A. H. Belo Corporation

YOUR 2018 CDHP MEDICAL PLAN

PLAN FEATURES	IN-NETWORK	OUT-OF-NETWORK[1]
Deductible		
Employee-only	$2,000	$4,000
Employee and dependent(s)	$4,000	$8,000
Out-of-Pocket Maximum (includes deductible)		
Employee-only	$4,000	$8,000
Employee and dependent(s)	$6,800	$13,600
Office Visits	80% after deductible	50% after deductible
Preventive Care	Covered in Full	50% after deductible
Hospital or Facility Expenses (facility expenses include such services as lab and x-ray)		
Inpatient	80% after deductible	50% after deductible
Outpatient	80% after deductible	50% after deductible
Emergency care in an emergency room	80% after deductible	Same as in-network
Urgent care	80% after deductible	50% after deductible
Mental Health and Substance Abuse		
Inpatient	80% after deductible	50% after deductible
Outpatient	80% after deductible	50% after deductible

[1] The plan payment percentage is based on Blue Cross and Blue Shield allowable amounts.

This summary is intended to serve as an overview of benefits only. Complete details of the plan are contained in the ***Plan Document & Summary Plan Description.***

Blue Cross and Blue Shield of Texas
Internet Address: www.bcbstx.com
Member Services: 1-888-514-5662

www.ahbelobenefits.com

214-977-5911 or 1-877-235-6242

NOTE: The CDHP Medical Plan meets IRS high deductible health plan requirements to allow funding to a Health Savings Account (HSA) if participant is eligible to make contributions.

YOUR 2018 CDHP PRESCRIPTION DRUG PROGRAM

PLAN FEATURES	CDHP PRESCRIPTION DRUG COVERAGE	
	In-Network	**Out-of-Network**
Out-of-Pocket Rx Maximum	Included in Medical Plan Out-of-Pocket	
Annual Rx Deductible	Included in Medical Plan Annual Deductible *Copays/Coinsurance applies after Annual Deductible unless on Preventive Drug List*	
Preventive Drugs*	See BCBSTX Preventive Drug List for Eligible Drugs **Preventive Drugs not Subject to Annual Deductible**	
Retail Per Prescription Maximum	$100 per prescription for preferred $125 per prescription for non-preferred	
Retail (up to a 30-day supply)		
Generic	$5 copay	Not Covered
Preferred Drug	25% coinsurance, minimum of $30 copay; maximum of $100	
Non-Preferred Drug	25% coinsurance, minimum of $60 copay; maximum of $125	
Specialty Drug	$150 copay	
Mail Order Per Prescription Maximum	$250 per 90-day prescription for preferred $312.50 per 90-day prescription for non-preferred	
Mail Order (up to a 90-day supply)		
Generic	$12.50 copay	Not covered
Preferred Drug	25% coinsurance, minimum of $75 copay; maximum of $250	
Non-Preferred Drug	25% coinsurance,minimum of $150 copay; maximum of $312.50	

IMPORTANT INFORMATION:

The prescription drug benefit does not cover brand-name proton pump inhibitors (PPIs). PPIs are a class of drugs used to treat conditions associated with acid reflux disease or ulcers.

If a generic equivalent drug is available and a brand name drug is dispensed, *the member pays the brand copay **plus** the difference in cost between the generic equivalent and the brand name drug. The cost difference does not count towards deductible or out of pocket maximum.*

The Performance Drug List applies to this plan.

Prior Authorizations and Step Therapy are required for certain medications.

Compound drugs are not covered for participants over the age of 13.

Specialty drugs must be purchased through Prime Therapeutics Specialty Pharmacy.

Prime Therapeutics
Internet Address: www.myrxhealth.com or link via www.bcbstx.com
Customer Service: 877-357-7463

*This summary is intended to serve only as an overview of your medical and prescription drug benefits. Complete details are contained in the medical **Plan Document & Summary Plan Description.***

www.ahbelobenefits.com

214-977-5911 or 877-235-6242