BE CONNECTED TO YOUR BENEFITS

2013 ANNUAL ENROLLMENT

HEARST *corporation*

Make Sure You Enroll On Time!

2013 Annual Enrollment
November 19 – December 5, 2012

BE *connected*. Enroll Now!

Welcome to 2013 CHOICE Health Care Program Enrollment!

As a Hearst Corporation employee, your work delivers content that inspires, enlightens, and educates. You connect people, ideas, and information. Equally important is the need for you to be connected to your health at Annual Enrollment and throughout the year.

Annual Enrollment is your once-a-year opportunity to review the CHOICE Health Care Program options available to you, decide which coverage will be best for your and your family's needs for 2013, and enroll for your 2013 benefits. You'll be able to:

- Select the medical, dental, and/or vision coverage you want for 2013;
- Elect to contribute to a Health Savings Account (if you enroll in CDHP medical coverage for 2013);
- Elect to contribute to a Health Care and/or Dependent Care Flexible Spending Account (FSA) for 2013; and
- Decide which dependents to cover in 2013.

You can only enroll in a CHOICE plan outside of the Annual Enrollment period if you experience a qualified status change. Generally, a qualified status change includes events such as birth, marriage, loss of benefits, or loss of employment. For more information, view the **Life Events** section on **BenefitsInsider** at **www.benefitsinsider.com**.

We want you to be informed and understand your health care benefit options and their costs. We want you to be involved in choosing and using your health care coverage. We want you to be connected to your benefits now and throughout the year so you gain the most value from them. Please review this Guide carefully; it connects you to your 2013 CHOICE Health Care Program benefits.

BE *informed*. BE *involved*. BE *connected*.

Enrolling if You Are a New Hire

If you are a new hire, you must enroll for the CHOICE Program by the date indicated in your enrollment material. If you don't, you will automatically waive all CHOICE Program coverage. You will not have any medical, dental, and/or vision coverage for 2013, and you will not be able to contribute to a Health Care Flexible Spending Account or a Dependent Care Flexible Spending Account in 2013. You can only enroll in a CHOICE plan when you first become eligible, during the Annual Enrollment period (usually in November), or if you experience a qualified status change.

What Happens If I Don't Enroll During Annual Enrollment?

If you don't enroll in medical, dental, and/or vision coverage during 2013 Annual Enrollment, you will receive the same level of coverage that you had in 2012 at 2013 contribution rates. You must actively elect to contribute to an **FSA(s) and/or Health Savings Account (HSA)** if you wish to have one in 2013. **Even if you were enrolled in an FSA(s) or HSA in 2012, your contributions will default to zero if you do not actively enroll for 2013.**

Before You Enroll...

Step 1 — Be Informed about Your Benefits

- Read this Guide to learn about your CHOICE benefits, including what's changing for 2013, so you have the information you need to gain the most value from them.
- Learn about the medical, dental, and vision plans and tax-advantaged accounts available in the **CHOICE Health Care Program** section on page **7**.
- Become familiar with the differences between a **Health Care FSA**, **Health Savings Account (HSA)**, and **Health Reimbursement Account (HRA)** and the tax-savings opportunities each offers. You'll find all the information you need in the **FSA, HSA, and HRA** section of this Guide on page **24**.

Step 2 — Be Involved so You Can Make the Best Choices for Your 2013 Benefits

- Take advantage of the tools available to help you understand your benefits better and to make informed decisions for 2013.
  - The **Medical** and **Dental Plan Comparison charts** on pages **12 – 17** provide a side-by-side comparison of the benefits offered by each plan. The **Vision Plan chart** on page **18** provides highlights of the plan.
  - The **Medical** and **Dental Plan Compare** tools on **BenefitsInsider** allow you to look at the specific benefit provisions of only the plans that interest you.
  - Use the **Health Care** and **Dependent Care FSA Calculators** on **BenefitsInsider** to help you determine how much to contribute to these accounts based on personal information that you provide.
  - Visit the **Choosing Your Plan** section on page **21** to see what low, medium, and high-cost medical usage would cost with each medical plan.
  - Look at the **Summaries of Benefits and Coverage (SBCs)** on **BenefitsInsider** for information such as provider networks, drug tiers, and cost-sharing differences under each plan. These Summaries, required under Health Care Reform, are intended to make it easier to understand information about certain medical plan features. You can also call Cigna to request paper copies free of charge. If you are eligible for the Kaiser HMO, the Kaiser HMO SBC will also be available.
  - For information on dental and vision benefits, please refer to the SPDs.

Step 3 — Be Connected and Enroll

- Enroll for your medical, dental, vision, and/or FSA coverage online by **December 5**.
  - If you elect the Consumer Driven Health Plan (CDHP), you may also choose to contribute to an HSA (Health Savings Account) when you enroll.
- Visit the **Enrollment** page on **BenefitsInsider** to enroll for your benefits now!

Changes for 2013

What's New for 2013 Annual Enrollment

For 2013, the only changes to your CHOICE Program benefits will be those mandated by Health Care Reform and other regulations. There will be no plan changes; however, Hearst is realigning its strategy for setting your medical plan contributions.

- **Contribution increases**. Hearst continues to offer comprehensive health care coverage that is competitive with the benefits offered by peer media companies. However, rising health care costs make this challenging to sustain. To continue to offer the same level of benefits and ensure coverage is affordable for both Hearst and you, we will be changing how we share health care costs with you for 2013. As a result, you may have an increase in contributions depending on the plan option you choose and your salary level. Please see the **Salary-Based Contributions** section of this Guide on page 5 for more information on what you will pay for coverage in 2013.

- **Expanded coverage for women's preventive health services**. Beginning in 2013, the following women's preventive services will be covered at 100% in-network with no deductible or copays under all CHOICE Health Care Plans:
  - Well woman exams;
  - Gestational diabetes screening;
  - Human papillomavirus (HPV) DNA testing for women age 30 and older;
  - Screening for sexually transmitted infections;
  - Screening and counseling for HIV;
  - Screening and counseling for domestic violence;
  - Counseling for and payment of FDA-approved contraception methods (e.g., generic and single-source brand oral contraception, emergency contraception, injectables, etc.);
  - Counseling for breastfeeding and payment of rental equipment and supplies.

- **New limit on Health Care Flexible Spending Account (FSA) contributions**. For 2013, the most you can contribute to a Health Care Flexible Spending Account (FSA) will be $2,500.

- **Increased Health Savings Accounts (HSA) contribution limits**. For 2013, the most you can contribute to a Health Savings Account (HSA) if you're enrolled in the Consumer Directed Health Plan (CDHP) is $3,250 if you are enrolled in individual coverage and $6,450 if you are enrolled in family coverage.

- **Medco is now part of the Express Scripts family of pharmacies**. Your prescription drug coverage is not affected; only the name has changed. As part of the rebranding, when you log on to the website at **www.express-scripts.com**, you may be asked to read and accept a new Terms of Use, if you have not already done so. After that, you will be able to continue to use the website as before.

Salary-Based Contributions

Health care costs continue to increase nationwide and for Hearst as well. To offset rising costs, we are implementing a new contribution strategy to ensure everyone will pay his or her fair share for medical coverage.

In 2013, the amount that will be deducted from your paycheck for PPO Plan medical coverage or, if available to you, the Traditional Plan or Kaiser HMO medical coverage, will be determined by your annual compensation. This is commonly referred to as salary banding, and higher-paid employees will pay more for their medical/prescription drug coverage. Tying contributions more closely to what people can afford is a more equitable way to share costs while helping to control the overall cost of Hearst's plans.

Contributions for the CDHP and the CHOICE Allowance Plan will not be based on your compensation. CDHP contributions are not increasing for anyone, and CHOICE Allowance Plan contributions are not increasing for most employees. These plans are more cost-effective for Hearst and for you because you are more involved in making financial decisions about the care received.

Be sure you know how much each medical plan option will cost you in 2013. Then consider which plan option may be best for you. You will need to weigh the upfront cost of enrolling (your paycheck contributions) and future costs you may incur if and when you use the plan (your deductible, copays, and coinsurance). Be sure to consider the CDHP and the CHOICE Allowance Plan; both of these medical plan options will continue to cost you significantly less in paycheck contributions than the PPO Plan or the Traditional Plan or Kaiser HMO (if available) in 2013. It may be time to give one of these plans a try!

Hearst will continue to review its contribution strategy annually and make adjustments as needed to ensure we manage our plans responsibly. It's our intent to maintain a cost-sharing strategy that continues to make medical coverage affordable for the majority of our employees.

Here are answers to some questions you may have about salary-based medical plan contributions:

Question: How is my compensation determined for salary band purposes?
Answer: Your compensation is your annual salary as of September 30, 2012, plus any bonuses and/or commissions you received in the 12 months prior to September 30, 2012.

Question: I am a new employee hired after September 30, 2012. What compensation will be used to determine my salary band for 2013?
Answer: For 2013, your compensation is your annual salary as of your date of hire. For 2014 medical plan contributions, your annual salary as of September 30, 2013, plus any bonuses and/or commissions in the 12 months prior to September 30, 2013, will be used to determine your salary band.

Question: What happens if my compensation changes during the year?
Answer: Any changes to your salary after September 30, 2012, will not affect your salary band for 2013.

Question: What are the salary bands?
Answer: There are three salary bands:

- Band 1: $0 – $100,000;
- Band 2: $100,001 – $250,000;
- Band 3: $250,001 or more.

Question: How were the salary bands determined?
Answer: We wanted an approach to share increased medical plan costs for 2013 with employees that also minimized the increase in contributions for most Hearst employees. We reviewed compensation data for our workforce and determined that compensation for approximately 75% of our workforce was less than $100,000 and compensation for 5% of our workforce was over $250,000. Compensation for the remaining 20% of our workforce falls in between these two groups. Creating these three salary bands allowed us to lessen the impact of increases in health care costs and related medical insurance premiums for employees earning $100,000 or less.

Question: If I move to a different unit in the middle of the year, will my salary band change?
Answer: Transferring between units will not affect your salary band.

Question: What benefits does salary banding apply to?
Answer: Salary banding applies to your contributions for PPO, Traditional Plan or Kaiser HMO medical/prescription drug coverage. It does not apply to your contributions for dental or vision coverage or if you enroll in the CHOICE Allowance Plan or CDHP.

Question: I currently pay for my medical/prescription drug coverage on a before-tax basis. Does salary banding affect this?
Answer: You will continue to pay for your medical/prescription drug, dental, and vision coverage on a before-tax basis.

Question: Why should I pay my monthly contributions for medical/prescription drug coverage with before-tax dollars?
Answer: Paying with before-tax dollars allows you to take home more money in your paycheck because taxes are calculated *after* your contributions are deducted. This reduces your taxable income, which lowers your taxes and saves you money.

Question: Will my dental and vision plan contributions increase for 2013?
Answer: Your dental plan contributions will increase slightly and vision plan contributions will remain the same for 2013.

Question: How much is PPO Plan or Traditional Medical Plan coverage increasing?
Answer: The amount of increase depends on your coverage level and your salary band. Employees can expect anywhere from a 5% to 28% increase in contributions. You can log on to **www.benefitsinsider.com** and view a 2013 medical plan contribution summary to see your cost for coverage in 2013.

Question: How do I know if CHOICE Allowance Plan contributions are increasing for me?
Answer: You can log on to **www.benefitsinsider.com** and view a 2013 medical plan contribution summary to see your cost for coverage in 2013.

The CHOICE Health Care Program Plans

This year, Annual Enrollment is all about being connected to your benefits and using Hearst-provided resources to make informed health care decisions. With so much to choose from, it's important that you use the resources in this Guide and on **BenefitsInsider** to understand and consider your benefit choices.

Read through your medical plan options to a get a sense of how each plan works, then check out the **Medical Plans At-a-Glance chart** on page **20** for more details. Remember, all the options cover the same health care services and protect you in the event of a catastrophic illness. No matter which plan you choose, you'll have access to comprehensive health care and the flexibility to use any provider you choose.

How can I compare the medical plans against each other?

View the **Medical Plans At-a-Glance** on page **20** or the **Medical Plan Comparison Chart** on page **12** of this Guide.

Medical

Consumer Directed Health Plan (CDHP)

The CDHP is a high deductible health plan that combines low paycheck contributions with a deductible higher than the PPO Plan but lower than the CHOICE Allowance Plan. One of the CDHP's key features is a Health Savings Account (HSA), an employee-funded account with before-tax advantages that you can use for eligible medical expenses. The funds accumulate year to year, so you can put aside money for any unexpected medical expenses. The account is also portable — you take it with you, even if you leave the Company. The CDHP's high deductible is intended to encourage you to spend money on health care on an as-needed basis, and all covered services, including prescription drugs, are subject to the same deductible, except in-network medical expenses for preventive care.

CHOICE Allowance Plan

The CHOICE Allowance Plan is a high deductible health plan that features a Hearst-funded Health Reimbursement Account (HRA) that you can use to pay for eligible health care expenses. If you enroll for 2013, Hearst contributes $300 to your HRA if you enroll in individual coverage or $600 to your HRA if you enroll in family coverage. Any money left over in your account at year end will roll over to the next plan year as long as you continue to re-enroll in the CHOICE Allowance Plan. You can use these funds to pay for some of your health care expenses before you meet the deductible. Prescription drug benefits under the CHOICE Allowance Plan have a separate $75 per person deductible for prescriptions filled at a retail pharmacy.

Preferred Provider Organization (PPO) Plan

The PPO Plan provides the flexibility of coverage for in- and out-of-network care and features the highest paycheck contributions with the lowest annual deductible. When you visit an in-network doctor, you pay a $25 copay, except for preventive care services through an in-network doctor, which are covered at 100%. Prescription drug benefits under the PPO Plan have a separate $75 per person deductible for prescriptions filled at a retail pharmacy.

Traditional Medical Plan and Kaiser HMO

These options are available to limited participants in certain business units. Please visit **BenefitsInsider** at **www.benefitsinsider.com** to see if you're eligible for either of these plans and for more information.

You and the Company share in the cost of medical coverage. Your paycheck contributions depend on which plan you enroll in, the coverage level you select (Individual, Employee + Child, Family) and your annual salary.

We've got you covered with an out-of-pocket maximum

Every CHOICE medical plan comes with the protection of an out-of-pocket maximum — the most you would pay in a plan year — in case of a serious and expensive illness.

Dental

Cigna Traditional Dental Plan

This Plan lets you use any dentist but includes a Preferred Provider Organization (PPO) feature that can save you money when you use providers in the Cigna Dental Core Network. The Plan will cover the cost of two routine exams or preventive care visits. The Plan has an annual maximum benefit of $2,000 per person and coinsurance on procedures from root canals to bridges and inlays. Orthodontia is not covered.

Cigna Dental Health Plan

With this Dental Plan, you must choose a primary care dentist who will oversee and coordinate your care with specialists. There are no deductibles or annual benefit limits for care from dentists in the Cigna Dental HMO network or from specialists referred by a participating dentist. Plus, you'll pay nothing for preventive care and many procedures. If you use a dentist who is not in the Cigna Dental HMO network, you'll pay the full cost of services. The Cigna Dental Health Plan does not have an annual maximum benefit. For more information about the copay amounts for other dental services and orthodontia, see the **Cigna Patient Charge Schedule** on **BenefitsInsider**. Navigate to the "Health Plan Details" page, then, under "More Benefits Information," select "Dental Patient Charge Schedule."

You and the Company share in the cost of dental coverage. You pay the same amount in paycheck contributions regardless of which plan you enroll in. Your paycheck contributions depend on the coverage level (Individual, Employee + Child, Family) you select.

Vision

Vision Service Plan (VSP)

The Plan helps you pay for eye exams, corrective lenses, and frames. If you use a provider who participates in the VSP network, you'll pay a copay for covered services. If you use a non-participating provider, the Plan will reimburse you a specified amount for eligible expenses.

You pay the full cost if you enroll for vision coverage. Your paycheck contributions depend on the coverage level (Individual, Employee + Child, Family) you select.

Flexible Spending Accounts

Health Care Flexible Spending Account (FSA)

The Health Care FSA lets you save on taxes by using before-tax dollars to pay for eligible medical, dental, vision, and prescription drug expenses not covered by your health care plans. You do not have to enroll in a medical plan to contribute to a Health Care FSA.

The Health Care FSA features automatic claim forwarding, which simplifies the process for obtaining reimbursement from your Health Care FSA. Claims for services obtained from Cigna health care providers (including dental) will be automatically submitted to your Health Care FSA account (if enrolled) for reimbursement. You can also have your reimbursement deposited directly into your personal bank account. You can opt out of automatic claim forwarding by following the instructions on **myCigna.com** or by calling Cigna member services to have an opt-out form mailed to you for completion. If you choose to opt out of the automatic claim forwarding, you'll need to submit your claims manually for reimbursement. You can reinstate automatic claim forwarding at any time, through **myCigna.com** or by calling member services.

***Note**: If you are enrolled in the CHOICE Allowance Plan and the Health Care FSA, the Health Care FSA will automatically pay for eligible health care expenses before the HRA. If you'd like the funds to come from your HRA first, you must opt out of automatic claim forwarding by visiting **myCigna.com**. Remember, any Health Care FSA account balance remaining after all eligible expenses have been submitted for the plan year will be forfeited.*

Refer to the **FSA, HSA, and HRA** section on page **24** for more information.

Estimate Carefully: The "Use It or Lose It" Provision

The Health Care and Dependent Care FSAs are subject to the "use it or lose it" rule. Unused FSA funds ***do not*** roll over year to year. You have until March 31, 2014, to submit any FSA expenses you incurred during the 2013 plan year. That's why it's important to estimate carefully how much you contribute.

Dependent Care Flexible Spending Account (FSA)

The Dependent Care FSA is for dependent care expenses that allow you — and your spouse, if you're married — to work. You set aside money on a before-tax basis that you can use to be reimbursed for eligible child care or adult dependent care expenses that are necessary to allow you and your spouse if you're married, to work or attend school full-time. Here are the key features:

- Funded solely by you, not Hearst, through before-tax paycheck contributions. Funds are not subject to federal income tax at the time of the deposit.
- Funds can be used upon deposit to pay for day care expenses, nursery school expenses, in-home child care, and more. For more information about eligible expenses, see IRS publication 503, "Child and Dependent Care Expenses," on **www.irs.gov**.
- Unused funds in the FSA ***do not*** roll over year to year. If you don't use the funds in the account within the plan year, you'll lose them.
- The funds in your Dependent Care FSA cannot be used to pay for your dependents' medical expenses.

Employee Assistance Program (EAP)

The EAP offers a wide range of work/life support resources for you and your dependents. It is available to you if you are eligible for Hearst medical coverage. The EAP provides short-term assistance for:

- Substance abuse;
- Stress, grief, or depression;
- Marital and family problems;
- Legal concerns;
- Identity theft;
- Financial difficulties;
- Child or elder care needs; and
- Other personal difficulties.

It is free, confidential, and available 24 hours a day, 365 days a year. You can access the EAP by telephone, online, or schedule a face-to-face counseling session. To speak with an EAP counselor or to get more information, visit **www.cignabehavioral.com** or see the EAP Summary Plan Description (SPD) on **BenefitsInsider**. Navigate to the "Health Plan Details" page, then, under "Employee Assistance Programs," select "What Does the EAP Cover?"

Medical Plan Comparison Chart

See Plan highlights and compare plan features using this chart. See the **Glossary** on page **34** for definitions of the highlighted words below.

CHOICE Allowance Plan		PPO Plan		Consumer Directed Health Plan (CDHP)		Traditional Medical Plan Only available to current participants	Kaiser HMO Only available to limited business units in California
In-network	**Out-of-network**	**In-network**	**Out-of-network**	**In-network**	**Out-of-network**		
Plan Highlights							
• Cigna Open Access Plus (OAP) network • See any doctor or specialist • Higher benefit level for **in-network** care • Offers access to a Hearst-funded **Health Reimbursement Account (HRA)** • High **deductible** plan with lower contributions compared with the PPO Plan		• Cigna Open Access Plus (OAP) network • See any doctor or specialist • Higher benefit level for **in-network** care • Low **deductible** plan with higher contributions compared to the CHOICE Allowance Plan and CDHP		• Cigna Open Access Plus (OAP) network • See any doctor or specialist • Higher benefit level for **in-network** care • Offers access to a **Health Savings Account (HSA)** • High **deductible** plan with lowest contributions compared to the CHOICE Allowance Plan and PPO Plan		• Cigna Preferred Provider network • See any doctor or specialist • Same benefit level for **in-** and **out-of-network** care, but cost of **in-network** care is discounted • Low **deductible** plan with highest contributions of all plans	• Kaiser network only • Must see **in-network** provider • Primary Care Physician (PCP) required • **Out-of-network** services are not generally covered • Fixed **copay** for most services • No **deductible**
Annual Deductible							
Per person: $1,500 Family: $3,000 **Deductible** applies to most services. It also cross-applies between **in-** and **out-of-network**	Per person: $3,000 Family: $6,000 **Deductible** applies to all services. It also cross-applies between **in-** and **out-of-network**	Per person: $350 Family: $1,050 **Deductible** applies to some services. It also cross-applies between **in-** and **out-of-network**	Per person: $700 Family: $2,100 **Deductible** applies to all services. It also cross-applies between **in-** and **out-of-network**	Employee-only: $1,250 Family: $2,500 If enrolled in family coverage, no benefits will be paid until the full family **deductible** is met **Deductible** applies to some services. It also cross-applies between **in-** and **out-of-network**	Employee-only: $1,250 Family: $2,500 If enrolled in family coverage, no benefits will be paid until the full family **deductible** is met **Deductible** applies to some services. It also cross-applies between **in-** and **out-of-network**	Per person: $250 Family: $750 **Deductible** applies to most services	None

CHOICE Allowance Plan		PPO Plan		Consumer Directed Health Plan (CDHP)		Traditional Medical Plan Only available to current participants	Kaiser HMO Only available to limited business units in California
In-network	**Out-of-network**	**In-network**	**Out-of-network**	**In-network**	**Out-of-network**		
Annual Out-of-Pocket Maximum							
Employee-only: $3,000 Family: $6,000 Includes **deductible** Plan pays 100% of **covered charges** after you meet the annual **out-of-pocket maximum** (restrictions may apply) **Out-of-pocket maximum** cross applies between **in-** and **out-of-network**	Per person: $7,000 Includes **deductible** but not charges above **Maximum Reimbursable Charge (MRC)** Plan pays 100% of **MRC** after you meet the annual **out-of-pocket maximum** (restrictions may apply) **Out-of-pocket maximum** cross-applies between **in-** and **out-of-network**	Per person: $2,600 Includes **deductible** but does not include copays Plan pays 100% of **covered charges** after you meet the annual **out-of-pocket maximum** **Out-of-pocket maximum** cross applies between **in-** and **out-of-network**	Per person: $5,950 Includes **deductible** but not charges above **MRC** Plan pays 100% of **covered charges** after you meet the annual **out-of-pocket maximum** **Out-of-pocket maximum** cross applies between **in-** and **out-of-network**	Employee-only: $4,000 Family: $8,000 Includes **deductible** Plan pays 100% of **covered charges** after you meet the annual **out-of-pocket maximum** **Out-of-pocket maximum** cross applies between **in-** and **out-of-network**	Employee-only: $4,000 Family: $8,000 Includes **deductible**, but not charges above **MRC** Plan pays 100% of **covered charges** after you meet the **annual out-of-pocket maximum**	Per person: $1,250 Includes **deductible** but not charges above **MRC** Plan pays 100% of **covered charges** after you meet the annual **out-of pocket maximum**	Per person: $1,500 Family: $3,000 for certain services
Preventive Care (Annual physicals, well woman exams, prostate screenings, mammograms, well child care, and immunizations)							
Plan pays 100% with no **deductible** as long as there is no diagnosis. However, if there is a diagnosis, services will be subject to the **deductible** and coinsurance	Plan pays 65% of **MRC** **Deductible** applies	Plan pays 100% with no **deductible** as long as there is no diagnosis. However, if there is a diagnosis, services will be subject to the **copay** or the **deductible** and coinsurance, as appropriate	Plan pays 60% of **MRC** **Deductible** applies	Plan pays 100% with no **deductible** as long as there is no diagnosis. However, if there is a diagnosis, services will be subject to the **deductible** and coinsurance	Plan pays 70% of **MRC** **Deductible** applies	Plan pays 100% with no **deductible** as long as there is no diagnosis. However, if there is a diagnosis, services will be subject to the **deductible** and coinsurance.	Plan pays 100%
Doctor's Office Visit (Including specialists)							
Plan pays 85% of **covered charges** **Deductible** applies	Plan pays 65% of **MRC** **Deductible** applies	Plan pays 100% after $25 **copay** per office visit	Plan pays 60% of **MRC** **Deductible** applies	Plan pays 90% of **covered charges** **Deductible** applies	Plan pays 70% of **MRC** **Deductible** applies	Plan pays 80% of eligible charges **Deductible** applies	Plan pays 100% after PCP or specialist **copay**

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CHOICE Allowance Plan		PPO Plan		Consumer Directed Health Plan (CDHP)		Traditional Medical Plan Only available to current participants	Kaiser HMO Only available to limited business units in California
In-network	**Out-of-network**	**In-network**	**Out-of-network**	**In-network**	**Out-of-network**		
Hospital Expenses							
Plan pays 85% of **covered charges** **Deductible** applies **Pre-certification** required	Plan pays 65% of **MRC** **Deductible** applies **Pre-certification** required	Plan pays 80% of **covered charges** **Deductible** applies **Pre-certification** required	Plan pays 60% of **MRC** **Deductible** applies **Pre-certification** required	Plan pays 90% of **covered charges** **Deductible** applies **Pre-certification** required	Plan pays 70% of **MRC** **Deductible** applies **Pre-certification** required	Plan pays 80% of eligible charges **Deductible** applies **Pre-certification** required	Plan pays 100% after $250 copay
Maternity and Routine Nursery Care							
Plan pays 85% of **covered charges** **Deductible** applies	Plan pays 65% of **MRC** **Deductible** applies	You pay a $25 **copay** for the initial doctor's office visit to confirm pregnancy Plan pays 80% of all **covered charges** thereafter **Deductible** applies	Plan pays 60% of **MRC** **Deductible** applies	Plan pays 90% of **covered charges** **Deductible** applies	Plan pays 70% of **MRC** **Deductible** applies	Plan pays 80% of eligible charges **Deductible** applies	Generally pays 100% **Copays** may apply
Emergency Services (injuries or illnesses that are life-threatening or require immediate medical attention)							
Plan pays 85% of **covered charges** when using an emergency room or urgent care facility **Deductible** applies	Play pays 85% of **MRC** when using an emergency room or urgent care facility **Deductible** applies	Plan pays 100% after $75 **copay** when using a hospital emergency room Plan pays 100% after $50 **copay** when using an urgent care facility **Copay** waived if admitted	Plan pays 100% after $75 **copay** when using a hospital emergency room Plan pays 100% after $50 **copay** when using an urgent care facility **Copay** waived if admitted	Plan pays 90% of **covered charges** **Deductible** applies	Plan pays 90% of **MRC** **Deductible** applies	Plan pays 80% of eligible charges **Deductible** applies	Plan pays 100% after emergency room or urgent care facility **copay** **Copay** waived if admitted

CHOICE Allowance Plan		PPO Plan		Consumer Directed Health Plan (CDHP)		Traditional Medical Plan Only available to current participants	Kaiser HMO Only available to limited business units in California
In-network	Out-of-network	In-network	Out-of-network	In-network	Out-of-network		
Prescription Drugs							
Express Scripts Prescription Drug Plan: Participating Retail Pharmacy: (30-day supply) • You must meet a $75 per-person deductible before the Plan pays benefits • Plan pays 100% after you pay a $7 copay for a generic drug • Plan pays 80%, and you pay 20% ($15 minimum/$150 maximum) for a preferred brand name drug • Plan pays 80%, and you pay 20% ($30 minimum/$300 maximum) for a non-preferred brand name drug				Plan pays 90% **Deductible** applies **Participating Retail Pharmacy:** Cigna Prescription Drug network **Mail Order Program:** Tel-Drug	Plan pays 70% of **MRC** **Deductible** applies	Same Express Scripts Prescription Drug benefits as the CHOICE Allowance Plan and the PPO Plan	Plan pays 100% after the pharmacy **copay**
Express Scripts Prescription Drug Plan: Non-Participating Retail Pharmacy*: (30-day supply) • You must meet a $75 per-person **deductible** before the Plan pays benefits • Play pays 100% (of discounted drug price used by participating pharmacies) after you pay a $7 **copay** • Plan pays 80% (of discounted drug price used by participating pharmacies), and you pay 20% ($15 minimum/$150 maximum) for a preferred brand name drug • Plan pays 80% (of discounted drug price used by participating pharmacies), and you pay 20% ($30 minimum/$300 maximum) for a non-preferred brand name drug * *You will be responsible for the difference between the participating pharmacy discounted drug price and the retail price charged by the non-participating pharmacy* **The Express Scripts Pharmacy (mail order):** (90-day supply) Plan pays 100% after **copay** of: • $20 for a generic drug • $40 for a preferred brand name drug • $70 for a non-preferred brand name drug Certain maintenance medications are covered only through the Express Scripts Pharmacy after four fills at a participating retail pharmacy.							

CHOICE Allowance Plan		PPO Plan		Consumer Directed Health Plan (CDHP)		Traditional Medical Plan Only available to current participants	Kaiser HMO Only available to limited business units in California
In-network	Out-of-network	In-network	Out-of-network	In-network	Out-of-network		
Mental Health/Substance Abuse							
(Inpatient)							
Plan pays 85% of **covered charges** **Deductible** applies **Pre-certification** required	Plan pays 65% of **MRC** **Deductible** applies **Pre-certification** required	Plan pays 80% of **covered charges** **Deductible** applies **Pre-certification** required	Plan pays 60% of **MRC** **Deductible** applies **Pre-certification** required	Plan pays 90% of **covered charges** **Deductible** applies **Pre-certification** required	Plan pays 70% of **MRC** **Deductible** applies **Pre-certification** required	Plan pays 80% of eligible charges **Deductible** applies **Pre-certification** required	Plan pays 100% after $250 inpatient hospital **copay** **Pre-certification** required
(Outpatient)							
Plan pays 85% of **covered charges** **Deductible** applies	Plan pays 65% of **MRC** **Deductible** applies	Plan pays 100% after $25 **copay**	Plan pays 60% of **MRC** **Deductible** applies	Plan pays 90% of **covered charges** **Deductible** applies	Plan pays 70% of **MRC** **Deductible** applies	Plan pays 80% of eligible charges **Deductible** applies	Plan pays 100% after physician **copay**

Cigna benefits managed through Cigna Behavioral Health. Visit **www.cignabehavioral.com** (Employee ID: Hearst), call 1-800-892-4715, or visit **BenefitsInsider** for more information.

Dental Plan Comparison Chart

	Cigna Traditional Dental Plan	Cigna Dental Health Plan (DHMO)
Choice of Provider	You can visit any dentist you choose **Note**: • Using a Cigna Dental Core Network dentist can save you money • Your **deductible** for major services is waived if you use a Cigna Dental Core network dentist	You must choose a dentist from the Cigna Dental Health network However, if you don't use your Cigna dentist or specialist with a referral, your care will not be covered
Annual Deductible	$50 per person $100 per family For major services only; **deductible** is waived if you use a Cigna Dental Core Network dentist	None
Annual Maximum Benefit	$2,000 per person	None
Diagnostic and Preventive Services	Plan pays 100% of covered charges (based on the **Maximum Reimbursable Charge (MRC)** if you visit an **out-of-network** dentist) ***Deductible*** *does not apply*	Visit **www.benefitsinsider.com** to see the Cigna Dental Health Plan (DHMO) Patient Charge Schedule for copays
Restorative Services (Oral surgery, root canals, periodontic services, and denture and bridge repairs)	Plan pays 80% of covered charges (based on MRC if you visit an **out-of-network** dentist) ***Deductible*** *does not apply*	Visit **www.benefitsinsider.com** to see the Cigna Dental Health Plan (DHMO) Patient Charge Schedule for copays
Major Services (Dentures, bridges, crowns, and inlays)	Plan pays 50% of covered charges (based on MRC if you visit an **out-of-network** dentist) after **deductible**; **deductible** is waived if you use a network dentist	Visit **www.benefitsinsider.com** to see the Cigna Dental Health Plan (DHMO) Patient Charge Schedule for copays
Orthodontia	Not covered	Visit **www.benefitsinsider.com** to see the Cigna Dental Health Plan (DHMO) Patient Charge Schedule for copays

Vision Plan

Eligible Expense	VSP Provider	Out-of-Network Provider
Eye Exams (once every 12 months)	Covered in full, less $10 payment	Up to $43 allowance
Lenses (once every 12 months)		
Single Vision	Covered in full, less $20 **copay** for lenses and frames	Up to $35 allowance
Lined Bifocal	Covered in full, less $20 **copay** for lenses and frames	Up to $51 allowance
Lined Trifocal	Covered in full, less $20 **copay** for lenses and frames	Up to $68 allowance
Lenticular	Covered in full, less $20 **copay** for lenses and frames	Up to $80 allowance
Frames (once every 24 months)	$115 allowance for a frame of your choice plus 20% off the amount over your allowance	Up to $45 allowance
Contact Lenses (once every 12 months)	• If medically necessary: covered in full, less $20 **copay** • If elective: $105 allowance	• If medically necessary: the Plan pays up to $210 • If elective: the Plan pays up to $105

BE *Connected*

Being connected to your health isn't just about making the right decisions during Annual Enrollment. It's also about understanding how to make the most of your benefits during the year so you can be your healthiest.

BE *inspired*. BE *well*. BE *connected*.

Practice Preventive Care — Preventive care can help you maintain good health. It lets you know when you're healthy and helps identify and treat problems while they are still manageable. If you visit an in-network provider, preventive care is covered at 100% with no deductible or copay as long as there is no diagnosis of an illness. Preventive care generally includes well woman exams, annual physicals, pediatrician visits, and similar precautionary screenings. Since there's no cost to you, it pays to make your health a priority with preventive care.

Use In-Network Providers — Using in-network providers can save you money. Health care providers who are in-network have contracted with Cigna to provide services to you at lower "negotiated" rates. This saves you money because your share of the cost will be lower. And with the PPO Plan, you will pay only a $25 copay when you visit an in-network doctor. In addition, the CDHP, the CHOICE Allowance Plan, and the PPO Plan all pay a higher level of benefits when you use in-network providers.

Take Generic Drugs — All CHOICE Program medical plans cover prescription drugs, and the amount you pay is based on whether the medication is classified as generic, preferred-brand, or non-preferred brand. Generally, you pay the least for generic drugs. Generic drugs are **chemically equivalent, lower-cost versions** of preferred-brand and non-preferred brand name drugs, so choosing generic drugs gives you the same medical benefits while saving you money.

Order Maintenance Medications Through the Mail — All the CHOICE Program medical plans feature a prescription drug mail order program, which allows you to order up to a 90-day supply of maintenance medications — medications used for more than three months. This gives you the convenience of having to refill your prescriptions less frequently, delivery to your home, and lower costs because your share of the cost for a 90-day supply will be less than for three separate 30-day supplies.

Take Advantage of Cigna Your Health First — IIf you're enrolled in a Cigna medical plan, you'll have access to the Cigna Your Health First program to help manage chronic conditions or other ongoing health issues. Resources include health management coaches, a 24/7 nurseline, educational resources, and tools to help you monitor your condition. Whether you have asthma, diabetes, or another chronic condition, Cigna Your Health First can support you with your long-term health care goals. For more information, visit **myCignaplans.com**.

Medical Plans At-a-Glance

	CHOICE Allowance Plan	CDHP	PPO Plan
Paying for Coverage	Balances mid-range paycheck contributions with the highest deductible	Balances the lowest paycheck contributions with a high deductible	Balances high paycheck contributions with the lowest deductible
What It Offers	Offers you more control over how you spend your health care dollars and provides coverage for retail prescriptions after a separate small deductible and coinsurance	Offers you more control over how you spend your health care dollars and a prescription drug plan subject to your medical deductible	Offers predictable costs when a service is received and provides coverage for retail prescriptions after a separate small deductible and coinsurance
Related Accounts	A Health Reimbursement Account (HRA) funded by Hearst*	A Health Savings Account (HSA) funded by you. (You may not elect a Health Care FSA if you contribute to an HSA)	You may elect to enroll in a Health Care Flexible Spending Account using before-tax contributions
Provider Networks	All plans feature the Cigna Open Access Plus (OAP) Network. You can visit an out-of-network provider, but you will pay less when you receive care from in-network providers		

* *In addition to the HRA offered under the CHOICE Allowance Plan, you can also enroll in a Health Care FSA. If you are enrolled in the CHOICE Allowance Plan and the Health Care FSA, the Health Care FSA will pay for eligible health care expenses before the HRA through automatic claim forwarding. If you decide to opt out of automatic claim forwarding, then eligible expenses will be processed through the HRA first. Any Health Care FSA account balance remaining after all eligible expenses have been submitted for the plan year will be forfeited.*

Choosing Your Plan

Choosing your medical plan is about comparing costs — your paycheck contributions, deductibles, coinsurance, copays, and what you expect your medical expenses will be during the year. Then you can see which plan is best suited to meet your and your family's health care needs.

Take a look at these stories to see how costs may compare under the plans for people with low, medium, and high health care needs. They are a great starting point if you're having trouble deciding on a plan. But remember, the medical costs shown are estimates and may be different from what you could ultimately pay if you received the same service. The contributions are based on the salaries in the stories, and your contributions may be different. You should use these examples as a point of reference only to help you estimate your own medical costs.

***Note on Assumptions**: All services reflect using in-network providers and a consistent and typical average cost per service. Your specific cost per service will be different. You should confirm with your provider the costs that would apply to you.*

Low Health Care Services User

Jeff is a 27-year-old software engineer with Hearst Magazines who enrolled for single coverage under his Hearst benefits. Jeff's salary is $45,000 a year.

This past year, Jeff stayed healthy by exercising regularly and eating nutritious and well-balanced meals. He didn't even need to take a sick day at work. As of his routine annual physical in August, Jeff hadn't spent a dollar on health care aside from his year-round allergy medication. However, while playing basketball in the park one weekend, Jeff fell and injured his back. He needed to see a back pain specialist, who prescribed him painkillers and recommended a number of physical therapy sessions. Let's take a look at Jeff's medical expenses this year:

	CHOICE Allowance Plan	CDHP + HSA	PPO
Annual physical	$0	$0	$0
Back pain specialist	$150	$150	$25
Physical therapy (5 sessions)	$500	$500	$125
Painkiller (preferred brand, retail 3x)	$105	$225	$105
Allergy medication (non-preferred, mail order 4x)	$280	$482	$280
Annual cost of individual coverage	$1,656	$732	$1,920
Annual Hearst HRA contribution	(-$300)	$0	$0
Total cost to Jeff	**$2,391**	**$2,089**	**$2,455**

Medium Health Care Services User

Nancy is a 32-year-old sales manager with the Hearst Television Inc. station in Orlando. She enrolled herself and her husband Mike for family coverage under her Hearst benefits. Nancy's salary is $80,000 a year.

At Nancy's annual checkup, the doctor tells Nancy she's pregnant, and the child is due to arrive in early spring. Nancy found an obstetrician with whom she feels very comfortable and who is in the network. When Mike goes for his annual routine physical, his doctor tells him he's concerned about Mike's blood pressure, so he prescribes maintenance medication for the time being. Let's see what their costs will be this year:

	CHOICE Allowance Plan	CDHP + HSA	PPO
Annual physical	$0	$0	$0
Obstetrician visits (4x)	$400	$400	$25 for initial visit*
Blood pressure medication (preferred brand, mail order 4x)	$160	$900	$160
Annual cost of family coverage	$5,880	$3,036	$6,444
Annual Hearst HRA contribution	(-$600)	$0	$0
Total cost to Nancy	**$5,840**	**$4,336**	**$6,629**

** Note: The additional obstetric visits, delivery, and post partum visits are billed in one lump sum at the end of the pregnancy and are not reflected in the above scenario.*

High Health Care Services User

David is a 48-year-old director of strategic investment with Hearst Interactive Media. He enrolls for family coverage for himself, his wife, Susan, and their son, Paul, under his Hearst benefits. His salary is $120,000 a year.

After a recent soccer game, Paul has trouble breathing, so his parents take him to the doctor. His initial diagnosis is bronchitis, but after two more visits without the symptoms abating, his condition is eventually diagnosed as asthma, for which he needs ongoing treatment. Worse still, while on a family picnic, the entire family catches a case of poison ivy. Let's see the breakdown of David's costs this year:

	CHOICE Allowance Plan	CDHP + HSA	PPO
Annual physical	$0	$0	$0
Pediatrician visit (2x)	$200	$200	$50
Extra pediatrician visit (asthma diagnosis)	$100	$100	$25
Asthma specialist visit (2x)	$300	$300	$50
Asthma inhaler (preferred brand, retail 4x)	$120	$300	$120
Dermatologist visit (3x, poison ivy)	$450	$450	$75
Ointment (generic, retail 3x)	$21	$45	$21
Annual cost of family coverage	$5,880	$3,036	$6,948
Annual Hearst HRA contribution	(-$600)	$0	$0
Total cost to David	**$6,471**	**$4,431**	**$7,289**

Comparing the Health Care FSA, HSA, and HRA

There are several health care accounts associated with the CHOICE medical plans. These tax-advantaged accounts offer you additional ways to pay for eligible health care expenses and accumulate funds for medical care during the year. The medical plan you choose determines which health care accounts are available to you.

Can I have a Health Care FSA and an HRA?

Yes, however, with the automatic claim forwarding feature available for Health Care FSAs only, you must use the Health Care FSA funds in their entirety before you can use HRA funds. If you opt out of auto claim forwarding, funds from the HRA will be used first.

No Double-Dipping!

If you enroll in the CDHP, you may participate in the HSA **or** the Health Care FSA, but not both. In addition, if your spouse has an HSA, you may not elect a Health Care FSA, and if your spouse has a Health Care FSA, you may not use an HSA.

	HRA	FSA*	HSA
Type of Account	Health Reimbursement Account	Health Care Flexible Spending Account	Health Savings Account
Plans Associated with These Accounts	CHOICE Allowance Plan	• PPO Plan • Traditional Medical Plan • Kaiser HMO • CHOICE Allowance Plan • CDHP**	CDHP
Funding	Employer funded ($300 individual/$600 family)	You fund with before-tax dollars up to a maximum of $2,500 per plan year	You fund with before-tax dollars up to a maximum of $3,250 individual/ $6,450 family. (If you are age 55 or older, you may contribute an extra $1,000 in your account for 2013)
Availability of Funds for Use	Funds are available immediately for use as of January 1 or once you are eligible for benefits	Entire fund amount elected for the plan year is available for use as of January 1, regardless of when the actual funds are deposited in the account	Your contributions accrue throughout the year
Covered Expenses* **	Eligible health care expenses incurred under the plan throughout the year	Eligible health care expenses incurred under the plan throughout the year	Eligible health care expenses or non-eligible expenses with a 20% penalty
Portability	You cannot take your HRA with you if you leave the Company or change plans	You cannot take your FSA with you if you leave the Company	You can take your HSA with you if you leave the Company or change plans
Rollover	Any unused funds in the account at the end of the year will roll over to the next year, provided you re-enroll in the CHOICE Allowance Plan	Any unused funds in the account at the end of the year **do not** roll over to the next year	Any unused funds in the account at the end of the year will roll over to the next year

* You can participate in a Health Care FSA whether or not you enroll in any of the CHOICE Program medical plans
** Only available if you do not participate in an HSA
*** See the IRS website at **www.irs.gov** for a list of eligible expenses

Legal Notices

U.S. Health Care Reform

Restrictions for Over-the-Counter Medications

Over-the-counter medications (except insulin and diabetic supplies) will not be considered a qualified medical expense under the Health Care FSA, HRA, or HSA unless accompanied by a doctor's prescription. Please be sure to calculate your contributions carefully, taking into consideration that over-the-counter medications other than insulin and diabetic supplies will not be reimbursable from a tax-advantaged or reimbursement account without a prescription.

Penalties on Health Savings Accounts (HSAs)

If you use your CDHP Health Savings Account to pay for non-qualified medical expenses, you will be required to pay income tax and a 20% penalty tax on the distribution when you file your income taxes.

Primary Care Physicians

The Kaiser HMO requires the designation of a primary care provider. You have the right to designate any primary care provider who participates in our network and who is available to accept you or your family members. For children, you may designate a pediatrician as the primary care provider. For information on how to select a primary care provider and for a list of the participating primary care providers, contact Kaiser.

OB/GYN Visits

You do not need a referral or prior authorization from the CHOICE Program or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a health care professional in your network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or following procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, contact your medical plan.

Advance Notice of Rescission

The CHOICE Health Care Program cannot retroactively cancel or terminate an individual's coverage, except in cases of deliberate fraud and other limited circumstances. The Plan will give affected individuals at least 30 days' advance written notice. The notice will confirm the rescission of coverage, the date coverage ends, and the reason for rescission.

Out-of-Network Payment for Emergency Services

The CHOICE Health Care Program must meet minimum payment standards for emergency services from out-of-network providers. If a state law prohibits balanced billing, the CHOICE Program is not required to meet the minimum payment standards; however, participants will be provided with adequate and prominent notice that they have no financial responsibility with respect to such amounts.

Women's Health and Cancer Rights Act (WHCRA) Notice

If you have had or are going to have a mastectomy, you may be entitled to certain benefits under the Women's Health and Cancer Rights Act of 1998 (WHCRA). For individuals receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending physician and the patient, for:

- Reconstruction of the breast on which the mastectomy was performed;
- Surgery and reconstruction on the other breast to achieve symmetry;
- Prostheses; and
- Treatment of complications resulting from a mastectomy (including lymphedema).

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this plan. If you would like more information on WHCRA benefits, please contact the Employee Benefits Department at 1-704-348-8312.

Newborns' and Mothers' Health Protection Act Notice

Group health plans and health insurance issuers generally may not, under federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under federal law, require that a provider obtain authorization from the plan or the insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

SPDs Available Online

Summary Plan Descriptions (SPDs) for the CHOICE Health Care Program and the CHOICE Program Flexible Spending Accounts are available on **BenefitsInsider** in the **Benefits Library**. You can print the SPDs directly from **BenefitsInsider** or request a print version to be sent to you.

SBCs Available Online

Summaries of Benefits and Coverage (SBCs) are now available on **www.benefitsinsider.com** and **myCignaplans.com**, which help employees understand and compare certain medical plan features. Employees can also call Cigna at 1-800-421-6764 to request paper copies free of charge. The Kaiser HMO SBC will also be available if you are eligible for the Kaiser HMO.

HIPAA and CHIP Special Enrollment Notice

As described in the Summary Plan Descriptions (SPDs) for the CHOICE Program, if you have declined enrollment in the CHOICE Program for you or your eligible dependents (including your spouse) because of other health insurance coverage, you or your dependents may be able to enroll in certain coverage under this program without waiting for the next Annual Enrollment period, provided that you request enrollment within 31 days after your other coverage ends. 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, provided that you request enrollment within 31 days after the marriage, birth, adoption, or placement for adoption..

The CHOICE Program allows a special enrollment opportunity if you or your eligible dependents either:

- Lose Medicaid or Children's Health Insurance Program (CHIP) coverage for which you are no longer eligible, or
- Become eligible for a state's premium assistance program under Medicaid or CHIP.

For these special enrollment opportunities, you will have 60 days — instead of 31 — from the date of the Medicaid/CHIP eligibility change to request enrollment in the CHOICE Program. Note that this 60-day extension doesn't apply to enrollment opportunities other than the Medicaid/CHIP eligibility change.

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

If you or your children are eligible for Medicaid or CHIP and you are eligible for health coverage from your employer, your state may have a premium assistance program that can help pay for coverage. These states use funds from their Medicaid or CHIP programs to help people who are eligible for these programs, but also have access to health insurance through their employer. If you or your children are not eligible for Medicaid or CHIP, you will not be eligible for these premium assistance programs.

If you or your dependents are already enrolled in Medicaid or CHIP and you live in a state listed below, you can 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, you can 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, you can ask the state if it has a program that might help you pay the premiums for an employer-sponsored plan.

Once it is determined that you or your dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under your employer plan, your employer must permit you to enroll in your employer plan if you are not 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, you can contact the Department of Labor electronically at **www.askebsa.dol.gov** or by calling toll-free 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, 2012. You should contact your state for further information on eligibility

ALABAMA – Medicaid	**ALASKA – Medicaid**
Website: **http://www.medicaid.alabama.gov** Phone: 1-855-692-5447	Website: **http://dhss.alaska.gov/dpa/Pages/medicaid/default.aspx** Phone (Outside of Anchorage): 1-888-318-8890 Phone (Anchorage): 907-269-6529
ARIZONA – CHIP	**COLORADO – Medicaid**
Website: **http://www.azahcccs.gov/applicants** Phone: 1-800-523-0231 Phone (Maricopa County): 602-417-5437	Website: **http://www.colorado.gov/** Phone (In state): 1-800-866-3513 Phone (Out of state): 1-800-221-3943
FLORIDA – Medicaid	**GEORGIA – Medicaid**
Website: **https://www.flmedicaidtplrecovery.com/** Phone: 1-877-357-3268	Website: **http://dch.georgia.gov/** Click on Programs, then Medicaid, then Health Insurance Premium Payment (HIPP) Phone: 1-800-869-1150
IDAHO – Medicaid and CHIP	**INDIANA – Medicaid**
Medicaid Website: **www.accesstohealthinsurance.idaho.gov** Medicaid Phone: 1-800-926-2588 CHIP Website: **www.medicaid.idaho.gov** CHIP Phone: 1-800-926-2588	Website: **http://www.in.gov/fssa** Phone: 1-800-889-9949
IOWA – Medicaid	**KANSAS – Medicaid**
Website: **www.dhs.state.ia.us/hipp/** Phone: 1-888-346-9562	Website: **http://www.kdheks.gov/hcf/** Phone: 1-800-792-4884
KENTUCKY – Medicaid	**LOUISIANA – Medicaid**
Website: **http://chfs.ky.gov/dms/default.htm** Phone: 1-800-635-2570	Website: **http://www.lahipp.dhh.louisiana.gov** Phone: 1-888-695-244

MAINE – Medicaid	MASSACHUSETTS – Medicaid and CHIP
Website: **http://www.maine.gov/dhhs/ofi/public-assistance/index.html** Phone: 1-800-977-6740 TTY 1-800-977-6741	Website: **http://www.mass.gov/MassHealth** Phone: 1-800-462-1120
MINNESOTA – Medicaid	**MISSOURI – Medicaid**
Website: **http://www.dhs.state.mn.us/** Click on Health Care, then Medical Assistance Phone: 1-800-657-3629	Website: **http://www.dss.mo.gov/mhd/participants/pages/hipp.htm** Phone: 573-751-2005
MONTANA – Medicaid	**NEBRASKA – Medicaid**
Website: **http://medicaidprovider.hhs.mt.gov/clientpages/clientindex.shtml** Phone: 1-800-694-3084	Website: **www.ACCESSNebraska.ne.gov** Phone: 1-800-383-4278
NEVADA – Medicaid	**NEW HAMPSHIREv– Medicaid**
Website: **http://dwss.nv.gov/** Phone: 1-800-992-0900	Website: **http://www.dhhs.nh.gov/oii/documents/hippapp.pdf** Phone: 603-271-5218
NEW JERSEY – Medicaid and CHIP	**NEW YORK – Medicaid**
Medicaid Website: **http://www.state.nj.us/humanservices/dmahs/clients/medicaid/** Medicaid Phone: 1-800-356-1561 CHIP Website: **http://www.njfamilycare.org/index.html** CHIP Phone: 1-800-701-0710	Website: **http://www.nyhealth.gov/health_care/medicaid/** Phone: 1-800-541-2831
NORTH CAROLINA – Medicaid	**NORTH DAKOTA – Medicaid**
Website: **http://www.ncdhhs.gov/dma** Phone: 919-855-4100	Website: **http://www.nd.gov/dhs/services/medicalserv/medicaid/** Phone: 1-800-755-2604
OKLAHOMA – Medicaid and CHIP	**OREGON – Medicaid and CHIP**
Website: **http://www.insureoklahoma.org** Phone: 1-888-365-3742	Website: **http://www.oregonhealthykids.gov** **http://www.hijossaludablesoregon.gov** Phone: 1-877-314-5678

PENNSYLVANIA – Medicaid	RHODE ISLAND – Medicaid
Website: **http://www.dpw.state.pa.us/hipp** Phone: 1-800-692-7462	Website: **www.ohhs.ri.gov** Phone: 401-462-5300
SOUTH CAROLINA – Medicaid	**SOUTH DAKOTA - Medicaid**
Website: **http://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: **http://www.hhsc.state.tx.us/medicaid/StatePlan.html** Phone: 1-800-440-0493	Website: **http://health.utah.gov/upp** Phone: 1-866-435-7414
VERMONT– Medicaid	**VIRGINIA – Medicaid and CHIP**
Website: **http://www.greenmountaincare.org/** Phone: 1-800-250-8427	Medicaid Website: **http://www.dmas.virginia.gov/** Medicaid Phone: 1-800-432-5924 CHIP Website: **http://www.famis.org/** CHIP Phone: 1-866-873-2647
WASHINGTON – Medicaid	**WEST VIRGINIA – Medicaid**
Website: **http://hrsa.dshs.wa.gov/premiumpymt/Apply.shtm** Phone: 1-800-562-3022 ext. 15473	Website: **www.dhhr.wv.gov/bms/** Phone: 1-877-598-5820, HMS Third Party Liability
WISCONSIN – Medicaid	**WYOMING – Medicaid**
Website: **http://www.badgercareplus.org/pubs/p-10095.htm** Phone: 1-800-362-3002	Website: **http://health.wyo.gov/healthcarefin/equalitycare** Phone: 307-777-7531

To see if any more states have added a premium assistance program since July 31, 2012, or for more information on special enrollment rights, you can contact either:

U.S. Department of Labor
Employee Benefits Security Administration
www.dol.gov/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, Ext. 61565

HIPAA Privacy Information

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) imposes numerous requirements on employer health plans concerning the use and disclosure of individual health information. This information, known as protected health information, includes virtually all individually identifiable health information held by the Plan, whether received in writing, in an electronic medium, or as an oral communication.

The Plan is required by law to maintain the privacy of your health information and to provide you with a notice of the Plan's legal duties and privacy practices with respect to your health information. If you participate in an insured Plan option, you will receive a notice directly from the insurer. It's important to note that HIPAA rules apply to the Plan, not Hearst Corporation as an employer. Different policies may apply to other Hearst Corporation programs or to data unrelated to the Plan.

The privacy rules generally allow the use and disclosure of your health information without your permission (known as an authorization) for purposes of health care treatment, payment activities, and health care operations. The amount of health information used or disclosed will be limited to the "minimum necessary" for these purposes, as defined under the HIPAA rules.

The Plan, or its health insurer, may disclose your health information without your written authorization to Hearst Corporation for Plan administration purposes. Hearst Corporation agrees not to use or disclose your health information other than as permitted or required by the Plan documents and by law. Employee Benefits personnel are the only Hearst Corporation employees who will have access to your health information for Plan administration functions, including obtaining bids to provide coverage under the Plan or for modifying, amending, or terminating the Plan.

Use and disclosure of your health information other than as authorized under HIPAA will be made only with your written authorization. You may revoke your authorization as allowed under the HIPAA rules. You received a copy of the CHOICE Program HIPAA Privacy Notice in April 2006, or when you became covered under the Plan, if later. You can view and print the Notice from the Benefits Library on BenefitsInsider.

Summary of Material Modifications

This guide is a summary of material modifications to your Health Care Summary Plan Description and your Flexible Spending Accounts Summary Plan Description. Neither this summary of material modifications nor the Summary Plan Descriptions on **BenefitsInsider** include complete details of the CHOICE Program. Complete CHOICE Program details are contained in the official Plan documents, which legally govern the administration of the Plan. If there is a difference between what is written in the summary of material modifications and the Plan documents, the Plan documents will always rule.

Hearst Corporation plans to continue the CHOICE Program but reserves the right to amend, change, modify, or terminate the Program at any time and for any reason both during and after your employment. This summary of material modifications is not an offer or contract of continued employment with Hearst Corporation.

Who to Contact

Contact	Where You Can
BenefitsInsider **www.benefitsinsider.com** or via **www.MyHearst.com**	• Enroll in your benefits • Learn about your 2013 benefits • Obtain provider contact information • Obtain forms • View Summary Plan Descriptions • View Summaries of Benefits and Coverage
Employee Benefits Department 1-704-348-8312 or via **hsc_benefits@hearstsc.com**	If you cannot find the information you need on BenefitsInsider at **www.benefitsinsider.com**, call the Employee Benefits Department with your benefit and enrollment questions

Glossary

Term	Definition
Copay	A fixed dollar amount that you are required to pay for certain covered services. This amount does not vary with the cost of the services and is due at the time of service.
Covered Charges	Charges for medically-necessary services provided for the purpose of preventing, diagnosing or treating the symptoms of sickness, injury, mental illness and/or substance abuse.
Deductible	The amount that you must pay out of your pocket for certain covered charges before the Plan begins reimbursing for services. Once you meet the deductible, the Plan will pay for all or a portion of covered services.
Emergency	An accidental injury or the sudden and unexpected onset of a medical condition posing significant life-threatening circumstances and requiring immediate medical or surgical care. For instance, a heart attack, stroke, poisoning, major fractures or breaks, convulsions, or loss of consciousness or respiration would qualify as emergencies.
Health Care Flexible Spending Account (FSA)	A Health Care FSA is a tax-advantaged account that is funded by you through before-tax paycheck contributions. FSA funds can be used to pay for eligible health care expenses for you *and/or* a qualified dependent and *do not* roll over year to year. If you don't use the funds within the plan year, you'll lose them.
Health Reimbursement Account (HRA)	A Hearst-funded account provided in conjunction with the CHOICE Allowance Plan. It can be used to pay for eligible health care expenses once any available FSA dollars have been used. Money left in the account at year end will roll over to the next plan year if you re-enroll in the Plan.
Health Savings Account (HSA)	A tax-advantaged account offered by Hearst in conjunction with the CDHP. It is funded with your before-tax dollars that can be used toward eligible health care expenses. The funds accumulate year to year and the account is also portable, so you take it with you if you leave the Company.
In-Network	Care received from a network of hospitals, doctors, and other health care providers who are contracted to provide services to you at a negotiated fee. In joining the network, providers must meet standards for quality and efficiency and demonstrate a commitment to providing the most appropriate care at the most reasonable cost.
Mail Order Program	A benefit available through your Pharmacy Benefits Manager to deliver some or all of your maintenance medications to you by mail at a cost that is generally less than a participating retail pharmacy's.

Term	Definition
MRC	The "maximum reimbursable charge" (previously referred to as "R&C/ reasonable and customary") for covered services is determined based on the smaller of the following two amounts: • The provider's normal charge for a similar service or supply; or • A certain percentage of the prevailing charges for comparable services in your provider's area.
Non-Participating Retail Pharmacy	A retail pharmacy that is not a part of the Pharmacy Benefit Manager's Network.
Out-of-Network	Care received from health care providers who do not participate in your Plan's network. The Plan reimburses you based on Maximum Reimbursable Charges so your costs will generally be higher when you receive out-of-network care.
Out-of-Pocket Maximum	The maximum amount you must pay for covered services during the year. Once you have reached the total out-of-pocket maximum, the Plan will pay 100% of the remaining covered charges for that year.
Participating Retail Pharmacy	A local pharmacy or pharmacy chain that participates in the Pharmacy Benefit Manager's Network.
Pre-Certification	Authorization from the Plan Administrator to cover non-emergency hospitalization or surgery under the Plan. Failure to obtain pre-certification will result in services being reduced or not being covered by the Plan.