STAR TRIBUNE
MEDIA COMPANY LLC

Employee benefits

2020

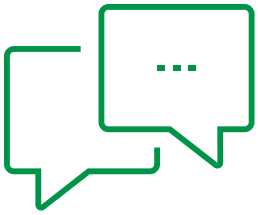
WELCOME TO **ANNUAL ENROLLMENT!**

At Star Tribune Media Company LLC we recognize our ultimate success depends on our talented and dedicated workforce. We value the contributions each and every employee makes to our accomplishments, and our goal is to provide a comprehensive program of competitive benefits to attract and retain the best employees available. Through our benefits programs, we strive to support the needs of our employees and their dependents by providing a benefit package that is easy to access and understand while remaining affordable.

Please read this guide carefully. It has a summary of your plan options and helpful tips for getting the most value from your benefits plans. We understand that you may have questions about annual enrollment, and we'll do our best to help you understand your options and guide you through the process.

If you (and/or your dependents) have Medicare or will be eligible for Medicare within the next 12 months, a federal law gives you more choices about your prescription drug coverage. Please see page 25 for more details.

Here's where to find ...



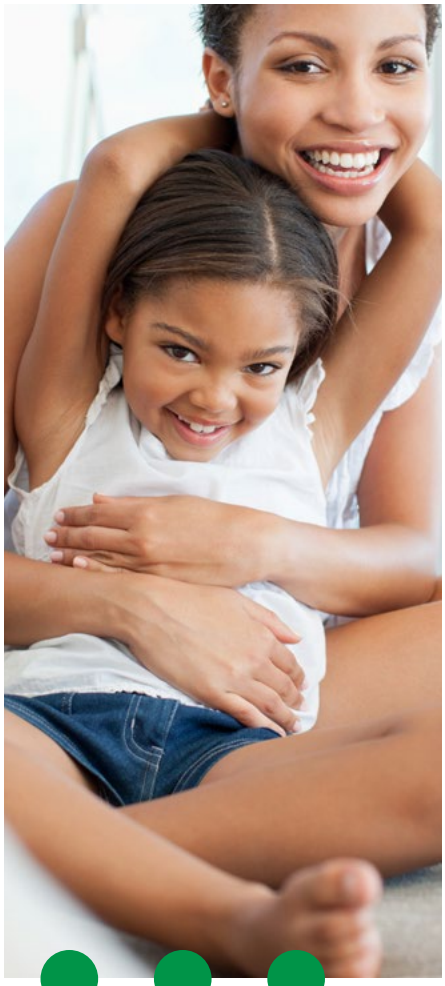
WHAT'S NEW FOR 2020

Medical

Effective January 1, 2020 there will be some changes to your benefits. The medical plan administrator will change to UMR, a UnitedHealthcare company. You may be wondering, What does that mean for you? It means that UMR will be processing your health claims, making sure they are handled quickly and accurately. UMR even has medical professionals on staff who can help coordinate care if you are in the hospital or are dealing with a chronic health condition.

We are also partnering with UMR for our Flexible Spending Account (FSA) administration effective January 1, 2020. A new debit card option will be offered allowing enrolled participants to pay for eligible medical, dental and vision expenses with the swipe of their card.

Last but not least, we are excited to offer a new wellness program administered by Wellworks for You starting in 2020. The new program will offer additional opportunities to earn incentives by completing key wellness activities. Wellworks for You will provide you with tools and resources you can use to improve and maintain your overall health and wellbeing



ELIGIBILITY

You must be regularly scheduled to work 30 or more hours per week to be eligible for medical plans and 20 or more hours per week for other benefits plans. Your Star Tribune benefits will be effective the first of the month following 28 days of employment as an eligible employee.*

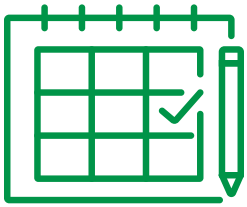
*See your bargaining unit contract for eligibility.

Dependent eligibility

You may enroll your eligible dependents in the same plans you choose for yourself. Eligible dependents on our corporate sponsored benefit plans include your legal spouse and your children up to age 26. Spouses that have other employer sponsored medical coverage available to them are not eligible to be enrolled in Star Tribune's medical plans.

Unmarried children over the age of 26 may continue to be covered if they are incapable of self-support due to a disability. Proof is required.

Please remember – the choices you make at this time will be effective through the end of the plan year (i.e., December 31), and cannot be changed unless you experience a qualifying status change.



MAKING CHANGES DURING THE YEAR

Once you are enrolled, you must wait until the next open enrollment period to change your benefits or add or remove coverage for dependents, unless you have a qualified status change as defined by the IRS.

Examples of qualified status changes include, but are not limited to, the following:

- Marriage, divorce, legal separation, or annulment.
- Birth or adoption of a child.
- Change in your residence or workplace (if your benefit options change).
- Loss of other coverage.
- Change in your dependent's eligibility status because of marriage, age, etc.
- Spouse's open enrollment that occurs at a different time of year.

The IRS mandates that changes to your coverage, due to a qualifying status change, must be made within 31 days of that status change. Proof of the qualifying status change is required (marriage certificate, divorce decree, birth certificate, loss of coverage letter, etc.). Note: Any change you make to your coverage must be consistent with the change in status.

ANNUAL OPEN ENROLLMENT

Each fall, Star Tribune hosts an open enrollment period. During open enrollment, you have the opportunity to:

- Add, change, or delete coverage.
- Add or drop dependents from coverage.
- Enroll or re-enroll in the healthcare or dependent flexible spending accounts (FSA).

All elections/changes made during open enrollment are effective January 1.

MEDICAL BENEFITS

Star Tribune is committed to helping you and your dependents maintain your health and wellness by providing you with access to the highest levels of care. We offer you a choice of two medical plan options for 2020:

- HSA Health Plan
- Preferred PPO — With Wellness or Standard PPO without Wellness

If you newly enroll in the HSA health plan, a health savings account (HSA) will be opened for you with Optum Bank. To learn more about HSAs, please see page 9.

Here are some terms you'll see in this guide:

COINSURANCE: Your share of the costs of a healthcare service, usually figured as a percentage of the amount charged for services. You start paying coinsurance after you've paid your plan's deductible. Your plan pays a certain percentage of the total bill, and you pay the remaining percentage.

COPAY: A fixed amount you pay for a specific medical service (typically an office visit) at the time you receive the service. The copay can vary depending on the type of service. Copays cannot be included as part of your annual deductible, but they do count toward your out-of-pocket maximum.

DEDUCTIBLE: The amount you pay for healthcare services before your health insurance begins to pay. For example, if your plan's deductible is $3,000, you'll pay 100 percent of eligible healthcare expenses until the bills total $3,000 for the year. After that, you share the cost with your plan by paying coinsurance.

IN-NETWORK: A group of doctors, clinics, hospitals and other healthcare providers that have an agreement with your medical plan provider. You'll pay less when you use in-network providers.

OUT-OF-NETWORK: Care received from a doctor, hospital or other provider that is not part of the medical plan agreement. You'll pay more when you use out-of-network providers.

OUT-OF-POCKET MAXIMUM: This is the most you must pay for covered services in a plan year. After you spend this amount on deductibles, copayments and coinsurance, your health plan pays 100 percent of the costs of covered benefits. However, you must pay for certain out-of-network charges above reasonable and customary amounts.

REASONABLE AND CUSTOMARY: The amount of money a health plan determines is the normal or acceptable range of charges for a specific health-related service or medical procedure. If your healthcare provider submits higher charges than what the health plan considers normal or acceptable, you may have to pay the difference.

Medical and prescription drug plan summary

Side-by-side

Medical	HSA Health Plan*		Preferred PPO		Standard PPO	
	In-network	Out-of-network	In-network	Out-of-network	In-network	Out-of-network
Deductible Employee only Family	 $2,800 $4,600	 $5,000 $10,000	 $400 $800	 $1,200 $2,400	 $800 $1,600	 $1,200 $2,400
Out-of-pocket maximum (includes deductible) Employee only Family	 $4,000 $8,000	 $8,000 $16,000	 $5,000 $10,000	 $8,000 $16,000	 $5,000 $10,000	 $8,000 $16,000
Preventive care	No charge	Not covered	No charge	Deductible, then 40% coinsurance	No charge	Deductible, then 40% coinsurance
Office visit (PCP and specialist)	Deductible, then 10% coinsurance	Deductible, then 40% coinsurance	Deductible, then 20% coinsurance	Deductible, then 40% coinsurance	Deductible, then 20% coinsurance	Deductible, then 40% coinsurance
Emergency room	Deductible, then 10% coinsurance	Deductible, then 40% coinsurance	Deductible, then 20% coinsurance	Deductible, then 40% coinsurance	Deductible, then 20% coinsurance	Deductible, then 40% coinsurance
Urgent care	Deductible, then 10% coinsurance	Deductible, then 10% coinsurance	Deductible, then 20% coinsurance	Deductible, then 20% coinsurance	Deductible, then 20% coinsurance	Deductible, then 20% coinsurance
Inpatient care	Deductible, then 10% coinsurance	Deductible, then 40% coinsurance	Deductible, then 20% coinsurance	Deductible, then 40% coinsurance	Deductible, then 20% coinsurance	Deductible, then 40% coinsurance
Outpatient care	Deductible, then 10% coinsurance	Deductible, then 40% coinsurance	Deductible, then 20% coinsurance	Deductible, then 40% coinsurance	Deductible, then 20% coinsurance	Deductible, then 40% coinsurance
Prescription drugs	**Employee pays**					
Retail (30-day supply)						
Tier 1 — generics	Deductible, then 10% coinsurance	Deductible, then 40% coinsurance	$15 copay	Deductible, then 40% coinsurance	$15 copay	Deductible, then 40% coinsurance
Tier 2 — preferred	Deductible, then 10% coinsurance	Deductible, then 40% coinsurance	$35 copay	Deductible, then 40% coinsurance	$35 copay	Deductible, then 40% coinsurance
Mail order (90-day supply)						
Tier 1 — generics	Deductible, then 10% coinsurance	Not covered	$30 copay	Not covered	$30 copay	Not covered
Tier 2 — preferred	Deductible, then 10% coinsurance	Not covered	$70 copay	Not covered	$70 copay	Not covered

Non-formulary drugs are not covered.

*Includes an employer HSA contribution depending upon your coverage level and wellness program completion. See page 10 for more information.

Monthly employee payroll contributions for medical plans

Effective Jan. 1, 2020

	HSA Health Plan	Standard and Preferred PPO
Employee	$119.18	$140.27
Employee + spouse	$238.35	$280.55
Employee + child(ren)	$228.46	$268.92
Family	$347.65	$409.20

Employees can elect the medical and prescription drug plan without enrolling in the dental plan.

HEALTH SAVINGS ACCOUNT (HSA)

An HSA is a personal healthcare bank account you can use to pay out-of-pocket medical expenses with pretax dollars. If you enroll in the HSA Health Plan offered by Star Tribune, the company will open an HSA account on your behalf to receive the company contributions. You may also opt to contribute to your account.

You own and administer your HSA. You determine how much you contribute to your account, when to use your money to pay for qualified medical expenses, and when to reimburse yourself. Remember, this is a bank account; you must have money in the account before you can spend it.

HSAs offer you the following advantages:

1. **TAX SAVINGS:** You contribute pretax dollars to the HSA. Star Tribune will also contribute to your HSA for 2020. See page 10 for employer contribution amounts. Interest accumulates tax-free, and funds are withdrawn tax-free to pay for medical expenses.
2. **REDUCED OUT-OF-POCKET COSTS:** You can use the money in your HSA to pay for eligible medical expenses and prescriptions. The HSA funds you use can help you meet your plan's annual deductible.
3. **A LONG-TERM INVESTMENT THAT STAYS WITH YOU:** Unused account dollars are yours to keep even if you retire or leave the company. You can invest your HSA funds, so your available healthcare dollars can grow over time.
4. **THE OPPORTUNITY FOR LONG-TERM SAVINGS:** Save unused HSA funds from year to year — you can use this money to reduce future out-of-pocket health expenses. You can even save HSA dollars to use after you retire.

You are eligible to open and fund an HSA if:

- You are enrolled in an HSA-eligible high-deductible health plan, such as Star Tribune's HSA Health Plan.
- You are not covered by your spouse's health plan (unless it is a qualified HDHP), flexible spending account (FSA) 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, TRICARE or TRICARE For Life.
- You have not received Veterans Administration benefits in the past three months.

How to access/make contributions to your HSA

Once your account is open, you can access it via www.optumbank.com. You'll set up your payroll contributions during open enrollment. You can make contribution changes at any time during the year by contacting benefits@startribune.com. Note that it may take between one and two payroll periods for an HSA change to be processed.

What are some HSA-eligible expenses?

- Dental services
- Lab exams/tests
- Vision services
- Medical treatments/ procedures
- Medical equipment supplies and services
- Medication with prescriptions
- Obstetric services
- Practitioners

More details about health savings accounts

The HSA is administered by Optum. Star Tribune pays the monthly administrative fee for your HSA. If your coverage status or employment status changes, you will be responsible for all HSA account holder fees.

You'll notice two separate line items on your paycheck when you participate in the HSA Health Plan — one for your employee premium contributions for the health plan and one for your pretax contributions to the HSA.

IMPORTANT! How much you can deposit into an HSA in 2020

Under age 55 (and not enrolled in Medicare):

- Up to $3,550 for individual coverage.
- Up to $7,100 for family coverage.

Age 55 or older (and not enrolled in Medicare):

- The maximum contribution increases by $1,000 (considered a "catch-up" contribution).
- Up to $4,550 for individual coverage.
- Up to $8,100 for family coverage.

- Star Tribune employer contributions count toward the annual HSA contribution limits, so you need to plan carefully how much you'll contribute annually to avoid excess contributions.

Star Tribune HSA employer contribution

Once you enroll in the HSA Health Plan, Star Tribune will open a health savings account with Optum for you. The employer contribution, in addition to the contributions you elect to make into the HSA will be deposited each pay period (the first two pay periods of each month).

2020 Star Tribune employer contributions

- Individual coverage without wellness: Star Tribune will contribute $550 annually.
- Dependent coverages without wellness: Star Tribune will contribute $1,100 annually.
- Individual coverage with wellness: Star Tribune will contribute an additional $300 or $850 annually.
- Dependent coverages with wellness: Star Tribune will contribute an additional $600 or $1,700 annually.

Optum Bank

Contact Optum Bank by calling 866.234.8913 or visiting www.optumbank.com.

UMR TOOLS

How to find a UMR provider

The UnitedHealthcare Choice Plus Network designation identifies doctors in the UMR network who have achieved top results on UMR's quality and cost-efficiency measures.

Be informed

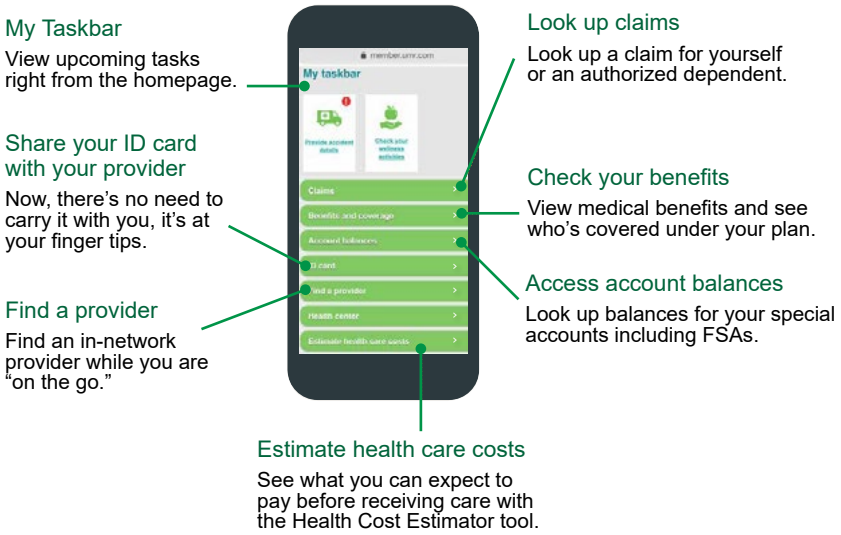
Find all of your information when you need it at www.umr.com. Call 800.826.9781 anytime, day or night, 365 days a year, for assistance.

To find one of these doctors:

- Visit www.umr.com.
- Select "Find a provider."
- Search for "United Healthcare Choice Plus Network."
- For medical providers, choose "View Providers." For behavioral health providers (including counseling and substance abuse), choose "Behavioral health directory."

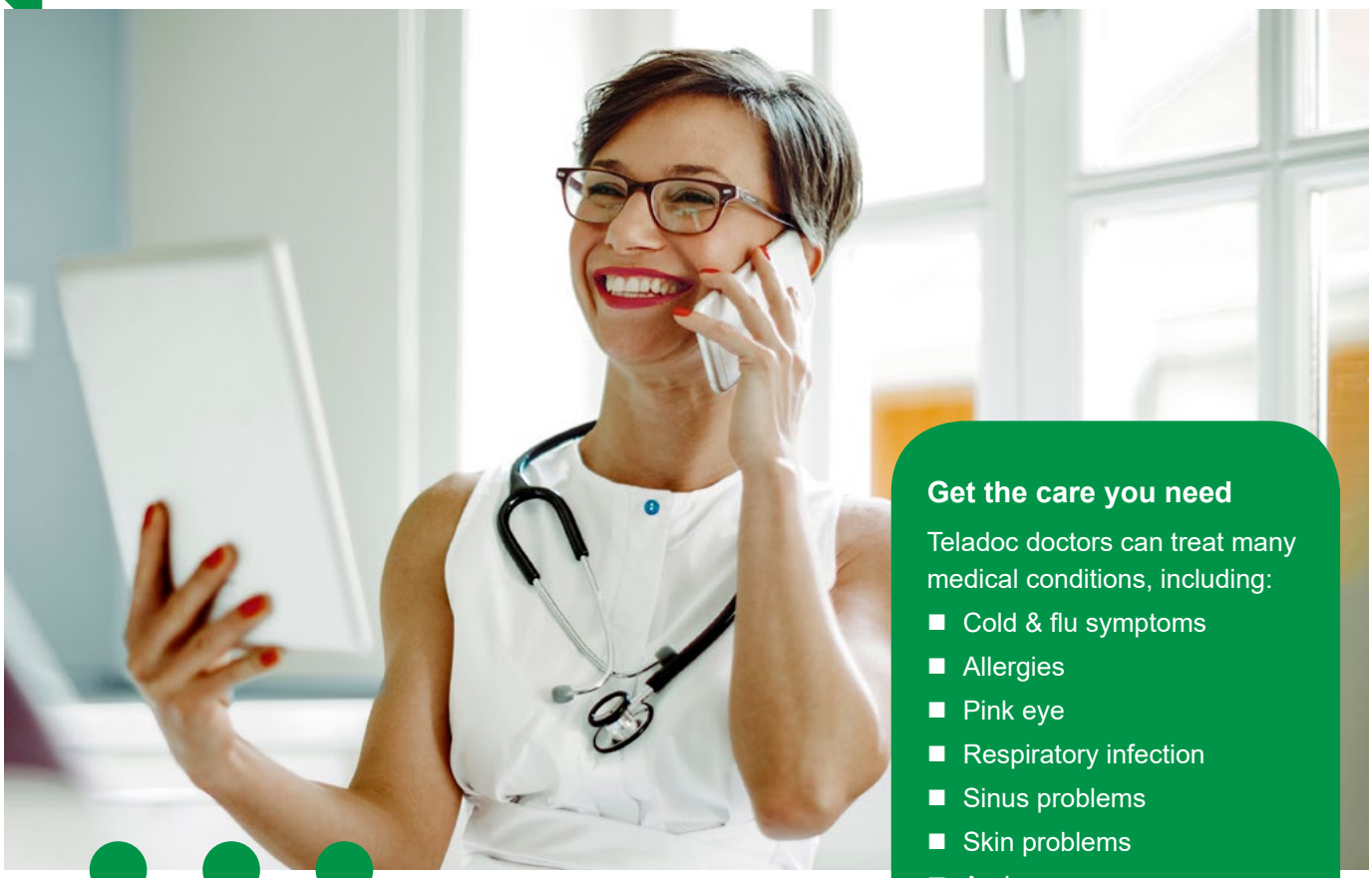
UMR.com on the go

Access umr.com on your mobile device to:



How UMR can help you

- Coverage details (copays, deductibles, out-of-pocket maximums, etc.).
- Review your claims activity and history.
- Print a temporary ID card, or order a new ID card.
- See frequently asked questions (FAQs).



Get the care you need

Teladoc doctors can treat many medical conditions, including:

- Cold & flu symptoms
- Allergies
- Pink eye
- Respiratory infection
- Sinus problems
- Skin problems
- And more

TELEHEALTH

Teladoc gives you access 24 hours, 7 days a week to a U.S. board-certified doctor through the convenience of phone, video or mobile app visits. It's an affordable option for quality medical care.

Talk to a doctor anytime, anywhere you happen to be.	Receive quality care via phone, video or mobile app.	Prompt treatment, median call back, in 10 minutes.	A network of doctors that can treat every member of the family.	Prescriptions sent to pharmacy of choice if medically necessary.	Teladoc is less expensive than the ER or urgent care.

It's free to enroll in and available through the Teladoc mobile app at www.teladoc.com, or 1.800.TELADOC.

WELLNESS PROGRAM

We are excited to offer you a new wellness program available through Wellworks for You starting in 2020. We encourage you to participate.

WellWorks for You provides you with tools and resources you can use to improve your overall health and fitness and to maintain it. In 2020, you'll have even more opportunities to earn incentives by completing key wellness activities.

Who is eligible to participate?

Employees and spouses enrolled in Star Tribune medical benefit plan will have the opportunity to participate in the program and earn an incentive.

Here's what you can earn in 2020

Employee-only coverage

You can earn increased contributions to your HSA when you complete a combination of wellness activities and preventive screenings.

Family coverage

You can earn increased contributions to your HSA when you and your dependents complete a combination of wellness activities and preventive screenings.

You can apply these rewards to any out-of-pocket expenses, including deductibles and coinsurance.

You can earn a lower deductible for the PPO plan in 2021 if you complete these three steps in 2020.

1. Complete the Know Your Number Health Risk Assessment in the wellness portal.
2. Complete one Biometric screening.
3. Complete one wellness activity.

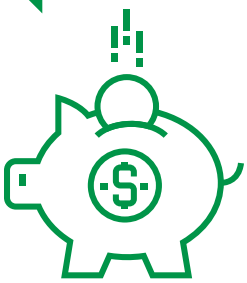
How to enroll in the WellWorks for You program

Every eligible employee will have an account set up for them, but they will need to enroll through these steps.

Please visit www.wellworksforyoulogin.com. You can:

- Find detailed instructions on how to get started.
- View a list of eligible goals and matching rewards.
- Check and track your completed goals and earned incentives.

You will not be able to enroll in the program until January. The date will be announced.



401(K) RETIREMENT PLAN

The Star Tribune 401(k) retirement savings plan is designed to help you prepare for retirement and attain your financial goals. The 401(k) retirement plan makes it easy for you to save money on a tax-deferred basis. When you enroll in the plan, a personal account will be established with Fidelity Investments in your name, funded by:

- Your contributions (pretax and/or Roth).
- Employer-matching contributions.
- Investment earnings on both types of contributions.

Star Tribune adds to your savings through its employer match, matching 25% of the contributions you make during a payroll period. However, the company's match will only apply to the first 6% of your compensation for a payroll period. The company may make a discretionary match of up to 25% of your contributions (also limited to 6% of your compensation) depending on company financial performance.

Members of the International Brotherhood of Electrical Workers, local #292 (Electricians) are not eligible for a company match.

Your contribution rate	Company match	Total investment
1%	.25%	1.25%
2%	.50%	2.50%
3%	.75%	3.75%
4%	1.00%	5.00%
5%	1.25%	6.25%
6% and up	Employee contribution rate + 1.50% company match	

Eligibility

An employee scheduled to work 20 or more hours per week is immediately eligible to become a participant in the plan, provided he/she is an eligible employee.

A part-time employee, scheduled to work less than 20 hours per week or a temporary employee will become a participant on the January 1 or July 1 after being credited with 1,000 hours of service in a one-year period, provided he/she is an eligible employee.

401(k) provider information

Employees can contact Fidelity Investments at 1-800-835-5091 or at www.fidelity.com.

Beneficiary designation

An important aspect of estate planning is making beneficiary designations and keeping them up to date after life changes. It's generally quick and easy to assign or update your beneficiary designation by visiting www.fidelity.com. You will need to provide the name and Social Security number of each beneficiary. If you cannot complete the designation online, you can obtain a paper form. If you are married and want to name someone other than your spouse as your primary beneficiary, your spouse must consent in writing in the presence of a notary public.

Employee contributions

As soon as you're eligible to participate in the 401(k) retirement plan, you will be automatically enrolled.

Newly hired employees scheduled to work 20 or more hours per week who do not enroll in the plan (or affirmatively elect to not enroll) within 30 days after hire will be automatically enrolled in the Plan. The employee will be deemed to have elected to contribute 6% of eligible pay. The 6% will remain in effect until the employee stops or changes the contribution. Contribution to the plan are made by payroll deduction and are withheld from each paycheck. An employee may contribute from 1% to 25% of eligible compensation.*

If an employee was hired between January 1, 2010 and prior to July 1, 2018 and has not taken any action to change the automatic contribution rate of 3%, contribution rates will automatically be increased by 1% each September until the contribution rate reaches 6% of eligible pay.

Employees hired or rehired as part-time employees, scheduled to work fewer than 20 hours per week, are not subject to the automatic contributions and should contact Fidelity Investments to change deferral elections.

An employee may elect to have contribution percentages increase each year by 1% as of the first pay date following September 1 by contacting Fidelity Investments.

Employer-matching contribution

The Star Tribune matching contributions and their earnings are 100% vested upon completion of one year of vesting service in the 401(k) retirement plan. You are always fully vested in your contributions and earnings.

Pretax 401(k) contributions

Pretax contributions allow you to reduce your current taxable income. In addition, any earnings on your contributions are also tax-deferred. Any contributions and earnings are fully taxable as ordinary income when you withdraw them.

Roth 401(k) contributions

You make Roth 401(k) contributions with after-tax money, so you see no immediate tax benefit. Any earnings from those contributions are tax-free when you take a qualified distribution.

*All contributions subject to IRS limits.

DENTAL PLAN

Delta Dental

View covered services, claim status or your account balance; find a dentist; update your information; and much more at www.deltadentalmn.org.

Although you can choose any dental provider, when you use an in-network dentist, you will generally pay less for treatments because your share of the cost will be based on negotiated discount fees. With out-of-network dentists, the plan will pay the same percentage, but the reimbursement will be based on out-of-network rates. You may be billed for the difference.

Dental exams can tell your doctor a lot about your overall health. It's important to schedule regular exams to help detect significant medical conditions before they become serious.

To see a current provider directory, please visit www.deltadentalmn.org.

	Delta Dental PPO and Delta Dental Premier Networks	Non-Participating
Deductible		
Per person	$25	$25
Is the deductible waived for preventive services?	Yes	Yes
Annual plan maximum (per individual)	$1,500	$1,500
Diagnostic and preventive		
Oral exams, X-rays, cleanings, fluoride, space maintainers, sealants	100%	100%
Basic		
Oral surgery, fillings, endodontic treatment, periodontic treatment, repairs of dentures and crowns	80%	80%
Major		
Crowns, jackets, dentures, bridge implants	50%	50%
Orthodontia		
Dependent children (through age 18)	50%	50%
Lifetime orthodontia plan maximum (per individual)	$1,000	$1,000

Employee monthly dental payroll contributions

Effective Jan. 1, 2020

	Monthly contribution
Employee	$6.61
Employee + spouse	$13.22
Employee + child(ren)	$16.52
Family	$23.13

- You can elect the Delta Dental plan regardless of whether you are enrolled in the medical plan.
- You will not receive a dental ID card because you typically do not need to present one when visiting your dentist. To print an ID card, log in to www.deltadentalmn.org.

GROUP TERM LIFE INSURANCE

If you are an employee regularly scheduled to work 20 or more hours per week, you automatically receive the life insurance benefit even if you elect to waive other coverage.* Your basic life insurance benefit is a percentage of your annual salary. Contact HR for information on your specific benefit amount.

In the event of your death, your life insurance will be paid to the beneficiary (or beneficiaries) you designate.

*See your bargaining unit contract for eligibility.

Here are some helpful insurance terms

IMPUTED INCOME:
Federal regulations require payment of income and Social Security taxes on the value of the life insurance premiums in excess of $50,000 when paid for by your employer. These values are known as imputed income. Contact your tax professional for information regarding these tax consequences if you have questions or concerns.

AGE REDUCTION:

- Ages 70+: Benefit decrease to 65% of original benefit.
- Ages 75+: Benefit decreases an additional 30.77%.

PORTABILITY AND CONVERSION:
Portability and conversion are available if your employment with Star Tribune ends. Portability allows you to continue your term life coverage, while the conversion option allows you to convert your term life policy into an individual whole life policy.

VOLUNTARY LIFE AND AD&D

You have the opportunity to purchase voluntary life for yourself and your spouse. You also have the option to purchase AD&D insurance for yourself or your family. Your cost for this coverage is based on the amount you elect and your age. You must purchase voluntary life for yourself in order to purchase coverage for your spouse. You are able to purchase voluntary AD&D insurance for yourself and/or your family. If you did not enroll in supplemental life coverage when you were first eligible, you will be subject to medical underwriting.*

*Does not apply to AD&D.

Spouse rates will be determined by the employee age.

Voluntary life rates for employee and dependent per $1,000 of coverage			
Under 25	$0.06	50-54	$0.40
25-29	$0.06	55-59	$0.64
30-34	$0.07	60-64	$0.85
35-39	$0.10	65-69	$1.34
40-44	$0.15	70-74	$2.34
45-49	$0.24	75+	$4.10

Voluntary AD&D employee only rate per $10,000 of coverage	Voluntary AD&D rate for employee and family per $10,000 of coverage
$0.35	$0.60

Example

If the rate is $0.40 per $1,000 and a 52 year old enrollee elects $20,000 in coverage, the monthly premium will be $8.00.

0.40	x	20	=	$8.00
Plan rate (determined by age)		Coverage per $1,000		Monthly premium

SHORT- AND LONG-TERM DISABILITY PLANS

Star Tribune offers two company paid disability plans to provide financial assistance in case you become disabled or are unable to work. The short-term disability plan is administered by HealthPartners and the long-term disability plan is provided by The Hartford.

Short-term disability (STD) plan

Short-term disability (STD) provides a benefit to replace a portion of your income when you are disabled and unable to work due to a covered illness or injury. If you are a regular employee working 20 hours a week, you are automatically enrolled in STD, even if you waive other coverage.* Star Tribune pays the full cost of your STD benefit. Any income replacement benefits you receive are taxable. Contact Human Resources for additional information on your short term disability benefit.

*See your bargaining unit contract for eligibility.

Coordination of disability benefits

Your benefit may be reduced if you receive disability benefits from retirement, Social Security, workers' compensation, state disability insurance, no-fault benefits and return-to-work earnings. Refer to your certificate of coverage for more details.

Long-term disability (LTD) plan

Long-term disability (LTD) is intended to protect your income for a longer duration after you have depleted short-term disability. If you are an eligible employee, you are automatically enrolled in LTD, even if you waive other coverage.* The cost of this coverage is paid entirely by Star Tribune.** Any income replacement benefits you receive are taxable.

If you are permanently disabled and have satisfied your elimination period, this plan will provide you coverage, a percent of your annual salary, until you reach normal Social Security retirement age. Your benefit amount may be offset by other benefits you are receiving, such as Social Security or workers' compensation. Your monthly benefits are subject to federal income tax and may be subject to state and local taxes.

*See your bargaining unit contract for eligibility.
**Additional LTD coverage may be purchased by eligible employees.

HEALTHCARE FLEXIBLE SPENDING ACCOUNT (FSA)

Whether you are married with children, single with no children, a single parent or any other lifestyle status, a flexible spending account (FSA) can save you money. An FSA allows you to set aside before-tax dollars from your paycheck to cover qualified expenses that you would normally pay out of your pocked with after-tax dollars. You pay no federal income, state income, or Social Security taxes on the money you place in your FSA. You are able to enroll in the healthcare FSA if you are NOT enrolled in the HSA health plan.

Funds contributed to the healthcare FSA are available in full on the first day of the plan year; however, please plan your contributions carefully as any funds not used by the end of the plan year will be forfeited by the plan.

You have until February 28, 2021 to file claims for expenses incurred during the plan year.

The FSA Carryover allows you to carry forward up to $500 of unused healthcare funds to the new calendar year which can be used for eligible healthcare expenses. This feature reduces the impact of the “use it or lose it” rule. Any unused amounts in excess of $500 will be forfeited at the end of the plan year not carried forward. You MUST re-enroll in the FSA for the new plan year to access any roll over funds.

Healthcare FSA

The healthcare FSA lets you pay for certain IRS-approved medical care expenses not covered by your insurance plan with pre-tax dollars. For example, cash that you now spend on deductibles, copayments, or other out-of-pocket medical expenses can instead by placed in the healthcare reimbursement FSA pre-tax, to pay for these expenses. You can even elect to have a debit card that allows you to pay for expenses at the same time you receive them, which avoids you having to wait for reimbursement. However, please note that a receipt may need to be submitted to prove your expense was qualified. The maximum contribution to the healthcare reimbursement FSA is $2,700 per plan year.*

*Limits subject to change.

DEPENDENT CARE FLEXIBLE SPENDING ACCOUNT

If you need child care for your dependents to allow you or your spouse to work or attend school full-time, you can open a dependent care FSA. This allows you to be reimbursed on a pretax basis for child care.

The maximum amount you can set aside in a dependent care FSA is $5,000 per year per family, or $2,500 if married and filing separately. Funds in your dependent care FSA are available to you only as they are deducted from your paycheck. Remember to use all of your contributions each plan year because no funds may be carried over to the next year. In other words, you use it or lose it.*

Eligible expenses include the care of children under age 13 and the care for dependents of any age who are physically or mentally incapable of self-care (includes day care for elderly dependents, but not nursing home confinements).

Examples of eligible expenses are day care, after-school care and elder care. You decide how much to deduct from each paycheck (annual minimum is $250 and annual maximum is $5,000). These contributions are made before taxes are taken from your earnings, which reduces your taxable income for the year. You can file claims at any time during the plan year, but they must be postmarked by the February 28, 2021, claims deadline. If you fax, upload or use an e-receipt, it must be received by midnight Eastern time on the annual claims deadline indicated on your plan-year claim form.

Remember: Use it or lose it

Use all your contributions each plan year because no funds can be carried over to the next year.

*Limits subject to change.

Remember

Changes to your dependent care FSA elections can be made only during open enrollment or if you experience a qualifying life event.

WORK/LIFE EMPLOYEE ASSISTANCE PROGRAM (EAP)

We all know that life can be challenging at times. Issues like illness, debt and family problems can leave us feeling worried or anxious and not able to be at our best. The EAP, sponsored by LifeWorks, provides confidential support and resources for you and your dependents at no charge. You can seek expert guidance for any kind of issue, from everyday matters to more serious problems affecting your well-being.

Here's what the program offers:

- EAP: Three visits with experienced clinicians (per occurrence), without any per-session cost to you.
- Legal resources: Free 30-minute consultation with an attorney in-person or by phone per issue. 25% discount on other services. Free 30-minute mediation consultation. State specific forms available at no cost.
- Financial resources: Up to one hour, with a financial planner. Unlimited phone access to financial professionals for information regarding personal finance and related issues.
- Work/life resources: Information and referrals on child care, elder care, adoption, relocation and other personal convenience matters.

The EAP provides counseling on all aspects of life, including:

- Difficulties in relationships.
- Emotional/ psychological issues.
- Stress and anxiety issues with work or family.
- Alcohol and drug abuse.
- Personal and life improvement.
- Legal or financial issues.
- Depression.
- Child care and elder care issues.
- Grief issues.

Assistance around the clock

Whenever you need assistance with a work/life issue, the EAP is there for you, 24 hours a day. Specialists are available for confidential 24/7 assistance and support.

LifeWorks

For more information and resources:

Contact LifeWorks 24/7 at: 888.456.1324
Go online: login.lifeworks.com
User ID: star
Password: 5466

CONTACTS

Medical and pharmacy

UMR
Member services: 800.826.9781
Website: www.umr.com

Wellness program

WellWorks for You
Hotline: 800.425.4657
Website: www.wellworksforyou.com

HSA

Optum Bank
Customer service: 866.234.8913
Website: www.optumbank.com

Retirement

Fidelity Investments
Customer service: 800.835.5091
Website: www.fidelity.com

Medical and dependent care FSA

UMR
Customer service: 800.826.9781
Website: www.umr.com

Dental

Delta Dental
Customer service: 800.553.9536
Website: www.DeltaDentalMN.org

Employee assistance program

LifeWorks
Hotline: 888.456.1324
Website: www.login.lifeworks.com

Life, AD&D and long-term disability

The Hartford
Customer service: 860.547.5000
Website: www.thehartford.com/employee-benefits

Short-term disability

HealthPartners
Customer service: 952.883.7540
Website: www.healthpartners.com

NOTICES

Star Tribune Media Company LLC

HEALTH PLAN NOTICES

TABLE OF CONTENTS

IMPORTANT NOTICE

This packet of notices related to our health care plan includes a notice regarding how the plan's prescription drug coverage compares to Medicare Part D. If you or a covered family member is also enrolled in Medicare Parts A or B, but not Part D, you should read the Medicare Part D notice carefully. It is titled, "Important Notice From Star Tribune Media Company LLC About Your Prescription Drug Coverage and Medicare."

IMPORTANT NOTICE FROM STAR TRIBUNE MEDIA COMPANY LLC ABOUT YOUR PRESCRIPTION DRUG COVERAGE AND MEDICARE

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with Star Tribune Media Company LLC and about your options under Medicare's prescription drug coverage. This information can help you decide whether you want to join a Medicare drug plan. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

If neither you nor any of your covered dependents are eligible for or have Medicare, this notice does not apply to you or your dependents, as the case may be. However, you should still keep a copy of this notice in the event you or a dependent should qualify for coverage under Medicare in the future. Please note, however, that later notices might supersede this notice.

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. Star Tribune Media Company LLC has determined that the prescription drug coverage offered by the Star Tribune Comprehensive Welfare Benefit and Cafeteria Plan ("Plan") is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is considered "creditable" prescription drug coverage. This is important for the reasons described below.

Because your existing coverage is, on average, at least as good as standard Medicare prescription drug coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to enroll in a Medicare drug plan, as long as you later enroll within specific time periods.

Enrolling in Medicare—General Rules

As some background, you can join a Medicare drug plan when you first become eligible for Medicare. If you qualify for Medicare due to age, you may enroll in a Medicare drug plan 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. If you qualify for Medicare due to disability or end-stage renal disease, your initial Medicare Part D enrollment period depends on the date your disability or treatment began. For more information you should contact Medicare at the telephone number or web address listed below.

Late Enrollment and the Late Enrollment Penalty

If you decide to *wait* to enroll in a Medicare drug plan you may enroll later, during Medicare Part D's annual enrollment period, which runs each year from October 15 through December 7. But as a general rule, if you delay your enrollment in Medicare Part D, after first becoming eligible to enroll, you may have to pay a higher premium (a penalty).

If after your initial Medicare Part D enrollment period you go **63 continuous days or longer without "creditable" prescription drug coverage** (that is, prescription drug coverage that's at least as good as Medicare's prescription drug coverage), your monthly Part D premium may go up by at least 1 percent of the premium you would have paid had you enrolled timely, for every month that you did not have creditable coverage.

For example, if after your Medicare Part D initial enrollment period you go 19 months without coverage, your premium may be at least 19% higher than the premium you otherwise would have paid. You may have to pay this higher premium for as long as you have Medicare prescription drug coverage. *However, there are some important exceptions to the late enrollment penalty.*

Special Enrollment Period Exceptions to the Late Enrollment Penalty

There are "special enrollment periods" that allow you to add Medicare Part D coverage months or even years after you first became eligible to do so, without a penalty. For example, if after your Medicare Part D initial enrollment period you lose or decide to leave employer-sponsored or union-sponsored health coverage that includes "creditable" prescription drug coverage, you will be eligible to join a Medicare drug plan at that time.

In addition, if you otherwise lose other creditable prescription drug coverage (such as under an individual policy) through no fault of your own, you will be able to join a Medicare drug plan, again without penalty. These special enrollment periods end two months after the month in which your other coverage ends.

Compare Coverage

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. See the Star Tribune Media Company LLC Plan's summary plan description for a summary of the Plan's prescription drug coverage. If you don't have a copy, you can get one by contacting us at the telephone number or address listed below.

Coordinating Other Coverage With Medicare Part D

Generally speaking, if you decide to join a Medicare drug plan while covered under the Star Tribune Media Company LLC Plan due to your employment (or someone else's employment, such as a spouse or parent), your coverage under the Star Tribune Media Company LLC Plan 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 below.

If you do decide to join a Medicare drug plan and drop your Star Tribune Media Company LLC prescription drug coverage, be aware that you and your dependents may not be able to get this coverage back. To regain coverage you would have to re-enroll in the Plan, pursuant to the Plan's eligibility and enrollment rules. You should review the Plan's summary plan description to determine if and when you are allowed to add coverage.

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

Contact the person listed below for further information, or call 612-673-7458. **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 Star Tribune Media Company LLC changes. You also may request a copy.

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 Creditable Coverage 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 whether or not you are required to pay a higher premium (a penalty).

Date:	January 1, 2020
Name of Entity/Sender:	Star Tribune Benefits
Contact—Position/Office:	Benefits Manager
Address:	650 3rd Ave. South, Suite 1300 Minneapolis, Minnesota 55488
Phone Number:	612-673-7458

Nothing in this notice gives you or your dependents a right to coverage under the Plan. Your (or your dependents') right to coverage under the Plan is determined solely under the terms of the Plan.

HIPAA COMPREHENSIVE NOTICE OF PRIVACY POLICY AND PROCEDURES

STAR TRIBUNE MEDIA COMPANY LLC
IMPORTANT NOTICE
COMPREHENSIVE NOTICE OF PRIVACY POLICY AND PROCEDURES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This notice is provided to you on behalf of:

Star Tribune Media Company LLC Medical Plan

Star Tribune Media Company LLC Flexible Benefits Plan

Star Tribune Comprehensive Welfare Benefit and Cafeteria Plan

* This notice pertains only to healthcare coverage provided under the plan.

The Plan's Duty to Safeguard Your Protected Health Information

Individually identifiable information about your past, present, or future health or condition, the provision of health care to you, or payment for the health care is considered "Protected Health Information" ("PHI"). The Plan is required to extend certain protections to your PHI, and to give you this notice about its privacy practices that explains how, when, and why the Plan may use or disclose your PHI. Except in specified circumstances, the Plan may use or disclose only the minimum necessary PHI to accomplish the purpose of the use or disclosure.

The Plan is required to follow the privacy practices described in this notice, though it reserves the right to change those practices and the terms of this notice at any time. If it does so, and the change is material, you will receive a revised version of this Notice either by hand delivery, mail delivery to your last known address, or some other fashion. This notice, and any material revisions of it, will also be provided to you in writing upon your request (ask your Human Resources representative, or contact the Plan's Privacy Official, described below), and will be posted on any website maintained by Star Tribune Media Company LLC that describes benefits available to employees and dependents.

You may also receive one or more other privacy notices from insurance companies that provide benefits under the Plan. Those notices will describe how the insurance companies use and disclose PHI and your rights with respect to the PHI they maintain.

How the Plan May Use and Disclose Your Protected Health Information

The Plan uses and discloses PHI for a variety of reasons. For its routine uses and disclosures it does not require your authorization, but for other uses and disclosures, your authorization (or the authorization of your personal representative (e.g., a person who is your custodian, guardian, or has your power-of-attorney) may be required. The following offers more description and examples of the Plan's uses and disclosures of your PHI.

- **Uses and Disclosures Relating to Treatment, Payment, or Health Care Operations.**
  - **Treatment:** Generally, and as you would expect, the Plan is permitted to disclose your PHI for purposes of your medical treatment. Thus, it may disclose your PHI to doctors, nurses, hospitals, emergency medical technicians, pharmacists, and other health care professionals where the disclosure is for your medical treatment. For example, if you are injured in an accident, and it's important for your treatment team to know your blood type, the Plan could disclose that PHI to the team in order to allow it to more effectively provide treatment to you.
  - **Payment:** Of course, the Plan's most important function, as far as you are concerned, is that it *pays for* all or some of the medical care you receive (provided the care is covered by the Plan). In the course of its payment operations, the Plan receives a substantial amount of PHI about you. For example, doctors, hospitals, and pharmacies that provide you care send the Plan detailed information about the care they provided, so that they can be paid for their services. The Plan may also share your PHI with other plans in certain cases. For example, if you are covered by more than one health care plan (e.g., covered by this Plan and your spouse's plan or covered by the plans covering your father and mother), we may share your PHI with the other plans to coordinate payment of your claims.
  - **Health care Operations:** The Plan may use and disclose your PHI in the course of its "health care operations." For example, it may use your PHI in evaluating the quality of services you received or disclose your PHI to an accountant or attorney for audit purposes. In some cases, the Plan may disclose your PHI to insurance companies for purposes of obtaining various insurance coverages. However, the Plan will not disclose, for underwriting purposes, PHI that is genetic information.
- **Other Uses and Disclosures of Your PHI Not Requiring Authorization.** The law provides that the Plan may use and disclose your PHI without authorization in the following circumstances:
  - **To the Plan Sponsor:** The Plan may disclose PHI to the employers (such as Star Tribune Media Company LLC) who sponsor or maintain the Plan for the benefit of employees and dependents. However, the PHI may only be used for limited purposes, and may not be used for purposes of employment-related actions or decisions or in connection with any other benefit or employee benefit plan of the employers. PHI may be disclosed to: the human resources or employee benefits department for purposes of enrollments and disenrollment's, census, claim resolutions, and other matters related to Plan administration; payroll department for purposes of ensuring appropriate payroll deductions and other payments by covered persons for their coverage; information technology department, as needed for preparation of data compilations and reports related to Plan administration; finance department for purposes of reconciling appropriate payments of premium to and benefits from the Plan, and other matters related to Plan administration; internal legal counsel to assist with resolution of claim, coverage, and other disputes related to the Plan's provision of benefits.
  - **To the Plan's Service Providers:** The Plan may disclose PHI to its service providers ("business associates") who perform claim payment and plan management services. The Plan requires a written contract that obligates the business associate to safeguard and limit the use of PHI.
  - **Required by Law**: The Plan may disclose PHI when a law requires that it report information about suspected abuse, neglect, or domestic violence, or relating to suspected criminal activity, or in response to a court order. It must also disclose PHI to authorities that monitor compliance with these privacy requirements.
  - **For Public Health Activities:** The Plan may disclose PHI when required to collect information about disease or injury, or to report vital statistics to the public health authority.
  - **For Health Oversight Activities:** The Plan may disclose PHI to agencies or departments responsible for monitoring the health care system for such purposes as reporting or investigation of unusual incidents.

- **Relating to Decedents:** The Plan may disclose PHI relating to an individual's death to coroners, medical examiners, or funeral directors, and to organ procurement organizations relating to organ, eye, or tissue donations or transplants.
- **For Research Purposes:** In certain circumstances, and under strict supervision of a privacy board, the Plan may disclose PHI to assist medical and psychiatric research.
- **To Avert Threat to Health or Safety:** In order to avoid a serious threat to health or safety, the Plan may disclose PHI as necessary to law enforcement or other persons who can reasonably prevent or lessen the threat of harm.
- **For Specific Government Functions:** The Plan may disclose PHI of military personnel and veterans in certain situations, to correctional facilities in certain situations, to government programs relating to eligibility and enrollment, and for national security reasons.

- **Uses and Disclosures Requiring Authorization:** For uses and disclosures beyond treatment, payment, and operations purposes, and for reasons not included in one of the exceptions described above, the Plan is required to have your written authorization. For example, uses and disclosures of psychotherapy notes, uses and disclosures of PHI for marketing purposes, and disclosures that constitute a sale of PHI would require your authorization. Your authorization can be revoked at any time to stop future uses and disclosures, except to the extent that the Plan has already undertaken an action in reliance upon your authorization.
- **Uses and Disclosures Requiring You to Have an Opportunity to Object:** The Plan may share PHI with your family, friend, or other person involved in your care, or payment for your care. We may also share PHI with these people to notify them about your location, general condition, or death. However, the Plan may disclose your PHI only if it informs you about the disclosure in advance and you do not object (but if there is an emergency situation and you cannot be given your opportunity to object, disclosure may be made if it is consistent with any prior expressed wishes and disclosure is determined to be in your best interests; you must be informed and given an opportunity to object to further disclosure as soon as you are able to do so).

Your Rights Regarding Your Protected Health Information

You have the following rights relating to your protected health information:

- **To Request Restrictions on Uses and Disclosures:** You have the right to ask that the Plan limit how it uses or discloses your PHI. The Plan will consider your request, but is not legally bound to agree to the restriction. To the extent that it agrees to any restrictions on its use or disclosure of your PHI, it will put the agreement in writing and abide by it except in emergency situations. The Plan cannot agree to limit uses or disclosures that are required by law.
- **To Choose How the Plan Contacts You:** You have the right to ask that the Plan send you information at an alternative address or by an alternative means. To request confidential communications, you must make your request in writing to the Privacy Official. We will not ask you the reason for your request. Your request must specify how or where you wish to be contacted. The Plan must agree to your request as long as it is reasonably easy for it to accommodate the request.
- **To Inspect and Copy Your PHI:** Unless your access is restricted for clear and documented treatment reasons, you have a right to see your PHI in the possession of the Plan or its vendors if you put your request in writing. The Plan, or someone on behalf of the Plan, will respond to your request, normally within 30 days. If your request is denied, you will receive written reasons for the denial and an explanation of any right to have the denial reviewed. If you want copies of your PHI, a charge for copying may be imposed but may be waived, depending on your circumstances. You have a right to choose what portions of your information you want copied and to receive, upon request, prior information on the cost of copying.
- **To Request Amendment of Your PHI:** If you believe that there is a mistake or missing information in a record of your PHI held by the Plan or one of its vendors you may request in writing that the record be corrected or supplemented. The Plan or someone on its behalf will respond, normally within 60 days of receiving your request. The Plan may deny the request if it is determined that the PHI is: (i) correct and

complete; (ii) not created by the Plan or its vendor and/or not part of the Plan's or vendor's records; or (iii) not permitted to be disclosed. Any denial will state the reasons for denial and explain your rights to have the request and denial, along with any statement in response that you provide, appended to your PHI. If the request for amendment is approved, the Plan or vendor, as the case may be, will change the PHI and so inform you, and tell others that need to know about the change in the PHI.

- **To Find Out What Disclosures Have Been Made:** You have a right to get a list of when, to whom, for what purpose, and what portion of your PHI has been released by the Plan and its vendors, other than instances of disclosure for which you gave authorization, or instances where the disclosure was made to you or your family. In addition, the disclosure list will not include disclosures for treatment, payment, or health care operations. The list also will not include any disclosures made for national security purposes, to law enforcement officials or correctional facilities, or before the date the federal privacy rules applied to the Plan. You will normally receive a response to your written request for such a list within 60 days after you make the request in writing. Your request can relate to disclosures going as far back as six years. There will be no charge for up to one such list each year. There may be a charge for more frequent requests.

How to Complain About the Plan's Privacy Practices

If you think the Plan or one of its vendors may have violated your privacy rights, or if you disagree with a decision made by the Plan or a vendor about access to your PHI, you may file a complaint with the person listed in the section immediately below. You also may file a written complaint with the Secretary of the U.S. Department of Health and Human Services. The law does not permit anyone to take retaliatory action against you if you make such complaints.

Notification of a Privacy Breach

Any individual whose unsecured PHI has been, or is reasonably believed to have been used, accessed, acquired or disclosed in an unauthorized manner will receive written notification from the Plan within 60 days of the discovery of the breach.

If the breach involves 500 or more residents of a state, the Plan will notify prominent media outlets in the state. The Plan will maintain a log of security breaches and will report this information to HHS on an annual basis. Immediate reporting from the Plan to HHS is required if a security breach involves 500 or more people.

Contact Person for Information, or to Submit a Complaint

If you have questions about this notice please contact the Plan's Privacy Official or Deputy Privacy Official(s) (see below). If you have any complaints about the Plan's privacy practices, handling of your PHI, *or breach notification process*, please contact the Privacy Official or an authorized Deputy Privacy Official.

Privacy Official

The Plan's Privacy Official, the person responsible for ensuring compliance with this notice, is:

Star Tribune Benefits
Benefits Manager
612-673-7458

The Plan's Deputy Privacy Official(s) is/are:

Star Tribune Human Resources
HR HIPAA Privacy Official
612-673-7458

Effective Date

The effective date of this notice is: January 1, 2020.

NOTICE OF SPECIAL ENROLLMENT RIGHTS

STAR TRIBUNE COMPREHENSIVE WELFARE BENEFIT AND CAFETERIA PLAN
NOTICE OF 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 toward 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 (e.g., 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 eligibility under Medicaid or the Children's Health Insurance Program (CHIP).

Unless the event giving rise to your special enrollment right is a loss of eligibility 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 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 toward 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:

Star Tribune Benefits
Benefits Manager
612-673-7458

**** This notice is relevant for healthcare coverages subject to the HIPAA portability rules.***

GENERAL COBRA NOTICE

January 1, 2020

Re: CONTINUATION COVERAGE RIGHTS UNDER COBRA

You are receiving this Notice of COBRA healthcare coverage continuation rights because you have recently become covered under one or more group health plans. The plan (or plans) under which you have gained coverage are listed at the end of this Form, and are referred to collectively as "the plan" except where otherwise indicated.

This notice contains important information about your right to COBRA continuation coverage, which is a temporary extension of healthcare coverage under the plan. The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to you and/or to other members of your family who are covered under the plan when you and/or they would otherwise lose the group health coverage. This notice gives only a summary of your COBRA continuation coverage rights. ***This notice generally explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect the right to receive it.*** For more information about your rights and obligations under the plan and under federal law, you should either review the plan's Summary Plan Description or contact the Plan Administrator. In some cases the plan document also serves as the Summary Plan Description.

Note you may have other options available to you when you lose group health coverage. When you become eligible for COBRA, you may also become eligible for other coverage options not provided by your employer that may cost less than COBRA continuation coverage. For example, you may be eligible to buy an individual plan through the Health Insurance Marketplace. By enrolling in coverage through the Marketplace, you may qualify for lower costs on your monthly premiums and lower out-of-pocket costs. Additionally, you may qualify for a 30-day special enrollment period for another group health plan for which you are eligible (such as a spouse's plan), even if that plan generally doesn't accept late enrollees.

COBRA Continuation Coverage and "Qualifying Events"

COBRA continuation coverage is a continuation of plan coverage when coverage would otherwise end because of a life event known as a "qualifying event." Specific qualifying events are listed later in this notice. COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." A qualified beneficiary is someone who will lose coverage under the plan because of a qualifying event. Depending on the type of qualifying event, employees, spouses of employees, and eligible children of employees may be qualified beneficiaries. Certain newborns, newly-adopted children and alternate recipients under qualified medical child support orders may also be qualified beneficiaries. This is discussed in more detail in separate paragraphs below. *Under the plan, qualified beneficiaries who elect COBRA continuation coverage generally must pay for this continuation coverage.*

If you are a covered ***employee***, you will become a qualified beneficiary if you lose your coverage under the plan because either one of the following qualifying events happens:

- Your hours of employment are reduced, or
- Your employment ends for any reason other than your gross misconduct.

If you are the ***spouse of a covered employee***, you will become a qualified beneficiary if you lose your coverage under the plan because any of the following qualifying events happens:

- Your spouse dies;
- Your spouse's hours of employment are reduced;
- Your spouse's employment ends for any reason other than his or her gross misconduct;
- Your spouse becomes enrolled in any part of Medicare (it is extremely rare for coverage of an employee's dependents to be terminated on account of the employee's Medicare enrollment); or
- You become divorced from your spouse. Note that if your spouse cancels your coverage in anticipation of a divorce and a divorce later occurs, then the divorce will be considered a qualifying event even though you actually lost coverage earlier. ***If you notify the Plan Administrator or its designee within 60days after the divorce and can establish that the employee canceled the coverage earlier in anticipation of the divorce, then COBRA coverage may be available for a period after the divorce (but not for the period between the date your coverage ended, and the date of divorce).*** But you <u>*must*</u> provide timely notice of the divorce to the Plan Administrator or its designee or you will not be able to obtain COBRA coverage after the divorce. See the rules in the box below, under the heading entitled, *"Notice Requirements,"* regarding the obligation to provide notice, and the procedures for doing so.

Your covered ***eligible children*** will become qualified beneficiaries if they lose coverage under the plan because any of the following qualifying events happens:

- The parent-employee dies;
- The parent-employee's hours of employment are reduced;
- The parent-employee's employment ends for any reason other than his or her gross misconduct;
- The parent-employee becomes enrolled in any part of Medicare (it is extremely rare for coverage of an employee's dependents to be terminated on account of the employee's Medicare enrollment);
- The parents become divorced; or
- The child stops being eligible for coverage under the plan as an "eligible child."

Sometimes, filing a proceeding in bankruptcy under title 11 of the United States Code can be a qualifying event. If a proceeding in bankruptcy is filed with respect to Star Tribune Media Company LLC, and that bankruptcy results in the loss of coverage of any retired employee covered under the plan, the retired employee is a qualified beneficiary with respect to the bankruptcy. The retired employee's spouse, surviving spouse, and eligible children will also be qualified beneficiaries if bankruptcy results in the loss of their coverage under the plan.

Notice Requirements

The plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator or its designee has been ***timely notified*** that a qualifying event has occurred. When the qualifying event is:

- the end of employment or reduction of hours of employment,
- death of the employee,
- commencement of a proceeding in bankruptcy with respect to the employer,; or

the employer (if the employer is not the Plan Administrator) must notify the Plan Administrator of the qualifying event within 30 days following the date coverage ends.

IMPORTANT:

For the other qualifying events (divorce or legal separation of the employee and spouse or an eligible child's losing eligibility for coverage as an eligible child), you or someone on your behalf must notify the Plan Administrator or its designee in writing within 60 days after the qualifying event occurs, using the procedures specified below. If these procedures are not followed or if the notice is not provided in writing to the Plan Administrator or its designee during the 60-day notice period, any spouse or eligible child who loses coverage will not be offered the option to elect continuation coverage.

NOTICE PROCEDURES:

Any notice that you provide must be ***in writing***. Oral notice, including notice by telephone, is not acceptable. You must mail, fax or hand-deliver your notice to the person, department, or firm listed below, at the following address:

Star Tribune Benefits
Benefits Manager
612-673-7458
650 3rd Ave. South, Suite 1300
Minneapolis, Minnesota 55488

If mailed, your notice must be postmarked no later than the last day of the required notice period. Any notice you provide must state:

- the ***name of the plan or plans*** under which you lost or are losing coverage,
- the ***name and address of the employee*** covered under the plan,
- the ***name(s) and address(es) of the qualified beneficiary(ies)***, and
- the ***qualifying event*** and the ***date*** it happened.

If the qualifying event is a ***divorce or legal separation***, your notice must include ***a copy of the divorce decree or the legal separation agreement***.

There are other notice requirements in other contexts. See, for example, the discussion below under the heading entitled, *"Duration of COBRA Coverage."* That explanation describes other situations where notice from you or the qualified beneficiary is required in order to gain the right to COBRA coverage.

Once the Plan Administrator or its designee receives *timely notice* that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered employees may elect COBRA continuation coverage for their spouses, and parents may elect COBRA continuation coverage on behalf of their children. For each qualified beneficiary who elects COBRA continuation coverage, COBRA continuation coverage will begin on the date of the qualifying event. ***If you or your spouse or eligible children do not elect continuation coverage within the 60-day election period described above, you will lose your right to elect continuation coverage.***

Duration of COBRA Coverage

COBRA continuation coverage is a temporary continuation of coverage. When the qualifying event is the death of the employee, enrollment of the employee in any part of Medicare, your divorce or legal separation, or an eligible child losing eligibility as an eligible child, COBRA continuation coverage lasts for up to ***36 months***.

When the qualifying event is the end of employment or reduction of the employee's hours of employment, COBRA continuation coverage lasts for up to ***18 months***.

There are *three ways* in which the period of COBRA continuation coverage can be extended…

1. Disability extension of 18-month period of continuation coverage.

If you or anyone in your family covered under the plan is determined by the Social Security Administration to be disabled as of the date of the qualifying event or at any time during the first 60 days of COBRA continuation coverage ***and you notify the Plan Administrator or its designee in writing and in a timely fashion***, you and your entire family can receive up to ***an additional 11 months*** of COBRA continuation coverage, for a total maximum of ***29 months***.

You must make sure that the Plan Administrator or its designee is notified in writing of the Social Security Administration's determination within 60 days after (i) of the date of the determination or (ii) the date of the qualifying event or (iii) the date coverage is lost due to the qualifying event, whichever occurs last. But in any event the notice must be provided before the end of the 18-month period of COBRA continuation coverage. The plan requires you to follow the procedures specified in the box above, under the heading entitled *"Notice Procedures."* In addition, your notice must include

- the name of the disabled qualified beneficiary,
- the date that the qualified beneficiary became disabled, and
- the date that the Social Security Administration made its determination.

Your notice must also include a copy of the Social Security Administration's determination. ***If these procedures are not followed or if the notice is not provided in writing to the Plan Administrator or its designee within the required period, then there will be no disability extension of COBRA continuation coverage.***

2. Second qualifying event extension of 18-month period of continuation coverage.

If your family experiences ***another qualifying event*** while receiving COBRA continuation coverage, the spouse and eligible children in your family can get additional months of COBRA continuation coverage, up to a maximum of ***36 months (including the initial period of COBRA coverage)***.

This extension is available to ***the spouse*** and ***eligible children*** if, while they and the covered former employee are purchasing COBRA coverage, the former employee:

- dies,
- gets divorced.

The extension is also available to an ***eligible child*** when that child stops being eligible under the plan as an eligible child.

In all of these cases, you must make sure that the Plan Administrator or its designee is notified in writing of the second qualifying event within 60 days after (i) the date of the second qualifying event or (ii) the date coverage is lost, whichever occurs last. The plan requires you to follow the procedures specified in the box above, under the heading entitled *"Notice Procedures."* Your notice must also ***name the second qualifying event*** and ***the date it happened***. If the second qualifying event is a divorce or legal separation, your notice must include ***a copy of the divorce decree or legal separation agreement***.

If these procedures are not followed or if the notice is not provided in writing to the Plan Administrator or its designee within the required 60-day period, then there will be no extension of COBRA continuation coverage due to the second qualifying event.

3. ***Medicare Extension for Spouse and Eligible Children.***

If a qualifying event that is a termination of employment or reduction of hours occurs within 18 months after the covered employee becomes entitled to any part of Medicare, then the maximum coverage period for the spouse and eligible children is ***36 months*** from the date the employee became entitled to Medicare (but the covered employee's maximum coverage period will be 18 months).

Shorter Maximum Coverage Period for Health Flexible Spending Accounts

The maximum COBRA coverage period for a health flexible spending arrangement (health "FSA") maintained by the employer ends on the last day of the cafeteria or flexible benefits plan "plan year" in which the qualifying event occurred. In addition, if at the time of the qualifying event the employee has withdrawn (during the plan year) more from the FSA than the employee has had credited to the FSA, no COBRA right is available at all.

OTHER RULES AND REQUIREMENTS

Same Rights as Active Employees to Add New Dependents. A qualified beneficiary generally has the same rights as similarly situated active employees to add or drop dependents, make enrollment changes during open enrollment, etc. Contact the Plan Administrator for more information. See also the paragraph below titled, *"Children Born or Placed for Adoption with the Covered Employee During COBRA Period,"* for information about how certain children acquired by a covered employee purchasing COBRA coverage may actually be treated as qualified beneficiaries themselves. ***Be sure to promptly notify the Plan Administrator or its designee if you***

need to make a change to your COBRA coverage. The Plan Administrator or its designee must be notified in writing within 30 days of the date you wish to make such a change *(adding or dropping dependents, for example).* See the rules in the box above, under the heading entitled, *"Notice Procedures,"* for an explanation regarding how your notice should be made.

Children Born to or Placed for Adoption with the Covered Employee During COBRA Period. A child born to, adopted by, or placed for adoption with a covered employee or former employee during a period of continuation coverage is considered to be a qualified beneficiary provided that, if the covered employee or former employee is a qualified beneficiary, the employee has elected COBRA continuation coverage for himself or herself. The child's COBRA coverage begins when the child is enrolled in the plan, whether through special enrollment or open enrollment, and it lasts for as long as COBRA coverage lasts for other family members of the employee. To be enrolled in the plan, the child must satisfy the otherwise applicable plan eligibility requirements (for example, age requirements). ***Be sure to promptly notify the Plan Administrator or its designee if you need to make a change to your COBRA coverage. The Plan Administrator or its designee must be notified in writing within 30 days of the date you wish to make such a change.*** See the rules in the box above, under the heading entitled, *"Notice Procedures,"* for an explanation regarding how your notice should be made.

Alternate Recipients Under Qualified Medical Child Support Orders. A child of the covered employee or former employee who is receiving benefits under the plan pursuant to a Qualified Medical Child Support Order (QMCSO) received by the Plan Administrator during the employee's period of employment with the employer is entitled the same rights under COBRA as an eligible child of the covered employee, regardless of whether that child would otherwise be considered a dependent. ***Be sure to promptly notify the Plan Administrator or its designee if you need to make a change to your COBRA coverage. The Plan Administrator or its designee must be notified in writing within 30 days of the date you wish to make such a change.*** See the rules in the box above, under the heading entitled, *"Notice Procedures,"* for an explanation regarding how your notice should be made.

Are there other coverage options besides COBRA Continuation Coverage?

Yes, other coverage options not sponsored by your employer may be available. Instead of enrolling in COBRA continuation coverage, there may be other coverage options for you and your family through the Health Insurance Marketplace, Medicaid, or other group health plan coverage options (such as a spouse's plan) through what is called a "special enrollment period." Some of these options may cost less than COBRA continuation coverage. You can learn more about many of these options at www.healthcare.gov.

If You Have Questions

Questions concerning your plan or your COBRA continuation rights should be addressed to the contact or contacts identified below. For more information about your rights under ERISA, including COBRA, the Health Insurance Portability or Accountability Act (HIPAA), and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA). Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's Web site at **www.dol.gov/ebsa.**"

Keep Your Plan Informed of Address Changes

In order to protect your family's rights, you should keep the Plan Administrator or its designee informed of any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Plan Administrator or its designee.

Plan Contact Information

Star Tribune Benefits
Benefits Manager
650 3rd Ave. South, Suite 1300
Minneapolis, Minnesota 55488
612-673-7458

NOTICE OF GRANDFATHERED STATUS

This Star Tribune Comprehensive Welfare Benefit and Cafeteria Plan believes this plan is a "grandfathered health plan" under the Patient Protection and Affordable Care Act (the Affordable Care Act). As permitted by the Affordable Care Act, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted. Being a grandfathered health plan means that your plan may not include certain consumer protections of the Affordable Care Act that apply to other plans, for example, the requirement for the provision of preventive health services without any cost sharing. However, grandfathered health plans must comply with certain other consumer protections in the Affordable Care Act, for example, the elimination of lifetime limits on benefits.

Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to the plan administrator at:

Star Tribune Benefits
Benefits Manager
612-673-7458

You may also contact the Employee Benefits Security Administration, U.S. Department of Labor at 1-866-444-3272 or www.dol.gov/ebsa/healthreform. This website has a table summarizing which protections do and do not apply to grandfathered health plans. You may also contact the U.S. Department of Health and Human Services at www.healthreform.gov.

WOMEN'S HEALTH AND CANCER RIGHTS NOTICE

The Star Tribune Comprehensive Welfare Benefit and Cafeteria Plan is required by law to provide you with the following notice:

The Women's Health and Cancer Rights Act of 1998 ("WHCRA") provides certain protections for individuals receiving mastectomy-related benefits. Coverage will be provided in a manner determined in consultation with the attending physician and the patient for:

- All stages of reconstruction of the breast on which the mastectomy was performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance;
- Prostheses; and
- Treatment of physical complications of the mastectomy, including lymphedemas.

The Star Tribune Comprehensive Welfare Benefit and Cafeteria Plan provide(s) medical coverage for mastectomies and the related procedures listed above, subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this plan.

If you would like more information on WHCRA benefits, please contact your Plan Administrator at:

Star Tribune Benefits
Benefits Manager
612-673-7458

NOTICE FOR EMPLOYER-SPONSORED WELLNESS PROGRAMS

The Star Tribune Media Company LLC Wellness Program is a voluntary wellness program available to all employees and spouses enrolled in the medical plan.. 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 (ADA), the Genetic Information Nondiscrimination Act of 2008 (GINA), and the Health Insurance Portability and Accountability Act, as applicable, among others.

Details about the wellness program, including criteria and incentives, can be found in the Open Enrollment Guide.

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 Star Tribune benefits at 612-673-7458 or benefits@startribune.com.

The information from the Biometric Screening and the Health Risk Assessment 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 coaching. 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 Star Tribune Media Company LLC may use aggregate information it collects to design a program based on identified health risks in the workplace, the wellness program 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. The only individual(s) who will receive your personally identifiable health information is (are) in order to provide you with services under the wellness program.

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 Star Tribune Benefits at 612-673-7458 or benefits@startribune.com.

PREMIUM ASSISTANCE UNDER MEDICAID AND THE CHILDREN'S HEALTH INSURANCE PROGRAM (CHIP) NOTICE

Premium Assistance Under Medicaid and the Children's Health Insurance Program (CHIP)

If you or your children are eligible for Medicaid or CHIP and you're eligible for health coverage from your employer, your state may have a premium assistance program that can help pay for coverage, using funds from their Medicaid or CHIP programs. If you or your children aren't eligible for Medicaid or CHIP, you won't be eligible for these premium assistance programs, but you may be able to buy individual insurance coverage through the Health Insurance Marketplace. For more information, visit **www.healthcare.gov**.

If you or your dependents are already enrolled in Medicaid or CHIP and you live in a State listed below, contact your State Medicaid or CHIP office to find out if premium assistance is available.

If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, contact your State Medicaid or CHIP office or dial **1-877-KIDS NOW** or **www.insurekidsnow.gov** to find out how to apply. If you qualify, ask your state if it has a program that might help you pay the premiums for an employer-sponsored plan.

If you or your dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under your employer plan, your employer must allow you to enroll in your employer plan if you aren't already enrolled. This is called a "special enrollment" opportunity, and **you must request coverage within 60 days of being determined eligible for premium assistance**. If you have questions about enrolling in your employer plan, contact the Department of Labor at **www.askebsa.dol.gov** or call **1-866-444-EBSA (3272)**.

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of July 31, 2019. Contact your State for more information on eligibility:

ALABAMA – Medicaid	FLORIDA – Medicaid
Website: http://myalhipp.com/ Phone: 1-855-692-5447	Website: http://flmedicaidtplrecovery.com/hipp/ Phone: 1-877-357-3268
ALASKA – Medicaid	**GEORGIA – Medicaid**
The AK Health Insurance Premium Payment Program Website: http://myakhipp.com/ Phone: 1-866-251-4861 Email: CustomerService@MyAKHIPP.com Medicaid Eligibility: http://dhss.alaska.gov/dpa/Pages/medicaid/default.aspx	Website: https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp Phone: 678-564-1162 ext 2131
ARKANSAS – Medicaid	**INDIANA – Medicaid**
Website: http://myarhipp.com/ Phone: 1-855-MyARHIPP (855-692-7447)	Healthy Indiana Plan for low-income adults 19-64 Website: http://www.in.gov/fssa/hip/ Phone: 1-877-438-4479 All other Medicaid Website: http://www.indianamedicaid.com Phone 1-800-403-0864
COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)	**IOWA – Medicaid**
Health First Colorado Website: https://www.healthfirstcolorado.com/ Health First Colorado Member Contact Center: 1-800-221-3943/ State Relay 711 CHP+: https://www.colorado.gov/pacific/hcpf/child-health-plan-plus CHP+ Customer Service: 1-800-359-1991/ State Relay 711	Website: http://dhs.iowa.gov/Hawki Phone: 1-800-257-8563

KANSAS – Medicaid	NEW HAMPSHIRE – Medicaid
Website: http://www.kdheks.gov/hcf/ Phone: 1-785-296-3512	Website: https://www.dhhs.nh.gov/oii/hipp.htm Phone: 603-271-5218 Toll free number for the HIPP program: 1-800-852-3345, ext 5218
KENTUCKY – Medicaid	**NEW JERSEY – Medicaid and CHIP**
Website: https://chfs.ky.gov Phone: 1-800-635-2570	Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ Medicaid Phone: 609-631-2392 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710
LOUISIANA – Medicaid	**NEW YORK – Medicaid**
Website: http://dhh.louisiana.gov/index.cfm/subhome/1/n/331 Phone: 1-888-695-2447	Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831
MAINE – Medicaid	**NORTH CAROLINA – Medicaid**
Website: http://www.maine.gov/dhhs/ofi/public-assistance/index.html Phone: 1-800-442-6003 TTY: Maine relay 711	Website: https://medicaid.ncdhhs.gov/ Phone: 919-855-4100
MASSACHUSETTS – Medicaid and CHIP	**NORTH DAKOTA – Medicaid**
Website: http://www.mass.gov/eohhs/gov/departments/masshealth/ Phone: 1-800-862-4840	Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/ Phone: 1-844-854-4825
MINNESOTA – Medicaid	**OKLAHOMA – Medicaid and CHIP**
Website: https://mn.gov/dhs/people-we-serve/seniors/health-care/health-care-programs/programs-and-services/other-insurance.jsp Phone: 1-800-657-3739	Website: http://www.insureoklahoma.org Phone: 1-888-365-3742
MISSOURI – Medicaid	**OREGON – Medicaid**
Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005	Website: http://healthcare.oregon.gov/Pages/index.aspx http://www.oregonhealthcare.gov/index-es.html Phone: 1-800-699-9075
MONTANA – Medicaid	**PENNSYLVANIA – Medicaid**
Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084	Website: http://www.dhs.pa.gov/provider/medicalassistance/healthinsurancepremiumpaymenthippprogram/index.htm Phone: 1-800-692-7462
NEBRASKA – Medicaid	**RHODE ISLAND – Medicaid and CHIP**
Website: http://www.ACCESSNebraska.ne.gov Phone: (855) 632-7633 Lincoln: (402) 473-7000 Omaha: (402) 595-1178	Website: http://www.eohhs.ri.gov/ Phone: 855-697-4347, or 401-462-0311 (Direct RIte Share Line)
NEVADA – Medicaid	**SOUTH CAROLINA – Medicaid**
Medicaid Website: https://dhcfp.nv.gov Medicaid Phone: 1-800-992-0900	Website: https://www.scdhhs.gov Phone: 1-888-549-0820
SOUTH DAKOTA - Medicaid	**WASHINGTON – Medicaid**
Website: http://dss.sd.gov Phone: 1-888-828-0059	Website: https://www.hca.wa.gov/ Phone: 1-800-562-3022 ext. 15473
TEXAS – Medicaid	**WEST VIRGINIA – Medicaid**
Website: http://gethipptexas.com/ Phone: 1-800-440-0493	Website: http://mywvhipp.com/ Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)
UTAH – Medicaid and CHIP	**WISCONSIN – Medicaid and CHIP**
Medicaid Website: https://medicaid.utah.gov/ CHIP Website: http://health.utah.gov/chip Phone: 1-877-543-7669	Website: https://www.dhs.wisconsin.gov/publications/p1/p10095.pdf Phone: 1-800-362-3002
VIRGINIA – Medicaid and CHIP	
Medicaid Website: http://www.coverva.org/programs_premium_assistance.cfm Medicaid Phone: 1-800-432-5924 CHIP Website: http://www.coverva.org/programs_premium_assistance.cfm CHIP Phone: 1-855-242-8282	

To see if any other states have added a premium assistance program since July 31, 2019, or for more information on special enrollment rights, contact either:

U.S. Department of Labor
Employee Benefits Security Administration
www.dol.gov/agencies/ebsa
1-866-444-EBSA (3272)

U.S. Department of Health and Human Services
Centers for Medicare & Medicaid Services
www.cms.hhs.gov
1-877-267-2323, Menu Option 4, Ext. 61565

Paperwork Reduction Act Statement: According to the Paperwork Reduction Act of 1995 (Pub. L. 104-13) (PRA), no persons are required to respond to a collection of information unless such collection displays a valid Office of Management and Budget (OMB) control number. The Department notes that a Federal agency cannot conduct or sponsor a collection of information unless it is approved by OMB under the PRA, and displays a currently valid OMB control number, and the public is not required to respond to a collection of information unless it displays a currently valid OMB control number. See 44 U.S.C. 3507. Also, notwithstanding any other provisions of law, no person shall be subject to penalty for failing to comply with a collection of information if the collection of information does not display a currently valid OMB control number. See 44 U.S.C. 3512.

The public reporting burden for this collection of information is estimated to average approximately seven minutes per respondent. Interested parties are encouraged to send comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the U.S. Department of Labor, Employee Benefits Security Administration, Office of Policy and Research, Attention: PRA Clearance Officer, 200 Constitution Avenue, N.W., Room N-5718, Washington, DC 20210 or email ebsa.opr@dol.gov and reference the OMB Control Number 1210-0137.

OMB Control Number 1210-0137 (expires 12/31/2019)

Final notes

This summary of benefits is not intended to be a complete description of Star Tribune's insurance benefit plans. Please refer to the plan document(s) for a complete description. Each plan is governed in all respects by the terms of its legal plan document, rather than by this or any other summary of the insurance benefits provided by the plan.

In the event of any conflict between a summary of the plan and the official document, the official document will prevail. Although Star Tribune maintains its benefit plans on an ongoing basis, Star Tribune reserves the right to terminate or amend each plan in its entirety or in any part at any time.

Please contact your Star Tribune human resources representative with questions regarding the information provided in this overview.

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The descriptions of the benefits are not guarantees of current or future employment or benefits. If there is any conflict between this guide and the official plan documents, the official documents will govern.

Employee benefits

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