment with A. H. Belo (effective on the last day of active employment)
- Cancel or drop coverage
- Stop making any required payments for coverage
- Die

Coverage also ends if the plan is terminated, your employer stops participating in the plan or the plan is amended to terminate coverage for a group or class of individuals that includes you. The BTA coverage is provided under a fully insured policy which is incorporated herein by reference. You can contact A. H. Belo Benefits for questions.

How the Plan Works

Covered Situations

Business travel accident insurance protects you and your eligible family members in the event of an accidental death, dismemberment or paralysis resulting:

- While you are traveling anywhere in the world on a business trip, including onboard commercial or military transport aircraft. It also covers your spouse and/or children if they are accompanying you on that trip
- While you are traveling as a passenger, pilot or member of the crew on a company aircraft
- While you are traveling to and from and attending meetings of the Board of Directors
- While your spouse and/or children are traveling anywhere in the world for relocation at A. H. Belo's request
- During a hijacking which occurs during a business trip

If you're eligible and you die or become dismembered or injured as described above, the plan pays a benefit to you or your beneficiaries of one and one-half times your annual earnings, rounded to the next higher $1,000, up to a maximum of $300,000. The minimum employee benefit is $100,000.

Annual earnings are defined as your current annual salary or wage (including commissions if you are in sales) on the date of the accident, excluding overtime pay, bonuses or any other extra compensation.

Eligible spouses are covered for $50,000, and each child is covered for $25,000. The benefit amount for non-employee directors is $100,000. Refer to How Benefits are Paid for a description of how the plan pays benefits for covered losses.

Definition of a Business Trip

A business trip means a bona fide trip:

- While on assignment or at the direction of A. H. Belo for the purpose of furthering the business
- Which begins when you leave your residence or place of regular employment, whichever occurs last, for the purpose of beginning the trip
- Which ends when you return to your residence or place of regular employment, whichever occurs first

Travel to and from work, bona fide leaves of absence and vacations are excluded from business travel accident coverage.

Definition of Injury

Injury means you are covered for bodily injury resulting directly and independently of all other causes from an accident that occurs while you are covered under this plan.

Loss resulting from illness or disease (except a pus-forming infection that occurs through an accidental wound) or medical or surgical treatment of an illness or disease is not considered to be resulting from injury.

Exposure

Exposure to the elements will be considered to be an injury if it results from the forced landing, stranding, sinking or wrecking of a conveyance in which you were an occupant at the time of the accident.

How Benefits Are Paid

Benefits for Loss of Life

The plan will pay any benefit due for loss of life:

- According to the beneficiary designation in effect at the time of death,
- If no beneficiary is designated, according to the beneficiary designation under the Group Life Insurance policy issued to A. H. Belo and in effect at the time of death, or
- To the survivors in equal shares in the first of the following classes to have a survivor at your death
    - Spouse
    - Children
    - Parents
    - Brother and sisters

If there is no survivor in any of these classes, payment will be made to your estate.

All other benefits due and not assigned will be paid to you, if living; otherwise, the benefits will be paid as described in this section.

Disappearance

You will be considered to have suffered loss of life if:

- Your body has not been found within one year after the disappearance of the form of transport in which you were an occupant at the time of its disappearance, and
- The disappearance of the form of transport was due to its accidental forced landing, stranding, sinking or wrecking

Accidental Death & Dismemberment Benefit

If your injury results in any of the following losses within 365 days after the date of the accident, the BTA plan will pay the sum shown below. The plan will not pay more than 100% of the benefit for all losses due to the same accident.

Loss Table for Accidental Death & Dismemberment Benefit

Covered Loss	Percentage of Benefit Paid
Life	100%
Speech and hearing	100%
Movement of both arms and legs	100%
Movement of both legs	75%
Sight of one eye	50%
Both hands or both feet or sight of both eyes	100%
Speech or hearing	50%
Movement of arm and leg on one side of body	50%
Thumb and index finger of same hand	25%
Either hand or foot and sight of one eye	100%
One hand and one foot	100%
Either hand or foot	50%

Loss means:

- Hands and feet, actual severance through or above wrist or ankle joints,
- Sight, speech or hearing (entire and irrecoverable loss),
- Thumb and index finger, actual severance through or above the metacarpophalangeal joints, and
- Movement of limbs, complete and irreversible paralysis of such limbs.

Aggregate Benefit Limits

An accident may involve more than one employee. Total benefits to all covered employees involved in a single aircraft accident are limited to $5,000,000. Total benefits for all covered employees involved in a single war risk accident are limited to $5,000,000 whether on the ground or in the air.

Exclusions

The business travel accident insurance policy does not cover any loss resulting from:

- Intentionally self-inflicted injury, suicide or attempted suicide, whether sane or insane
- War or act of war, whether declared or undeclared, occurring within the geographical limits, the territorial waters, or the airspace above the United States, Canada, Afghanistan, Algeria, Colombia, Iraq, Israel, Saudi Arabia, Sudan, and South Sudan and any country of which the employee is a permanent resident (the list of excluded countries is subject to change at any time as determined by the insurance carrier)
- Injury sustained while in the armed forces of any country or international authority
- Injury sustained while on any aircraft other than those described in Covered Situations
- Injury sustained while traveling to and from work, or while on bona fide leaves of absence and vacations

Note: In some cases, the company has been able to secure coverage through Sun Life Insurance and Gerber Life and Accident Insurance Company for employees working in some of the countries where there is a war, or the risk of war, occurring. Contact A. H. Belo Benefits for more information.

Filing Disability, Life and Accident Claims

Long-Term Disability Claims

You and A. H. Belo must complete forms provided by the claims administrator, then have your attending physician complete the appropriate section of the form and send it directly to the claims administrator. Your claims administrator depends on your date of disability.

If you are disabled on or after January 1, 2015

Liberty Life Assurance Company of Boston is your claims administrator for LTD.

If you are disabled on or after January 1, 2008 and before January 1, 2015

MetLife is your claims administrator for LTD.

Proof of Disability

The claims administrator requires you to provide proof of your claim, which may include:

- That you are under the regular care of a physician
- The appropriate documentation of your monthly earnings
- The date your disability began
- The cause of your disability
- The extent of your disability, including restrictions and limitations preventing you from performing your regular occupation
- The name and address of any hospital or institution where you received treatment, including all attending physicians

You should file the claim and provide proof of your disabling condition within 30 days of the date on which your disablijng condition began or became disabling, whichever is later. The date on which your disabling condition began or became disabling is the date your elimination period starts. If your disabling condition continues beyond the date on which the group long-term disability insurance policy states your elimination period ends, then your disability benefits can commence, provided you have filed a claim with the long-term disability insurer for your claimed disability. However, you must send the claims administrator written proof of your claim no later than 30 days after your elimination period. If it is not possible to provide proof within 30 days, it must be given no later than one year after the time proof is otherwise required (unless you are legally incompetent).

You must notify the claims administrator immediately when you return to work in any capacity. The claims administrator will periodically ask you to ask your doctors to provide updated medical records on your condition and treatment plan and progress. You must provide the requested information to the claims administrator to avoid termination of your benefits or delay in payment of any benefits.

You may, at the claims administrator's request, be required to provide proof of your continued disability to continue receiving LTD benefits. The claims administrator will pay for an examination by a physician of its choice and may ask its representative to interview you.

Life Insurance and Personal Accident Claims

You (or your beneficiary, if you die) should notify the claims administrator, Lincoln Financial Group, within 30 days of a death or 12 months of a covered loss. A claim form will be provided to you upon notification. You must complete the claim form and provide proof of the loss (as explained below) within 90 days. If it is not possible to provide proof within 90 days, you must supply it as soon as reasonably possible, but no later than one year after the time it is otherwise required (unless you are legally incompetent).

You (or your beneficiary) must provide a certified copy of the death certificate before death benefits can be paid. Benefits will be paid in a single lump-sum payment as soon as possible after all information is received.

Proof of Loss

The claims administrator requires you to provide proof of a life insurance or personal accident insurance claim. Proof of your claim includes information about the nature, date and cause of the loss, disability or expense and may require you to submit one or more of the following:

- Police accident report

- Autopsy reports
- Laboratory results
- Hospital and physician records
- Receipts

Business Travel Accident Insurance Claims

You (or your beneficiary) should notify the claims administrator, The Hartford, within 30 days of the covered loss (or as soon as reasonably possible). The notice should include the insured person's name and policy number. The claims administrator will send you or your beneficiary a claim form within 15 days after receiving notice of the loss. Complete the claim form and return it with proof of the loss within 90 days.

Eligibility Claims

If there is a question as to whether you or your dependents are eligible for coverage under any benefit option provided by the plans, that question will be decided by the plan administrator. If the eligibility question is not accompanied by a claim for benefits, the decision of the plan administrator will be final and will not be subject to review. However, if the eligibility question is being decided in connection with a claim for benefits, you may appeal the decision of the plan administrator.

Denied Claims

Long-Term Disability

If a claim for LTD benefits is denied, the claims administrator will notify you no later than 45 days after the receipt of the claim. This 45-day period may be extended for an additional 30 days if the claims administrator determines the extension is necessary due to matters beyond the control of the plan and notifies you of the extension before the end of the initial 45-day period. If you have not furnished information that is necessary for determining the claim, the claims administrator will notify you and describe the information that is needed.

If, prior to the end of the first 30-day extension, the claims administrator determines that, due to matters beyond the control of the plan, a decision cannot be made within that extension period, the period for making a determination with respect to the your claim may be extended for an additional 30 days, provided the claims administrator notifies you prior to the end of the first 30-day extension period of the circumstances requiring the extension and the expected date for making a determination.

In addition, in the case of any extension of the period in which to make a determination, the notice of extension will explain the standards on which your entitlement to an LTD a benefit is based, the unresolved issues that prevent a determination with respect to the claim and the additional information needed to resolve those issues. You will be given a reasonable period of time, but not less than 45 days, in which to supply the missing information.

While the claims administrator is waiting for the missing information, the deadline for responding to your claim will automatically be extended until 30 days after you furnish the missing information or, if you do not furnish the missing information, until 30 days after the date for furnishing such information.

If an LTD claim is denied by the claims administrator, you will have 180 days to file an appeal of the denial.

Other Claims

With respect to all claims other than claims for medical, dental, vision, flexible spending account and LTD benefits, the claims administrator will notify you of its determination no later than 90 days after the receipt of the claim. This 90-day period may be extended for an additional 90 days if the claims administrator determines the extension is necessary due to special circumstances and notifies you of the extension before the end of the initial 90-day period.

The notice of extension will indicate the special circumstances and the date by which the claims administrator expects to make a determination. If you have not furnished information that is necessary for determining the claim, the claims administrator will notify you no later than 30 days after receiving the claim and will describe the information that is needed. You will be given a reasonable period of time, but not less than 45 days, in which to supply the missing information.

While the claims administrator is waiting for the missing information, the deadline for responding to your claim will automatically be extended until 90 days after the claimant furnishes the missing information or, if you do not furnish the missing information, until 90 days after the date for furnishing such information.

If your claim is denied by the claims administrator, you will have 60 days to file an appeal of the denial.

Notice of Denied Claims

If a claim for benefits is denied, you will be notified in writing, and the written notice will contain the following information:

- The specific reasons for the benefit denial
- Reference to the plan provisions on which the denial is based
- A description of any additional material or information necessary to perfect your claim and an explanation of why such information is necessary
- A description of the plan's appeal process and applicable time limits (including the expedited process applicable to urgent care claims) and a statement of your right to bring a civil action under ERISA following an adverse determination on appeal
- If an internal rule, guideline, protocol or other similar criterion was relied on in denying your benefit claim, a statement to that effect. A copy of the applicable rule, guideline, protocol or other similar criterion will be provided to you, upon request, free of charge
- If the benefit denial was based on medical necessity or experimental treatment or a similar exclusion on limit, an explanation of such scientific or clinical judgment and its application to your medical circumstances

If your claim for benefits is denied, you may not bring a lawsuit to recover the denied benefits until you have exercised all of your appeal rights and your appeal has been denied in whole or part.

Appeal of Denied Claims

If you wish to appeal the denial of a claim for benefits under the plan, you or your authorized representative must file written notice of the appeal before the time for filing the appeal expires. Your appeal must be filed with the claims administrator for all appeals related to denied claims for life insurance, personal accident insurance, long-term disability or business travel accident insurance.

Your written notice should state in reasonable detail all of the grounds upon which your appeal is based, including references to applicable plan provisions, and any issues or comments you feel are relevant to your claim. You should supply any documents, records or other information relating to your claim. You may also request copies of documents, records and other information relevant to your claim that are in the possession of the plan, which will be provided to you free of charge.

The appeals administrator will review the denial of your claim without deference to the decision of the claims administrator. If the denial of your claim was based in whole or in part on a medical judgment, the appeals administrator will consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment and who did not participate in the denial of your claim (and is not the subordinate of a health care professional who participated in the claim denial). The appeals administrator will also identify the medical or vocational experts whose advice was obtained on behalf of the plan in denying your claim, without regard to whether the plan relied on such advice.

The applicable time limits to file an appeal of a benefit denial are set forth below:

- **LTD Claims:** 180 days after the benefit denial; the appeals administrator will issue a decision within 45 days after receiving the appeal (this 45-day period may be extended for up to an additional 45 days on prior written notice to you).
- **All Other Claims:** 60 days after the benefit denial; the appeals administrator will issue a decision within 60 days after receiving the appeal (this 60-day period may be extended for up to an additional 60 days on prior written notice to you).

Notice of Appeal Decision

If your appeal is denied, you will be notified in writing, and the written notice will contain the following information:

- The specific reasons for the denial
- Reference to the plan provisions on which the denial is based
- A statement that you are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records and other information relevant to your claim for benefits
- If an internal rule, guideline, protocol or other similar criterion was relied on in denying your benefit claim, a statement to that effect. A copy of the applicable rule, guideline, protocol or other similar criterion will be provided to you, upon request, free of charge
- If the benefit denial was based on medical necessity or experimental treatment or a similar exclusion on limit, an explanation of such scientific or clinical judgment and its application to your medical circumstances

Other Legal Information

Consistency of Treatment

The plan administrator will take such action from time to time as may be necessary to assure that all claims for benefits under the plan are determined in accordance with the applicable plan documents and that the provisions of the applicable plan documents are applied consistently to similarly situated plan participants and their dependents.

Liability for Payment

Neither A. H. Belo nor any A. H. Belo company will have any obligation to make a benefit payment to you or your dependents under a plan or program that is fully insured. The insurer is solely responsible to make such benefit payments, and A. H. Belo and the A. H. Belo companies will have no liability to you or your dependents if the insurer fails to make any payments required under any insured plan or program.

The plans and programs that are fully insured are the following:

- Long-Term Disability Plan
- Life Insurance Plan (basic, supplemental and dependent life insurance)
- Personal Accident Insurance Plan
- Business Travel Accident Insurance Plan

Recovery of Overpayments

The amount of your plan benefits will be adjusted if:

- You have misstated any information in your application for plan coverage (including any statement of health)
- You do not report required information while receiving company provided benefits
- Any error is made in calculating your benefits

If a benefit is overpaid or benefits are duplicated, you are expected to repay the plan within 60 days. If you do not, the plan may reduce or refuse future benefits until the overpayment is repaid. The plan may also take additional action allowed by law.
In most cases, no interest will be charged on the amount of any overpayment or duplication of benefits, and, unless required by law, no interest will be paid on any underpayment of benefits or on any benefit payments, which have been delayed for any reason.

A. H. Belo Severance Plan

The A. H. Belo Severance Plan is intended to provide transition income to eligible employees following their involuntary termination of employment by the company, including but not limited to reduction in force and re-engineering actions. The full cost of the Severance Plan is paid by A. H. Belo. You are not required to contribute toward the cost of the Plan, nor are you required to enroll.

Who Is Eligible

You will be eligible for participation in the A. H. Belo Severance Plan if you are a regular full-time employee. A. H. Belo may, in its discretion, determine that certain regular part-time employees are eligible to participate. If your employment should be involuntarily terminated and you are determined to be eligible for severance, you must sign, and not revoke, a release in a form prescribed by A. H. Belo in order to receive a severance benefit.

You **are not eligible** to participate in the A. H. Belo Severance Plan if you are:

- A temporary employee
- A leased employee
- An individual treated as an independent contractor at the time services are provided (even if you should be later retroactively reclassified as an employee).

You **will not be eligible** to receive benefits under the Severance Plan if:

- You are terminated for cause (as defined in the Severance Plan);
- You terminate employment voluntarily, due to death or disability or upon expiration of a leave of absence;
- You fail to complete any transition tasks assigned to you by an employer to the employer's sole satisfaction;
- You are an employee who is offered comparable employment (as defined in the Severance Plan), whether or not you accept such an offer;
- You accept an enhanced voluntary early retirement benefit offered by an employer (should an employer choose to offer one);
- You are covered by a collective bargaining agreement between an employer and a labor organization, unless that agreement provides for participation in the Severance Plan;
- You are eligible for severance pay or other termination benefits under any employment or other agreement with A. H. Belo or any other participating employer (including without limitation a change of control or similar agreement); or
- You are receiving benefits under a long-term disability plan sponsored by A. H. Belo.

Notwithstanding anything in the Severance Plan or in this SPD to the contrary, A. H. Belo reserves the right to determine on a case-by-case basis whether an individual will be eligible for a severance benefit under the Severance Plan or whether any otherwise eligible employee will be excluded from participation in the Severance Plan, and to instruct the plan administrator to approve an amount of severance benefit that is different than that described in the Severance Plan or in this SPD (either higher or lower) with respect to any participant.

How the A. H. Belo Severance Plan Works

When Are Severance Benefits Paid?

Benefits will be payable under the Severance Plan only if you are an eligible employee, receive notice from A. H. Belo that your employment is or will be terminated, without cause, and the plan administrator determines that you are eligible for severance plan benefits.

What Is the Plan's Severance Benefit?

If you are determined to be eligible for severance benefits, the calculation of the benefit payable under the Severance Plan will depend upon your position, your completed Years of Service and your Base Salary as of your termination date. However, in order for you to receive any severance benefits under the Severance Plan, you must execute, and not revoke, a release in a form prescribed by A. H. Belo.

For purposes of the Severance Plan, **"Base Salary"** means annual base compensation rate at the time of your termination of employment. If you are a salaried employee, your weekly Base Salary will be calculated by dividing your annual Base Salary by 52. If you are an hourly employee, your weekly Base Salary will be calculated by multiplying your base hourly rate of pay by the number of hours in your employer's standard work week. Base Salary does not include commissions, bonuses, overtime, incentive compensation, cost of living adjustments, benefits paid under any qualified plan, any group medical, dental or other welfare benefit plan, noncash compensation or any other additional compensation, but it will include salary reduction amounts under A. H. Belo's 401(k) or cafeteria plans, or a nonqualified elective deferred compensation arrangement, if any, to the extent that in each such case the reduction is to base salary.

For purposes of the Severance Plan, a **"Year of Service"** means each 12-month period of service with a participating employer commencing on your date of hire and each anniversary thereof. Years of Service for this purpose will include service with any company that is (or was during your employment) affiliated with A. H. Belo or, for periods prior to February 8, 2008, was affiliated with Belo Corp. and its affiliates. Any benefits payable under the Severance Plan will be reduced by amounts withheld to satisfy your federal, state or local income or other tax obligations.

Vice Presidents and Above

Under the Severance Plan's formula, an eligible participant employed at or above the level of Vice-President will be entitled to receive a lump sum severance benefit equal to the sum of (i) 1.0 week of Base Salary multiplied by the participant's Years of Service, but in no event less than 16 weeks' Base Salary, plus (ii) an amount equal to six times the monthly COBRA premium applicable to the participant's coverage level under the A. H. Belo Health Care and Welfare Benefit Plan (or its successor).

Positions Below Vice-President

An eligible participant employed below the level of Vice-President will be entitled to receive a lump sum severance benefit equal to 1.25 weeks' Base Salary multiplied by the participant's Years of Service, but in no event less than two weeks' Base Salary or greater than 10 weeks' Base Salary.

Examples

The following examples will illustrate the calculation of benefits under the Severance Plan:

Vice President or Above

Example #1: Calculation of Severance Benefit
If a participant's weekly Base Salary is $3375 and he or she has 33 Years of Service, the participant will be eligible to receive a lump sum severance benefit of: $111,375 (1.0 week of Base Salary multiplied by 33 Years of Service), plus six months of then-current COBRA premiums.

Example #2: Calculation of Minimum Severance Benefit
If a participant's weekly Base Salary is $3,375 and he or she has 15 Years of Service, the participant will be eligible to receive a lump sum severance benefit of: $54,000 (1.0 week of Base Salary multiplied by 15 Years of Service, but not less than 16 weeks' Base Salary), plus six months of then-current COBRA premiums.

Positions Below Vice-President

Example #1: Calculation of Severance Benefit
If a participant's weekly Base Salary is $961 and the participant has 5 Years of Service, he or she will be eligible to receive a total severance benefit of $6,006 (1.25 weeks' Base Salary multiplied by 5 Years of Service).

Example #2: Calculation of Maximum Severance Benefit
If a participant's weekly Base Salary is $961 and the participant has 28 Years of Service, he or she will be eligible to receive a total severance benefit of $33,635 (1.25 weeks' Base Salary multiplied by 28 Years of Service, subject to a maximum benefit of 10 weeks of Base Salary.)

When Are Severance Benefits Paid?

As a condition to receiving a benefit under the Severance Plan, an eligible participant will be required to sign a release addressing certain promises and covenants pertaining to their employment with A. H. Belo. Each participant will have a period of time specified by the Committee to consider the severance benefit available under the Severance Plan, as well as the terms of the release. The Severance Plan and the release require that any dispute or controversy arising under or in connection with the release be settled exclusively by arbitration.

Severance benefits will be paid to eligible participants in a cash lump sum within 10 business days (or at such earlier time as required by applicable law) following the later of the participant's termination of employment or the effective date of the release.

Important: if a participant does not sign the release described above or signs it and revokes it after signing it, he or she will not be entitled to any severance benefits under the Severance Plan.

You are not required to seek other employment or to attempt in any way to reduce any amounts payable to you pursuant to the Severance Plan in order to receive severance benefits. Further, the amount of the severance benefit will not be reduced by any compensation earned as a result of employment by another employer or otherwise. The amount of the severance benefits under the Severance Plan will satisfy A. H. Belo's obligation to make any payments otherwise due under the Worker Adjustment and Retraining Notification Act (WARN) or similar law.

Duration of the Plan

A. H. Belo reserves the right to amend or terminate the Severance Plan by action of the Board (or an authorized committee thereof) at any time and for any reason.

Filing Severance Claims

If you question the amount of your benefit under the Severance Plan, your eligibility for a benefit under the Severance Plan, or any other aspect of the operation of the Severance Plan, you must file a written application with the A. H. Belo Benefits Administrative Committee (the "Committee") or such other person designated by the Committee from time to time for such purpose. Such claim must be filed before the execution of a release.

You will be notified of the acceptance or denial of your claim for a benefit within 90 days from the date the Committee or such other designated person receives your election. In some cases, your request may take more time to review and an additional processing period of up to an additional 90 days may be required. If this happens, you will be notified.

If your claim is denied in whole or in part, you will be notified in writing of the reason for the denial and the specific references to the Severance Plan provisions on which the denial is based. This notice also will explain what additional information is needed to perfect the claim and an explanation of why the information is necessary, together with an explanation of the Severance Plan's review procedure.

If you are not notified within 90 days from the date you notify the Committee, you may request a review of your application as if your claim had been denied.

Appeals

If your claim **has been denied** and you wish to have your claim reviewed:

- You must request, in writing, within 60 days, a review of your claim by the Committee
- You may review all documents relevant to the denial (upon reasonable notice)
- You must submit all issues and comments in writing.

The Committee will make a final written decision on a claim review, in most cases within 60 days, but in no event later than 120 days after a receipt of a request for a review, giving the specific reasons for the denial and making specific references to the Severance Plan provisions on which the decision is based. The Committee has the sole discretion, based on the Severance Plan documents, to decide any claim and any such decision is final, conclusive and binding on all persons.

Retiree Benefits

The plans do not provide retiree benefits for any employee, spouse or dependent, except as noted in this section.

For more information on retiree benefits, contact A. H. Belo Benefits.

A. H. Belo Corporate and The Dallas Morning News

The company reserves the right to amend or modify retiree benefit coverage in any respect, including the amount to be charged to retirees, spouses and dependents for such coverage, or to terminate such coverage at any time with respect to current or future retirees.

Eligibility

Retiree health insurance is not provided to employees leaving the A. H. Belo company corporate office or The Dallas Morning News after December 31, 2002.

If you terminated employment before 2003 and met the eligibility requirements, you could continue medical, dental and vision coverage under the A. H. Belo Health Care and Welfare Benefit Plan for yourself and your spouse to whom you were married when you retired from the company. In addition, your spouse must have been covered under the company plans at the time you retired. No other dependents are eligible for retiree benefits.

If health coverage for you and/or your dependents ends for any reason, you cannot re-enroll for coverage at a later date.

Your Choices

Your medical coverage choice is limited to the CDHP, and dental coverage is available only under the Delta Dental plan.

Cost of Coverage

The cost for health coverage is 100% of the monthly cost to the plan to provide the same coverage for active employees.

When Retiree Benefits End

Retiree benefits end separately for you and your spouse when each of you reaches age 65. Coverage can continue for you or your spouse if one of you has not yet turned 65 and the other individual's coverage has ended. Coverage will be cancelled and will not be reinstated if your retiree medical payment is not made on a timely basis.

Medicare and Your Company Plan

The company's health plan pays secondary if you no longer are an employee and you or your spouse are enrolled in Medicare before age 65. In calculating your benefits, Medicare benefits are coordinated with those from the company medical plan. If you are enrolled in a Part D (prescription drug) plan, the company pays secondary. If you are not enrolled in a Part D (prescription drug) plan, the company will pay as primary.

The Press-Enterprise Company Retirees

A. H. Belo reserves the right to amend or modify retiree benefit coverage in any respect, including the amount to be charged to retirees, spouses and dependents for such coverage, or to terminate such coverage at any time with respect to current or future retirees.

Eligibility

Retiree medical and life insurance is not provided to employees leaving The Press-Enterprise Company after December 31, 2009.

If you terminated employment with The Press-Enterprise Company before 2010 and met the eligibility requirements, you, your spouse and dependent children were eligible for retiree medical benefits (provided each were enrolled at the time of your retirement). Coverage ceases for the covered person when Medicare eligibility is attained (due to age or disability) or a dependent no longer meets eligibility requirements.

If health coverage for you and/or your dependents ends for any reason, you cannot re-enroll for coverage at a later date. Coverage will be cancelled and will not be reinstated if your retiree medical payment is not made on a timely basis.

Your Choices

Your medical coverage choice is limited to the CDHP.

If you retired from the Press-Enterprise Company before January 1, 2010, were not yet age 65 and satisfied the eligibility requirements for retiree medical benefits, you received life insurance coverage in the amount of $20,000. Retiree life insurance ceases when you attain age 65.

Cost of Coverage

The premium for retiree medical benefits will differ depending on your retirement date. Contact A. H. Belo Benefits for information. The company pays the cost of the retiree life insurance.

When Retiree Benefits End

Retiree medical benefits end upon attainment of Medicare eligibility or when a dependent no longer meets eligibility requirements.

Medicare and Your Company Plan

Once you or a covered dependent (spouse or child) becomes Medicare-eligible, retiree medical coverage ceases for that individual.

The Providence Journal Company Retirees

Eligibility

Retiree life insurance is not provided to employees leaving the Providence Journal Company after December 31, 2010.

Cost of Coverage

If you left the Providence Journal Company before 2011 and were eligible, the company pays the cost of the retiree life insurance.

The company reserves the right to amend, modify and terminate the retiree benefit coverage in any respect for all retiree groups.

Group Auto and Home Insurance

How the Program Works

A. H. Belo offers access to a group auto and home insurance program from MetLife Auto & Home®. This voluntary benefit program offers features and conveniences that are designed to save you money. Through the program, you may apply for auto, home and other property insurance at special group rates. These are voluntary benefits that are not sponsored by the company, but made available to you.

There are a variety of policies available through the program, including:

- Auto
- Home
- Landlord's rental dwelling
- Condo
- Mobile home
- Renters
- Recreational vehicle
- Boat
- Personal Excess Liability ("Umbrella")

In addition to special group rates, there are additional discounts that could also save you money. They include:

- Auto (anti-theft devices, passenger restraints (air bags), and superior driver)
- Home (home security system and new home)

For more information and details about the program, call MetLife Auto & Home directly at **1-800-GET-MET8** (1-800-438-6388), or visit www.metlife.com/mybenefits.

Applying for Coverage

You can call MetLife Auto & Home toll-free at **1-800-GET-MET8** (1-800-438-6388) for a free insurance review and no-obligation quotes. If you want, you can even apply for coverage while you're on the phone with an insurance consultant.

Insurance consultants are available during business hours, Monday through Saturday and weekday evenings. To be able to make the most accurate comparisons to your current coverage, it's a good idea to have your current policies with you when you call.

Paying for Coverage

You pay the full cost of any insurance you purchase. The program offers payment options for paying your premiums, including payroll and checking account deduction. With these payment methods, you can spread your payments out over the term of the policy. (A down payment may be required.) Additionally, there are no interest charges or service fees.

There are additional payment options available. For more information, call MetLife Auto & Home at **1-800-GET-MET 8** (1-800-438-6388).

If You Leave the Company

If you retire or terminate employment, you can continue your auto or home insurance without interruption. If you retired, you would still remain eligible for the discounted group rates through A. H. Belo.

Group Legal

Your Legal Plan

Hyatt Legal Plans, Inc. (HLP) has been selected to provide Legal Plan benefits. The services are provided through a panel of carefully selected participating law firms. Lawyers in this network are called **plan attorneys**.

Your participation in the plan entitles you to certain legal services, outlined in the MetLaw SPD. All legal matters are treated confidentially — A. H. Belo will know nothing about your legal problems or the services you use under the plan.

This is a voluntary benefit. You pay the cost of the plan through after-tax payroll deductions.

Important information on the group legal plan is provided separately:

For specific group legal plan details, please refer to the separate METLAW Summary Plan Description (SPD), which is available at life360ahbelo.com >Voluntary Benefits >Group Legal For more information you should review the insurance policy which is available from A. H. Belo Benefits.

When Coverage Begins and Ends

When Coverage Begins

When you first join the company, your legal plan coverage begins on the first of the month after you have submitted a properly completed enrollment form, provided you enroll within 30 days of your eligibility period.

When Coverage Ends

If you are no longer eligible to participate in the plan or your employment with A. H. Belo ends, the plan will cover the legal fees for those covered services that were opened and pending during the period you were enrolled in the plan. Of course, no new matters may be started after you become ineligible.

Generally, coverage under A. H. Belo's legal plan for you and your eligible dependents ends when you:

- No longer meet eligibility requirements described in Eligibility and Participation
- Terminate employment with A. H. Belo (effective at the end of the month you terminate or, through special arrangement and payment, through the end of the calendar year you terminate)
- Cancel or drop coverage
- Stop making any payments for coverage
- Die

Coverage also ends if the plan is terminated, your employer stops participating in the plan or the plan is amended to terminate coverage for a group or class of individuals that includes you.

How the Plan Works

Enrolling in the Plan

During our annual enrollment period, you can change or update your benefits selection. An eligible employee may choose to join or drop out of the plan at that time.

If you become an eligible employee after the annual enrollment period, you can elect to participate in the Legal Plan by completing your election form within 90 days of employment or of becoming newly eligible.

The plan has a minimum participation period of one year, and you must maintain the coverage for the entire year.

How to Enter MetLife's MyBenefits Site

From www.metlife.com/mybenefits, input your company name. The next screen will give the company's official name. If it is correct, click Submit.

- If already registered, sign in by entering your Social Security number and ZIP code. Then click Group Legal Services.
- If this is your first time using the site, click Register Now. You'll be prompted to enter your name, Social Security number, date of birth and e-mail address. The next screen will ask you to verify information. You will then be prompted to create a user name and password. This allows you to enter the MyBenefits site. Click Group Legal Services.

If you have any questions regarding site navigation, call (877) 9METWEB.

If you are having any kind of problem, please call Hyatt Legal Plans at (800) 821-6400. A Hyatt Legal Plans representative will help you solve the problem.

Critical Illness Insurance

MetLife Critical Illness Plan

The company makes available as a voluntary benefit an optional Critical Illness policy that provides a lump-sum payment in the event of certain major illnesses, medical conditions or when you undergo a major procedure included in the plan. The plan is designed to provide financial coverage to help pay the costs not typically covered by other types of insurance, such as copays, out-of-network treatments, child care, mortgage payments and other expenses.

Important information on the group critical illness plan is provided separately:

For specific critical illness plan details, please refer to the separate documents which are available at life360ahbelo.com >Voluntary Benefits >Critical Illness You should review the insurance policy at the website before you decide to purchase this individual policy as a voluntary benefit.

How to Enroll

You must enroll in the program through MetLife by filling out the benefit election form. Contact MetLife to talk to a Critical Illness Insurance Customer Representative (Monday through Friday, 8 a.m. – 6 p.m., EST) at **1-800-438-6388**.

Benefits at a Glance

The Critical Illness plan pays a specified amount for specific conditions, as shown in the following table.

CRITICAL ILLNESS COVERAGE	
Condition	**Plan Coverage**
Category 1: Certain Cancer-related conditions ▸ Full Benefit Cancer ▸ Partial Benefit Cancer ▸ Bone Marrow Transplant	▸ $15,000 for full benefit ▸ $3,750 for partial benefit
Category 2 Certain Heart-related conditions ▸ Heart Attack ▸ Heart Transplant ▸ Stroke ▸ Coronary Artery Bypass Graft	▸ $15,000 for full benefit ▸ $3,750 for partial benefit
Category 3: Other Covered Conditions ▸ Major Organ Transplant ▸ Kidney Failure	▸ $15,000 for full benefit ▸ $3,750 for partial benefit

Who Is Eligible

- You, the A. H. Belo employee
- Your lawful spouse

- Your unmarried dependent children to age 25 for a benefit of $10,000
    - "Children" includes natural children, step-children, adopted children, foster children or children for whom you are responsible as a result of a court order.
- Children older than 25 who are not self-supporting because of mental retardation or physical handicap (proof of eligibility must be shown within 31 days of the child reaching age 25).

When Coverage Begins and Ends

When Coverage Begins

After enrollment and once the certificate effective date has passed, coverage begins. You are then eligible for the benefit should you acquire one of the conditions or require one of the procedures. You must enroll in the program through MetLife by filling out the benefit election form and mailing it to MetLife, or by faxing it to **1-866-268-2621**. You may also call MetLife to talk to a **Critical Illness Insurance Customer Representative** (Monday through Friday, 8 a.m. – 6 p.m., EST) at **1-800-438-6388.**

When Coverage Ends

Coverage under the plan ends when you:

- No longer meet the eligibility requirements described in Eligibility and Participation
- Terminate employment with A. H. Belo Corporation (effective at the end of the month you terminate)
- Cancel or drop coverage
- Stop making any required payments for coverage
- Die

Coverage also ends if the plan is terminated, your employer stops participating in the plan or the plan is amended to terminate coverage for a group or class of individuals that includes you.

HIPAA

Protecting Your Health Information

This Notice is effective as of January 1, 2019. This Notice of Privacy Practices describes how the A. H. Belo Health Care and Welfare Benefit Plan and the A. H. Belo Flexible Spending Account Benefit Plan (referred to in this Notice as "the Plan") may use and disclose the individually identifiable health information the Plan receives about you, including genetic information (this information is referred to as your Protected Health Information or "PHI"). This Notice also sets out the Plan's legal obligations concerning your protected health information and describes your rights to access and control your protected health information. This Notice has been drafted in accordance with the HIPAA Privacy Regulation, contained in the Code of Federal Regulations at 45 CFR Parts 160 through 164 (the "Privacy Regulations"). The Genetic Information Nondiscrimination Act of 2008 ("GINA") and the Health Information Technology for Economic and Clinical Health Act ("HITECH") under the American Recovery and Reinvestment Act of 2009 ("ARRA") both amended the privacy requirements under the Privacy Regulations. Terms not defined in this Notice have the same meaning as the HIPAA Privacy Regulation. The Plan will notify you if there is a breach with respect to your PHI.

Questions and Further Information. If you have any questions or want additional information about the Notice or the policies and procedures described in the Notice, please contact the Plan Administrator using the Contact Information provided in this Notice.

The Plan's Responsibilities

The Plan is required by law to maintain the privacy of your protected health information. It is obligated to provide you with a copy of this Notice setting forth the Plan's legal duties and its privacy practices with respect to your protected health information. The Plan must abide by the terms of this Notice.

Uses and Disclosures of Protected Health Information

The following is a description of when the Plan is permitted or required to use or disclose your protected health information.

Payment, Treatment and Health Care Operations. The Plan has the right to use and disclose your protected health information for all activities that are included within the definitions of "payment," "treatment" and "health care operations" as defined in the HIPAA Privacy Regulation.

Payment. The Plan will use or disclose your protected health information to fulfill its responsibilities for coverage and providing benefits as established under the Plan. For example, the Plan may disclose your protected health information when a provider requests information regarding your eligibility for benefits under the Plan, or it may use your information to determine if a treatment that you received was medically necessary, experimental or investigational. The Plan may use or disclose your information to evaluate a claim or claim appeal, or to obtain reimbursement under insurance, reinsurance, stop loss or excessive loss policies. ARRA requires disclosures for purposes of payment to meet its minimally necessary standard effective on and after February 17, 2010.

Health Care Operations. The Plan will use or disclose your protected health information to support the Plan's business functions. These functions include, but are not limited to: quality assessment and improvement, reviewing provider performance, licensing, business planning, underwriting, premium rating and business development. For example, the Plan may use or disclose your protected health information: (1) to provide you with information about a disease management program; (2) to respond to a customer service inquiry from you; (3) in connection with fraud and abuse detection and compliance programs; or (4) to survey you concerning how effectively the Plan is providing services, among other issues. The Plan is prohibited from using or disclosing your PHI that is genetic information for underwriting purposes, premium rating, and coverage renewal. ARRA requires disclosures for purposes of health care operations to meet its minimally necessary standard effective on and after February 17, 2010.

Treatment. The Plan may use or disclose your protected health information to a health care provider who is treating you for purposes related to your treatment. For example, if you were unconscious, the health care provider treating you could contact the Plan to find out what kinds of conditions you might have, such as diabetes, or what prescription drugs you might be taking.

Business Associates. The Plan contracts with service providers — called business associates — to perform various functions on its behalf. For example, the Plan may contract with a third party administrator to perform the administrative functions necessary to pay your medical claims. To perform these functions or to provide services, business associates will receive, create, maintain, use or disclose protected health information, but only after the Plan and the business associate agree in writing to contract terms requiring the business associate to appropriately safeguard your information and agrees to permit the Plan to terminate the contract if the business associate violates the contract.

Organized Health Care Arrangement. The Plan, each dental HMO option offered under the Plan, the Vision Service Plan benefit and the Health Care Flexible Spending Account offered under the Plan are part of an "organized health care arrangement," and may share your protected health information with each other to carry out payment and health care operations activities.

Other Covered Entities. The Plan may use or disclose your protected health information to assist health care providers in connection with their treatment or payment activities, or to assist other covered entities in connection with certain health care operations. For example, the Plan may disclose your protected health information to a health care provider when needed by the provider to render treatment to you, and the Plan may disclose protected health information to another covered entity to conduct health care operations in the areas of quality assurance and improvement activities, or

accreditation, certification, licensing, or credentialing. This also means that the Plan may disclose or share your protected health information with other health care programs or insurance carriers (such as Medicare) to coordinate benefits if you or your family members have other health insurance or coverage or with other health plans maintained by A. H. Belo that are part of the same organized health care arrangement.

Required by Law. The Plan may use or disclose your protected health information to the extent required by federal, state or local law.

Public Health Activities. The Plan may use or disclose your protected health information for public health activities that are permitted or required by law. For example, it may use or disclose information for the purpose of preventing or controlling disease, injury or disability, or it may disclose such information to a public health authority authorized to receive reports of child abuse or neglect.

Health Oversight Activities. The Plan may disclose your protected health information to a health oversight agency for activities authorized by law. For example, these oversight activities may include audits; investigations; inspections; licensure or disciplinary actions; or civil, administrative or criminal proceedings or actions. Oversight agencies seeking this information include government agencies that oversee the health care system, government benefit programs, other government regulatory programs and government agencies that ensure compliance with civil rights laws.

Immunization Records. The Plan may disclose your PHI constituting immunization records if you are a student or prospective student of a school to comply with state or local laws requiring proof of immunization be provided to a school prior to admission to the school.

Lawsuits and Other Legal Proceedings. The Plan may disclose your protected health information in the course of any judicial or administrative proceeding or in response to an order of a court or administrative tribunal (to the extent such disclosure is expressly authorized). Consistent with applicable laws, the Plan may also disclose your protected health information in response to a subpoena, a discovery request or other lawful process.

Abuse or Neglect. As required by law, the Plan may disclose your protected health information to a government authority that is authorized by law to receive reports of abuse, neglect or domestic violence. Additionally, as required by law, if the Plan believes you have been a victim of abuse, neglect or domestic violence, it may disclose your protected health information to a governmental entity authorized to receive such information.

Law Enforcement. Under certain conditions and consistent with applicable laws, the Plan also may disclose your protected health information to law enforcement officials for law enforcement purposes. These law enforcement purposes include, by way of example: (1) responding to a court order or similar process; (2) as necessary to locate or identify a suspect, fugitive, material witness or missing person; or (3) as relating to the victim of a crime.

Coroners, Medical Examiners and Funeral Directors. The Plan may disclose protected health information to a coroner or medical examiner when necessary for identifying a deceased person or determining a cause of death. The Plan also may disclose protected health information to funeral directors as necessary to carry out their duties.

Organ and Tissue Donation. Consistent with applicable laws, the Plan may disclose protected health information to organizations that handle organ, eye or tissue donation and transplantation.

Research. The Plan may disclose your protected health information to researchers when (1) their research has been approved by an institutional review board that has reviewed the research proposal and established protocols to ensure the privacy of your protected health information, or (2) the research involves a limited data set which includes no unique identifiers (information such as name, address, Social Security number, etc. that can identify you).

To Prevent a Serious Threat to Health or Safety. Consistent with applicable laws, the Plan may disclose your protected health information if disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public. It also may disclose protected health information if it is necessary for law enforcement authorities to identify or apprehend an individual.

Military. Under certain conditions, the Plan may disclose your protected health information if you are, or were, Armed Forces personnel for activities deemed necessary by appropriate military command authorities. If you are a member of foreign military service, the Plan may disclose, in certain circumstances, your information to the foreign military authority.

Workers' Compensation. The Plan may disclose your protected health information to comply with workers' compensation laws and other similar programs that provide benefits for work-related injuries or illnesses.

Disclosures to the Plan Sponsor. The Plan (or its health insurance issuers or HMOs) may disclose your protected health information to the plan sponsor for Plan administration purposes.

Others Involved in Your Health Care. The Plan may disclose your protected health information to a friend or family member that is involved in your health care or in the payment for your healthcare, unless you object or request a restriction (in accordance with the process described under Right to Request a Restriction). The Plan also may disclose your information to an entity assisting in a disaster relief effort so that your family can be notified about your condition, status and location. If you are not present or able to agree to these disclosures of your protected health information, then, using professional judgment, the Plan may determine whether the disclosure is in your best interest.

Disclosures to the Secretary of the U.S. Department of Health and Human Services. The Plan is required to disclose your protected health information to the Secretary of the U.S. Department of Health and Human Services when the Secretary is investigating or determining the Plan's compliance with the HIPAA Privacy Regulation.

Disclosures to You. The Plan is required to disclose to you or your personal representative most of your protected health information when you request access to this information. The Plan will disclose your protected health information to an individual who has been designated by you as your personal representative and who has qualified for such designation in accordance with relevant law. Prior to such a disclosure, however, the Plan must be given written documentation that supports and establishes the basis for the personal representation. The Plan may elect not to treat the person as your personal representative if it has a reasonable belief that you have been, or may be, subjected to domestic violence, abuse or neglect by such person; treating such person as your personal representative could endanger you; or the Plan determines, in the exercise of its professional judgment, that it is not in your best interest to treat the person as your personal representative.

Other Uses and Disclosures of Your Protected Health Information

Other uses and disclosures of your protected health information that are not described above will be made only with your written authorization, such as for release of psychotherapy notes, or if your PHI is to be used for fundraising, marketing or to be sold. The Plan has no intention of selling your PHI, but is required to disclose such a use is possible. If you provide the Plan with an authorization, you may revoke the authorization in writing, and this revocation will be effective for future uses and disclosures of protected health information. However, the revocation will not be effective for information that the Plan has used or disclosed in reliance on the authorization.

Contacting You

The Plan (or its health insurance issuers, HMOs, third-party administrators or pharmacy benefit managers) may contact you about appointment reminders, refill reminders, treatment alternatives or other health benefits or services that might be of interest to you, such as case management, disease management, wellness programs or employee assistance programs.

Your Rights

The following is a description of your rights with respect to your protected health information.

Right to Request a Restriction. You have the right to request a restriction on the protected health information the Plan uses or discloses about you for treatment, payment or health care operations. You also have a right to request a limit on disclosures of your protected health information to family members or friends who are involved in your care or the payment for your care. You may request such a restriction using the Contact Information provided in this Notice. The Plan is required to comply with your request only if (1) the disclosure is to a health care plan for purposes of carrying out payment or health care operations, and (2) the PHI pertains solely to a health care item or service for which the health care provider involved has already been paid in full. Otherwise, the Plan is not required to agree to any restriction that you request. If the Plan agrees to the restriction, it can stop complying with the restriction upon providing notice to you. Your request must include the protected health information you wish to limit, whether you want to limit the Plan's use, disclosure or both, and (if applicable), to whom you want the limitations to apply (for example, disclosures to your spouse). You may also request a restriction on the disclosure of any health information related to healthcare for which you paid fully.

Right to Request Confidential Communications. If you believe that a disclosure of all or part of your protected health information may endanger you, you may request that the Plan communicate with you in an alternative manner or at an alternative location. For example, you may ask that all communications be sent to your work address. You may request a confidential communication using the Contact Information provided in this Notice. Your request must specify the alternative means or location for communication with you. It also must state that the disclosure of all or part of the protected health information in a manner inconsistent with your instructions would put you in danger. The Plan will accommodate a request for confidential communications that is reasonable and that states that the disclosure of all or part of your protected health information could endanger you.

Right to Request Access. You have the right to inspect and copy protected health information that may be used to make decisions about your benefits. You must submit your request in writing. For your convenience, you may request a form using the Contact Information provided in this Notice. To the extent that the Plan uses or maintains an electronic health record you have a right to obtain a copy of your PHI from the Plan in an electronic format. In addition, you may direct the Plan to transmit a copy of your PHI in such electronic format directly to an entity or person designated by the individual.

Note that under federal law, you may not inspect or copy the following records: psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal or administrative action or proceeding; and protected health information, the access to which is prohibited by law. Depending on the circumstances, a decision to deny access may be eligible for review. In some, but not all, circumstances, you may have a right to have this decision reviewed.

Note that under federal law, you may not inspect or copy the following records: psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal or administrative action or proceeding; and protected health information, the access to which is prohibited by law. Depending on the circumstances, a decision to deny access may be eligible for review. In some, but not all, circumstances, you may have a right to have this decision reviewed.

Right to Request an Amendment. You have the right to request an amendment of your protected health information held by the Plan if you believe that information is incorrect or incomplete. If you request an amendment of your protected health information, your request must be submitted in writing using the Contact Information provided in this Notice and must set forth a reason(s) in support of the proposed amendment.

In certain cases, the Plan may deny your request for an amendment. For example, the Plan may deny your request if the information you want to amend is accurate and complete or was not created by the Plan. If the Plan denies your request, you have the right to file a statement of disagreement. Your statement of disagreement will be linked with the disputed information and all future disclosures of the disputed information will include your statement.

Right to Request an Accounting. You have the right to request an accounting of certain disclosures the Plan has made of your protected health information. You may request an accounting using the Contact Information provided in this Notice. You can request an accounting of disclosures made up to six years prior to the date of your request, except that the Plan is not required to account for disclosures made either: (1) prior to April 14, 2003; (2) to carry out treatment, payment or health care operations activities occurring prior to January 1, 2014 or which do not include your electronic health record disclosures occurring after January 1, 2014 of your electronic health record will be required to be included in the accounting for three years after the disclosure;; (3) to you about your own protected health information; (4) pursuant to a valid authorization; (5) incident to a use or disclosure that is otherwise permitted or required under the Privacy Regulations; or (6) that is disclosed as part of a limited data set as defined in the Privacy Regulations.

Right to Request a Paper Copy of This Notice. You have the right to a paper copy of this Notice, even if you have agreed to accept this Notice electronically. To obtain such a copy, please contact the Plan's Complaint Officer, Vice President/Legal, using the Contact Information provided in this Notice.

Complaints

If you believe the Plan has violated your privacy rights, you may complain to the Plan or to the Secretary of the U.S. Department of Health and Human Services. You may file a complaint with the Plan using the Contact Information provided in this Notice. The Plan will not penalize you for filing a complaint.

Changes to This Notice / Effective Date

Changes to This Notice

The Plan reserves the right to change the provisions of this Notice and make the new provisions effective for all protected health information that it maintains. If the Plan makes a material change to this Notice, it will provide a revised Notice to you at the address that the Plan has on record for the participant enrolled in the Plan.

Effective Date

This Notice of Privacy Practices became effective on January 1, 2019.

Contact Information

To exercise any of the rights described in this Notice, for more information or to file a complaint, please contact:

A. H. Belo Corporation
P. O. Box 224866
Dallas, Texas 75222-4866
(214)977-7210

Privacy Officer — Director/Corporate Human Resources

Complaint Officer — Vice President/Legal

Legal and Administrative Information

Legal Information

About the Information in This Document

This document is intended to provide easy-to-understand descriptions of each benefit program provided by A. H. Belo's health and welfare benefit plans, and contains Summary Plan Descriptions (SPDs), as well as information provided by plan administrators, for the A. H. Belo Health Care and Welfare Benefit Plan and the component plans contained therein, the A. H. Belo Flexible Spending Account Benefit Plan and the Hyatt Legal Plan (referred to on this site as a "plan" or the "plans"). The provisions of these SPDs and booklets apply to eligible employees of A. H. Belo and its participating subsidiaries and their family members and beneficiaries who are covered by the plans.

None of these SPDs nor updated materials are contracts or assurances of compensation, continued employment or benefits of any kind. If any summary of benefits differs from the official plan documents in any way, including applicable insurance contracts, the official plan documents will govern.

A. H. Belo reserves the right to modify or terminate any of its plans or programs at its discretion. Plan changes will not affect claims for services or supplies incurred before the change. Only A. H. Belo is authorized to change the plans. From time to time, you will receive updated information concerning plan changes.

Your ERISA Rights

This section contains statements of your rights under the Employee Retirement Income Security Act of 1974 (ERISA), as amended.

As a participant in one or more of the plans, you are entitled to certain rights and protections under 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 worksites and union halls, all documents governing the plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.
- Obtain, upon written request to the plan administrator, copies of documents governing the operation of the plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated summary plan description. The administrator may make a reasonable charge for the copies.

Receive a 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 on the rules governing your COBRA continuation coverage rights.

Prudent Actions by Plan Fiduciaries

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

Enforcing Your Rights

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

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

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

Assistance with Your Questions

If you have any questions about your plan, you should contact the 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, DC 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.

Plan Amendments

Although the company expects to continue the benefits described on this document, the Compensation Committee of the company's Board of Directors and the Board of Directors each has the right to amend the A. H. Belo Health Care and Welfare Benefit Plan, the A. H. Belo Flexible Spending Account Benefit Plan, and the Hyatt Legal Plan at any time, including the right to amend any of the benefits programs included in the plan. In addition, the plan administrator or any other authorized representative of A. H. Belo may amend the list of participating employers to reflect the adoption of or withdrawal from the plans by any A. H. Belo company, and may amend the plans to add or delete a benefit program, without further approval from A. H. Belo. The effective date of any amendment may be before, on or after the date of such action.

The right to amend or end a plan includes the right to reduce or eliminate coverage for any treatment, procedure or service, regardless of whether any participant is receiving such treatment, procedure or service for an injury, illness or disease that occurred before the effective date of the amendment.

Discounts and Refunds

Under some of the medical and dental plan coverage options, some providers may agree to charge participants negotiated rates that are lower than the regular rates. In these cases, the amount you pay will be based on the reduced rate that the provider has agreed to charge plan participants.

However, some of the contracts between the plan and providers, insurers or other organizations provide for other kinds of discounts, refunds and incentive rebates, which belong solely to the plan. These discounts, refunds and rebates are designed to reduce the cost of benefits to the plan, but do not reduce participants' monthly premiums, deductibles or copays. The plan has no obligation to pass on any of these discounts, refunds or rebates to participants.

If a Third Party Is Liable for Expenses

In some cases, the plan may pay expenses for an injury or illness that was caused by another person, company or organization that could be legally responsible for those expenses due to negligence, a wrongful act or a willful act of omission. By participating in the A. H. Belo medical plan and accepting benefits, you agree that if you or your enrolled dependents are injured by a third party, the A. H. Belo medical plan will have the rights described in this section. You must provide information to A. H. Belo about any claim you or your enrolled dependents may have against a third party for injury caused by that party.

If you or your enrolled dependents recover any payment from a third party—through a lawsuit, judgment or settlement, for instance—as a result of injuries caused by the third party, the A. H. Belo medical plan has the right to reduce any benefits otherwise payable to you or your dependents by the amount of the recovery and the plan shall have a constructive lien of first priority on any recovery you may receive. In addition, you must reimburse A. H. Belo for any benefits already paid to you or your dependents relating to the injuries caused by the third party, up to the amount of any recovery from the third party.

These rights of the A. H. Belo medical plan apply even if the third party does not admit causing the injury and even if the payment does not specifically relate to medical expenses, and regardless of whether you or your dependents were fully compensated by the third party's payment. The amount you are required to reimburse the A. H. Belo medical plan will be reduced by an appropriate share of the legal fees you may incur.

If you or your enrolled dependents are injured by a third party, the A. H. Belo medical plan will be "subrogated" to your rights against the third party and the third party's insurance carrier. This means that the A. H. Belo medical plan may recover from the other party (or insurance carrier) any amount you or your dependents could have recovered due to the injury (whether or not for medical expenses). The A. H. Belo medical plan may recover any amount up to the total amount paid or will pay as a result of the injury, without regard to whether you or your dependent would be fully compensated by the recovery.

The A. H. Belo plan's subrogation rights do not limit your or your dependent's right to take legal action against the third party who caused your injury to recover medical expenses and other damages. However, you or your dependent must obtain A. H. Belo's consent before you settle any claim or release any third party from liability.

You must cooperate with A. H. Belo by providing information about the injury and your future medical care needs, and by assisting in the effort to recover from the party responsible for the injuries. You and any dependent must execute and deliver any documents that are required by A. H. Belo in connection with its subrogation rights.

Assignment of Benefits if You Divorce

If you become divorced or legally separated, certain court orders could require that you provide health care coverage to your dependent children. That type of court order is known as a Qualified Medical Child Support Order (QMCSO). If the QMCSO satisfies legal requirements and you are eligible to participate, you may enroll yourself and your eligible children covered by the QMCSO in the medical, dental and vision plans. You may obtain a copy of the plan's QMCSO procedures from the plan administrator at no charge.

Misrepresentation or Omission of Information

When you file a claim for benefits, you certify that the statements you make on the claim form are complete and accurate to the best of your knowledge. If you misrepresent information or submit fraudulent claims, you will be responsible for repaying any benefits based on that claim, and you may be subject to disciplinary action (including termination). If you do not give the claims administrator all the information it needs regarding your claim, your benefits may be delayed or denied until complete information is provided.

No Guarantee of Employment

These SPDs are intended only to describe certain benefit plans. The plans and these SPDs and booklets are not intended to form a contract between A. H. Belo and its employees and in no way guarantee your continued employment with an A. H. Belo company. If you leave the employment of an A. H. Belo company, or if you are discharged, the plans do not give you rights to any benefits, plan assets or company assets, except as specifically provided in the plans.

Administrative Information

Plan Names and Numbers

This document describes benefits provided under:

The A. H. Belo Health Care and Welfare Benefit Plan (Plan Number 501), which includes the following:

- Medical Plan
- Dental Plan
- Vision Service Plan
- Health Care Flexible Spending Account
- Employee Assistance Plan
- Basic Life Insurance Plan
- Supplemental Life Insurance Plan
- Dependent Life Insurance Plan
- Personal Accident Insurance Plan
- Long-Term Disability Insurance Plan
- Business Travel Accident Plan
- A. H. Belo Severance Plan
- Legal Plan
- Long-Term Care Insurance Plan (for grandfathered employees only; no longer offered)

The A. H. Belo Flexible Spending Account Benefit Plan which describes Health Care Flexible Spending Account and the Dependent Care Flexible Spending Account

Plan Administrator

A. H. Belo Benefits Administrative Committee
P.O. Box 224866
Dallas, Texas 75222-4866
(214)977-7210

Plan Funding

The hospitals, physicians and other service providers that participate in the CDHP, dental and vision network are completely independent of A. H. Belo. Neither A. H. Belo nor the network administrators are responsible for the medical services provided.

The coverage for the following health benefit is self-funded through A. H. Belo (with employee contributions required):

- BlueCross BlueShield Consumer-Driven Health Plan (CDHP)and PPO

The coverage for the following health benefits is fully insured and paid by A. H. Belo (with employee contributions required):

- Group dental

The coverage for the following benefits is fully insured and premiums are paid by A. H. Belo:

- Basic term life insurance
- Basic long-term disability insurance
- Business travel accident insurance
- Employee Assistance Program

The following are fully insured and premiums are paid by employee contributions:

- Vision Service Plan
- Supplemental life insurance
- Personal accident insurance
- Dependent life insurance
- Group legal

The following is self-funded and paid by A. H. Belo:

- A. H. Belo Severance Plan

Participating Employers

- A. H. Belo Corporation
- A. H. Belo Management Services, Inc.
- Al Dia, Inc.
- The Dallas Morning News, Inc.
- Distibion, Inc.
- Marketing CDFX,LLC
- Vertical Nerve, Inc.

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Plan Sponsor ID Number

38-3765318

Agent for Service of Legal Process

A. H. Belo Corporation
1954 Commerce St
Dallas, Texas 75201
Attention: Legal Department

Plan Year

January 1 through December 31

A. H. Belo Benefits

A. H. Belo Benefits
1954 Commerce St.
Dallas, Texas 75201
(214) 977-7210
life360ahbelo.com

Claims Administrators

Medical for the CDHP Plan and PPO Plan (Includes Mental Health/Substance Abuse)

BlueCross BlueShield of Texas
P.O. Box 660044
Dallas, TX 75266
(888) 514-5662

Prescription Drug Claims for the CDHP Plan

Prime Therapeutics
P.O. Box 650041
Dallas, TX 75265-0041
(877) 357-7463

Dental

Delta Dental PPO
P.O. Box 1809
Alpharetta, GA 30023-1809
(800) 521-2651

MetLife Dental HMO
P.O. Box 30900
Laguna Hills, CA 92654-0900
(800) 653-7353

Vision

Vision Service Plan
P. O. Box 997105
Sacramento, CA 95899-7105
(800) 877-7195

Flexible Spending Accounts

TaxSaver Plan
4131 N. Central Expressway, Suite 105 LB 45
Dallas, TX 75204
(800) 328-4337

Employee Assistance Plan (EAP)

Beacon Health
P.O. Box 1920
Lantham, NY 12110
(800) 4351986

Long-Term Disability

For disabilities beginning on or after January 1, 2015:

Liberty Life Assurance Company of Boston
175 Berkeley St.
Boston, MA 02166
(617) 357-9500

For disabilities beginning on or after January 1, 2008 and before January 1, 2015:

Metropolitan Life Insurance Company
P.O. Box 14590
Lexington, KY 40511-4590
(800) 635-6707
Fax: (866) 690-1264

For disabilities beginning before January 1, 2008

UNUM Life Insurance Company of America
2211 Congress Street
Portland, ME 04122
(800) 235-5540

Life & Accident Insurance

Lincoln Financial Group8801 Indian Hills DriveOmaha, NE 68114-4066(800) 423-2765
Gerber Life and Accident Insurance Company
c/o A. C. Newman
Attn: Claims Department
4969 East McKinley Avenue
Suite 202
Fresno, CA 93727
(559) 252-2525

Business Travel Accident Insurance

The Hartford
P. O. Box 2999
Hartford, CT 06104-2999
(888) 563-1124

Severance

A. H. Belo Benefits Administrative Committee
1954 Commerce St
Dallas, Texas 75201
(214) 977-5911

Legal Plan

Hyatt Legal Plans, Inc.
1111 Superior Avenue, Suite 800
Cleveland, OH 44114-2507
(800) 821-6400

(For Florida plans, contact Hyatt Legal Plans of Florida, Inc. at the above address.)

Voluntary Benefits and Discount Arrangements that may be Available

As an added option for you, there are voluntary options you can elect. For information on the voluntary options or benefits, contact A. H. Belo Benefits at the A. H. Belo Corporation for the informational flyers available. There are flyers available A. H. Belo Benefits for other optional coverage available, you can purchase and various discount arrangements. These are not sponsored, endorsed or sanctioned in any way by A. H. Belo Corporation.

Glossary of Terms

Accidental Injury

An injury caused by an outside and unforeseen traumatic force, independent of all other causes.

Active Work

Active work means you perform your regular duties, either at A. H. Belo or while traveling on company business, for the number of hours you are scheduled to work.

Basic Annual Earnings

Basic annual earnings are defined as your current salary or wage. They do not include bonuses, overtime pay or any other extra compensation. If your job currently includes sales commissions, your basic annual earnings will be averaged over the previous 12-month period, or averaged from the date of employment, whichever is less. If your salary changes during the year, your coverage amounts will also change, effective on the date of your salary increase.

Child

- Biological child
- Legally adopted child or child placed for adoption
- Stepchild, foster child or legal ward
- Child for whom you or your spouse are required to provide coverage under a Qualified Medical Child Support Order (Qualified Medical Child Support Order (QMCSO))
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Child Placed for Adoption

A child will be considered placed for adoption with you if you have assumed a legal obligation for total or partial support of the child in anticipation of the adoption. For this reason, you should provide A. H. Belo Benefits with documentation (such as a signed court order) that the adoption agency or other entity had legal custody of the child on the date the child was placed with you for adoption.

Claims Administrator

Organization contracted by A. H. Belo (such as BlueCross BlueShield, Prime Therapeutics and VSP) who provides administrative services for specific company benefit programs offered to company employees and their dependents.

Coinsurance

The percentage of eligible expenses you are responsible for paying, most often after the deductible is met; the plan pays the remaining percentage.

Concurrent Care Claim

A concurrent care claim is a claim to continue a course of treatment previously approved by a health care program that the claims administrator proposes to reduce or terminate before the expiration of the period of time or number of treatments that was originally approved.

Copay

A flat fee you pay for certain services.

Deductible

The amount an eligible person or family must pay each year before the plan begins paying benefits for most eligible expenses.

Disabled

Under the long-term disability (LTD) plan, this term means that due to sickness or as a result of accidental injury you are receiving appropriate care and treatment consistent with the LTD policy definition and are complying with the requirements of such treatment; and you are unable to earn:

- During the elimination period and the next 24 months of sickness or accidental injury, more than 80% of your predisability earnings at your own occupation from any employer in your local economy; and
- After such period, approved for disability benefits under the Federal Social Security Act for your sickness or accidental inury.

For the purposes of determining whether a disability is the direct result of an accidental injury, the disability must have occurred within 90 days of the accidental injury and resulted from such injury independent of other causes.

Eligible Expenses

The portion of regular, medically necessary services, supplies, care and treatment of non-occupational injuries or illnesses up to the allowable fee limits (plan's acceptable contacted rate), when ordered by a licensed physician acting within the scope of his or her license. Services, supplies, care and treatment must be generally accepted in the medical profession as required to treat the specific condition, must not be considered experimental and must be covered by the plan.

Explanation of Benefits (EOB)

A statement provided by the claims administrator that shows how a service was covered by the plan, how much is being reimbursed and what portion (if any) is not covered.

Health Care Flexible Spending Account (FSA)

An employee-funded account that allows you to be reimbursed for eligible health care expenses using dollars deducted from your paycheck before taxes are taken out. FSA funds are subject to a "use it or lose it" provision and must be used by March 15 following the end of the plan year.

Health Savings Account

A personal health care bank account that you can use to pay for qualified medical expenses with pre-tax dollars when you are enrolled in a qualified high-deductible health plan, such as the CDHP. The contributions are tax free, and the money in the account is yours. HSAs allow you to control your own money, year in and year out.

Hospital

A licensed institution with organized facilities for the care and treatment of ill or injured persons, or for treatment of mental illness or substance abuse. The institution must include facilities for diagnosis and surgery, as well as 24-hour nursing services and medical supervision. Homes for the aged, the chronically ill, convalescent homes, rest homes and nursing homes are not considered accredited hospitals.

Incapacitated Child

An "incapacitated child" age 26 or over is eligible if:

- The child was covered as your dependent under this plan before reaching age 26 and proof of incapacity is provided within 31 days of reaching age 26,
- The child is mentally or physically incapable of self-support,
- The child continues to otherwise meet the criteria for dependent coverage under this plan, and
- You provide additional medical proof of incapacity as may be required from time to time. Coverage will be terminated and cannot be reinstated if you cannot provide proof or if it is determined that the child is no longer incapacitated. If you elect to drop coverage for your child, you may not later reinstate coverage.

Also, one of the following provisions must apply:

- The child maintains legal residence with you and is primarily (more than half) dependent on you for maintenance and support, or
- You are required to provide coverage under a Qualified Medical Child Support Order (Qualified Medical Child Support Order (QMCSO)) issued by the court or a state agency.

Medically Necessary

A medical or dental service or supply required for the diagnosis or treatment of a non-occupational illness, accidental injury or pregnancy. The plan determines medical necessity based on standards approved by the claims administrator's medical personnel. To be medically necessary, the service or supply must meet all of the following requirements:

- It must be ordered by a physician
- It must be appropriate and required for the treatment and diagnosis of the illness, injury or pregnancy
- There is not a more appropriate place of service, or diagnostic or treatment alternative that could have been used
- It must be either:
  - Safe and effective according to accepted clinical evidence reported by generally recognized medical professionals or publications, or
  - Provided in a clinically controlled research setting using a specific research protocol that meets standards equivalent to those defined by the National Institute of Health for a life threatening or seriously debilitating condition.

A service or supply to prevent illness must also meet the above conditions to be considered medically necessary. A service is not considered medically necessary if it is educational or experimental in nature.

Network

A group of physicians, hospitals, pharmacies and other medical service providers who have agreed to discount their fees to health plan participants.

Physician

A legally qualified doctor who performs services within the scope of his or her license, including:

- Doctor of Medicine (M.D.)
- Doctor of Osteopathy (D.O.)
- Podiatrist (D.P.M.)
- Optometrist (O.D.)
- Chiropractor (D.C.)
- Ph.D. or M.C.S.W. working under the direction of an M.D.

Post-Service Claim

A post-service claim is a claim for a benefit under a health care program that is not required to be approved in advance of receiving health care.

Preferred Provider Organization (PPO) Network

A health plan allows providers both in- or out-of-network, and visit specialists without a referral. In-network, the PPO offers a group of physicians, hospitals, pharmacies and other medical service providers who have agreed to accept contracted fees for their services to plan participants.

Pre-Service Claim

A pre-service claim is a claim for a benefit under a health care program that is required to be approved in advance of receiving health care and that is not an urgent care claim.

Providers

Medical benefits extend to covered services provided by the following licensed providers:

- Acupuncturists
- Chiropractors
- Medical doctors
- Osteopaths

- Podiatrists
- Physical and occupational therapists
- Midwives
- Speech therapists
- Licensed clinical psychologists
- Licensed dietician

Provided they practice within the scope of their license and generally accepted medical practices, and are recognized by the state in which they practice, licensed clinical social workers and licensed marriage, family and/or child counselors are also covered. They must either:

- Be licensed or certified by the appropriate governmental authority having jurisdiction over such licensure or certification in the jurisdiction where the provider renders service, or
- Be a member or fellow of the American Psychological Association if there is no licensure or certification in the jurisdiction where that provider renders service.

Providers who are professionally registered in their state, but do not meet the above criteria, will not be covered.

Qualified Medical Child Support Order (QMCSO)

Federal law authorizes state courts and administrative agencies to issue Qualified Medical Child Support Orders (QMCSOs). A QMCSO may require you to add your child as a dependent for health and dental benefits in some situations, typically a divorce. The order must include the name and address of the alternate recipient and the time period for coverage. The plan administrator has final discretionary authority to determine whether a medical child support order qualifies as a QMCSO.

Self-reported Symptoms

Symptoms you have reported to your doctor that are not verifiable using tests, procedures or clinical exams usually accepted in the practice of medicine. Examples of self-reported symptoms include, but are not limited to, headaches, pain, fatigue, stiffness, soreness, ringing in ears, dizziness, numbness and loss of energy.

Spouse

Your eligible spouse is the person who is legally married to you, including common law marriage according to the laws of your state.

Urgent Care Claim

An urgent-care claim is a claim for a benefit under a health-care program that is required to be approved in advance of receiving health care and that requires a faster determination by the claims administrator because the time periods for making non-urgent care pre-service claims could seriously jeopardize the life or health of a participant or dependent or the ability of such person to regain maximum function, or would subject such person to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim. The claims administrator will determine whether a claim is an urgent-care claim applying the judgment of a prudent layperson who possesses an average knowledge of health and medicine; provided, however, that if a physician with knowledge of the claimant's medical condition determines that the claim involves urgent care, the claims administrator will treat the claim as an urgent-care claim.