2020 EMPLOYEE BENEFITS

PEOPLE TEAM
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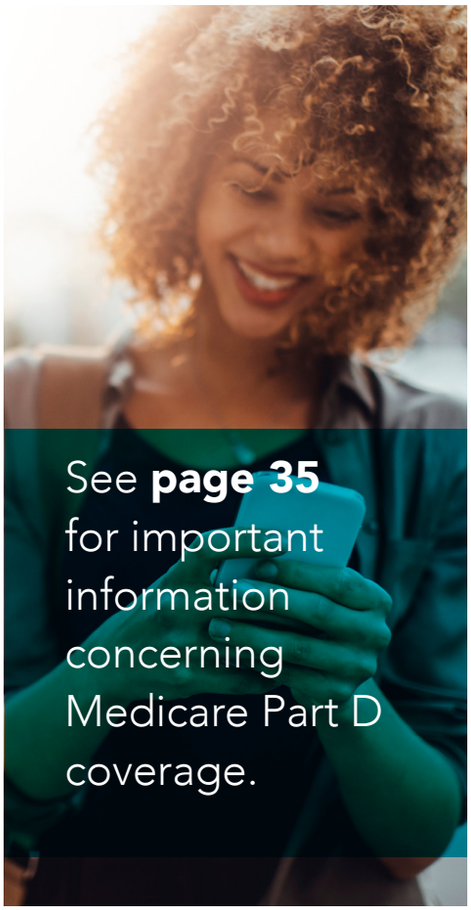
A. H. Belo Corporation

TABLE OF CONTENTS



In this Guide, we use the term Company to refer to A. H. Belo Corporation. This Guide is intended to describe the eligibility requirements, enrollment procedures and coverage effective dates for the benefits offered by the Company. It is not a legal plan document and does not imply a guarantee of employment or a continuation of benefits. While this Guide is a tool to answer most of your questions, full details of the plans are contained in the Summary Plan Descriptions (SPDs), which govern each plan's operation. Whenever an interpretation of a plan benefit is necessary, the actual plan documents will be used.

ELIGIBILITY & ENROLLMENT

You're a valued member of A. H. Belo Corporation, and your health and well-being are important to us. We are proud to provide you and your dependents with valuable and significant benefits. This guide is an overview of the benefits available to you and their impact on your hard-earned compensation. Please read it carefully in order to make the best choices for you and your family in the 2020 plan year and consult your HR representative with any questions.

You and your family have unique needs, which is why A. H. Belo Corporation offers a variety of benefit plans from which you may choose. If applicable, please make sure to consider your spouse's benefits through his or her place of employment and your dependents' eligibility when weighing each option.

Eligibility

If you are a full-time employee of A. H. Belo Corporation who works at least 30 hours per week, you are eligible to participate in the medical, dental, vision, life and disability plans, and other additional benefits.

When Does Coverage Begin?

The elections you make are effective January 1, 2020. For new hires, coverage begins on the first of the month following two months of continuous service for all benefits with the exception of Long Term Disability, which is effective the first of the month following 12 months of full-time continuous service. Due to IRS regulations, once you have made your choices for the 2020 plan year, you won't be able to change your benefits until the next enrollment period unless you experience a qualifying life event.

Eligible Dependents

Dependents eligible for coverage in the A. H. Belo Corporation benefits plans include:

- Your legal spouse (or common-law spouse in states which recognize common-law marriages). See the Working Spouse Exclusion section on the next page for rules regarding coverage for employed spouses.
- Children up to age 26 (includes birth children, stepchildren, legally-adopted children, children placed for adoption, foster children, and children for whom legal guardianship has been awarded to you or your spouse).
- Dependent children, regardless of age, provided he or she is incapable of self-support due to a mental or physical disability, is fully dependent on you for support as indicated on your federal tax return, and is approved by your medical plan to continue coverage past age 26.

Verification of dependent eligibility will be required upon enrollment.

Working Spouse Exclusion

If your spouse is employed and has access to health care coverage through their employer, they are not eligible for A. H. Belo Corporation coverage. If your spouse does not work, works only part time, is not eligible for coverage or has lost coverage as an active employee but has been offered COBRA, the spousal exclusion does not apply. If your spouse is covered by Medicare, the exclusion does not apply.

If your spouse experiences a Qualifying Life Event (loss of job, etc.) during the year, he or she can be added to your A. H. Belo Corporation coverage within 31 days of the Qualifying Life Event.

Note: The company reserves the right to verify whether or not your spouse is provided coverage elsewhere. We expect this information to be consistent with the information you reported during Open Enrollment. Misrepresenting whether your spouse has access to medical coverage outside of A. H. Belo Corporation may result in disciplinary action.

Things to Consider

Take the following situations into account before you enroll to make sure you have the right coverage.

- Does your spouse have benefits coverage available through another employer?
- Did you get married, divorced or have a baby recently? If so, do you need to add or remove any dependent(s) and/or update your beneficiary designation?
- Did any of your covered children reach their 26th birthday this year? If so, they are no longer eligible for benefits unless they meet specific criteria. Additional details can be found in the Eligible Dependents section of this guide.

Qualifying Life Events

When one of the following events occurs, you have 31 days from the date of the event to notify A. H. Belo Benefits and/or request changes to your coverage.

- Change in your legal marital status (marriage, divorce or legal separation)
- Change in the number of your dependents (for example, through birth or adoption, or if a child is no longer an eligible dependent)
- Change in your spouse's employment status, resulting in a loss or gain of coverage
- Change in your employment status from full time to part time, or part time to full time, resulting in a gain or loss of eligibility
- Entitlement to Medicare or Medicaid
- Eligibility for coverage through the Marketplace

Your change in coverage must be consistent with your change in status. Please direct questions regarding specific life events and your ability to request changes to A. H. Belo Benefits.

Preparing to Enroll

A. H. Belo Corporation provides its employees the best coverage possible. As a committed partner in your health, A. H. Belo Corporation will be absorbing a significant amount of the costs. Your share of the contributions for medical, dental, vision, Optional AD&D, HSA and FSA benefits is deducted on a pre-tax basis, which lessens your tax liability. Please note that employee contributions for medical, dental and vision coverage vary depending on the level of coverage you select. In general, the more coverage you have, the higher your contribution will be.

Keep in mind that you may select any combination of medical, dental and/or vision plan coverage categories. For example, you could select medical coverage for you and your entire family, but select dental and vision coverage only for yourself. The only requirement is that you, as an eligible employee of A. H. Belo Corporation, must elect coverage for yourself in order to elect any dependent coverage. Be sure to have the Social Security numbers and birthdates for any eligible dependent(s) that you plan to enroll. You cannot enroll your dependent(s) without this information.

How to Enroll If You're a New Hire

Log into WorkDay with your Employee ID and password by going to: https://www.myworkday.com/ahbelo/d/home.htmld

Once you are logged in, click on the cloud in the upper right corner, then click on your inbox.

- In your inbox, you should have a 'Benefit Change – New Hire,' click on that link and follow the steps to elect benefits.
- Be sure to review and submit your elections.

How to Change Your Elections

For qualifying family status changes, you will log into WorkDay as outlined above. Once you are logged in, click on the Benefits worklet. Under Change on the left side, select Benefits. Follow prompts.

OPEN ENROLLMENT CHECKLIST

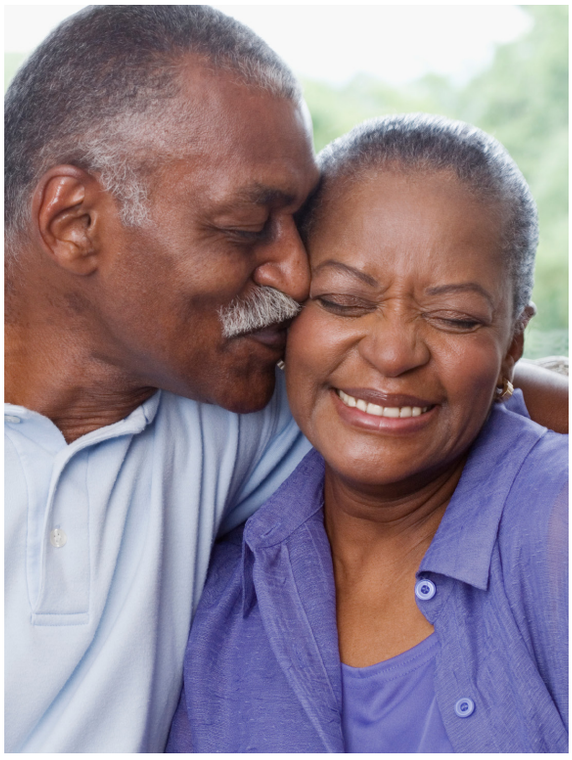
You only have a small window of time to make changes that are effective for the entire plan year (unless you have a qualifying life event). To save time and money, here are some things you should check off of your to-do list before Open Enrollment begins.

1. Update your personal information.

If you've experienced a qualifying life event in the last year (moving, new baby, change in marital status, etc.), you may need to change your elections. This seems like an obvious action to take, but failure to update your personal information could cost you in the long run.

2. Double-check covered and restricted medications.

Any plan changes could have an impact on prescription costs. If you currently take a medication that requires prior authorization, you may be prompted to try a lower-cost drug or even be limited in the amount of medication you can buy at one time. Review your available options outlined in this guide.



3. Review available plans.

A. H. Belo is offering two medical plan options for the 2020 plan year. If you're planning on having a baby or major surgery this year, think carefully about your out-of-pocket medical costs and deductible.

4. Consider your HSA or FSA.

Think about how much you plan to spend on health care in the coming year — this includes dental and vision services, prescriptions and more. Maybe this is the year to consider an FSA. Or, if you already have an HSA, take into account any rollover money from last year and your long-term financial goals.

5. Check to see if your pharmacy is in-network.

Many plans offer incentives for using in-network pharmacies. Read through your plan for any changes or amendments from last year to guarantee that your preferred pharmacy will not be negatively affected.

WELLNESS

Making healthier lifestyle choices saves you time and money in the long run. This is why we offer a biometric screening program to all benefits-eligible employees. This benefit is provided to you at no cost and is completely confidential.

Wellness Surcharge

We support your efforts to live healthy and take preventive measures to keep sickness and disease at bay, which is why A. H. Belo Corporation is organizing onsite biometric screenings for employees and eligible spouses. The biometric screenings will consist of the following measurements: blood pressure, blood lipids (HDL cholesterol), glucose, height, weight, body mass index, triglycerides, waist circumference and tobacco (cotinine). Individual test results are confidential; A. H. Belo Corporation will not have access to this private health information.

If you are not able to participate in the onsite biometric screenings, there are additional options available to you. You may get your screening directly through LabCorp. Please see the Biometric Screening FAQ's for more information.

The wellness surcharge for 2020 is $100 per month for each employee and each covered spouse who doesn't meet the requirements. To avoid the wellness surcharge, employees and spouses covered under the medical plan prior to July 2, 2019 must:

- Have a biometric screening comprised of blood work, completed through a blood draw procedure, as well as body measurements
- Complete the screening no later than July 31, 2020
- Pass three of the five outlined risk factors, or
- Show an improvement of at least 10% from a 2018 measure for that measure to be given passing credit (Onsite Health Diagnostics will calculate the 10% improvement measurement)

	REQUIRED MEASUREMENTS	
	MEN	WOMEN
HDL CHOLESTEROL	≥ 40	≥ 50
TRIGLYCERIDES	< 150	
BMI (HEIGHT & WEIGHT) OR	< 25	< 25
WAIST CIRCUMFERENCE	<40	<35
BLOOD PRESSURE	< 130/85	
FASTING GLUCOSE	< 100	

If it is unreasonably difficult for you and/or your eligible spouse to meet the criteria, an appeal process is available. Please refer to the Biometric Screening FAQ or contact Onsite Health Diagnostics for more information.

Special rules apply to new hires. Contact A. H. Belo Benefits at 214-977-7210 for details.

Privacy Reminder: A. H. Belo Corporation does not have access to individual health information. Personal health information is always treated privately and we take this very seriously.

Tobacco User Surcharge

The tobacco user surcharge is $75 per month for each employee and each covered spouse. This surcharge is applicable to employees and eligible spouses enrolled in the medical plan. It will apply to any employee and/or spouse who fails the tobacco (cotinine) test performed during the biometric screening. An employee and/or spouse who does not take the biometric screening to test for nicotine will automatically receive the Tobacco User Surcharge.

If you make the decision to eliminate tobacco use, A. H. Belo Corporation offers a tobacco cessation program to support this effort. Kick It! is a tobacco cessation program offered through Beacon Health Options. Contact Beacon Health Options at 800-435-1986 to get started.

Notice Regarding Wellness Program

The Biometric Screening Program is a voluntary wellness program available to enrolled employees and their enrolled spouses. The program is administered according to federal rules permitting employer-sponsored wellness programs that seek to improve employee health or prevent disease, including the Americans with Disabilities Act of 1990, the Genetic Information Nondiscrimination Act of 2008, and the Health Insurance Portability and Accountability Act, as applicable, among others. If you choose to participate in the wellness program you will be asked to complete a voluntary health risk assessment or "HRA" that asks a series of questions about your health-related activities and behaviors and whether you have or had certain medical conditions (e.g., cancer, diabetes, or heart disease). You will also be asked to complete a biometric screening, which will include a blood test for total cholesterol, HDL, LDL, triglycerides and glucose (include cotinine screening, if appropriate). Your blood pressure, height, weight, and waist circumference will also be measured. You are not required to complete the HRA or to participate in the blood test or other medical examinations.

However, employees who choose to participate in the wellness program will receive an incentive of (or avoid a penalty, if appropriate) of indicate the incentive for specify criteria. (IF the employer screens for cotinine/nicotine include tobacco surcharge information).

Additional incentives may be available for employees who participate in certain health-related activities or achieve certain health outcomes. If you are unable to participate in any of the health-related activities or achieve any of the health outcomes required to earn an incentive, you may be entitled to a reasonable accommodation or an alternative standard. You may request a reasonable accommodation or an alternative standard by contacting Onsite Health Diagnostics.

The information from your HRA and the results from your biometric screening will be used to provide you with information to help you understand your current health and potential risks, and may also be used to offer you services through the wellness program, such as wellness programming and content. You also are encouraged to share your results or concerns with your own doctor.

Protections from Disclosure of Medical Information

We are required by law to maintain the privacy and security of your personally identifiable health information. Although the wellness program and A. H. Belo Corporation may use aggregate information it collects to design a program based on identified health risks in the workplace, Onsite Health Diagnostics will never disclose any of your personal information either publicly or to the employer, except as necessary to respond to a request from you for a reasonable accommodation needed to participate in the wellness program, or as expressly permitted by law. Medical information that personally identifies you that is provided in connection with the wellness program will not be provided to your supervisors or managers and may never be used to make decisions regarding your employment.

Your health information will not be sold, exchanged, transferred, or otherwise disclosed except to the extent permitted by law to carry out specific activities related to the wellness program, and you will not be asked or required to waive the confidentiality of your health information as a condition of participating in the wellness program or receiving an incentive. Anyone who receives your information for purposes of providing you services as part of the wellness program will abide by the same confidentiality requirements. In order to provide you with services under the wellness program, your personally identifiable health information may be shared with one or more of the following: Lockton Companies.

In addition, all medical information obtained through the wellness program will be maintained separate from your personnel records, information stored electronically will be encrypted, and no information you provide as part of the wellness program will be used in making any employment decision. Appropriate precautions will be taken to avoid any data breach, and in the event a data breach occurs involving information you provide in connection with the wellness program, we will notify you immediately.

You may not be discriminated against in employment because of the medical information you provide as part of participating in the wellness program, nor may you be subjected to retaliation if you choose not to participate.

If you have questions or concerns regarding this notice, or about protections against discrimination and retaliation, please contact A. H. Belo Benefits.

MEDICAL BENEFITS

Our medical coverage helps you maintain your well-being through preventive care and access to an extensive network of providers, as well as prescription medication. Medical benefits are offered through BlueCross BlueShield of Texas (BCBSTX). Choose the plan that best matches your needs and please keep in mind that the option you elect will be in place for all of the 2020 plan year, unless you have a qualifying life event.

TAKE ADVANTAGE OF PREVENTIVE CARE OFFERED BY AN IN-NETWORK PHYSICIAN. THIS WILL SAVE YOU TIME AND MONEY IN THE LONG RUN!

Medical Premiums

Premium contributions for medical will be deducted from your paycheck on a pre-tax basis. Your level of coverage will determine your monthly contributions.

How to Find a Provider

To see a current list of BCBSTX network providers, visit www.bcbstx.com/ahbelo or call Customer Care at 888-514-5662 for assistance.

Medical Plan Summary

The chart on the next page gives a summary of the 2020 medical coverage provided by BCBSTX. All covered services are subject to medical necessity as determined by the plan. Please be aware that all out-of-network services are subject to Reasonable and Customary (R&C) limitations.

Health Care Cost Transparency

Consumer-Driven Health Plans and tools such as Health Savings Accounts have helped put the power of health care spending in consumers' hands. This means you have control over how your health care dollars are spent. But with the cost of services varying widely, make sure you're making the best choice for your health and your wallet. Enter health care cost transparency tools. These online tools, which are available through BCBSTX, allow consumers to compare costs for everything from prescription drugs to major surgeries. For more information, visit www.bcbstx.com/ahbelo.

	CDHP PLAN				PPO PLAN			
	<$50K	>$50K UP TO $75K	>$75K UP TO $100K	>$100K	<$50K	>$50K UP TO $75K	>$75K UP TO $100K	>$100K
MONTHLY CONTRIBUTIONS								
Employee Only	$93.80	$113.40	$133.05	$168.12	$93.80	$113.40	$133.05	$168.12
Employee + Spouse	$351.42	$419.45	$460.14	$523.96	$351.42	$419.45	$460.14	$523.96
Employee + Child(ren)	$261.21	$314.35	$346.01	$396.21	$261.21	$314.35	$346.01	$396.21
Employee + Family	$495.77	$587.62	$642.76	$728.37	$495.77	$587.62	$642.76	$728.37
	IN-NETWORK		OUT-OF-NETWORK		IN-NETWORK		OUT-OF-NETWORK	
ANNUAL DEDUCTIBLE								
Individual	$2,500		$5,000		$2,500		$5,000	
Family	$5,000		$10,000		$5,000		$10,000	
Coinsurance (Plan Pays)	80%*		50%*		80%*		50%*	
ANNUAL OUT-OF-POCKET MAXIMUM (INCLUDES DEDUCTIBLE)								
Individual	$4,500		$9,000		$4,500		$9,000	
Family	$7,300		$14,600		$7,300		$14,600	
COPAYS/COINSURANCE								
Preventive Care	Covered in Full		50%*		Covered in Full		50%*	
Primary Care / Specialist Visit	80%*		50%*		$20 / $40		50%*	
Diagnostic Services	80%*		50%*		80%*		50%*	
Urgent Care	80%*		50%*		$40		50%*	
Emergency Room	80%*		80%*		80%*		80%*	

*After Deductible

Each covered individual is not required to meet the individual deductible. The medical plans have an aggregate deductible, meaning the family deductible amount will include all combined eligible expenses that you and your covered dependents incur. The family deductible amount may be satisfied by one member or a combination of two or more members covered under your medical plan.

Urgent Care Centers vs. Freestanding Emergency Rooms

Freestanding emergency rooms may look a lot like urgent care centers, but the costs and services can be drastically different. In general, consider an urgent care center as an extension of your primary care physician, while freestanding emergency rooms should be used for health conditions that require a high level of care. Research the options in your area and determine which ones are covered by your insurance plan's network; note that balance billing may apply. Choosing an urgent care center for everyday health concerns rather than an ER could save you hundreds of dollars.

Looking for a Network Provider?

You can access BCBSTX's Provider Finder online through Blue Access for Members (BAM) at bcbstx.com/ahbelo. With Provider Finder you can find a network provider, get cost estimates for various procedures, review providers' certification and recognitions, and determine if a Blue Distinction Center is available for your treatment.

Blue Distinction Centers are hospitals, which are recognized for their expertise in delivering specialty care; Blue Distinction Plus Centers are hospitals recognized for their expertise and efficiency in delivering specialty care. Choosing a Blue Distinction Center may help you achieve a better outcome if you need treatment for the following conditions:

- Bariatric Surgery
- Cardiac Care
- Complex and Rare Cancers
- Knee and Hip Replacement
- Spine Surgery
- Transplants

You can also call Customer Service at 888-514-5662 if you need assistance finding a provider.

THERE ARE NO PRICING STANDARDS FOR HEALTH CARE SO CHARGES FOR MEDICAL SERVICES CAN VARY GREATLY — EVEN FOR THE SAME PROCEDURE, IN THE SAME AREA, WITHIN THE SAME NETWORK. MAKE SURE TO USE HEALTH CARE COST TRANSPARENCY TOOLS TO ENSURE THE MOST COST-EFFECTIVE CHOICE.

BENEFITS VALUE ADVISOR & MEMBER REWARDS PROGRAM

Helping You Maximize Your Benefit Plan

BlueCross BlueShield of Texas (BCBSTX) is working to help you maximize your benefits and plan for your health care. You can speak to a BCBSTX Benefits Value Advisor who can help you get benefits information and find contracting, in-network providers for a number of health care services such as:

- CAT or CT scans (precertification required)
- MRIs (precertification required)
- Endoscopy procedures
- Colonoscopy procedures
- Back or spinal surgery
- Knee surgery
- Shoulder surgery
- Hip or joint replacement surgery
- Bariatric surgery

Benefits Value Advisors can also help you plan for your health care by:

- Helping you better understand your benefits
- Giving you a cost estimate for health care services
- Scheduling a doctor or procedure appointment
- Helping you get general health information about your condition
- Helping you with precertification
- Telling you about online educational tools

To reach a Benefits Value Advisor, call the Customer Service number on the back of your BCBSTX ID card. They are standing by and ready to assist you.

Precertification Requirements:

You are required to contact BCBSTX Benefits Value Advisors PRIOR to having an outpatient MRI or CT scan. They will provide you with a list of providers and associated costs; you will still have the choice to select where the procedure will be performed. Failure to contact them prior to obtaining services will result in a $200 surcharge, which will be your responsibility to pay in addition to any deductible or coinsurance.

Member Rewards:

If your doctor recommends a service or procedure such as the ones listed here, we encourage you to contact BCBSTX Benefits Value Advisors or use the Member Rewards tool online at www.bcbstx.com. You will be presented with several cost-effective options nearby from which to choose. If you select the most cost-effective option for your procedure, a reward check will be mailed directly to you after you have the procedure and the claim is paid. If you choose the 2nd or 3rd most cost-effective option, you may be eligible for a smaller reward. Rewards checks can vary in value up to several hundred dollars depending on the procedure and facility you choose. All rewards are subject to tax.

MDLIVE

Employees and dependents covered under the HDHP or PPO medical plans will have 24/7 access to board certified physicians through MDLIVE. MDLIVE physicians are available by telephone, webcam or online and can prescribe medication and treat a long list of common conditions. MDLIVE is not designed to handle emergency situations or replace your primary care physician, and they must operate under state regulations; therefore, not all services are available in all states.

Speak to a doctor quickly or schedule an appointment based on your availability. Whether you're in the city, a rural area, or on a weekend camping trip, you have access to a board-certified MDLIVE doctor, available 24 hours a day/seven days a week. You can speak to a doctor immediately or schedule an appointment based on your availability. Telehealth can also be a better alternative than going to the emergency room or urgent care.

MDLIVE doctors can help treat the following conditions and more:

GENERAL HEALTH

- Allergies
- Asthma
- Joint aches
- Sinus infections

PEDIATRIC CARE

- Cold/flu
- Ear infections
- Pink eye

BEHAVIORAL HEALTH

- Online counseling
- Child behavior/learning issues
- Stress management

To contact MDLive, call **888-680-8646**, or log onto **www.mdlive.com/bcbstx**.

PREVENTIVE CARE

Did you know that most health plans must cover a set of preventive services — such as shots and screening tests — at no cost to you? Work with your Primary Care Physician to stay up to date on preventive services — identifying and treating illnesses early will save you time and money, and promote a healthy lifestyle in the long run!

Any screening test done in order to catch a disease early is considered a preventive service. Due to the U.S. Patient Protection and Affordable Care Act (ACA), many services, screenings and supplies are paid at 100% including, but not limited to, the following:

- Wellness visits, yearly physicals and standard immunizations
- Screenings for blood pressure, cancer, cholesterol, depression, obesity and Type 2 diabetes
- Pediatric screenings for hearing, vision, obesity, depression, autism and developmental disorders
- Anemia screenings, breastfeeding support and breastfeeding pumps for pregnant and nursing women
- Iron supplements (for children ages 6 to 12 months at risk for anemia)

Key Things to Remember:

- Many preventive care services and tests are covered at 100%. You can find a list of covered services in your plan documents.
- Think of preventive care visits as routine check-ups. Things that may occur during a preventive visit include immunizations, blood pressure and cholesterol measurement, diabetes screening, or counseling on healthy weight.
- Diagnostic care to identify potential health risks are covered according to plan benefits, even if recommended or done during a preventive care visit.
- If your physician finds a specific health risk or new medical condition during your appointment, your doctor may bill those services as diagnostic medicine. These types of diagnostic services may result in out-of-pocket costs for you (i.e., deductibles, coinsurance, or copayments) because they are no longer considered preventive care.

Check your benefit summary to see what preventive services are available to you at no cost.

PHARMACY BENEFITS

Prescription Drug Coverage for Medical Plans

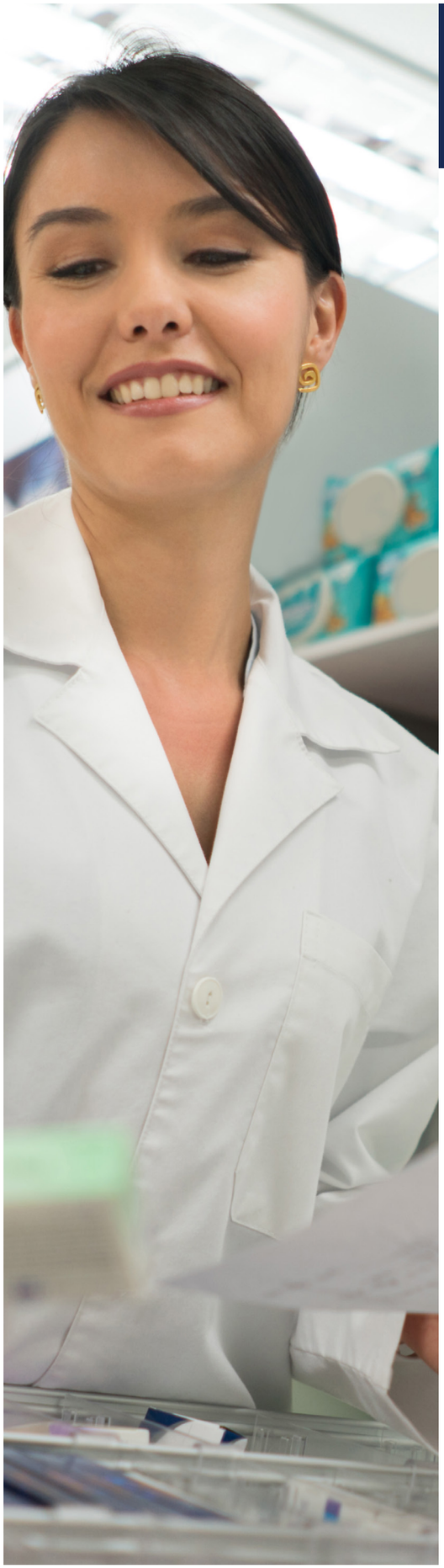
Our Prescription Drug Program is coordinated through BlueCross BlueShield of Texas (BCBSTX).

That means you will only have one ID card for both medical care and prescriptions. You may find information on your benefits coverage and search for network pharmacies by logging on to www.bcbstx.com/ahbelo or by calling the Customer Care number on your ID Card.

Your cost is determined by the tier assigned to the prescription drug product. All products on the list are assigned as generic, preferred, non-preferred or specialty.

	CDHP PLAN		PPO PLAN	
	IN-NETWORK	OUT-OF-NETWORK	IN-NETWORK	OUT-OF-NETWORK
RETAIL RX (30-DAY SUPPLY)				
Generic	$5 Copay*	Not Covered	$15 Copay	50%*
Preferred	25% Coinsurance **, $30 Minimum, $100 Maximum*	Not Covered	$40 Copay	50%*
Non-Preferred	25% Coinsurance **, $60 Minimum, $125 Maximum*	Not Covered	$55 Copay	50%*
Specialty	$150 Copay*	Not Covered	$150 Copay	Not Covered
MAIL ORDER RX (90-DAY SUPPLY)				
Generic	$12.50 Copay*	Not Covered	$30 Copay	Not Covered
Preferred	25% Coinsurance **, $75 Minimum, $250 Maximum*	Not Covered	$80 Copay	Not Covered
Non-Preferred	25% Coinsurance**, $150 Minimum, $312.50 Maximum*	Not Covered	$110 Copay	Not Covered

*After Deductible
**Member portion of the coinsurance



Q & A: GENERIC DRUGS

What is a generic drug?

Generic drugs are copies of brand-name drugs that have exactly the same dosage, intended use, effects, side effects, route of administration, risks, safety and strength as the original drug. In other words, their pharmacological effects are exactly the same as those of their brand-name counterparts.

Are generic drugs as effective as brand-name drugs?

Yes. A generic drug is the same as a brand-name drug in dosage, safety, strength, quality, the way it works, the way it is taken and the way it should be used. FDA requires generic drugs have the same high quality, strength, purity and stability as brand-name drugs.

What standards do generic drugs have to meet?

Health professionals and consumers can be assured that FDA approved generic drugs have met the same rigid standards as the innovator drug. To gain FDA approval, a generic drug must:

- Contain the same active ingredients as the innovator drug (inactive ingredients may vary)
- Be identical in strength, dosage form, and route of administration
- Have the same use indications
- Be bioequivalent
- Meet the same batch requirements for identity, strength, purity, and quality
- Be manufactured under the same strict standards of FDA's good manufacturing practice regulations required for innovator products

Are generic drugs that much cheaper than brand-name medications?

Yes. On average, the cost of a generic drug is 80% to 85% lower than the brand-name equivalent.

Is there a generic equivalent for my brand-name drug?

To find out if there is a generic equivalent for your brand-name drug, visit www.fda.gov to view a catalog of FDA-approved drug products, as well as drug labeling information.

PLAN OPTIONS: WHICH IS BEST FOR YOU?

CDHP/ HSA Plan — HSA Eligible, HSA Contribution from A. H. Belo

PPO PLAN — Copays for Office Visits, Not HSA Qualified, No HSA Contribution from A. H. Belo

SCENARIO 1: JOHN

(LOW HEALTH CARE EXPENSES)

John is 26 years old and is just starting out in his career. He has few health care needs aside from preventive exams (paid at 100% when he uses in-network providers). John is single, has no children, and earns $40,000 a year. He doesn't anticipate any major health care expenses in 2020 and wants to spend as little on health care as possible.

	PLAN COST WITH NETWORK DISCOUNTS	CDHP/ HSA PLAN	PPO PLAN
Preventive Exam: 1	$100	$0	$0
Primary Care Visit: 1	$120	$120	$20
Specialist Visits: 1	$250	$250	$40
Rx Generic @ Retail (1)	$60	$60	$60
John's Total Health Care Cost		$430	$120
John's Annual Payroll Contributions		$1,126	$1,126
A. H. Belo's Contribution to the HSA		($650)	$0
John's Total Cost		$906	$1,246

John's Choice

John's preferred option is the CDHP/HSA Plan. Although his out-of-pocket costs are higher, John can use the HSA contribution from A. H. Belo to cover it. John likes the tax advantages of the Health Savings Account, knowing that he can use it to pay his out-of-pocket expenses in the near term and carry the balance forward to use towards future health care expenses.

John plans on contributing $1,000 to his HSA in 2020. Although the contributions are deducted from his paycheck, they are tax-free, which lowers his taxable income. In addition, the earnings and interest on his HSA are tax-free, along with the withdrawals when he uses the account for qualified health care expenses. If he doesn't use the money this year, it rolls over to use for future expenses.

Disclaimer: Please be advised that these scenarios are only examples. Your actual experience may vary. All expenses assume the use of in-network providers and are eligible expenses under the plan

SCENARIO 2: FELICIA

(MODERATE HEALTH CARE EXPENSES)

Felicia is a 45 year-old single mom and earns $55,000 a year. She is healthy, but she and her daughter have a few health care needs. She is on a maintenance prescription she fills through mail order, and she sees a primary care physician and a specialist occasionally. Her daughter is prone to ear infections and had to go to the urgent care clinic as well as her primary care physician, and was put on an antibiotic.

	PLAN COST WITH NETWORK DISCOUNTS	CDHP/HSA PLAN	PPO PLAN
Preventive Exam: 1	$100	$0	$0
Primary Care Visit: 4	$480	$480	$80
Specialist Visits: 2	$500	$500	$80
Urgent Care Visit: 1	$400	$400	$40
Rx Generic @ Mail Order (4)	$240	$240	$240
Rx Generic @ Retail (1)	$50	$50	$50
Felicia's Total Health Care Cost		$1,670	$490
Felicia's Annual Payroll Contributions		$3,772	$3,772
A. H. Belo's Contribution to the HSA		($1,150)	$0
Felicia's Total Cost		$4,292	$4,262

Felicia's Choice

Felicia's preferred option is the PPO plan. She likes being able to predict her medical expenses with the copays offered on the PPO plan. Felicia is able to budget for her family's expenses, and enjoys the peace of mind knowing that most of her medical expenses can be covered with a copay.

Disclaimer: Please be advised that these scenarios are only examples. Your actual experience may vary. All expenses assume the use of in-network providers and are eligible expenses under the plan.

DENTAL BENEFITS

Regular dental checkups do more for your well-being than just preserve a healthy smile. A. H. Belo Corporation's dental coverage will provide you and your family affordable options for overall health. Coverage is available from Delta Dental and MetLife.

Network Dentists

If you enroll in the MetLife DHMO, please note that benefits are not available for out-of-network services unless it is considered an emergency. Upon enrollment, you will be asked to select a general dentist who will be responsible for coordinating all your dental care. You and each family member may select a different general dentist, as long as they are in the network. To find a network dentist, visit MetLife at www.metlife.com.

If you enroll in the Delta Dental PPO Plan, you can lower your out-of-pocket costs by using a network dentist. Network dentists have agreed to charge lower fees; therefore, the plan's in-network services cover a larger share of the charges. If you choose to use a dentist who doesn't participate in the network, your out-of-pocket costs will be higher, and you are subject to any charges beyond Allowable Charges. To find a network dentist, visit Delta Dental at www.deltadentalins.com.

Dental Premiums

Premium contributions for dental will be deducted from your paycheck on a pre-tax basis. Your tier of coverage will determine your monthly premium.

Dental Plan Summary

Dental plan benefits are available to you on a voluntary basis. The chart below gives a summary of the 2020 dental coverage provided by Delta Dental and MetLife. All out-of-network services are subject to Reasonable and Customary (R&C) limitations.

	DELTA DENTAL PPO	METLIFE DHMO
MONTHLY CONTRIBUTIONS		
Employee Only	$20.24	$7.93
Employee + Spouse	$41.66	$15.07
Employee + Child(ren)	$41.17	$15.86
Employee + Family	$63.54	$24.58
	DELTA DENTAL PPO ALL SERVICES*	METLIFE DHMO IN-NETWORK ONLY**
ANNUAL DEDUCTIBLE		
Individual	$25	No Deductible
Family	$75	No Deductible
ANNUAL MAXIMUM		
Per Person	$2,000 (Preventive does not count toward deductible)	No Maximum
COVERED SERVICES		
Preventive Services (Plan Pays)	100%	See Schedule of Benefits
Basic Services (Plan Pays)	80%***	See Schedule of Benefits
Major Services (Plan Pays)	50%***	See Schedule of Benefits
Orthodontics (Plan Pays)	50% – Children Only	See Schedule of Benefits
Orthodontic Lifetime Maximum	$1,500	See Schedule of Benefits

* All out-of-network services are subject to Allowable Charges; you will be responsible for any amount above the Allowable Charge.
** You must go through your DHMO selected general dentist to coordinate your care.
***After Deductible.

VISION BENEFITS

Even those with perfect eyesight should have their vision checked on a regular basis. To ensure that you and your family have access to quality vision care, A. H. Belo Corporation offers a comprehensive vision benefit provided by Vision Service Plan.

Vision Premiums

Premium contributions for vision will be deducted from your paycheck on a pre-tax basis. Your tier of coverage will determine your monthly premium.

Vision Plan Summary

The chart on the next page gives a summary of the 2020 vision coverage provided by Vision Service Plan. All out-of-network services are subject to Reasonable and Customary (R&C) limitations.

EYE DOCTORS ARE OFTEN THE FIRST HEALTH CARE PROFESSIONALS TO DETECT CHRONIC SYSTEMIC DISEASES SUCH AS HIGH BLOOD PRESSURE AND DIABETES.

MONTHLY CONTRIBUTIONS	VSP SIGNATURE
Employee Only	$14.64
Employee + Spouse	$30.77
Employee + Child(ren)	$30.77
Employee + Family	$30.77

YOUR COVERAGE WITH A VSP SIGNATURE NETWORK DOCTOR		VSP SIGNATURE	
Benefit	Description	Copay	Frequency
WellVision Exam	Focuses on your eyes and overall wellness	$15	Every Calendar Year
Prescription Glasses*		$25	See Frame and Lenses
Frame	$130 allowance for a wide selection of frames $150 allowance for featured frame brands 20% off amount over your allowance	Included in Prescription Glasses	Every Calendar Year
Lenses	Single vision, lined bifocal, and lined trifocal lenses	Included in Prescription Glasses	Every Calendar Year
Lens Options	Polycarbonate lenses for dependent children Photochromics & tints Standard progressive lenses Premium progressive lenses Custom progressive lenses Average 35-40% off other lens options	$0 $0 $50 $80–$90 $120–$160	Every Calendar Year
Contacts (instead of glasses)	Contact lens exam (fitting and evaluation) $150 allowance for contacts and contact lens exam	$0	Every Calendar Year
Diabetic Eyecare Plus Program	Services related to diabetic eye disease, glaucoma and age-related macular degeneration (AMD). Retinal screening for eligible members with diabetes. Limitations and coordination with medical coverage may apply. Ask your VSP doctor for details.	$20	As Needed
EXTRA SAVINGS AND DISCOUNTS			
Glasses and Sunglasses	30% off additional glasses and sunglasses, including lens options, from the same VSP doctor on the same day as your WellVision Exam. Or get 20% off from any VSP doctor within 12 months of your last WellVision Exam.		
Retinal Screening	Guaranteed pricing on retinal screening as an enhancement to your WellVision Exam.		
Laser Vision Correction	Average 15% off the regular price or 5% off the promotional price; discounts only available from contracted facilities. After surgery, use your frame allowance (if eligible) for sunglasses from any VSP doctor		

* Plan provides a second pair of glasses (frame & lenses) or contacts every calendar year at the same benefit level/copay as the first pair.

VISIT VSP.COM FOR DETAILS, IF YOU PLAN TO SEE A PROVIDER OTHER THAN A VSP DOCTOR	
Service	Reimbursement Level After Applicable Copay:
Exam	Up to $50
Frame	Up to $70
Single Vision Lenses	Up to $50
Lined Bifocal Lenses	Up to $75
Lined Trifocal Lenses	Up to $100
Progressive Lenses	Up to $75
Contacts	Up to $150

HEALTH SAVINGS ACCOUNT

Take charge of your health care spending with a Health Savings Account (HSA). Contributions to an HSA are tax free and withdrawals for qualified medical expenses are tax free.

Your HSA can be used for qualified expenses, including those of your spouse and/or tax dependent(s), even if they are not covered by your plan. If you are not enrolled in a CDHP but you have unused HSA funds from a previous account, those funds can still be used for qualified medical expenses.

Fidelity will issue you a debit card, giving you direct access to your account balance. When you have a qualified medical expense, you can use your debit card to pay. You must have a balance to use your debit card. There are no receipts to submit for reimbursement.

Eligible expenses include doctors' office visits, eye exams, prescription expenses, laser eye surgery and more. IRS Publication 502 provides a complete list of eligible expenses and can be found on www.irs.gov.

AN HSA IS A GREAT WAY TO SAVE FOR POST-RETIREMENT HEALTH CARE NEEDS. AIM TO CONTRIBUTE THE MAXIMUM AMOUNT ALLOWED EACH YEAR.

Eligibility

You are eligible to open and fund an HSA if:

- You are enrolled in the HSA-eligible Consumer-Driven Health Plan (CDHP). If you are enrolled in the PPO Plan, you are not eligible for an HSA.
- You are not covered by your spouse's non-CDHP health plan.
- Your spouse does not have a health care Flexible Spending Account or Health Reimbursement Account.
- You are not eligible to be claimed as a dependent on someone else's tax return.
- You are not enrolled in Medicare or TRICARE.
- You have not received Department of Veterans Affairs medical benefits in the past 90 days for non-service-related care. (Service-related care will not be taken into consideration.)

Individually Owned Account

You own and administer your Health Savings Account. You determine how much you'll contribute to the 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 portable, even if you change plans or jobs. There are no vesting requirements or forfeiture provisions.

How to Enroll

You must elect the CDHP with A. H. Belo Corporation. You will need to complete all HSA enrollment materials and designate the amount to contribute on a pre-tax basis. A. H. Belo Corporation will establish an HSA account in your name and send in your contribution once bank account information has been provided and verified.

Maximize Your Tax Savings

Contributions to an HSA are tax-free (they 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.

Per IRS regulations, if HSA funds are used for purposes other than qualified medical expenses and you are younger than age 65, you must pay federal income tax on the amount withdrawn, plus a 20% penalty tax.

HSA Funding Limits

Each year, the IRS places a limit on the maximum amount that can be contributed to HSA accounts. For 2020, contributions (which include any employer contribution) are limited to the following:

HSA FUNDING LIMITS	
Employee	$3,550
Family	$7,100
Catch -Up Contribution (ages 55+)	$1,000

A. H. Belo will provide an HSA employer contribution for eligible employees who enroll in the CDHP Plan. The PPO Plan is not HSA-eligible. The purpose of the company contribution is to provide dedicated dollars for medical costs to individuals who may not be able to make individual contributions. Therefore, the company will not be providing a company HSA contribution to our most highly compensated employees, who make more than $100,000 (inclusive of commissions). In addition, to make sure that there are funds in your HSA when you need it, the company HSA contribution will be deposited quarterly into your Fidelity HSA on the first pay date at the beginning of each quarter.

EMPLOYER HSA CONTRIBUTION				
SALARY BAND	<$50K	$50K to <$75K	$75K to <$100K	$100K+
Employee Only	$650	$575	$500	$0
Employee + Family	$1,300	$1,150	$1,000	$0

HSA contributions in excess of the IRS annual contribution limits ($3,550 for individual coverage and $7,100 for family coverage for 2020) are not tax deductible and are generally subject to a 6% excise tax.

If you've contributed too much to your HSA this year, you can do one of two things:

- Remove the excess contributions and the net income attributable to the excess contribution before you file your federal income tax return (including extensions). You'll pay income taxes on the excess removed from your HSA.
- Leave the excess contributions in your HSA and pay 6% excise tax on excess contributions. Next year you may want to consider contributing less than the annual limit to you HSA to make up for the excess contribution during the previous year.

The A. H. Belo Corporation HSA will be established with Fidelity. You may be able to roll over funds from another HSA. For more enrollment information, contact Human Resources or visit www.401k.com.

FLEXIBLE SPENDING ACCOUNTS

Flexible Spending Accounts (FSAs) allow you to set aside pre-tax payroll deductions to pay for various out-of-pocket expenses.

YOUR FSA MONEY CAN COVER THE COST OF GOING TO A CHIROPRACTOR OR ACUPUNCTURIST, IF YOUR INSURANCE DOESN'T ALREADY COVER IT.

Health Care Flexible Spending Account

You can contribute up to $2,700 for qualified medical expenses (deductibles, copays and coinsurance, for example) with pre-tax dollars, which will reduce the amount of your taxable income and increase your take-home pay. You can even pay for eligible expenses with an FSA debit card at the same time you receive them, so you don't have to wait for reimbursement. You cannot enroll in a Health Care Flexible Spending Account if you are eligible for an HSA.

Please note: Over-the-counter (OTC) drugs are not eligible for reimbursement through an FSA without a doctor's prescription.

Limited Use Flexible Spending Account

Designed to complement a Health Savings Account, a Limited Use Flexible Spending Account (LUFSA) allows for reimbursement of eligible dental and vision expenses. You must decide how much to set aside for this account. You may contribute up to $2,700 in the LUFSA.

Dependent Care Flexible Spending Account

In addition to the Health Care FSA, you may opt to participate in the Dependent Care FSA as well — whether or not you elect any other benefits. The Dependent Care FSA allows you to set aside up to $5,000 in pre-tax funds to help pay for expenses associated with caring for elder or child dependents. Unlike the Health Care FSA, reimbursement from your Dependent Care FSA is limited to the total amount that is deposited in your account at that time.

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. To be sure your total contribution is within the $5,000 legal limit, during Annual Enrollment, the most you can elect to contribute from paychecks is $3,960.

- Eligible dependents include children younger than the age of 13 and dependents of any age who are incapable of caring for themselves.
- Expenses are reimbursable as long as the provider is not anyone considered your dependent for income tax purposes.
- In order to be reimbursed, you must provide the tax identification number or Social Security number of the party providing care.

Eligible Dependent Care Flexible Spending Account Expenses

This account covers dependent day care expenses that are necessary for you and your spouse to work or attend school full time. The dependent must be a child younger than the age of 13 and claimed as a dependent on your federal income tax return or a disabled dependent who spends at least eight hours a day in your home.

Examples of eligible dependent care expenses include:

- In-Home Baby-Sitting Services (not by an individual you claim as a dependent)
- Care of a Preschool Child by a Licensed Nursery or Day Care Provider
- Before- and After-School Care
- Day Camp
- In-House Dependent Day Care

How to Use the Account

You can your FSA debit card at locations such as doctor and dentist offices, pharmacies, and vision service providers. The card cannot be used at locations that do not offer services under the plan, unless the provider has also complied with IRS regulations. The swipe transaction will be denied if you attempt to use the card at an ineligible location.

Once you incur an eligible expense, submit a claim form along with the required documentation. If you have a question about a reimbursement, contact TaxSaver Plan. Should you need to submit a receipt, you will receive an email or be mailed a receipt notification from TaxSaver Plan. You should always retain a receipt for your records.

While FSA debit cards allow you to pay for services at point of sale, they do not remove the IRS regulations for substantiation. This means that you must always keep receipts and Explanation of Benefits (EOBs) for any debit card charges. If you don't provide proof that an expense was valid can result in your card being turned off and your expense being deemed taxable.

General Rules and Restrictions

In exchange for the tax advantages that FSAs offer, the IRS has imposed the following rules and restrictions for both Health Care and Dependent Care FSAs:

- Your expenses must be incurred during the 2020 plan year.
- Your dollars cannot be transferred from one FSA to another.
- You cannot participate in Dependent Care FSA and claim a dependent care tax deduction at the same time.
- You must "use it or lose it"— any unused funds will be forfeited.
- You cannot change your FSA election in the middle of the plan year unless you experience a qualifying life event like marriage, divorce or birth of a child.

Grace Period

- FSA participants have an additional 2½-month grace period of time to incur expenses after the plan year ends (December 31, 2020).
- If an expense is incurred between December 31, 2020 and March 15, 2021, AND submitted for reimbursement on or before April 30, 2021, any remaining balance in the previous plan year that ended December 31, 2020, will be paid out from the claim, even though the service was provided in the NEW plan year.
- The grace period applies to both the Dependent Care and Health Care FSAs.

FSA VS. HSA: WHICH IS RIGHT FOR YOU?

Flexible Spending Accounts (FSAs) and Health Savings Accounts (HSAs) are two ways to save pre-tax money to pay for your eligible health care costs. But how do you know which one is right for you?

	FSA	HSA
Ownership	The FSA is owned by your employer. If you leave your employer, you lose access to the account unless you have a COBRA right.	The HSA is an account owned by you. It is a savings account in your name and you always have access to the funds, even if you leave your employer.
Eligibility & Enrollment	The employer determines eligibility for an FSA. You cannot make changes to your contribution during the Plan Year without a Qualifying Life Event.	You must be enrolled in a Qualified High Deductible Health Plan to be eligible to contribute money to your HSA. You cannot be covered by a spouse's non-High Deductible plan or enrolled in Medicare or TRICARE. You can change your contribution at any time during the Plan Year.
Taxation	Contributions are tax free via payroll deduction.	The money in the account is "triple tax free," meaning: 1. Contributions are tax free. 2. The account grows tax free. 3. Funds are spent tax free (if used for qualified expenses).
Contributions	Both you and your employer can contribute to the account according to IRS limits. The contribution limit for 2019 is $2,700. This amount does not have to include the employer contribution.	Both you and your employer can contribute to the account according to IRS limits. The contribution limit for 2020 is $3,550 for individuals and $7,100 for families. This amount includes the employer contribution. If you are 55 or older, you may make a "catch-up" contribution of $1,000 per year.
Payment	Some plans include an FSA debit card to pay for eligible expenses. If not, you pay up front and get reimbursed from the account. You must submit your receipts for reimbursement.	Many HSAs include a debit card, ATM withdrawal or checkbook. You may use the debit card to pay for qualified expenses directly. You could also use online bill payment services from the HSA financial bank to pay for qualified expenses. You decide when and if you should use the money in your HSA to pay for qualified expenses, or if you want to use another account to pay for services and save the money in your HSA for future qualified expenses or retirement.
Roll Over or Grace Period	You must use the money in the account by end of Plan Year, however some plans allow up to $500 to roll over to the next year. Other plans include a 2.5-month grace period after the end of the Plan Year for any extra expenses to be incurred and reimbursed. A plan can have either a rollover or a grace period, but not both. Any unclaimed funds at the end of the run out are lost and returned to your employer.	The money in the account rolls over from year to year. Funds are always yours and may be used for future qualified expenses.
Qualified Expenses	Physician services, hospital services, prescriptions, dental care and vision care. A full listing of eligible expenses is available at www.irs.gov.	Physician services, hospital services, prescriptions, dental care, vision care, Medicare Part D plans, COBRA premiums and long-term care premiums. A full listing of eligible expenses is available at www.irs.gov.
Other Types	Other types of FSAs include: • Dependent Care FSA – Allows you to set aside pre-tax dollars for elder or child dependent care and covers expenses such as baby-sitting, day care and before- and after-school care. • Limited Use FSA – Some employers offer a Limited Use FSA that only covers eligible Dental and Vision expenses. Limited Use FSAs are typically offered in conjunction with an HSA as the IRS does not allow someone to have a Health FSA and an HSA.	There is only one type of HSA.

Please refer to your Summary Plan Description or plan certificate for your plan's specific FSA or HSA benefits.

SURVIVOR BENEFITS

It's not always easy to talk with your family about how they'll be provided for if you weren't around, but it's an important conversation to have. Survivor benefits provide financial assistance in an absence, and can help you plan for the unexpected. If you secure Life insurance now, chances are you can take comfort in knowing that those who depend on you will be provided for.

Basic Life Insurance

Life insurance benefits are essential to your family's financial security. As such, it is important to understand how your plan works and what benefits you will receive. Basic Life insurance benefits are provided to you as a part of your basic coverage. A. H. Belo Corporation provides employees with Basic Life insurance through Lincoln Financial, which guarantees that loved ones, such as a spouse or other designated survivor(s), continue to receive part of an employee's benefits after death.

Your Basic Life insurance benefit is two times your basic annual earnings (rounded up to the next $1,000), up to $1,000,000. If you are a full-time employee, you automatically receive Life insurance even if you elect to waive other coverage.

Beneficiary Designation

A beneficiary is the person you designate to receive your Life insurance benefits in the event of your death. This includes any benefits payable under Basic Life offered by A. H. Belo Corporation. You receive the benefit payment for a dependent's death under the Lincoln Financial insurance.

Make sure your beneficiary designation is clear so there is no question as to your intentions, and remember to name a primary and contingent beneficiary. When naming your beneficiary(ies), please indicate their full name, address, Social Security number, relationship, date of birth and distribution percentage. If the beneficiary is not legally related, insert the words "Not Related" in the relationship field.

Please note that in most states, benefit payments cannot be made to a minor younger than 18. If you elect to designate a minor as beneficiary, all proceeds may be held under the beneficiary's name, and will earn interest until the minor reaches majority age at 18.

If you name more than one beneficiary with unequal shares, please show the amount of insurance to be paid to each beneficiary in percentages. If you need assistance, contact Human Resources or your own legal counsel.

YOUR BENEFICIARY DOESN'T HAVE TO BE A PERSON. A TRUST, OR A LEGAL AGREEMENT THAT LETS YOU PLACE PROPERTY UNDER THE CONTROL OF A TRUST MANAGER, CAN BE NAMED THE BENEFICIARY. THE BENEFICIARY CAN ALSO BE A CHARITY OR SIMPLY YOUR ESTATE.

Life and AD&D Insurance

Eligible employees may purchase Voluntary Life and AD&D insurance for themselves and their families. Premiums are paid through payroll deductions.

BASIC LIFE	
Coverage Amount	Two times your basic annual earnings (rounded up to the next $1,000)
Who Pays	The company pays. Basic Life is provided to you as a part of your basic coverage.
Benefits Payable	In the event of your death.
Maximum Benefit	Basic Life Maximum: $1,000,000
Guaranteed Issue	$750,000
Evidence of Insurability (EOI) Required	Evidence of Insurability will be required for amounts over $750,000.

SUPPLEMENTAL EMPLOYEE LIFE	
Coverage Amount	Increments of one to five times your basic annual earnings
Who Pays	You pay. This coverage is available on a voluntary basis.
Benefits Payable	If you die while covered under the plan. This benefit is in addition to your Basic Life benefit.
Maximum Benefit	Supplemental Life Maximum: The lesser of five times your annual salary or $1,000,000.
Guaranteed Issue	$750,000
Evidence of Insurability (EOI) Required	For newly eligible employees, EOI will be required for elections greater than $750,000. Any future elections or increases will require EOI.

SUPPLEMENTAL DEPENDENT LIFE			
Coverage Amount Family Member	Option 1	Option 2	Option 3
Spouse	$10,000	$5,000	$20,000
Each unmarried child 14 days to age 26	$5,000	$2,500	$10,000
Each child from 24 hours to 13 days old	$1,000	$500	$3,000
Who Pays	You pay. This coverage is available on a voluntary basis.		
Benefits Payable	If your dependent dies while covered under the plan.		
Maximum Benefit	Spouse: $20,000 Child: $10,000		
Evidence of Insurability (EOI) Required	EOI will be required if you try to elect or increase coverage more than 31 days after your initial eligibility date or the date you acquire a new dependent.		

VOLUNTARY AD&D	
Employee Coverage Amount	Increments of one to six times salary
Dependent Coverage Amount (as % of your principal amount)	Spouse Only: 60% Child(ren) Only: 20% Spouse & Child(ren): 50% & 15%, respectively
Who Pays	You pay. This coverage is available on a voluntary basis.
Maximum Benefit	$500,000
Evidence of Insurability (EOI) Required	No

SUPPLEMENTAL EMPLOYEE LIFE	
Rates/$1,000 (MONTHLY)	
Age	Employee
Less than 30	$0.097
30-34	$0.146
35-39	$0.162
40-44	$0.308
45-49	$0.389
50-54	$0.859
55-59	$1.069
60-64	$1.620
65-69	$2.318
70+	$3.581

SUPPLEMENTAL DEPENDENT LIFE	
Premium Rates – (MONTHLY)	
Option 1	$2.40
Option 2	$1.20
Option 3	$4.80

SUPPLEMENTAL AD&D	
Premium Rates – $1,000 (MONTHLY)	
Employee Only	$0.027
Employee + Family	$0.045

TO CALCULATE HOW MUCH YOUR VOLUNTARY LIFE COVERAGE WILL COST:					
$	÷ 1,000 =	$	x Age Based Rate =	$	
Benefit Elected				Monthly Premium	

INCOME PROTECTION

A. H. Belo Corporation offers disability coverage to protect you against any debilitating injury. This insurance protects a portion of your income until you can return to work, or until you reach retirement age.

Short Term Disability (STD) Insurance

Short Term Disability (STD) benefits are provided to you as part of your basic coverage if you are a regular full-time employee.

Time off for a lengthy illness is recorded and paid by a combination of using PTO and Short Term Disability (STD). Employees will be required to use PTO for the first 40 hours of an extended illness. Short Term Disability will then provide for salary continuation for the 2nd through the 26th week of an extended illness. In the first calendar year of employment, the maximum Short Term Disability payment is limited to 30 days (240 hours). Payment eligibility for STD benefits and return to work programs will be managed by medically trained disability management specialists through Lincoln Financial. STD will be paid in accordance with the schedule below.

SHORT TERM DISABILITY			
Length of Service	1st Week Paid Under PTO	Number of Days/Hours Paid at 100%	Number of Days/Hours Paid at 60%
1st Calendar Year	5 days (as available)	10 days (80 hours)	20 days (160 hours)
1st January 1	5 days (40 hours)	15 days (120 hours)	110 days (880 hours)
3rd January 1	5 days (40 hours)	25 days (200 hours)	100 days (800 hours)
5th January 1	5 days (40 hours)	45 days (360 hours)	80 days (640 hours)
10th January 1	5 days (40 hours)	75 days (600 hours)	50 days (400 hours)
15th January 1	5 days (40 hours)	125 days (1000 hours)	0

Employees may use any available PTO time to cover the difference between 60% and 100% of their pay while on Short Term Disability. After 26 weeks of Short Term Disability, eligible employees may apply for Long Term Disability benefits which will be managed by Lincoln Financial.

Long Term Disability (LTD) Insurance

Long Term Disability (LTD) benefits are provided to you as a part of your basic coverage once you've been continuously employed for 12 months. LTD insurance protects a portion of your income if you become partially or totally disabled for an extended period of time. This insurance replaces 60% of your income, up to a maximum of $10,000 per month, depending on your current annual earnings. You must be sick or disabled for at least 26 weeks before you can receive a benefit payment. Payments will last for as long as you are disabled or until you reach your Social Security Normal Retirement Age, whichever is sooner. Certain exclusions, along with any pre-existing condition limitations, may apply. Please refer to your Certificate of Coverage for details or contact A. H. Belo Benefits for specific benefits.

ADDITIONAL BENEFITS

A. H. Belo Corporation knows the value of well-rounded, balanced employees, which is why we offer a variety of additional benefits to help manage life's daily stresses.

Employee Assistance Program

A. H. Belo Corporation cares about you and your family's total health management — mental, emotional and physical. For that reason, we provide an Employee Assistance Program (EAP) at no cost to you.

Whether you are interested in work/life resources, mental health assistance, or legal and financial advice, the EAP service can connect you and members of your household with a variety of professionals. With just one phone call, at any hour of the day or night, you can have access to helpful resources. The EAP benefit includes five face-to-face visits per issue with a licensed professional. All services provided are confidential and will not be shared with A. H. Belo Corporation. You may also access information, benefits, educational materials and more either by phone at 800-435-1986 or online at www.myachieve.com.

The Program provides referrals to help with:

- Emotional Health and Well-Being
- Alcohol or Drug Dependency
- Marriage or Family Relationship Problems
- Job Pressures
- Stress, Anxiety, Depression
- Grief and Loss
- Financial or Legal Advice

Home/Auto Insurance

A. H. Belo Corporation provides you access to discounted Auto and Homeowners insurance through MetLife. Your coverage will belong to you and stay with you, even if you leave the company, so you can always take advantage of low rates. Homeowners insurance includes coverage for your house, condo or rental property. Residency restrictions may apply.

Auto insurance includes coverage for your automobile, boat, motor home or recreational vehicle. You may start or stop your coverage at any time during the year. Call 800-GET-MET8 to sign up today.

Legal Assistance

As a A. H. Belo Corporation employee, you may sign up for a discounted Legal Services plan through MetLife. Telephone and in-person legal consultations are available. Your coverage is portable, so you can continue to take advantage of low rates even if you leave A. H. Belo Corporation. Call 800-GET-MET8 if you have any questions.

Covered services include:

- Real Estate Issues
- Debt and Credit Concerns (Including Identity Theft)
- Document Preparation and Review
- Wills and Estate planning
- Some Family Law

Voluntary Critical Illness

Critical Illness insurance pays a lump sum benefit in the event that you or a covered family member is diagnosed with a covered illness. This benefit can be used any way you choose, and benefits are paid regardless of any other insurance coverage you may have.

Retirement Planning

It's never too early — or too late — to start planning for your retirement. Making contributions to a 401(k) account is the first step toward achieving financial security later in life. The A. H. Belo 401(k) plan provides you with the tools and flexibility you need to retire comfortably and securely.

Eligible employees can invest for retirement while receiving certain tax advantages. A. H. Belo offers immediate dollar-for-dollar matching for the first 1.5% employee contribution per paycheck. A. H. Belo matching contributions are immediately vested. Both pre-tax and Roth deferrals are available. Administrative and record keeping services for this plan are provided by Fidelity Investments.

Immediate 401(k) Vesting and Match

The 401(k) plan offers an immediate match* dollar-for-dollar on your employee contributions not to exceed 1.5% of the employee contribution per paycheck. Company matching contributions are immediately vested. This means that as soon as your contributions and the company's contributions are deposited into your 401(k) account, all funds will be immediately vested at 100%.

True-Up Match

The 401(k) plan incorporates a True-Up match contribution for 401(k) employee contributions for anyone who might have missed out on the full match due to maxing out at the IRS limit before the end of the year.

Contributing to the Plan

Deferred contributions are based on a flat dollar amount not to exceed plan limits set by the IRS. The limit for 2019 is $19,000. New employees will be automatically enrolled in the 401(k) plan at a rate of 3%, which will commence within 60 days of hire date; however, new hires can enroll prior to the 60 days by contacting Fidelity Investments upon hire to initiate the contributions sooner. 401(k) contribution limits for 2020 have not yet been announced by the IRS.

Catch-Up Contributions

If you are or will be age 50 or older during this calendar year and you already contribute the maximum allowed to your 401(k) account, you may also make a "catch-up contribution." This additional deposit of funds accelerates your progress toward your retirement goals. The maximum catch-up contribution is $6,000 for 2019 — for a combined total contribution allowance of $25,000. See your plan administrator for more details.

Changing or Stopping Your Contributions

You may change the amount of your contributions any time. All changes will become effective as soon as administratively feasible and will remain in effect until you modify them. You may also discontinue your contributions any time. If you stop making contributions, you may start again at any time.

Investing in the Plan

You decide how to invest the assets in your account. The A. H. Belo 401(k) plan offers a selection of investment options for you to choose from. You may change your investment choices any time. For more details, refer to your 401(k) Enrollment Guide.

*Immediate match means that as soon as administratively possible, your employee contributions will commence. As a new hire, this means that your contributions will commence within 60 days for date of hire; however, you can contact Fidelity Investments before 60 days to initiate your contributions sooner. It is important to note if you are a rehire, you will be required to contact Fidelity Investments to initiate your new contributions as auto enrollment only applies to new hires.

An additional way to save in your plan

Unlike a traditional pretax 401(k), the Roth 401(k) allows you to contribute after-tax dollars and then withdraw tax-free dollars from your account when you retire. *The following information can help you decide whether the Roth 401(k) makes sense for you.

How the Roth 401(k) compares with a traditional pretax 401(k)

Just as with a traditional pretax 401(k):

- You elect how much of your salary you wish to contribute.
- Your contributions to a Roth 401(k) and traditional pretax 401(k) cannot exceed IRS limits.
- Your contribution is based on your eligible compensation.

Unlike a traditional pretax 401(k), the Roth 401(k) allows you to withdraw your money tax free when you retire. *But it will also require you to make after-tax contributions now.

Who might benefit from a Roth 401(k)?

- Younger employees who have a longer retirement horizon and more time to accumulate tax-free earnings.
- Highly compensated individuals who aren't eligible for Roth IRAs, but who want a pool of tax-free money to draw on in retirement.
- Employees who want to leave tax-free money to their heirs.

TAXES: PAY NOW OR PAY LATER		
	Traditional Pre-tax 401(k)	Roth 401(k)
Employee contributions	Pre-tax dollars	After-tax dollars
Employee withdrawals	Taxable upon withdrawal	Tax free upon withdrawal*

*In the event of either retirement or termination, your earnings can be withdrawn tax free as long as it has been five tax years since your first Roth 401(k) contribution and you are at least 59½ years old. In the event of death, beneficiaries may be able to receive distributions tax free if the deceased started making Roth contributions more than five tax years prior to the distribution. In the event of disability, your earnings can be withdrawn tax free if it has been five tax years from your first Roth 401(k) contribution.

Maternity and Paternity Leave

The Maternity and Paternity Leave program allows new parents more quality time to bond with newborns. The maternity leave runs concurrently with FMLA and STD, and provides:

- One year waiting period
- Maternity benefits up to eight weeks
- Paternity benefits up to four weeks
- Paid at 100% of base salary

Can be taken intermittently within the first six months of the qualifying life event (birth)

Community Service Time Off

The Community Service Time Off program allows employees to volunteer up to eight hours each year toward their favorite cause and get paid for it. The program features include:

- One paid day off per employee per year
- Hours can be used in half-day or full-day increments, but need to be approved in advance by your reporting manager
- Workday tracking is used for annual review

Workplace Flexibility

Workplace flexibility is designed with you and your family in mind, and is handled at a local level and should be discussed with your reporting manager. The following options are encouraged throughout our organization:

- Flextime
- Shift arrangements or part-time schedules
- Part-year work
- Work from home (Virtual commuters)
- Satellite locations

You can find more information on the Workplace Flexibility policy by navigating to www.belointel.com/peopl-team/ and clicking on the policy tab. Speak to your manager about alignment and offerings that might work for you.

GLOSSARY

Coinsurance – Your share of the cost of a covered health care service, calculated as a percent (for example, 20%) of the allowed amount for the service, typically after you meet your deductible. For instance, if your plan's allowed amount for an office visit is $100 and you've met your deductible (but haven't yet met your out-of-pocket maximum), your coinsurance payment of 20% would be $20. Your plan sponsor or employer would pay the rest of the allowed amount.

Consumer-Driven Health Plan (CDHP) – A plan option that provides choice, flexibility and control when it comes to spending money on health care. Preventive care is covered at 100% with in network providers, and all qualified employee-paid medical expenses count toward your deductible and your out-of-pocket maximum.

Copay – The fixed amount, as determined by your insurance plan, you pay for health care services received.

Deductible – The amount you owe for health care services before your health insurance or plan sponsor (employer) begins to pay its portion. For example, if your deductible is $1,000, your plan does not pay anything until you've met your $1,000 deductible for covered health care services. This deductible may not apply to all services, including preventive care.

Employee Contribution – The amount you pay for your insurance coverage.

Explanation of Benefits (EOB) – A statement sent by your insurance carrier that explains which procedures and services were provided, how much they cost, what portion of the claim was paid by the plan, and what portion is your liability, in addition to how you can appeal the insurer's decision. These statements are also posted on the carrier's website for your review.

Flexible Spending Accounts (FSAs) – A special tax-free account you put money into that you use to pay for certain out-of-pocket health care costs. This means you'll save an amount equal to the taxes you would have paid on the money you set aside.

- **Health Care FSA –** A pre-tax benefit account used to pay for eligible medical, dental, and vision care expenses that aren't covered by your insurance plan or elsewhere. All expenses must be qualified as defined in Section 213(d) of the Internal Revenue Code. Please note that over-the-counter medications are not eligible for reimbursement without a doctor's prescription with the Health Care FSA.
- **Limited Use FSA –** Designed to complement a Health Savings Account, a Limited Use Flexible Spending Account allows for reimbursement of eligible dental and vision expenses.
- **Dependent Care FSA –** A pre-tax benefit account used to pay for dependent care services, such as preschool, summer day camp, before- or after-school programs, and child or elder daycare. For additional information on eligible expenses, refer to Publication 503 on the IRS website.

Flexible Spending Accounts are "use it or lose it," meaning that funds not used by the end of the plan year will be lost. Although, some Heath Savings Accounts allow for a grace period or a rollover into the next plan year.

Health Care Cost Transparency – Also known as Market Transparency or Medical Transparency. Health care provider costs can vary widely, even within the same geographic area. To make it easier for you to get the most cost-effective health care products and services, online cost transparency tools, which are typically available through health insurance carriers, allow you to search an extensive national database to compare costs for everything from prescription drugs and office visits to MRIs and major surgeries.

Health Savings Account (HSA) – A personal health care bank account funded by your or your employer's tax-free dollars to pay for qualified medical expenses. You must be enrolled in a CDHP to open an HSA. Funds contributed to an HSA roll over from year to year and the account is portable, meaning if you change jobs your account goes with you.

Network – A group of physicians, hospitals, and other health care providers that have agreed to provide medical services to a health insurance plan's members at discounted costs.

- **In-Network –** In-network providers are doctors, hospitals and other providers that contract with your insurance company to provide health care services at discounted rates.
- **Out-of-Network –** Out-of-network providers are doctors, hospitals and other providers that are not contracted with your insurance company. If you choose an out-of-network doctor, services will not be provided at a discounted rate.
- **Non-Participating –** Providers that have declined entering into a contract with your insurance company.

Out-of-Pocket Maximum – The most you pay during a policy period (usually a 12-month period) before your health insurance or plan begins to pay 100% of the allowed amount. This limit does not include your premium, charges beyond the Reasonable & Customary, or health care your plan doesn't cover. Check with your health insurance carrier to confirm what payments apply to the out-of-pocket maximum.

Over-the-Counter (OTC) Medications – Medications made available without a prescription.

Prescription Medications – Medications prescribed to you by a doctor. Cost of these medications is determined by their assigned tier: generic, preferred, non-preferred or specialty

- **Generic Drugs –** Drugs approved by the U.S. Food and Drug Administration (FDA) to be chemically identical to corresponding preferred or non-preferred versions. The color or flavor of a generic medicine may be different, but the active ingredient is the same. Generic drugs are usually the most cost-effective version of any medication.
- **Preferred Drugs –** Brand-name drugs on your provider's list of approved drugs. You can check online with your provider to see this list.
- **Non-Preferred Drugs –** Brand-name drugs not on your provider's list of approved drugs. These drugs are typically newer and have higher copayments.
- **Specialty Drugs –** Prescription medications used to treat complex, chronic and often costly conditions such as multiple sclerosis, rheumatoid arthritis, hepatitis C and hemophilia. Because of the high cost of these specialty drugs, many insurers require that specific criteria be met before a drug is covered. These requirements often include:
  - Performing a prior authorization to request coverage of the medication
  - Having a specific disease that the drug is FDA-approved to treat
  - Having a history of trying and failing cheaper medications
  - Creating high out-of-pocket costs when purchasing the medication
  - Restricting what pharmacy can dispense these medications
- **Prior Authorization –** A requirement that your physician obtain approval from your health insurance plan to prescribe a specific medication for you.

Step Therapy – The goal of a Step Therapy Program is to steer employees to less expensive, yet equally effective, medications while keeping member and physician disruption to a minimum. You must typically try a generic or preferred-brand medication before "stepping up" to a non-preferred brand.

Reasonable and Customary Allowance (R&C) – The amount paid for a medical service in a geographic area based on what providers in the area usually charge for the same or similar medical service. The R&C amount sometimes is used to determine the allowed amount.

Summary of Benefits and Coverage (SBC) – Mandated by health care reform, your insurance carrier or plan sponsor will provide you with a clear and easy to follow summary of your benefits and plan coverage.

Required Notices

Important Notice from A. H. Belo About Your Prescription Drug Coverage and Medicare under the BCBS PPO and BCBS HDHP Plan(s)

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with A. H. Belo and about your options under Medicare's prescription drug coverage. This information can help you decide whether or not you want to join a Medicare drug plan. If you are considering joining, you should compare your current coverage, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare prescription drug coverage in your area. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

There are two important things you need to know about your current coverage and Medicare's prescription drug coverage:

1. Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.

2. A. H. Belo has determined that the prescription drug coverage offered by the BCBS PPO and BCBS HDHP plan(s) is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

When Can You Join A Medicare Drug Plan?

You can join a Medicare drug plan when you first become eligible for Medicare during a seven-month initial enrollment period. That period begins three months prior to your 65th birthday, includes the month you turn 65, and continues for the ensuing three months. You may also enroll each year from October 15th through December 7th.

However, if you lose your current creditable prescription drug coverage, through no fault of your own, you will also be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan.

What Happens To Your Current Coverage If You Decide to Join A Medicare Drug Plan?

If you decide to join a Medicare drug plan, your current A. H. Belo coverage will not be affected. For most persons covered under the Plan, the Plan will pay prescription drug benefits first, and Medicare will determine its payments second. For more information about this issue of what program pays first and what program pays second, see the Plan's summary plan description or contact Medicare at the telephone number or web address listed herein.

If you do decide to join a Medicare drug plan and drop your current A. H. Belo coverage, be aware that you and your dependents will not be able to get this coverage back.

When Will You Pay A Higher Premium (Penalty) To Join A Medicare Drug Plan?

You should also know that if you drop or lose your current coverage with A. H. Belo and don't join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.

If you go 63 continuous days or longer without creditable prescription drug coverage, your monthly premium may go up by at least 1% of the Medicare base beneficiary premium per month for every month that you did not have that coverage. For example, if you go nineteen months without creditable coverage, your premium may consistently be at least 19% higher than the Medicare base beneficiary premium. You may have to pay this higher premium (a penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to join.

For More Information about This Notice or Your Current Prescription Drug Coverage…

Contact the person listed at the end of these notices for further information. **NOTE:** You'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage through A. H. Belo changes. You also may request a copy of this notice at any time.

For More Information about Your Options under Medicare Prescription Drug Coverage…

More detailed information about Medicare plans that offer prescription drug coverage is in the "Medicare & You" handbook. You'll get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare drug plans.

For more information about Medicare prescription drug coverage:

- Visit www.medicare.gov
- Call your State Health Insurance Assistance Program (see the inside back cover of your copy of the "Medicare & You" handbook for their telephone number) for personalized help
- Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048

If you have limited income and resources, extra help paying for Medicare prescription drug coverage is available. For information about this extra help, visit Social Security on the web at www.socialsecurity.gov, or call them at 1-800-772-1213 (TTY 1-800-325-0778).

Remember: Keep this Medicare Part D notice. If you decide to join one of the Medicare drug plans, you may be required to provide a copy of this notice when you join to show whether or not you have maintained creditable coverage and, therefore, whether or not you are required to pay a higher premium (a penalty).

Date:	January 1, 2020
Name of Entity/Sender:	A. H. Belo
Contact—Position/Office:	Human Resources
Address:	1954 Commerce St. Dallas, TX 75201
Phone Number:	214-977-7210

Women's Health and Cancer Rights Act

The Women's Health and Cancer Rights Act of 1998 was signed into law on October 21, 1998. The Act requires that all group health plans providing medical and surgical benefits with respect to a mastectomy must provide coverage for all of the following:

- Reconstruction of the breast on which a mastectomy has been performed
- Surgery and reconstruction of the other breast to produce a symmetrical appearance
- Prostheses
- Treatment of physical complications of all stages of mastectomy, including lymphedema

This coverage will be provided in consultation with the attending physician and the patient, and will be subject to the same annual deductibles and coinsurance provisions which apply for the mastectomy. For deductibles and coinsurance information applicable to the plan in which you enroll, please refer to the summary plan description or contact Human Resources at 214-977-7210.

HIPAA Privacy and Security

The Health Insurance Portability and Accountability Act of 1996 deals with how an employer can enforce eligibility and enrollment for health care benefits, as well as ensuring that protected health information which identifies you is kept private. You have the right to inspect and copy protected health information that is maintained by and for the plan for enrollment, payment, claims and case management. If you feel that protected health information about you is incorrect or incomplete, you may ask your benefits administrator to amend the information. For a full copy of the Notice of Privacy Practices, describing how protected health information about you may be used and disclosed and how you can get access to the information, contact Human Resources at 214-977-7210.

HIPAA Special Enrollment Rights

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to later enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing towards your or your dependents' other coverage).

Loss of eligibility includes but is not limited to:

- Loss of eligibility for coverage as a result of ceasing to meet the plan's eligibility requirements (i.e. legal separation, divorce, cessation of dependent status, death of an employee, termination of employment, reduction in the number of hours of employment);
- Loss of HMO coverage 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;
- Elimination of the coverage option a person was enrolled in, and another option is not offered in its place;
- Failing to return from an FMLA leave of absence; and
- Loss of coverage under Medicaid or the Children's Health Insurance Program (CHIP).

Unless the event giving rise to your special enrollment right is a loss of coverage under Medicaid or CHIP, you must request enrollment within 30 days after your or your dependent's(s') other coverage ends (or after the employer that sponsors that coverage stops contributing toward the coverage).

If the event giving rise to your special enrollment right is a loss of coverage under Medicaid or the CHIP, you may request enrollment under this plan 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 towards this plan, you may request enrollment under this plan within 60 days after the date Medicaid or CHIP determine that you or the dependent(s) qualify for the subsidy.

In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents. However, you must request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption.

To request special enrollment or obtain more information, contact Human Resources at 214-977-7210.

N O T E S

IMPORTANT CONTACTS

Medical
BlueCross BlueShield of Texas
(BCBSTX)
888-514-5662
www.bcbstx.com/ahbelo
Policy #: 020323

Pharmacy
Prime Therapeutics
877-357-7463
www.myprime.com

Wellness
Onsite Health Diagnostics
877-366-7483
https://my.onsitehd.com/signup.ahbelo

Dental
Delta Dental
800-521-2651
www.deltadentalins.com

MetLife DHMO
800-653-7353
www.metlife.com

Vision
Vision Service Plan
800-877-7195
www.vsp.com

Health Savings Account
Fidelity
800-835-5098
www.401k.com

Flexible Spending Accounts
TaxSaver Plan
800-328-4337
www.taxsaverplan.com

Life and AD&D
Lincoln Financial
800-423-2765
www.lincolnfinancial.com
Reference ID: AHBELO

Disability
Lincoln Financial
888-408-7300
www.mylibertyconnection.com
Reference ID: AHBELO

Employee Assistance Program
Beacon Health Options
800-435-1986
www.myachieve.com

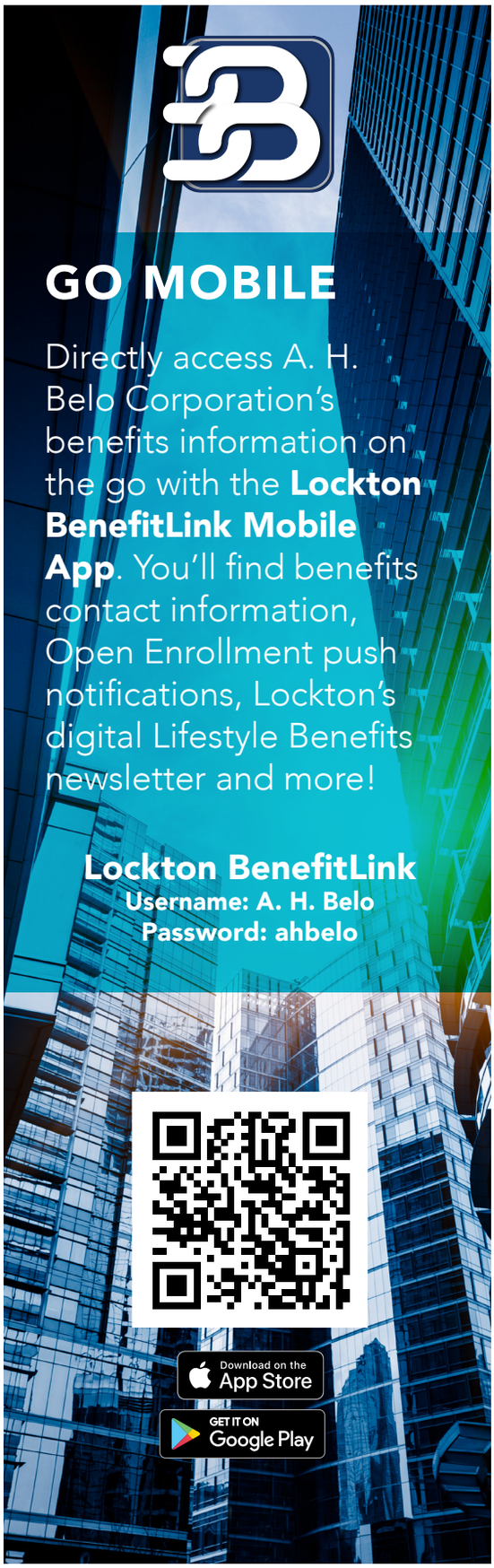
Home/Auto
MetLife
800-GET-MET8
www.metlife.com/mybenefits

Legal Assistance
MetLife
800-GET-MET8
Reference ID: AHBELO

Voluntary Critical Illness
MetLife
800-GET-MET8
www.metlife.com/mybenefits

Retirement
Fidelity Investments
800-835-5098
www.401k.com

A. H. Belo Corporation Human Resources
1954 Commerce St.
Dallas, TX 75201
214-977-7210
www.ahbelobenefits.com



A. H. Belo Corporation