2024 BENEFITS GUIDE

Star Tribune
Media Company, LLC

Here's where to find ...

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 34 FOR MORE DETAILS.

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 employee handbook for FMLA and disability benefit 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

UMR | UMR.COM | 800.207.3172
SUREST | JOIN.SUREST.COM/STARTRIBUNE | ACCESS CODE: STARTRIBUNE2024 | 866.683.6440

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 three medical plan options for 2024:

- HSA Health Plan
- PPO Plan
- Surest Plan

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 pages 12-14. See page 17 for HSA wellness incentive.

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% 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% 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.

What is the Surest plan?

The Surest plan is a health insurance plan offering you choice and certainty. With Surest, you can see treatment options and costs before getting treatment or choosing a doctor. You can make informed decisions and have the potential to save money by selecting the treatment that's best and most cost-effective for you.

With the Surest plan, you have access to the UnitedHealthcare Choice Plus network, a broad national network of doctors, clinics, and hospitals.

With the Surest plan, you can see clear prices for treatments and doctors, so you know before you go what your healthcare choices will cost.

The Surest plan does not have deductibles or coinsurance. You pay copays for all services.

Find out more about Surest

- View Brite for a basic introduction on how the Surest plan works
  - britehr.app/startribune-2024
- For more information on how the plan works along with nationwide provider search and provider-specific copays
  - join.surest.com/startribune
  - Access code: startribune2024
- If you choose the Surest plan, register at benefits.surest.com to view claims, digital ID card, provider search and more.
- There's also a Surest app on the App Store or Google Play

Value adds for UMR and Surest

	UMR	Surest
Member Services	UMR Plan Advisor 800.207.3172	Surest Call Center 866.683.6440
Provider Network	UnitedHealthcare Choice Plus	UnitedHealthcare Choice Plus
Member Site	umr.com	benefits.surest.com
Mobile App	UMR app	Surest App
Healthcare Cost Estimator	Included in Choice Plus network search features	Embedded in App
UnitedHealth Premium Providers	Embedded (when searching for a provider ♥ ♥)	Embedded (as a Quality Signal)
General Medicine and Dermatology Virtual Visits	Teladoc	Doctor On Demand, K-Health
Second Opinion Service	Teladoc – Expert Medical Services	2ndMD
Virtual Physical Therapy	Not included	Kaia
Maternity CARE	Embedded	Not included
Behavioral Health Virtual Visits	Available with Teladoc	Available with Doctor On Demand
AbleTo Digital+	Go to umr.com to access	Not available
Talkspace — virtual mental health pay applicable co-insurance or co-pay amount	Embedded	Embedded

Clear answers about your costs, your coverage, your options.

surest™
A UnitedHealthcare Company

GENERAL PLAN DETAILS

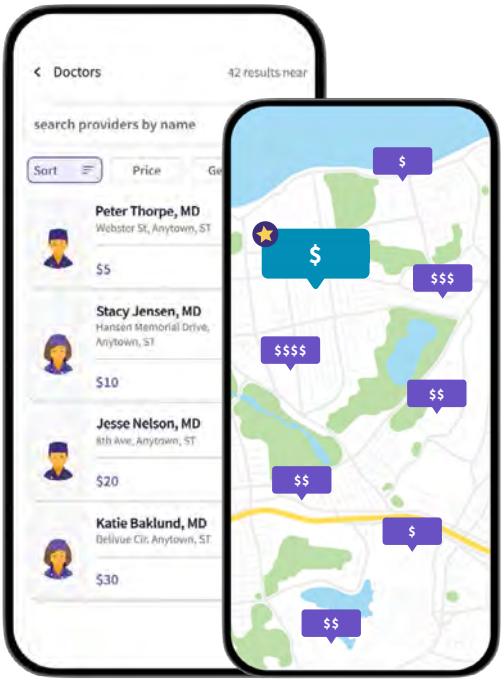
Deductible	$0
Out-of-pocket limit	
Employee	$5,500
Family	$11,000
Prescription drugs – 30-day	
Preventive drugs	$0
Tier 1	$10
Tier 2	$90
Tier 3	$120

YOUR COPAYS

Preventive visit	$0
Office visit	$25 – $125
Virtual visit (primary & urgent)	$0
Virtual visit (specialty)	$0 – $140
Mental health office visit	$25
Urgent care visit	$70
Emergency room visit	$700
Basic diagnostic lab tests, X-rays and ultrasounds	$0
Physical therapy*	$15 – $95
Maternity labor and delivery	$1,300 – $2,350

"Everything is just **easy and affordable.** I feel in control of my health plan for the first time."

Jaime A., Surest member



Providers, locations, and prices are fictional. Prices are representative of member copays, no deductible.

See how powerful simple can be.

To check prices or see if your doctor is in-network:

Join.Surest.com/StarTribune | Access code: **StarTribune2024**

Get started

britehr.app/StarTribune-2024

*See plan for visit limit details. In-network costs only. For out-of-network costs, exclusions and limitations, see website. Administrative services provided by Bind Benefits, Inc. d/b/a Surest, its affiliate United HealthCare Services, Inc., or by Bind Benefits, Inc. d/b/a Surest Administrators Services, in CA. B2C_23-AI-627670_1023

Medical and prescription drug plan summary

Side-by-side

Medical	HSA Health Plan**	Preferred PPO with wellness	Standard PPO without wellness	Surest Plan
	In-network	In-network	In-network	In-Network
Deductible Employee only Family	 $3,200 $5,400	 $400 $800	 $800 $1,600	 $0 $0
Out-of-pocket maximum (includes deductible)				
Employee only Family	$5,000 $10,000	$5,000 $10,000	$5,000 $10,000	$5,500 $11,000
Preventive care	No charge	No charge	No charge	No charge
Office visit (PCP and specialist)	Deductible, then 10% coinsurance	Deductible, then 20% coinsurance	Deductible, then 20% coinsurance	$25-$125 copay
Emergency room	Deductible, then 10% coinsurance	Deductible, then 20% coinsurance	Deductible, then 20% coinsurance	$700 copay
Urgent care	Deductible, then 10% coinsurance	Deductible, then 20% coinsurance	Deductible, then 20% coinsurance	$50-$3,500 copay
Inpatient care	Deductible, then 10% coinsurance	Deductible, then 20% coinsurance	Deductible, then 20% coinsurance	$50-$3,500 copay
Outpatient care	Deductible, then 10% coinsurance	Deductible, then 20% coinsurance	Deductible, then 20% coinsurance	$50-$3,500 copay
Prescription drugs*		Employee pays		
Retail (30-day supply)				
Tier 1 — generics	Deductible, then 10% coinsurance	$15 copay	$15 copay	$10 copay
Tier 2 — preferred	Deductible, then 10% coinsurance	$35 copay	$35 copay	$90 copay
Tier 3	N/A	N/A	N/A	$120 copay
Mail order (90-day supply)				
Tier 1 — generics	Deductible, then 10% coinsurance	$30 copay	$30 copay	$25 copay
Tier 2 — preferred	Deductible, then 10% coinsurance	$70 copay	$70 copay	$225 copay

*Non-formulary drugs are not covered.

**Includes an employer HSA contribution depending upon your coverage level and wellness program completion. See page 14 for more information.

Monthly employee payroll contributions for medical plans

Effective January 1, 2024

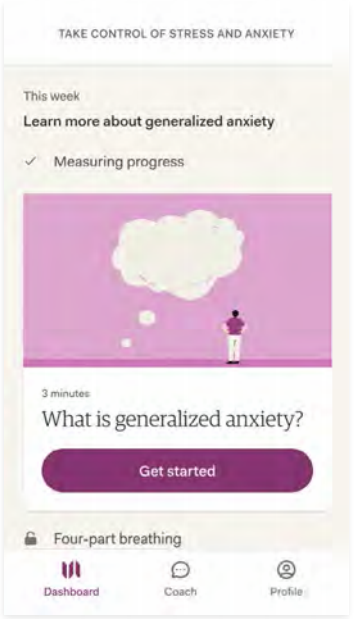
	HSA Health Plan	Standard and Preferred PPO	Surest Plan with wellness credit	Surest Plan without wellness credit
Employee	$151.04	$177.90	$134.58	$159.58
Employee + spouse	$302.10	$354.66	$268.14	$318.14
Employee + child(ren)	$289.78	$340.12	$255.08	$305.08
Family	$441.94	$518.02	$414.68	$464.68

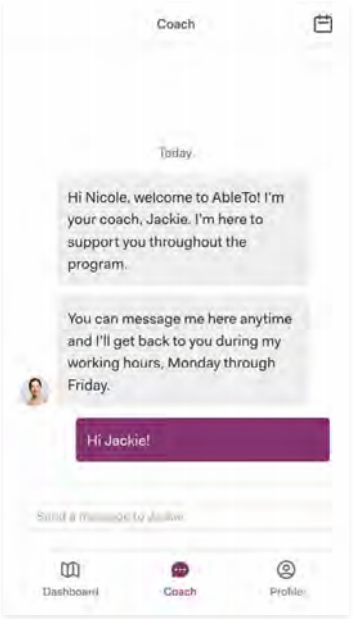
Medical premiums are deducted from your paycheck on a pretax basis.

AbleTo Program

AbleTo Digital+ is a digital self-paced well-being program with the support of a dedicated coach offered at no cost. It is available to members enrolled in the UMR medical benefit plans who are over the age of 18.

This program is focused on members who would like help managing symptoms of depression, stress, or anxiety and want to learn coping tools to make each day more manageable.





Access to activities and motivational coaches

- Mobile or web experience
- 8 weekly modules
- 5-6 bite-sized activities each week
- Unlimited access to a coach via phone, video, in-app messaging, or secure email

To get started

1. To begin, log on to ableto.com/umr.
2. Click on the “Get started” button, which will bring you to a quiz about your emotional health.
3. Upon completion of the quiz, you will be prompted to create an account.
4. After creating an account, you will create a profile and check eligibility.
5. Once your eligibility is confirmed, you will need to complete a questionnaire of self-reported symptoms.
6. You will then be able to review the results of the questionnaire and read about how AbleTo can help you feel better.
7. Once you’ve reviewed your results, AbleTo will empower you to select a focus for your program.

Talkspace

Now you can get the extra support you need in a way that works for you. With Talkspace, you can reach out to a licensed, in-network employee assistance program provider, 24/7.

With Talkspace online therapy, you can regularly communicate with a therapist, safely and securely from your phone or desktop. No office visit required.

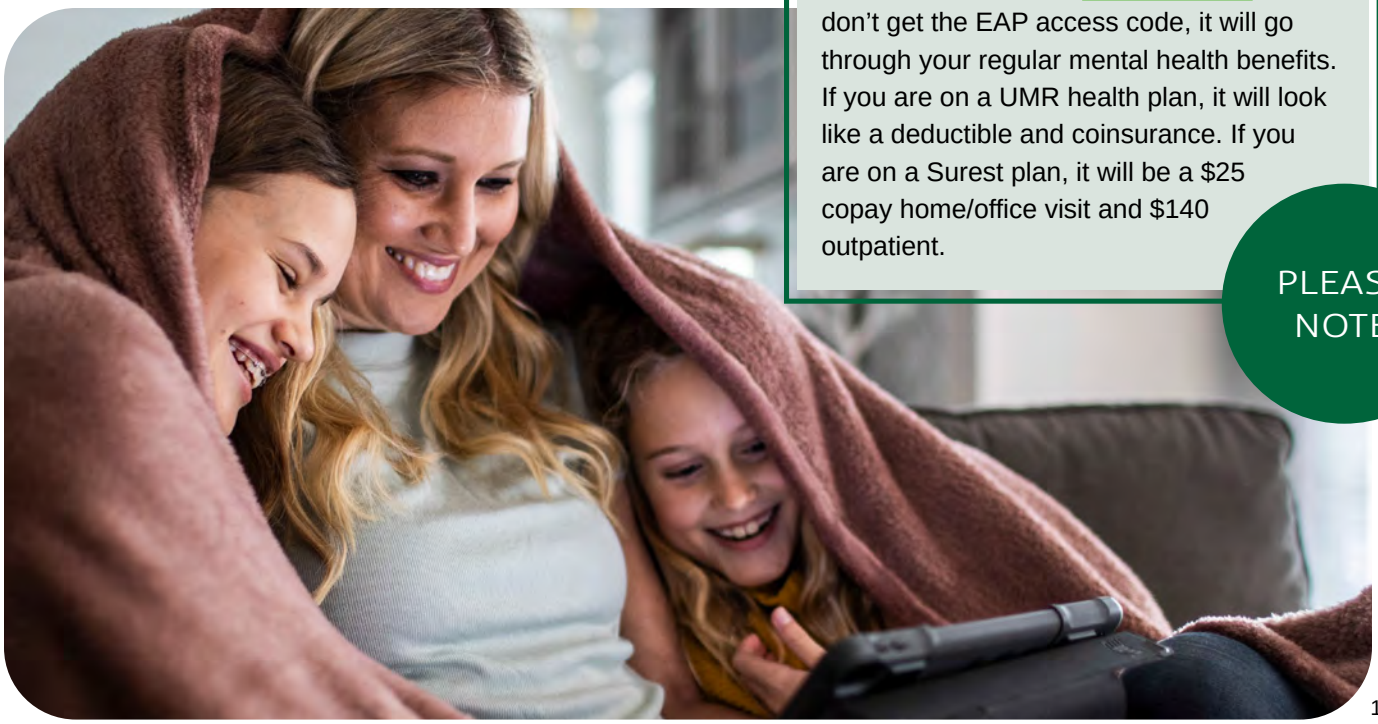
Here's how Talkspace can fit your life:

- Access Talkspace anytime, anywhere.
- Find an EAP provider with an online matching tool.
- Start therapy within hours of choosing your EAP provider.
- Message your EAP provider whenever — no appointments necessary.
- Get messages back throughout the day, five days a week.
- Choose real-time face-to-face video visits by appointment, when needed.

To get started, call your employee assistance program at 866.248.4096 to obtain an authorization code prior to registering (first visit only), choose a provider, and message anywhere, anytime. talkspace.com/connect

After you register, download the Talkspace app on your mobile phone.

Talkspace is your space. To use in your time. It's private, secure, confidential and convenient. And it's covered under your employee assistance program benefits as a participating provider.



PLEASE NOTE

If you access through talkspace.com and don't get the EAP access code, it will go through your regular mental health benefits. If you are on a UMR health plan, it will look like a deductible and coinsurance. If you are on a Surest plan, it will be a $25 copay home/office visit and $140 outpatient.

HEALTH SAVINGS ACCOUNT (HSA)

OPTUM | OPTUMBANK.COM | 866.234.8913

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:

TAX SAVINGS: You contribute pretax dollars to the HSA. Star Tribune will also contribute to your HSA for 2024. See page 14 for employer contribution amounts. Interest accumulates tax-free, and funds are withdrawn tax-free to pay for qualified medical expenses.

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.

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.

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

Following enrollment, you will receive a welcome letter from Optum Bank listing out the following next steps.

1. **REGISTER YOUR ACCOUNT:** Visit optumbank.com and click "Register" to get online account access. Once registered, you can go online to view your account balance, manage your HSA, and tap into many helpful tools and resources.
2. **SIGN AND ACTIVATE YOUR CARD:** Read through the cardholder agreement. Then activate your new Optum Bank debit Mastercard following the activation label instructions.
3. **DOWNLOAD THE OPTUM BANK MOBILE APP:** View your balance, pay bills, upload receipts, and track your progress through the five key stages of HSA savings. Available for Android and Apple devices.

There are times that additional documentation is needed to open the health savings account. In that case another letter will go out with the heading “Notification: Action required for your Health Savings Account.” It states that the USA PATRIOT Act requires Optum to obtain, verify and record information that identifies each person who opens a new account and provides the following instructions:

Here is what you will need to provide

1. A copy of the notification.
2. A copy of your Social Security card.
3. A copy of an unexpired, valid, government-issued form of identification with your photo and current physical address on it (for example, your driver’s license, passport, state or government-issued photo ID).
4. If your photo ID does not have your current physical address, please send a copy of a utility bill with your name and current physical address listed, such as an electricity bill, gas bill, renter’s agreement or mortgage statement.
5. Please make sure all documents are clear and readable. Increase the copy size of your Social Security card and photo ID to 200%.

The notice will instruct you to upload the above documents online at optumbank.com/hsaenroll.

How to make or change contributions to the HSA

Once your account is open, you can access it via 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
- Menstrual products
- Obstetric services
- Over-the-counter medications (e.g., aspirin)
- Medical equipment supplies and services
- Medication with prescriptions
- 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 2024

Under age 55 (and not enrolled in Medicare):

- Up to $4,150 for individual coverage.
- Up to $8,300 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 $5,150 for individual coverage.
- Up to $9,300 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).

2024 Star Tribune employer contributions*

- Individual coverage without wellness: Star Tribune will contribute $650 annually.
- Dependent coverages without wellness: Star Tribune will contribute $1,300 annually.
- Individual coverage with wellness: Star Tribune will contribute an additional $300 or $950 annually.
- Dependent coverages with wellness: Star Tribune will contribute an additional $600 or $1,900 annually.

*Employer HSA contributions are prorated if joining the plan mid-year.

OPTUM BANK

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

UMR TOOLS

How to find a UMR provider

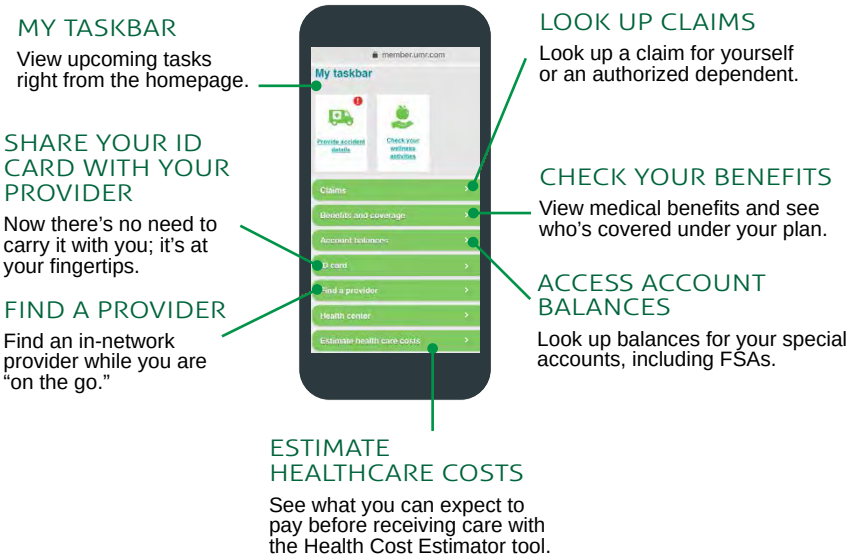
The UnitedHealthcare Choice Plus Network designation identifies doctors in the UMR network who have achieved top results on UMR's quality and cost-efficiency measures.

To find one of these doctors:

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

UMR on the go

Access to your health care benefits information on demand — anytime, anywhere.



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).

Find all of your information when you need it at when you need it on the UMR app or on www.umr.com. You can also call 800.207.3172 anytime, day or night, 365 days a year, for assistance.

BE INFORMED

TELEHEALTH (FOR UMR MEMBERS)

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 800.TELADOC.

Enhanced Telehealth Services Available toYou

- Expert medical services
  - Get an expert medical opinion: Are you unsure about a diagnosis or need help deciding on a treatment option?
  - Get treatment decision support: Receive guidance and clarity on treatment options to make the best decision for your health.
- Mental health care
- Dermatology

DR. ON DEMAND & K HEALTH (FOR SUREST MEMBERS)

Doctor On Demand: virtual urgent care & behavioral health

Doctor On Demand is a fully virtual network of licensed physicians and behavioral health specialists available 24/7 on-demand or by appointment. They can diagnose, treat and prescribe medications.

Key program features

- On-demand virtual consultations with licensed physician or mental health provider
- Virtual urgent care or behavioral health visits by appointment
- Access via smartphone, tablet or computer
- Provers can diagnose, order labs, treat and prescribe medications for many common conditions (UTIs, migraines, mental health issues, skin rashes/acne, cold and flu)

How are the fees structured?

- $49 per virtual visit, billed through claims (mental health visits are higher based on the provider type)

Who is eligible for Dr. On Demand?

- All members enrolled in Surest.

K Health 24/7 primary care services

K Health is a virtual primary and urgent care provider using the power of data and a team of clinicians dedicated to delivering members the quality care they deserve, 24/7, on-demand when they need it.

Key program features

- Full suite of primary care services, coordinated by a care team
- Preventive care, including and annual health checkup with labs and Rx prescribing
- Proactive chronic care management, including common behavioral health concerns
- 24/7 access to doctors for acute and urgent care (no appointment needed)
- Symptom assessment/management leveraging artificial intelligence from billions of medical records

How is K Health Paid?

- Unlimited access to primary care services billed as a claim per active enrollee ($16/month first three months, then $13/month ongoing for active users)
- Enrollee's dependent children ages 3-17 receive primary care services at no charge
- Urgent care services billed as a claim per encounter, if not enrolled in primary care ($19/visit)

Who is eligible for K Health?

- All members enrolled in Surest.

WELLNESS

WELLWORKS FOR YOU | WELLWORKSFORYOU.COM | 800.425.4657

Wellworks For You provides you with tools and resources you can use to improve your overall health and fitness and to maintain it. In 2024, you'll have opportunities to earn incentives by completing key wellness activities.

Who is eligible to participate?

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

Here's what you can earn in 2025

Employee-only coverage

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

If you enroll in the PPO or Surest plan and complete a combination of wellness activities and biometrics, you can earn a $25 monthly reduction in premiums.

Family coverage

You can earn increased contributions to your HSA when you and your covered spouse complete a combination of wellness activities and biometrics.

If you enroll in the PPO or Surest plan and you and your covered spouse complete a combination of wellness activities and biometrics, you can earn a monthly premium reduction of $50.

You can earn an increased HSA contribution, or a PPO or Surest premium reduction in 2025 if you complete these three steps in 2024.

1. Complete the Know Your Number Health Risk Assessment in the wellness portal.
2. Complete one self-reported biometric screening.
3. Complete one wellness activity.

401(K) RETIREMENT

FIDELITY INVESTMENTS | 401K.COM | 800.835.5091

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 500 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 800.835.5091 or at www.401k.com. Fidelity also provides free financial education and resources to employees.

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.401k.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 50% 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 less 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

DELTA DENTAL OF MN | DELTADENTALMN.ORG | 800.553.9536

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.

NOTE: Children can stay on the dental plan until age 26, regardless of student status. To see a current provider directory, please visit 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

*X-rays and fluoride treatments will now be available 2 times per calendar year instead of 2 times every 12 months in 2024.

NEW plan enhancement, Smile Buddies!

- Smile Buddies provides coverage for your child up to 14 years old without adding to your annual maximum.
- Smile Buddies covered benefits include:
  - Cleaning and exams — up to four per calendar year
  - Fillings and crowns — covered
  - Endodontics and periodontics — covered
  - Fluoride treatment — up to four per calendar year
  - X-rays and oral surgery — covered
  - Space maintainers and sealants — covered

Note: It does NOT include orthodontics coverage at 100%.

Employee monthly dental payroll contributions

EFFECTIVE JANUARY 1, 2024

	Monthly contribution
Employee	$7.14
Employee + spouse	$14.30
Employee + child(ren)	$16.90
Family	$25.04

- Dental premiums are deducted from your paycheck on a pretax basis.
- You can elect the Delta Dental plan regardless of whether you are enrolled in the medical plan.
- To print an ID card, log in to www.deltadentalmn.org.

VISION

EYEMED | EYEMED.COM | 866.800.5457

Star Tribune is pleased to offer a voluntary vision plan. EyeMed's vision care benefits include coverage for eye exams, standard lenses and frames, contact lenses, and discounts for laser surgery. The vision plan is built around a network of eye care providers, with better benefits at a lower cost to you when you use providers who belong to the EyeMed network. When you use an out-of-network provider, you will have to pay more for vision services.

Register on eyemed.com or get the EyeMed app (App Store or Goolge Play)

In-network providers include private practitioners as well as selected chains, including Target Optical, LensCrafters, Pearle Vision, and Cohen's Fashion optical. To locate a provider, visit www.eyemed.com.

	In-network	Out-of-network reimbursement
Eye exam (once per 12 months) Preventive eye exams are also covered under the medical plan at in-network providers.	$10 copay	Up to $40
Frames	$150 allowance	Up to $105
Fit and follow-up exams	$40 copay	N/A
Standard lenses (once per 12 months)		
Single vision	$25 copay	Up to $30
Bifocal	$25 copay	Up to $50
Trifocal	$25 copay	Up to $70
Lenticular	$25 copay	Up to $70
Contact lenses (once per 12 months)		
Medically necessary	$0 copay	Up to $210
Elective	$150 allowance	Up to $105

Value adds

- 40% off additional pairs of glasses and a 15% discount on conventional lenses once funded benefit is used
- 20% off any item not covered by the plan, including non-prescription sunglasses
- LASIK or PRK from US Laser Network 15% off retail price or 5% off promotional price call 800.988.4221
- Amplifon Hearing Health Care Network 40% off hearing exams and a low price guarantee on discounted hearing aids call 877.203.0675

Log into eyemed.com/member to see all plans included in your benefits.

Employee monthly vision payroll contributions

EFFECTIVE JANUARY 1, 2024

	Monthly contribution
Employee	$7.60
Employee + spouse	$14.42
Employee + child(ren)	$15.18
Family	$22.32

- You can elect the EyeMed vision plan regardless of whether you are enrolled in the medical or dental plan.
- You will receive a printed ID in your welcome packet but can also access your electronic ID card via the EyeMed app.
- This is a voluntary benefit, so employees pay 100% of the cost through pretax payroll deductions.

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 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. The value of dependent life coverage paid for by your employer is also taxable. 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

THE HARTFORD | THEHARTFORD.COM/EMPLOYEE-BENEFITS | 860.547.5000

You have the opportunity to purchase voluntary life for yourself and your spouse. 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 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 are able to purchase voluntary AD&D insurance for yourself and/or your family.

If you did not enroll in voluntary 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	$0.08	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

Example

If the rate is $0.40 per $1,000 and an 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

HEALTHPARTNERS | HEALTHPARTNERS.COM | 952.883.7540
THE HARTFORD | THEHARTFORD.COM/EMPLOYEE-BENEFITS | 860.547.5000

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. You must apply for short-term disability benefits through HealthPartners Worksite Health at 952-883-7540 or WSH @ healthpartners.com.

*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 or 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 percentage of your annual salary, until you reach Social Security normal 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.

FEDLOGIC

FEDLOGICGROUP.COM | SERVICES@FEDLOGICGROUP.COM | 877.837.4196

New for 2024! Are you or your spouse ready to retire in the next year? Do you know if you or your family members are eligible for other health insurance plans offered by federal or state programs? Are you confused by all the complex information about Medicare, Medicaid, Social Security benefits or disability benefits?

Star Tribune has partnered with FEDlogic to provide guidance to explore alternative healthcare options for you and your family. The service is **confidential**, unlimited and provided at no cost to you.

Reasons for you or a household member to call FEDlogic

- You've reached or are approaching Medicare age and need to learn more
- You're approaching retirement age and want to learn more about your Social Security benefits
- You or a household family member has been diagnosed with a major illness
- You have a child with a disability or who was born prematurely
- You have lost a spouse
- You need assistance navigating Medicaid, Marketplace or COBRA
- You need help exploring alternative healthcare avenues based on your income
- You are currently on dialysis (ESRD)

How FEDlogic works

MAKE A PHONE CONSULTATION APPOINTMENT. Be sure to make the appointment at a time when family members are available to listen and ask questions as well. Calls typically last an hour.

TELL FEDLOGIC YOUR STORY, ASK QUESTIONS AND LEARN. You don't have to go through complex and confusing information to try and figure out what applies to you. They take the time to listen to your story and understand your needs, concerns and goals. Then they empower you with the information you need so you can maximize your benefits and make the best decision for your situation.

ENROLL FOR BENEFITS. Once you feel confident you have the information you need to make the best decision for you and your family, FEDlogic will walk you through the application and approval process.

RELAX AND CELEBRATE. Without education and guidance, many people are overpaying for benefits when they could be tapping into federal or state benefits that have great coverage and lower costs. By calling FEDlogic, you'll know you are getting all the benefits you and your family deserve.

HEALTHCARE FLEXIBLE SPENDING ACCOUNT (FSA)

UMR | UMR.COM | 800.826.9781

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 pocket 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, 2025, to file claims for expenses incurred during the plan year.

The FSA Carryover allows you to carry forward up to $550 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 $550 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 rollover funds.

TAX-FAVORED ACCOUNT

Healthcare FSA

The healthcare FSA lets you pay for certain IRS-approved medical care expenses not covered by your insurance plan with pretax 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 pretax 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 lets you avoid 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 $3,050 per plan year, and the minimum contribution is $250 annually.*

*Limits subject to change.

DEPENDENT CARE FLEXIBLE SPENDING ACCOUNT

UMR | UMR.COM | 800.826.9781

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, 2025, 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 FSA elections can be made only during open enrollment or if you experience a qualifying life event.

EMOTIONAL WELLBEING SOLUTIONS EMPLOYEE ASSISTANCE PROGRAM (EAP)

OPTUM | LIVEANDWORKWELL.COM | 866.248.4096 | CODE: STARTRIB

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 Optum EAP 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.

Counseling

Solution-focused consultation with an EAP intake counselor:

- You and every covered family member may attend five (5) counseling sessions for each problem per year at no cost to you. Members can schedule either in-person visits in their community, OR virtual visits, if preferred. You do not need to be enrolled in medical to use EAP services.
- Get expert guidance on managing almost any challenge affecting your well-being.
- Specialists listen and help identify issues, barriers, and ways to overcome them.
- No appointment necessary.
- Available 24/7 by phone.

ID Theft Services

ID Theft Core includes identity theft and fraud resolution services. It assists you at the beginning of fraud-related emergencies and offers an affordable and expedient process that:

- Provides you with free 60-minute consultations with fraud specialist who conduct seven emergency response activities
- Assists with restoring your identity and good credit
- To learn more or to use this service contact Optum

Legal services

Access to licensed state-specific attorneys:

- One 30-minute telephonic or in-person consultation with a Legal professional per year at no cost to you
- Ongoing representation by an attorney at a 25% discounted rate, paid by the member.
  - Consumer issues
  - Criminal matters
  - Deeds
  - IRS matters
  - Living wills
  - Power of attorney
  - Probate
  - Separation and divorce
  - Traffic matters
  - Trusts
  - And more

Financial consultations and advice

Access to credentialed financial professionals

- One telephonic consultation (30 to 60 minutes in length) per member per year
  - Bankruptcy
  - Budget management
  - College funding
  - Debt reduction
  - Estate planning
  - Investment plans
  - Retirement planning
  - Taxes

For more information and resources:

CONTACT OPTUM 24/7 AT: 866.248.4096
GO ONLINE: www.liveandworkwell.com
CODE: StarTrib

OPTUM EAP

CONTACTS

Medical and pharmacy

UMR

Member services: 800.207.3172
Website: www.umr.com

Surest

Member services: 866.683.6440
Website: join.surest.com/startribune
Access code: startribune2024

OptumRx

Member services: 877.559.2955
Website: www.optumrx.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.401k.com

FedLogic

Customer service: 877.837.4196
Email: services@fedlogicgroup.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

Vision

EyeMed

Customer service: 866.800.5457
Website: www.eyemed.com
Insight network

Emotional Wellbeing Solutions (EAP)

Optum

Hotline: 866.248.4096
Website: www.liveandworkwell.com
Code: StarTrib

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

IMPORTANT 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 Media Company, LLC Employee Health Care 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, 2024
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.

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 Comprehensive Welfare Benefit and Cafeteria

These plans comprise what is called an "Affiliated Covered Entity," and are treated as a single plan for purposes of this notice and the privacy rules that require it. For purposes of this notice, we will refer to these plans as a single "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 disenrollments, 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 Human Resources
HR HIPPA Privacy Official
612-673-7458

Organized Health Care Arrangement Designation

The Plan participates in what the federal privacy rules call an "Organized Health Care Arrangement." The purpose of that participation is that it allows PHI to be shared between the members of the Arrangement, without authorization by the persons whose PHI is shared, for health care operations. Primarily, the designation is useful to the Plan because it allows the insurers who participate in the Arrangement to share PHI with the Plan for purposes such as shopping for other insurance bids.

The members of the Organized Health Care Arrangement are:

Star Tribune Media Company, LLC Medical Plan
Star Tribune Media Company, LLC Flexible Benefits Plan

Effective Date

The effective date of this notice is: January 1, 2024.

NOTICE OF SPECIAL ENROLLMENT RIGHTS

STAR TRIBUNE MEDIA COMPANY, LLC EMPLOYEE HEALTH CARE PLAN

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

Introduction

You're getting this notice because you recently gained coverage under a group health plan (the Plan). This notice has important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. **This notice explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect your right to get it.** When you become eligible for COBRA, you may also become eligible for other coverage options that may cost less than COBRA continuation coverage.

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 other members of your family when group health coverage would otherwise end. For more information about your rights and obligations under the Plan and under federal law, you should review the Plan's Summary Plan Description or contact the Plan Administrator.

You may have other options available to you when you lose group health 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.

What is COBRA continuation coverage?

COBRA continuation coverage is a continuation of Plan coverage when it would otherwise end because of a life event. This is also called a "qualifying event." Specific qualifying events are listed later in this notice. After a qualifying event, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." You, your spouse, and your dependent children could become qualified beneficiaries if coverage under the Plan is lost because of the qualifying event. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

If you're an employee, you'll become a qualified beneficiary if you lose your coverage under the Plan because of the following qualifying events:

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

If you're the spouse of an employee, you'll become a qualified beneficiary if you lose your coverage under the Plan because of the following qualifying events:

- 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 entitled to Medicare benefits (under Part A, Part B, or both); or
- You become divorced or legally separated from your spouse.

Your dependent children will become qualified beneficiaries if they lose coverage under the Plan because of the following qualifying events:

- 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 entitled to Medicare benefits (Part A, Part B, or both);
- The parents become divorced or legally separated; or
- The child stops being eligible for coverage under the Plan as a "dependent 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 will become a qualified beneficiary. The retired employee's spouse, surviving

spouse, and dependent children will also become qualified beneficiaries if bankruptcy results in the loss of their coverage under the Plan.

When is COBRA continuation coverage available?
The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred. The employer must notify the Plan Administrator of the following qualifying events:

- 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;
- The employee's becoming entitled to Medicare benefits (under Part A, Part B, or both).

For all other qualifying events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), you must notify the Plan Administrator within 60 days after the qualifying event occurs. You must provide this notice in writing to the Plan Administrator. 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. The Plan Administrator will direct you to provide the appropriate documentation to show proof of the event.

How is COBRA continuation coverage provided?
Once the Plan Administrator receives 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 on behalf of their spouses, and parents may elect COBRA continuation coverage on behalf of their children.
COBRA continuation coverage is a temporary continuation of coverage that generally lasts for 18 months due to employment termination or reduction of hours of work. Certain qualifying events, or a second qualifying event during the initial period of coverage, may permit a beneficiary to receive a maximum of 36 months of coverage.

There are also ways in which this 18-month period of COBRA continuation coverage can be extended:
Disability extension of 18-month period of COBRA continuation coverage
If you or anyone in your family covered under the Plan is determined by Social Security to be disabled and you notify the Plan Administrator in a timely fashion, you and your entire family may be entitled to get up to an additional 11 months of COBRA continuation coverage, for a maximum of 29 months. The disability would have to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of COBRA continuation coverage. If you believe you are eligible for this extension, contact the Plan Administrator.

Second qualifying event extension of 18-month period of continuation coverage
If your family experiences another qualifying event during the 18 months of COBRA continuation coverage, the spouse and dependent children in your family can get up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if the Plan is properly notified about the second qualifying event. This extension may be available to the spouse and any dependent children getting COBRA continuation coverage if the employee or former employee dies; becomes entitled to Medicare benefits (under Part A, Part B, or both); gets divorced or legally separated; or if the dependent child stops being eligible under the Plan as a dependent child. This extension is only available if the second qualifying event would have caused the spouse or dependent child to lose coverage under the Plan had the first qualifying event not occurred.

Are there other coverage options besides COBRA Continuation Coverage?
Yes. Instead of enrolling in COBRA continuation coverage, there may be other coverage options for you and your family through the Health Insurance Marketplace, Medicare, Medicaid, Children's Health Insurance Program (CHIP), 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**.

Can I enroll in Medicare instead of COBRA continuation coverage after my group health plan coverage ends?

In general, if you don't enroll in Medicare Part A or B when you are first eligible because you are still employed, after the Medicare initial enrollment period, you have an 8-month special enrollment period[1] to sign up for Medicare Part A or B, beginning on the earlier of

- The month after your employment ends; or
- The month after group health plan coverage based on current employment ends.

If you don't enroll in Medicare and elect COBRA continuation coverage instead, you may have to pay a Part B late enrollment penalty and you may have a gap in coverage if you decide you want Part B later. If you elect COBRA continuation coverage and later enroll in Medicare Part A or B before the COBRA continuation coverage ends, the Plan may terminate your continuation coverage. However, if Medicare Part A or B is effective on or before the date of the COBRA election, COBRA coverage may not be discontinued on account of Medicare entitlement, even if you enroll in the other part of Medicare after the date of the election of COBRA coverage.

If you are enrolled in both COBRA continuation coverage and Medicare, Medicare will generally pay first (primary payer) and COBRA continuation coverage will pay second. Certain plans may pay as if secondary to Medicare, even if you are not enrolled in Medicare.

For more information visit https://www.medicare.gov/medicare-and-you.

If you have questions

Questions concerning your Plan or your COBRA continuation coverage rights should be addressed to the contact or contacts identified below. For more information about your rights under the Employee Retirement Income Security Act (ERISA), including COBRA, the Patient Protection and Affordable Care Act, and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit **www.dol.gov/ebsa**. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.) For more information about the Marketplace, visit **www.HealthCare.gov**.

Keep your Plan informed of address changes

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

Plan contact information

For additional information regarding your COBRA continuation coverage rights, please contact the Plan Administrator below:

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

[1] https://www.medicare.gov/sign-up-change-plans/how-do-i-get-parts-a-b/part-a-part-b-sign-up-periods.

WOMEN'S HEALTH AND CANCER RIGHTS NOTICE

Star Tribune Media Company, LLC Employee Health Care 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.

If you would like more information on WHCRA benefits, please refer to your Summary Plan Description or contact your Plan Administrator at:

Star Tribune Benefits
Benefits Manager
612-673-7458

NOTICE FOR EMPLOYER-SPONSORED WELLNESS PROGRAMS

Star Tribune Media Company, LLC Wellness Program is a voluntary wellness program available to Employees and Spouses enrolled in the Star Tribune medical benefit 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.

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 education or health 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) a doctor and UMR/Surest 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. The following additional confidentiality protections apply: . 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.

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, 2023. Contact your State for more information on eligibility –

ALABAMA – Medicaid	ALASKA – Medicaid
Website: http://myalhipp.com/ Phone: 1-855-692-5447	The AK Health Insurance Premium Payment Program Website: http://myakhipp.com/ Phone: 1-866-251-4861 Email: CustomerService@MyAKHIPP.com Medicaid Eligibility: https://health.alaska.gov/dpa/Pages/default.aspx
ARKANSAS – Medicaid	**CALIFORNIA – Medicaid**
Website: http://myarhipp.com/ Phone: 1-855-MyARHIPP (855-692-7447)	Health Insurance Premium Payment (HIPP) Program Website: http://dhcs.ca.gov/hipp Phone: 916-445-8322 Fax: 916-440-5676 Email: hipp@dhcs.ca.gov
COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)	**FLORIDA – Medicaid**
Health First Colorado Website: https://www.healthfirstcolorado.com/ Health First Colorado Member Contact Center: 1-800-221-3943/State Relay 711 CHP+: https://hcpf.colorado.gov/child-health-plan-plus CHP+ Customer Service: 1-800-359-1991/State Relay 711 Health Insurance Buy-In Program (HIBI): https://www.mycohibi.com/ HIBI Customer Service: 1-855-692-6442	Website: https://www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html Phone: 1-877-357-3268

GEORGIA – Medicaid	INDIANA – Medicaid
GA HIPP Website: https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp Phone: 678-564-1162, Press 1 GA CHIPRA Website: https://medicaid.georgia.gov/programs/third-party-liability/childrens-health-insurance-program-reauthorization-act-2009-chipra Phone: 678-564-1162, Press 2	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: https://www.in.gov/medicaid/ Phone: 1-800-457-4584
IOWA – Medicaid and CHIP (Hawki)	**KANSAS – Medicaid**
Medicaid Website: https://dhs.iowa.gov/ime/members Medicaid Phone: 1-800-338-8366 Hawki Website: http://dhs.iowa.gov/Hawki Hawki Phone: 1-800-257-8563 HIPP Website: https://dhs.iowa.gov/ime/members/medicaid-a-to-z/hipp HIPP Phone: 1-888-346-9562	Website: https://www.kancare.ks.gov/ Phone: 1-800-792-4884 HIPP Phone: 1-800-967-4660
KENTUCKY – Medicaid	**LOUISIANA – Medicaid**
Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP) Website: https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx Phone: 1-855-459-6328 Email: KIHIPP.PROGRAM@ky.gov KCHIP Website: https://kidshealth.ky.gov/Pages/index.aspx Phone: 1-877-524-4718 Kentucky Medicaid Website: https://chfs.ky.gov/agencies/dms	Website: www.medicaid.la.gov or www.ldh.la.gov/lahipp Phone: 1-888-342-6207 (Medicaid hotline) or 1-855-618-5488 (LaHIPP)
MAINE – Medicaid	**MASSACHUSETTS – Medicaid and CHIP**
Enrollment Website: https://www.mymaineconnection.gov/benefits/s/?language=en_US Phone: 1-800-442-6003 TTY: Maine relay 711 Private Health Insurance Premium Webpage: https://www.maine.gov/dhhs/ofi/applications-forms Phone: 1-800-977-6740 TTY: Maine relay 711	Website: https://www.mass.gov/masshealth/pa Phone: 1-800-862-4840 TTY: 711 Email: masspremassistance@accenture.com
MINNESOTA – Medicaid	**MISSOURI – Medicaid**
Website: https://mn.gov/dhs/people-we-serve/children-and-families/health-care/health-care-programs/programs-and-services/other-insurance.jsp Phone: 1-800-657-3739	Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005
MONTANA – Medicaid	**NEBRASKA – Medicaid**
Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084 Email: HHSHIPPProgram@mt.gov	Website: http://www.ACCESSNebraska.ne.gov Phone: 1-855-632-7633 Lincoln: 402-473-7000 Omaha: 402-595-1178

NEVADA – Medicaid	NEW HAMPSHIRE – Medicaid
Medicaid Website: http://dhcfp.nv.gov Medicaid Phone: 1-800-992-0900	Website: https://www.dhhs.nh.gov/programs-services/medicaid/health-insurance-premium-program Phone: 603-271-5218 Toll free number for the HIPP program: 1-800-852-3345, ext. 5218
NEW JERSEY – Medicaid and CHIP	**NEW YORK – Medicaid**
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	Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831
NORTH CAROLINA – Medicaid	**NORTH DAKOTA – Medicaid**
Website: https://medicaid.ncdhhs.gov/ Phone: 919-855-4100	Website: https://www.hhs.nd.gov/healthcare Phone: 1-844-854-4825
OKLAHOMA – Medicaid and CHIP	**OREGON – Medicaid**
Website: http://www.insureoklahoma.org Phone: 1-888-365-3742	Website: http://healthcare.oregon.gov/Pages/index.aspx Phone: 1-800-699-9075
PENNSYLVANIA – Medicaid and CHIP	**RHODE ISLAND – Medicaid and CHIP**
Website: https://www.dhs.pa.gov/Services/Assistance/Pages/HIPP-Program.aspx Phone: 1-800-692-7462 CHIP Website: Children's Health Insurance Program (CHIP) (pa.gov) CHIP Phone: 1-800-986-KIDS (5437)	Website: http://www.eohhs.ri.gov/ Phone: 1-855-697-4347, or 401-462-0311 (Direct RIte Share Line)
SOUTH CAROLINA – Medicaid	**SOUTH DAKOTA - Medicaid**
Website: https://www.scdhhs.gov Phone: 1-888-549-0820	Website: http://dss.sd.gov Phone: 1-888-828-0059
TEXAS – Medicaid	**UTAH – Medicaid and CHIP**
Website: Health Insurance Premium Payment (HIPP) Program | Texas Health and Human Services Phone: 1-800-440-0493	Medicaid Website: https://medicaid.utah.gov/ CHIP Website: http://health.utah.gov/chip Phone: 1-877-543-7669
VERMONT– Medicaid	**VIRGINIA – Medicaid and CHIP**
Website: Health Insurance Premium Payment (HIPP) Program | Department of Vermont Health Access Phone: 1-800-250-8427	Website: https://coverva.dmas.virginia.gov/learn/premium-assistance/famis-select https://coverva.dmas.virginia.gov/learn/premium-assistance/health-insurance-premium-payment-hipp-programs Medicaid/CHIP Phone: 1-800-432-5924
WASHINGTON – Medicaid	**WEST VIRGINIA – Medicaid and CHIP**
Website: https://www.hca.wa.gov/ Phone: 1-800-562-3022	Website: https://dhhr.wv.gov/bms/ http://mywvhipp.com/ Medicaid Phone: 304-558-1700 CHIP Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)

WISCONSIN – Medicaid and CHIP	WYOMING – Medicaid
Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm Phone: 1-800-362-3002	Website: https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/ Phone: 1-800-251-1269

To see if any other states have added a premium assistance program since July 31, 2023, 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 1/31/2026)

NOTES

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.

FS: 2667256