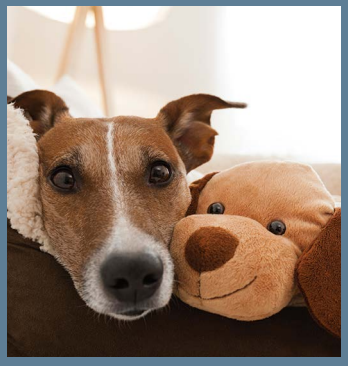
2017 EMPLOYEE BENEFITS



A. H. Belo Corporation

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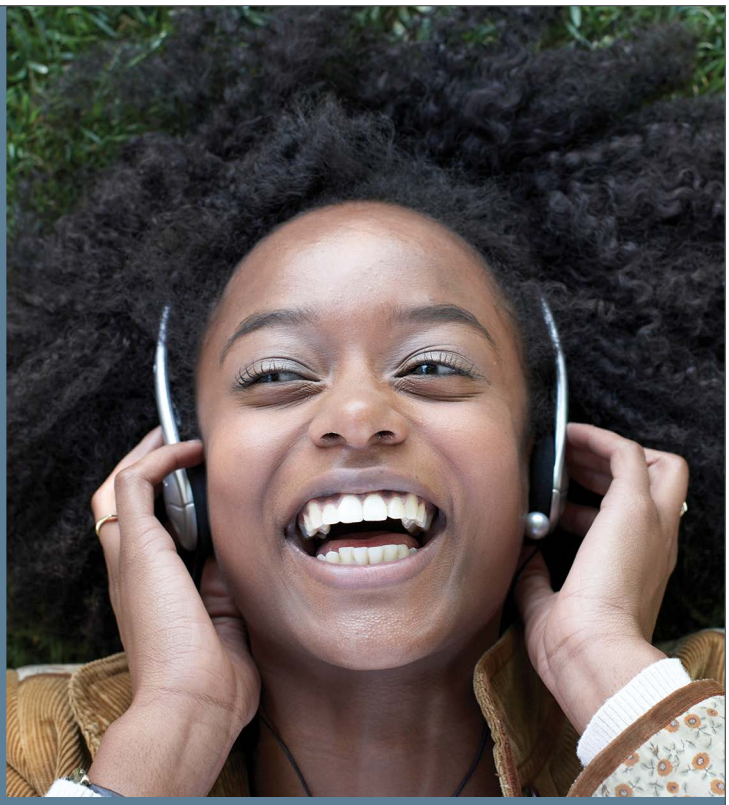
See **page 30** for important information concerning Medicare Part D coverage.

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.

WELCOME

At A. H. Belo Corporation, we are committed to your health and well-being. We are proud to provide you and your family with valuable and significant benefits. This Guide is an overview of the benefits available to you and their impact on your compensation as a whole. Please read it carefully in order to make the best choices for you and your family in the 2017 Plan Year.

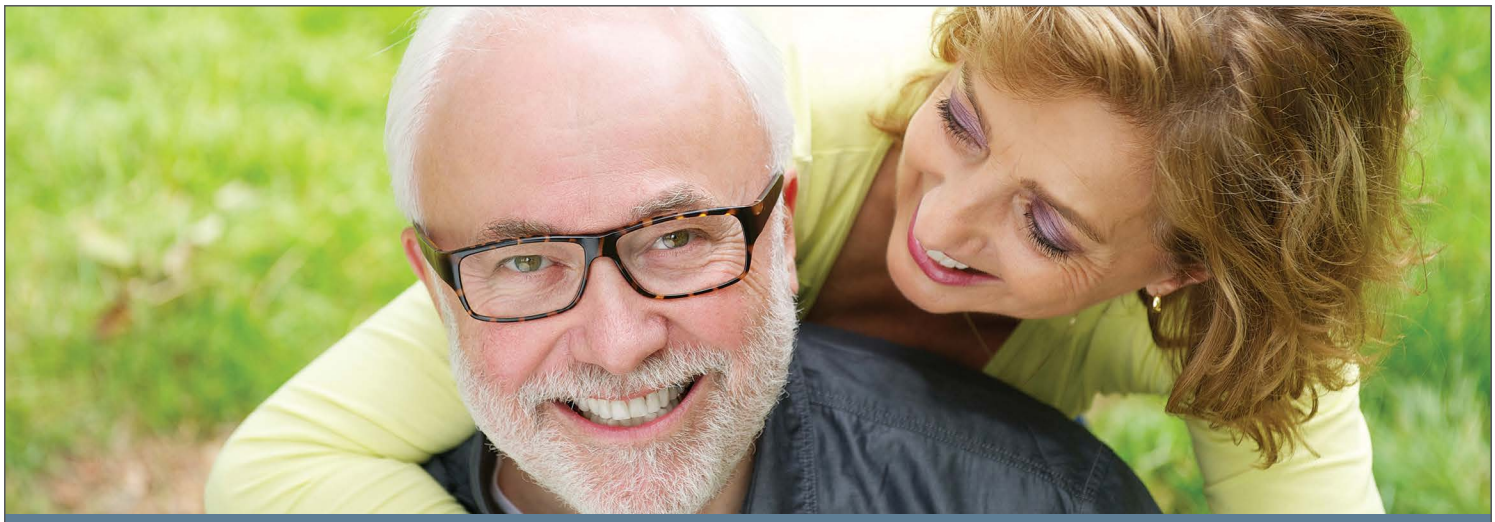


Have a Smartphone?

This Benefit Guide is equipped with mobile-friendly barcodes. These barcodes are more commonly referred to as "Quick Response" codes, or QR codes. Scanning these codes will take you to a separate site on your phone, allowing you to see new content. They might show you a website, video or article. They can take you anywhere — you just have to scan them first.

So How Do I Scan Them?

First, you'll need one of the many free QR Reader Apps available for smartphones or tablets. After the download, just open your new App and follow the directions to scan the QR code. The App will read it and immediately take you to that code's content.



ELIGIBILITY & ENROLLMENT

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. 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 regular, full-time employee of A. H. Belo Corporation who is regularly scheduled to work at least 30 hours per week, you are eligible to participate in the Medical, Dental, Vision, Life and Disability Plans, along with the Flexible Spending Accounts (FSAs) and additional benefits.

When Does Coverage Begin?

The elections you make during Annual Enrollment are effective January 1, 2017. 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 2017 Plan Year, you won't be able change your benefits until the next enrollment period unless you experience a Qualifying Life Event.

CURIOUS ABOUT

Qualifying Life Events and how they may affect your coverage?

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 covrerage 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.

TIP

You CANNOT change your benefit selections during the Plan Year unless you have a Qualifying Life Event, such as the birth or adoption of a child.

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 with no surcharge 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 Annual 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 coverage
- Entitlement to Medicare or Medicaid
- Eligibility for coverage through the Marketplace
- Change in your address or location that may affect the coverage for which you are eligible

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 employee 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. You have the option to select coverage from the following categories:

- Employee Only
- Employee + Spouse
- Employee + Child(ren)
- Employee + Family

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.

WELLNESS

From time to time, we all need a little extra advice from a health professional or a gentle nudge toward wellness. 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.

We realize the daily demands of life and work can make it hard to live a healthy lifestyle. Sometimes knowledge is half the battle – if you know your personal health risks you can make changes to improve your health. If each of us improves our health – or reduces our risk – we all win by having improved long-term health as well as lower claim costs.

The wellness surcharge for 2017 will remain $100 per month for both employees and covered spouses who don't meet the requirements outlined below. A. H. Belo conveniently offers screenings onsite through Onsite Health Diagnostics as well as a lab screening through LabCorp. Please see the Biometric Screening FAQ's for more information.

To avoid the wellness surcharge in 2017, employees and spouses covered under the Company's medical plan prior to October 1, 2016, 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 September 30, 2016
- Pass three of the five outlined risk factors* or
- Show an improvement of at least 10% from a 2015 measure for that measure to be given passing credit* (Onsite Diagnostic Health will calculate the 10% improvement measurement)

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

*If it is unreasonable for you 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 877-235-6242 for details.

Did you know?

A person with three or more risk factors is twice as likely to develop heart disease and five times more likely to develop diabetes, compared to a person with fewer risks. Each added risk factor takes years off your life.

TIP

90% of lung cancer cases are linked to smoking. Visit www.smokefree.gov to learn how to kick the habit for good.

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 affordable prescription medication. Medical benefits are offered through BlueCross BlueShield of Texas (BCBSTX). Please keep in mind that the coverage you elect will be in place for all of the 2017 Plan Year, unless you have a Qualifying Life Event.

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.

SALARY BAND	<$50K	>$50K UP TO $75K	>$75K UP TO $100K	> $100K
MONTHLY CONTRIBUTIONS				
EMPLOYEE ONLY	$76.57	$92.57	$108.62	$137.24
EMPLOYEE + SPOUSE	$286.89	$342.43	$375.64	$427.74
EMPLOYEE + CHILD(REN)	$213.24	$256.63	$282.46	$323.45
EMPLOYEE + FAMILY	$404.73	$479.71	$524.73	$594.62

Blue Access for Members

BCBSTX offers many online tools and resources, which you can access anytime, anywhere. Visit bcbstx.com/ahbelo and create your personal profile by clicking "Register Now", then use information on your BCBSTX ID card to complete the registration process.

While several tools are available on the public site, you will find more personalized tools through Blue Access for Members (BAM). With BAM, you can review your benefits, check the status or history of a claim, view or print Explanation of Benefits statements, locate a doctor or hospital in the network, request a new ID card or print a temporary one.

Text BCBSTXAPP to 33633 to get the BCBSTX app that lets you use BAM while your on the go.

Medical Plan Summary

The chart below gives a summary of the 2017 Medical coverage provided by BlueCross BlueShield of Texas (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 BCBSTX allowable charges.

	BCBSTX PLAN	
	IN-NETWORK	OUT-OF-NETWORK**
ANNUAL DEDUCTIBLE		
INDIVIDUAL	$2,000	$4,000
FAMILY	$4,000	$8,000
COINSURANCE (PLAN PAYS)	80%*	50%*
ANNUAL OUT-OF-POCKET MAXIMUM (INCLUDES DEDUCTIBLE)		
INDIVIDUAL	$4,000	$8,000
FAMILY	$6,800	$13,600
LIFETIME MAXIMUM	Unlimited	
WHAT THE PLAN PAYS		
OUTPATIENT SERVICES	80%*	50%*
SPECIALIST SERVICES	80%*	50%*
PREVENTIVE CARE	Covered in Full	50%*
URGENT CARE	80%*	50%*
EMERGENCY ROOM	80%*	80%*

*After Deductible

** The Plan payment percentage is based on Blue Cross and Blue Shield of Texas allowable amounts.

Each covered individual is not required to meet the individual deductible. The CDHP has 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 look a lot like the urgent care centers you are likely used to, 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 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're needing 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.

BENEFITS VALUE ADVISOR

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. Now 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

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.

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.

Prescription Drug Coverage for Medical Plans

Our Prescription Drug Program is coordinated through Prime Therapeutics.

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.myprime.com or by calling 877-357-7463.

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 Drugs (Prime Specialty).

	CDHP PRESCRIPTION DRUG COVERAGE	
ANNUAL RX DEDUCTIBLE	Included in Medical Plan Annual Deductible	
OUT-OF-POCKET RX MAXIMUM	Included in Medical Plan Out-of-Pocket	
PREVENTIVE DRUGS*	Deductible Waived; Applicable Copayment Applies (see below)	
	IN-NETWORK	OUT-OF-NETWORK
RETAIL RX (30-DAY SUPPLY) — AFTER DEDUCTIBLE		
GENERIC	$5 Copay	Not Covered
PREFERRED	25% Coinsurance, Minimum of $30 Copay; Maximum of $100	Not Covered
NON-PREFERRED	25% Coinsurance, Minimum of $60 Copay; Maximum of $125	Not Covered
SPECIALTY DRUGS (PRIME SPECIALTY)	Not Covered	Not Covered
MAIL ORDER RX (90-DAY SUPPLY) — AFTER DEDUCTIBLE		
GENERIC	$12.50 Copay	Not Covered
PREFERRED	25% Coinsurance; Minimum of $75 Copay; Maximum of $250	Not Covered
NON-PREFERRED	25% Coinsurance; Minimum of $150 Copay; Maximum of $312.50	Not Covered
SPECIALTY DRUGS (PRIME SPECIALTY)	$375 Copay	Not Covered

* For a list of preventive drugs, visit www.bcbstx.com/ahbelo. Click on "Coverage" tab. The Preventive Drug Benefit Program list is available under the CDHP section.

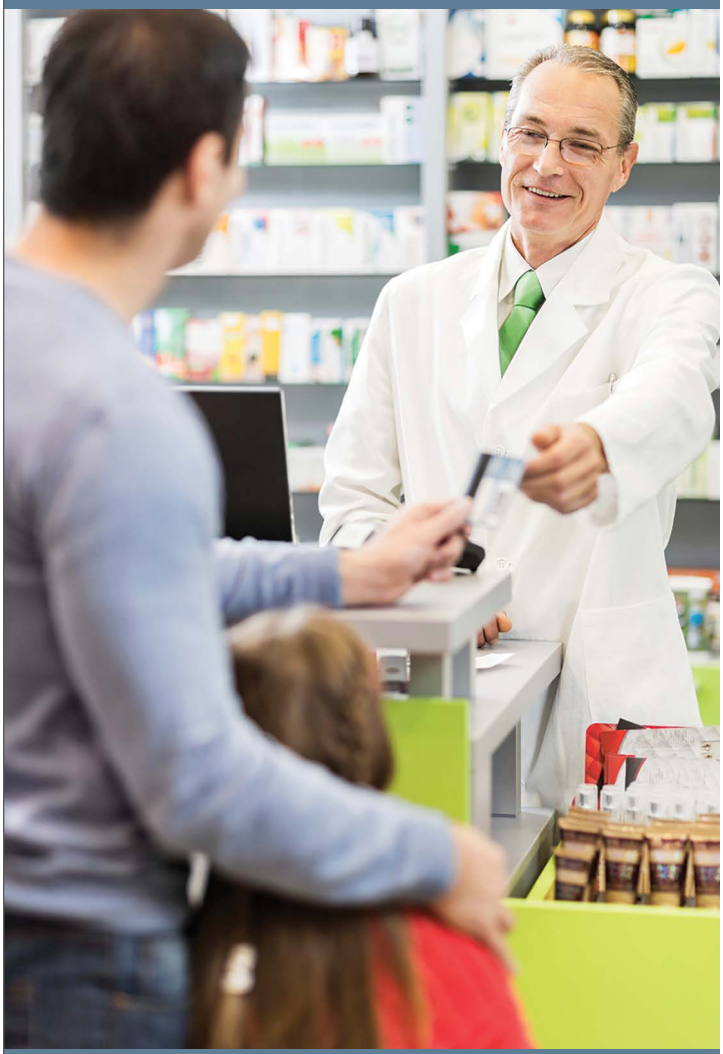
Important Information

To better manage increasing prescription costs, the following programs we have implemented the following programs:

- Generics: If a generic drug is available and a brand-name drug is dispensed, you will be responsible for the brand copay plus the difference in cost between the generic and the brand-name drug.
- Generics Plus Formulary: This program reclassifies many current Preferred Brands to Non-Preferred Brands (Tier 3) if there is a generic alternative for that drug. A table of impacted drugs is available at www.bcbstx.com/ahbelo. You may still purchase these medications, but because they are no longer on the formulary, your out-of-pocket cost may increase.
- Brand Proton Pump Inhibitors (PPI's): 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. Brand-name PPIs include Aciphex®, Dexilant®, Kapidex®, Nexium®, Prevacid®, Prevacid® Solutab, Prilosec®, Protonix®, and Zegerid®.
- Specialty Drugs: Specialty drugs continue to be the fastest growing prescription category with costs far surpassing traditional prescriptions. To better manage these costs, all specialty drugs must be dispensed through Prime Specialty Pharmacy. You will have access to a pharmacist for urgent medication issues; information about managing potential medication side effects, as well as education materials about your condition To start using Prime Specialty Pharmacy, you or your physician can call 877-627-MEDS (6337).

- Prior Authorization (PA): A Prior Authorization will be required for certain high-cost drugs and those that have the potential for misuse. If your medicine(s) is part of the PA program, your doctor will need to submit a request for coverage. This request must be approved before you can continue to receive coverage for that drug.
- Compound Exclusion: Compound drugs are not covered for health plan participants over 13 years of age. An appeal process is available; however, approvals will be based on medical efficacy of the medication, not patient preference.

More information about each of these programs, as well as related lists are available at www.bcbstx.com/ahbelo or www.ahbelobenefits.com. Additional specialty drug information can be found at www.primetherapeutics.com/specialty.



Q&A: GENERIC DRUGS

What is a generic drug?

When a new FDA-approved drug goes on the market, it may have patent or exclusivity protection that enables the manufacturer to sell the drug exclusively for a period of time. When those expire or no longer serve as a barrier to approval, other companies can make it in generic form.

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. The FDA requires generic drugs have the same high quality, strength, purity and stability as brand-name drugs.

Are generic drugs as safe as brand-name drugs?

Yes. The FDA must approve the generic drug before it can be marketed.

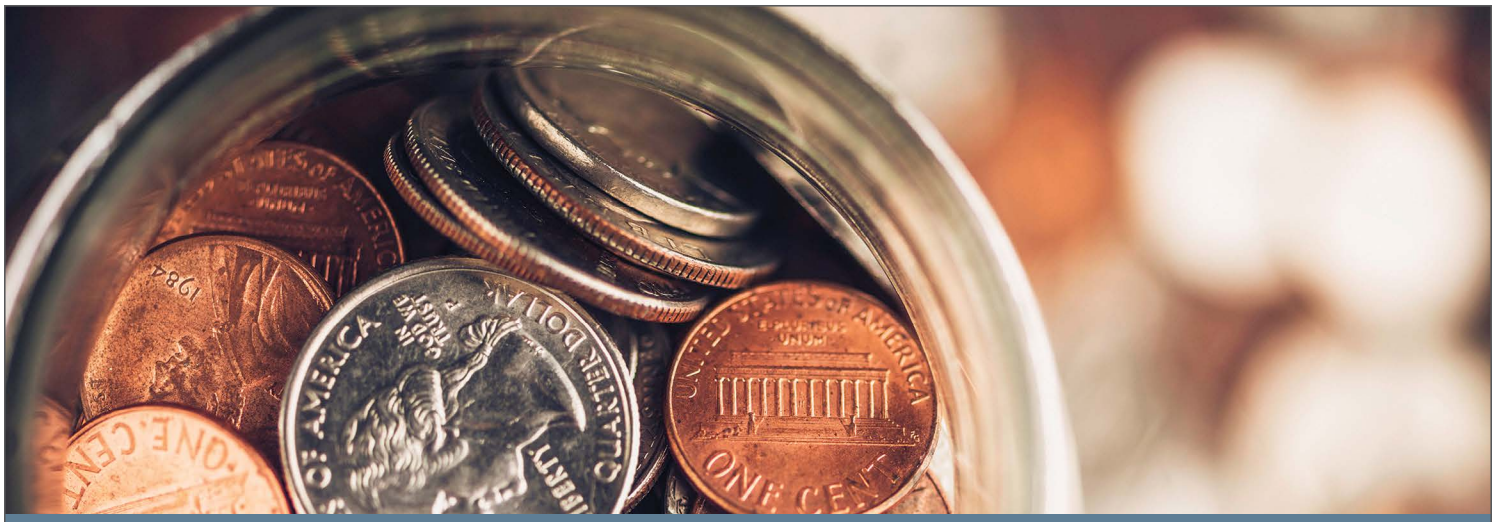
Are generic drugs that much cheaper than brand-name medications?

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.

NEED ADDITIONAL GENERIC DRUG FACTS?



HEALTH SAVINGS ACCOUNT

Take charge of your health care spending with a Health Savings Account (HSA). Contributions to an HSA are tax free, and no matter what, the money in the account is yours. Use it to pay for eligible health care expenses when you are enrolled in a qualified Consumer-Driven Health Plan (CDHP).

Health Savings Accounts (HSAs) will be available for all employees enrolled in the CDHP who are eligible to contribute to an HSA. An HSA is a personal health care bank account that you can use to pay out-of-pocket health care expenses with pre-tax dollars. You will own and administer your account, and there are no "use it or lose it" restrictions, like with Flexible Spending Accounts (FSAs). HSAs allow you to save and "roll over" money if you do not spend it in the Calendar Year. These are individual accounts. If you change health plans or jobs, the money in the account is yours to keep.

You are eligible to open and fund an HSA if:

- You are covered by an HSA-eligible High Deductible Health Plan (HDHP) or CDHP.
- You are not covered by your spouse's health plan that is not an HSA qualified High Deductible Health Plan, Health Care Flexible Spending Account or Health Reimbursement Account (HRA).
- You are not eligible to be claimed as a dependent on someone else's tax return.
- You are not enrolled in Medicare, Medicaid or TRICARE.
- You have not received Department of Veterans Affairs Medical benefits in the past 90 days.

Key features of the HSA:

- HSAs will be opened with Fidelity.
- You may contribute to the account through pre-tax payroll deductions.
- Funds withdrawn from your HSA to pay qualified medical expenses are tax free.
- Your HSA balance grows with tax-free interest.
- Any unused funds in your HSA roll over from year to year.
- Your HSA is portable; if you leave A. H. Belo or retire, you take the account and its balance with you.
- There are no vesting requirements or forfeiture provisions.

Opening An HSA

Once you enroll in the CDHP Medical Plan, you must open your HSA. An HSA is a real bank account that you own. Note: Enrolling in the CDHP does not automatically provide the HSA. You must open it to fund it, and it must be opened prior to incurring medical expenses you wish to use it for.

You can open your new HSA online:

- Log on to Fidelity NetBenefits at www.401k.com.
- Click on the HSA "open" link.

Your HSA can be used for your qualified expenses and those of your spouse and dependents, even if they are not covered by the CDHP. Once you open your HSA bank account, Fidelity will issue you a debit card, giving you direct access to your account balance. Any time you have a qualified medical expense, you may use your debit card to pay. You must have funds available in your HSA to use your debit card. There are no receipts to submit for reimbursement. Keep receipts to validate expenses if audited.

Using Your HSA to Pay Medical Expenses

You may use your Health Savings Account to pay for qualified medical expenses, such as doctors' office visits, hospital care and prescription drugs. You may also use it to pay for dental care, vision care and over-the-counter medication if you have a doctor's prescription. HSA funds can be used for medical expenses that you, your spouse and/or dependent(s) incur, even if your spouse and/or dependent(s) are not covered under your CDHP. You may also use your HSA funds to pay for health insurance premiums while you are unemployed, long-term care insurance premiums and, once you reach age 65, Medicare premiums.

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. The HSA will be established with Fidelity. You must log into www.401k.com to open your HSA.

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 health care expenses, they are spent tax-free.

HSA Funding Limits

Each year, the IRS places a limit on the maximum amount that can be contributed to HSA accounts. For 2017, contributions (which include any employer contribution) are limited to the following:

HSA FUNDING LIMITS	
EMPLOYEE ONLY	$3,400
EMPLOYEE + FAMILY	$6,750
CATCH-UP CONTRIBUTION (AGES 55+)	$1,000

A. H. Belo will provide an HSA employer contribution for eligible employees. 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.

SALARY BAND	< $50K	$50K TO <$75K	$75K TO <$100K	$100K+
EMPLOYER HSA CONTRIBUTION				
EMPLOYEE ONLY	$650	$575	$500	$0
EMPLOYEE + FAMILY	$1,300	$1,150	$1,000	$0

We encourage you to contribute funds to your HSA to take advantage of this unique tax-advantaged account. You may be able to roll over funds from another HSA. Contact A. H. Belo Benefits or visit www.401k.com for more information.

DENTAL BENEFITS

Routine preventive care such as regular Dental checkups can help lower your risk of stroke and heart disease. 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, vsist 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.

	DELTA DENTAL PPO	METLIFE DHMO
MONTHLY CONTRIBUTIONS		
EMPLOYEE ONLY	$23.26	$7.92
EMPLOYEE + SPOUSE	$47.89	$15.06
EMPLOYEE + CHILD(REN)	$47.32	$15.86
EMPLOYEE + FAMILY	$73.04	$24.58

BRUSH UP
ON CARING FOR YOUR TEETH.

Dental Plan Summary

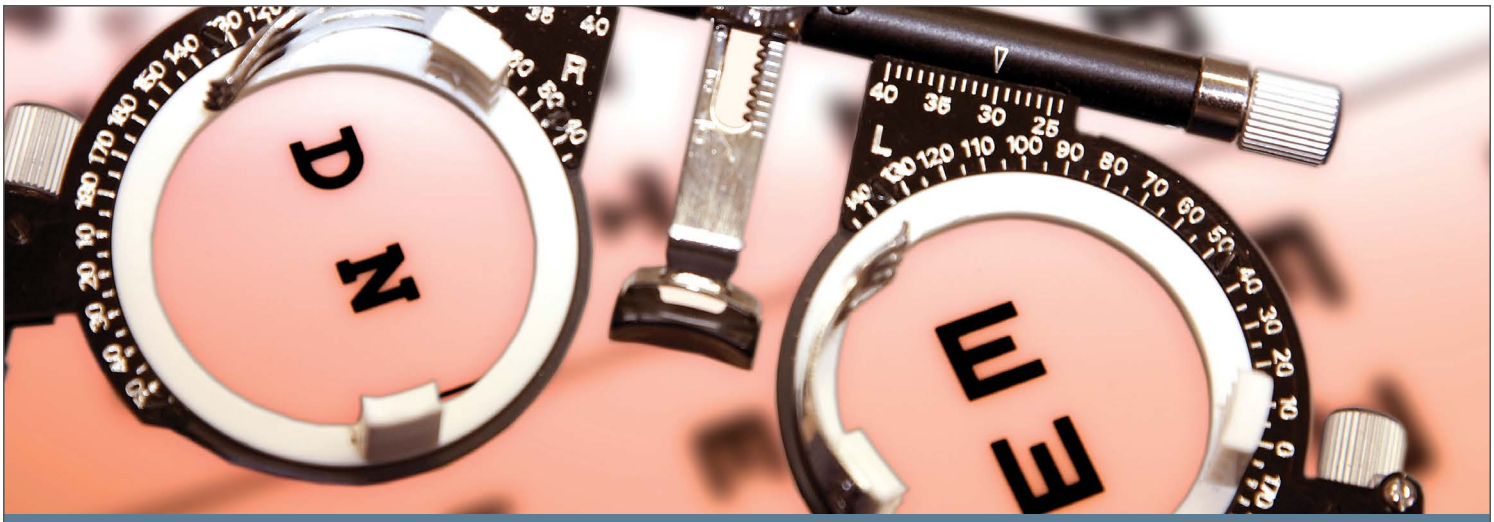
Dental Plan benefits are available to you on a voluntary basis. The chart below gives a summary of the 2017 Dental coverage provided by Delta Dental and Metlife. All out-of-network services are subject to Reasonable and Customary (R&C) limitations.

	DELTA DENTAL PPO	METLIFE DHMO**
	DELTA DENTAL PPO ALL SERVICES*	METLIFE DHMO IN-NETWORK ONLY
ANNUAL DEDUCTIBLE		
INDIVIDUAL	$50	No Deductible
FAMILY	$150	
ANNUAL MAXIMUM		
PER PERSON	$1,700	No Maximum
COVERED SERVICES		
PREVENTIVE SERVICES Oral Exams, Routine Cleanings, Bitewing X-rays, Full Mouth X-rays, Fluoride Applications, Sealants, Space Maintainers, Panoramic X-rays	100%	See Schedule of Benefits
BASIC SERVICES Fillings, Oral Surgery, Simple Extractions, Complex Extractions, Denture Adjustments and Repairs, Root Canal Therapy, Periodontics	80%	See Schedule of Benefits
MAJOR SERVICES Crowns, Dentures, Bridges	50%	See Schedule of Benefits
ORTHODONTICS Dependent Child(ren) Only	50%	See Schedule of Benefits
ORTHODONTIC LIFETIME MAXIMUM	$1,500	

* 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.

TIP

Flossing isn't fun, but it can go a long way toward preventing gum disease.



VISION BENEFITS

If you wear glasses or contacts, chances are you already have a steady appointment with an eye doctor. But 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.

	VSP SIGNATURE
MONTHLY CONTRIBUTIONS	
EMPLOYEE ONLY	$13.94
EMPLOYEE + SPOUSE	$29.30
EMPLOYEE + CHILD(REN)	$29.30
EMPLOYEE + FAMILY	$29.30

SET YOUR

EYES ON A FEW WAYS TO MAINTAIN YOUR VISION.

Vision Plan Summary

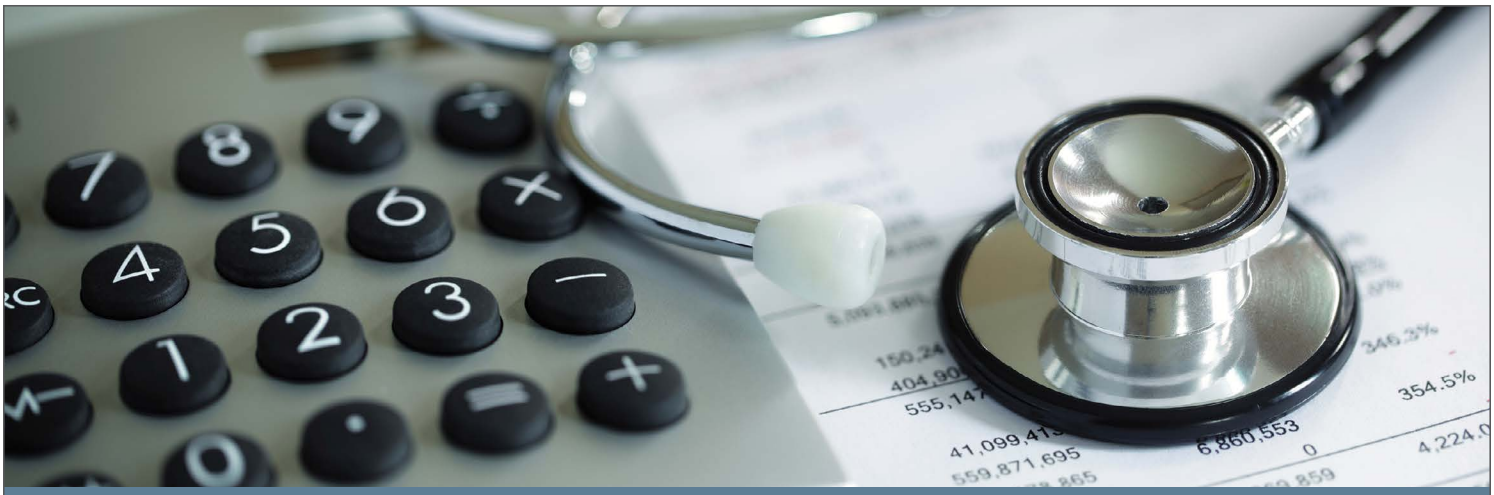
Vision Plan benefits are available to you on a voluntary basis. The chart below gives a summary of the 2017 Vision coverage provided by Vision Service Plan. All out-of-network services are subject to Reasonable and Customary (R&C) limitations. In-network copayments are paid directly to the provider. Out-of-network services will be reimbursed up to the scheduled amounts below.

BENEFIT	DESCRIPTION	COPAY	FREQUENCY
YOUR COVERAGE WITH A VSP SIGNATURE NETWORK DOCTOR			
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 age0related 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



FLEXIBLE SPENDING ACCOUNT

Flexible Spending Accounts (FSAs) allow you to set aside pre-tax payroll deductions to pay for out-of-pocket health care expenses such as deductibles, copays and coinsurance, as well as dependent care expenses.

Regular Purpose Flexible Spending Account

You can contribute up to $2,550 for qualified medical, dental and vision expenses 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, allowing you to avoid waiting for reimbursement. You cannot enroll in a Regular Purpose FSA 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 Purpose Flexible Spending Account

Designed to complement a Health Savings Account, a Limited Purpose Flexible Spending Account (LPFSA) 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 $2,550 in the LPFSA.

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.

LEARN

MORE ABOUT FSA LIMITS, GRACE PERIODS AND ROLLOVERS.

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

Once you incur an eligible expense, submit a claim form along with the required documentation. Remember that for the Limited Purpose FSA, you may only use the card for dental and vision expenses. Claim forms are available on www.ahbelobenefits.com or from the TaxSaver website at www.taxsaverplan.com. Claims must be postmarked by April 30, 2018, to be eligible for reimbursement.

You will be issued a Flex Debit Card for the Regular Purpose and Limited Purpose FSAs. You may use your FSA debit card at locations such as doctor and dentist offices, pharmacies and vision service providers; however, remember that you may only use the Limited Purpose FSA for dental and vision expenses. You will sometimes be required to submit a receipt to TaxSaver as documentation of the expense. You will be notified by mail or email if a receipt is required. You should always retain a receipt for your records.

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 2017 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.

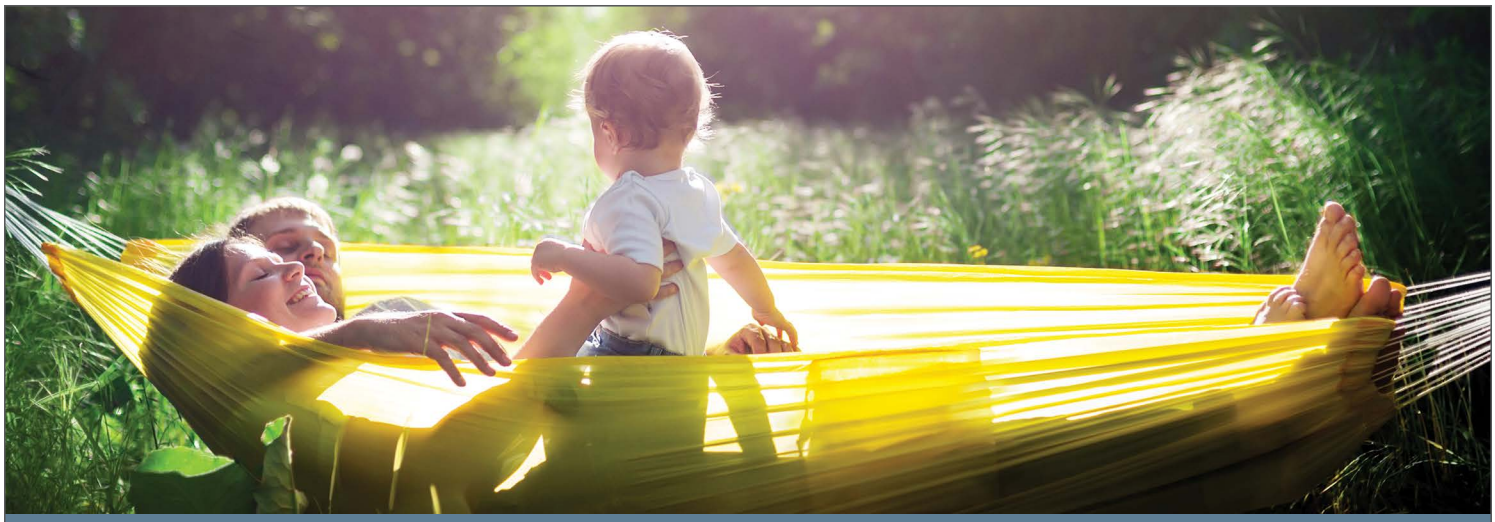
While FSA debit cards allow you to pay for services at point of sale, they do not remove the IRS regulations for substantiation. This means that you must always keep receipts and Explanation of Benefits (EOBs) for any debit card charges. Failure to provide proof that an expense was valid can result in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

2½-Month Grace Period

- FSA participants have an additional 2½-month grace period of time to incur expenses after the Plan Year ends (December 31, 2017).
- If an expense is incurred between December 31, 2017, and March 15, 2018, AND submitted for reimbursement on or before April 30, 2018, any remaining balance in the previous Plan Year that ended December 31, 2017, will be paid out from the claim, even though the service was provided in the NEW Plan Year.
- The 2½-month grace period applies to both the Dependent Care and Health Care FSAs.

TIP

You cannot use FSA funds to pay for insurance premiums.



SURVIVOR BENEFITS

Discussing what might happen to your family if you were not around to provide for them isn't always the easiest conversation, but it is necessary. Survivor benefits provide financial assistance in an absence and can help you plan for the unexpected. If you have Life insurance now, chances are you can take comfort in knowing that those who depend on you will be provided for.

Basic Life

Life benefits are essential to the financial security of you and your family. As such, it is important to understand how your Plan works and what benefits you will receive.

Basic Life 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 Basic Life insurance even if you elect to waive other coverage.

NEED HELP
CHOOSING THE RIGHT LIFE INSURANCE PLAN?

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. Benefits payable for a dependent's death under the Lincoln Financial insurance are payable to you.

You will be asked to provide a beneficiary during the enrollment process in WorkDay. Be sure to confirm your beneficiary designation if you experience a life event, and during annual enrollment.

It is important that your beneficiary designation is clear so there is no question as to your intentions. It is also important that you 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 you name more than one beneficiary with unequal shares, please show the amount of insurance to be paid to each beneficiary in percentages.

For example:

PRIMARY	CONTINGENT
Mary J. Doe, Wife (34%) Jane Doe, Daughter (33%) John Doe, Son (33%)	**Joseph W. Doe, Son (50%) Jane Doe, Daughter (50%) OR Estate of the Insured (100%)**

Life and AD&D Insurance

Eligible employees may purchase Supplemental Life and Voluntary AD&D (PAI) Insurance for themselves and their families. Premiums are paid through post-tax 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.

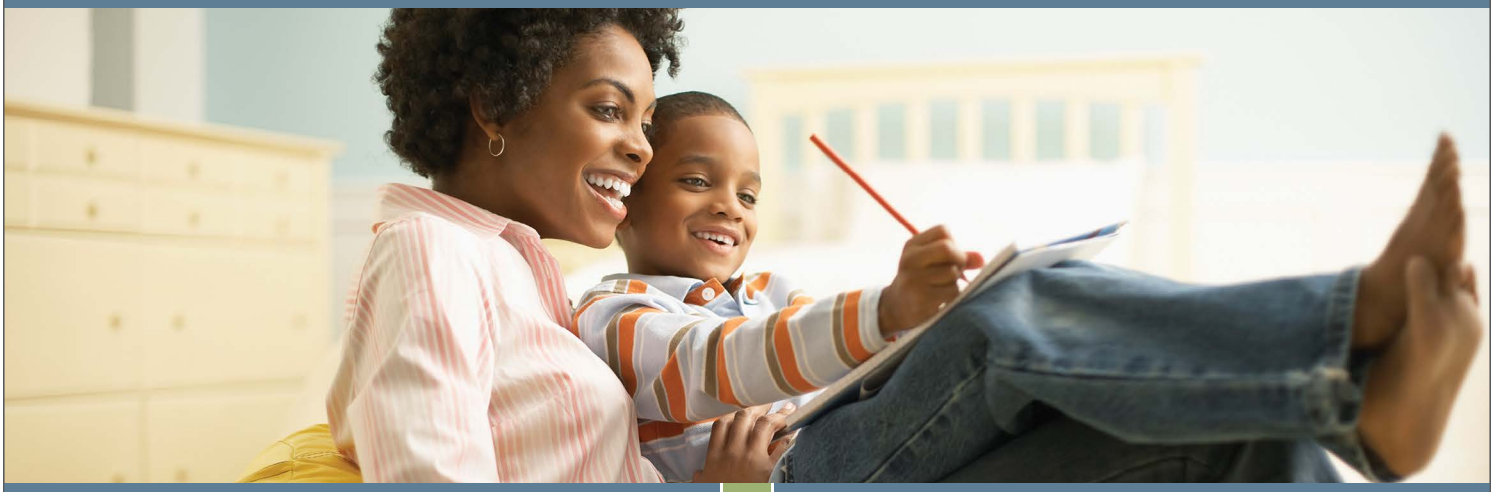
SUPPLEMENTAL DEPENDENT LIFE			
COVERAGE AMOUNT FAMILY MEMBER	**OPTION 1**	**OPTION 2**	**OPTION 3**
Spouse	$10,000	$5,000	$20,000
Each unmarried child 14 days to age 26	$5,000	$2,500	$10,000
Each child from 24 hours to 13 days old	$1,000	$500	$3,000
WHO PAYS	You pay. This coverage is available on a voluntary 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 (AS OF 10/1/15)	EMPLOYEE
Less than 30	$0.06
30–34	$0.09
35–39	$0.10
40–44	$0.19
45–49	$0.24
50–54	$0.53
55–59	$0.66
60–64	$1.00
65–69	$1.43
70+	$2.21

SUPPLEMENTAL DEPENDENT LIFE	
RATES (MONTHLY)	
Option 1	$2.40
Option 2	$1.20
Option 3	$4.80

SUPPLEMENTAL AD&D	
RATES/$1,000 (MONTHLY)	
Employee Only	$0.027
Employee + Family	$0.045



INCOME PROTECTION

A. H. Belo provides Short Term Disability (STD) and Long Term Disability (LTD) coverage to keep a portion of your paycheck coming if you can't work due to a serious illness or injury. You are eligible for Short Term Disability (STD) and Long Term Disability (LTD) if you are a regular full-time employee and have satisfied your waiting period. Part-time and temporary employees are not eligible for benefits.

Short Term Disability (STD)

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

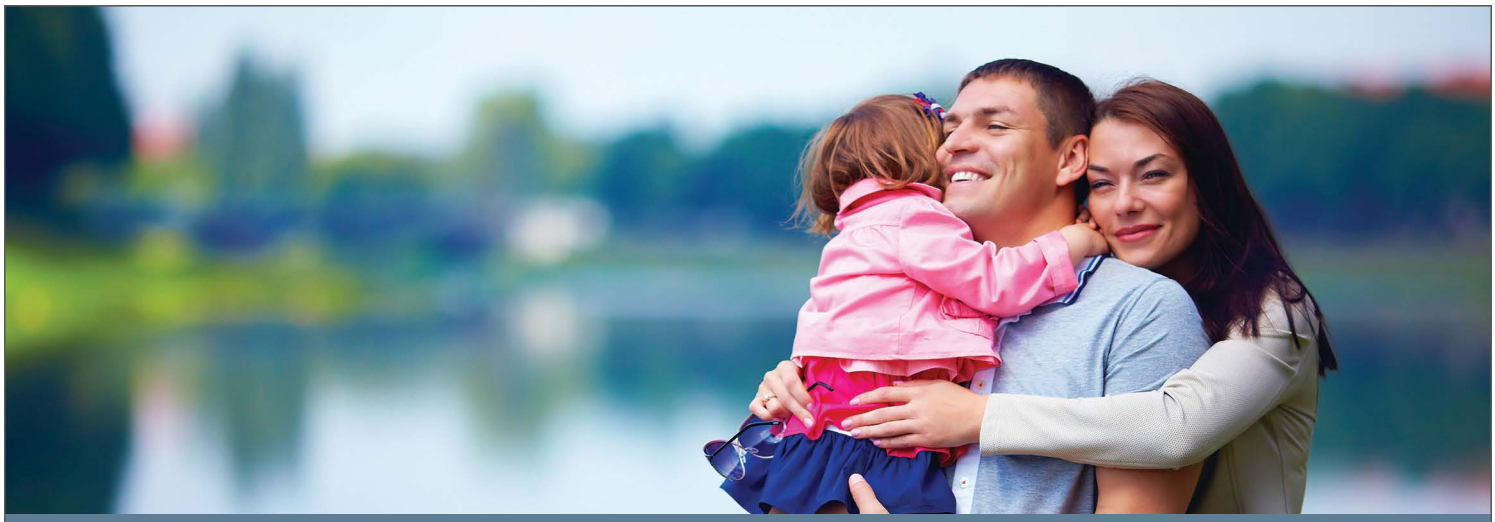
Time off for a lengthy illness is recorded and paid by a combination of using PTO and Short Term Disability (STD). Employees will be required to use PTO for the first 40 hours of an extended illness. Short Term Disability will then provide for salary continuation for the 2nd through the 26th week of 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 Liberty Mutual. STD will be paid in accordance with the schedule below.

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 Liberty Mutual.

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 additional benefits to help you manage your life.

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 have partnered with Beacon Health* to provide an Employee Assistance Program (EAP) at no cost to you.

This service connects you with the best mental health and counseling services. 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.

* Formerly ValueOptions EAP

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 (including classic and antique cars), 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

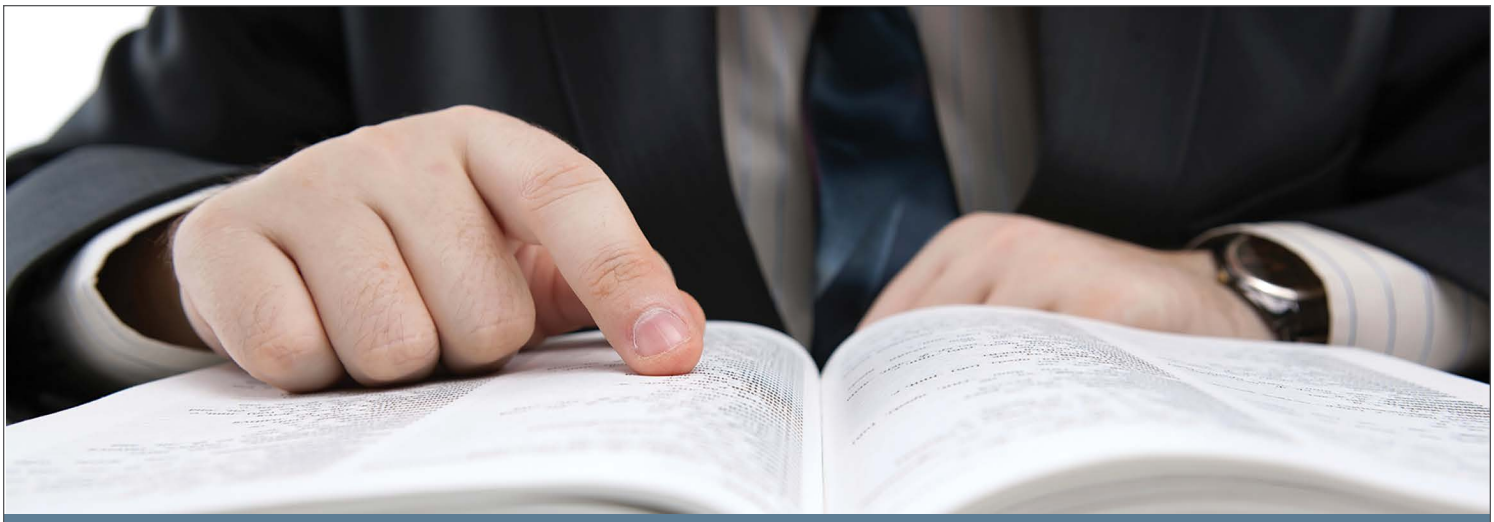
As a A. H. Belo Corporation employee, you may sign up for a discounted Legal Services Plan through MetLife Hyatt Legal. Telephone and in-person legal consultations are available. Your coverage is portable, so you can continue to take advantage of low rates even if you leave A. H. Belo Corporation. You must sign up within 60 days of your hire date. 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.



GLOSSARY

Allowable Amount – The amount your insurance company will allow for a Medical service in a geographic region based on what providers in the area usually charge for the same or similar Medical service.

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) – 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, there are no copays, 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 monthly 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.

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.

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.

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 typically 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 Drugs (Prime 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 copays.
- **Specialty Drugs (Prime 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

N O T E S

Required Notices

Important Notice from A. H. Belo Corporation About Your Prescription Drug Coverage and Medicare under the BCBSTX 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 Corporation 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 Corporation has determined that the prescription drug coverage offered by the BCBSTX 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 Corporation 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 Corporation 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 Corporation 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 Corporation 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, 2017
Name of Entity/Sender:	A. H. Belo Corporation
Contact—Position/Office:	Human Resources
Address:	508 Young St. Dallas, TX 75202
Phone Number:	877-235-6242

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 877-235-6242.

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. The Notice of Privacy Practices has been recently updated. 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 877-235-6242.

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 877-235-6242.

IMPORTANT CONTACTS

COVERAGE	CONTACT	
MEDICAL AND PHARMACY	BlueCross BlueShield of Texas (BCBSTX) 888-514-5662 www.bcbstx.com/ahbelo Prime Therapeutics 877-357-7463 www.myprime.com	
DENTAL	Delta Dental 800-521-2651 deltadentalins.com	MetLife DHMO (Safeguard) 800-653-7353 www.metlife.com
VISION	Vision Service Plan 800-877-7195 ww.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 Reference ID: AHBELO www.lincolnfinancial.com	
DISABILITY	Liberty Mutual 866-277-5276 www.mylibertyconnection.com	
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 www.legalplans.com	
VOLUNTARY CRITICAL ILLNESS	MetLife 800-GET-MET8 www.metlife.com/mybenefits	
A. H. BELO BENEFITS	A. H. Belo Corporation 508 Young St. Dallas, TX 75202 877-235-6242 www.ahbelobenefits.com	

Go Mobile!

Directly access A. H. Belo Corporation's benefits information with the **Lockton BenefitLink** Mobile App. You'll be immediately connected to provider websites and phone numbers. You can even capture and store important information like ID cards, your group numbers, doctors' names and more!

Lockton BenefitLink
Username: A. H. Belo
Password: ahbelo

Download on the App Store

GET IT ON Google play

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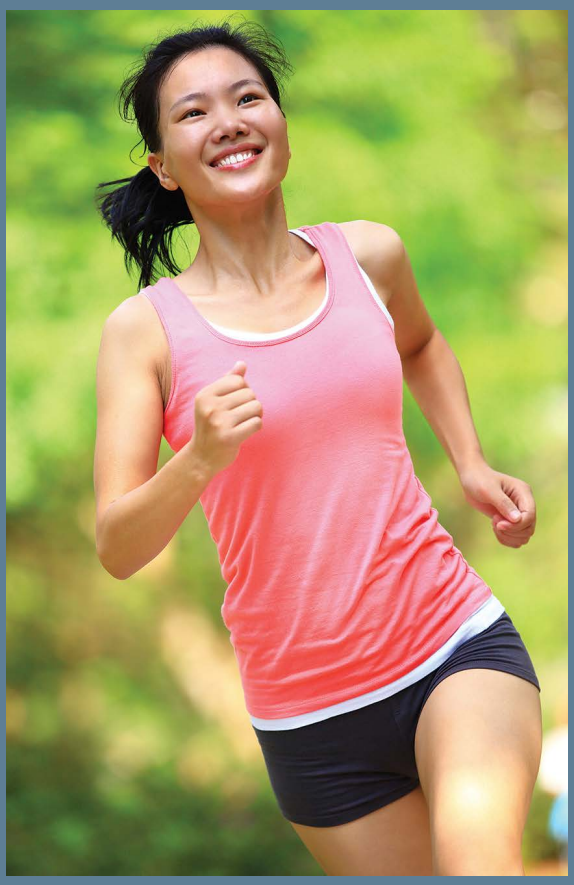

A. H. Belo Corporation