

THE MCCLATCHY COMPANY
COMPREHENSIVE WELFARE BENEFIT AND CAFETERIA PLAN
SUMMARY PLAN DESCRIPTION

(Amended and Restated Effective January 1, 2014)

TABLE OF CONTENTS

	Page
<i>Section 1.</i>	<i>Introduction 3</i>
<i>Section 2.</i>	<i>Benefits Eligibility 5</i>
<i>Section 3.</i>	<i>Health Benefits -- Medical, Dental, Vision and Employee Assistance Plan (EAP) 9</i>
<i>Section 4.</i>	<i>Welfare Benefits – Life, Long-Term Disability (LTD) and Accidental Death and Personal Loss Insurance 18</i>
<i>Section 5.</i>	<i>Premium Conversion Program 21</i>
<i>Section 6.</i>	<i>Health Care Flexible Spending Account 28</i>
<i>Section 7.</i>	<i>Dependent Care Flexible Spending Account 36</i>
<i>Section 8.</i>	<i>Health Savings Account 41</i>
<i>Section 9.</i>	<i>Wellness Program 47</i>
<i>Section 10.</i>	<i>Leaves of Absence 49</i>
<i>Section 11.</i>	<i>COBRA 52</i>
<i>Section 12.</i>	<i>Claims Procedure 59</i>
<i>Section 13.</i>	<i>Other Things You Should Know 71</i>
<i>Section 14.</i>	<i>Your ERISA Rights 73</i>
<i>Section 15.</i>	<i>Your Additional HIPAA Rights 75</i>
<i>Section 16.</i>	<i>Plan Administrative Information 78</i>
<i>Appendix A</i>	<i>Eligibility Requirements for Component Programs A-1</i>
<i>Appendix B</i>	<i>Premium Pass-Through and FSA Plans – Leave of Absence B-1</i>
<i>Appendix C</i>	<i>Eligible and Ineligible Health Care FSA Expenses C-1</i>

Section 1. Introduction

The McClatchy Company (“Company”) is pleased to offer The McClatchy Company Comprehensive Welfare Benefit and Cafeteria Plan (the “Plan”). This is an umbrella plan that covers all health, life, accident, long-term disability and wellness plans and programs for the employees who are part of The McClatchy Company controlled group. The Plan also covers the cafeteria and flexible spending account (FSA) plans, including the Premium Conversion Plan, the Dependent Care FSA and the Health Care FSA and the Health Savings Account. A listing of participating employers, covered health and welfare plans and programs and eligibility requirements is available in Appendix A.

Participating employers also offer a short-term disability program. However, those programs are not components under this Plan, but instead separate policies maintained by the employer.

This booklet explains how the Plan works. The McClatchy Company’s LiveWell website, found at www.mcclatchy.com/LiveWell, has detailed information on each of the benefit options available to you under the Plan. You can also use this booklet as a guide to help you decide what benefit options to elect and to answer questions you may have about the different benefits available under the Plan.

In addition to giving you general information on each benefit available under the Plan, this booklet contains information about what happens to your benefits in the event of life changes (like marriage, divorce, the birth of a child, etc.) and information regarding your rights.

1.1 What is the scope of this booklet?

Because of laws, government regulations, and the wide variety of possible exceptions to the situations described in this booklet, the information contained here is a summary of the most important provisions and most common situations associated with your benefits. While this booklet highlights the main features of the benefits available under the Plan, it is not a comprehensive description. The official Plan document will govern in case of any omission or conflict between this booklet and the Plan.

You may view the more detailed plan document that governs this Plan by contacting Human Resources. More detailed information regarding the administration of these benefits and your legal rights under the Employee Retirement Income Security Act appears in Section 14 of this booklet.

This booklet is neither a contract nor a guarantee of employment. Nothing contained in this booklet gives a Plan participant any rights to employment. Plan participants employed by the Company are subject to the policies, terms and conditions of employment as established at each paper.

It’s also important to remember that many things change during the course of running our business. In any given year, changes to The McClatchy Company’s benefits can range from minor administrative revisions to larger strategic revisions.

While no major revisions are planned at publication time, we would be remiss if we did not remind you that changes might occur at some point during your employment.

We hope this booklet answers most of your questions. If you need additional information or assistance, please contact your local Human Resources department.

1.2 What are the basic features of the Plan?

The Plan permits eligible employees:

- To purchase medical, dental, vision, and/or supplemental life insurance coverage for himself or herself, and, as applicable, 1) his or her federal spouse or domestic partner; 2) his or her eligible dependents and/or the eligible child(ren) of his or her domestic partner. See Section 2 for more information about eligibility.
- To purchase additional long-term disability (LTD) buy-up coverage for himself or herself.
- To be enrolled automatically for base long-term disability, basic life and accidental death and personal loss (AD&PL) insurance, and employee assistance coverage.
- Generally, to use pre-tax dollars to pay for the cost of elective benefit coverage, such that the cost is not treated as income for federal income tax purposes. There are significant exceptions to this general rule as follows:
 - For federal tax purposes, and under some state income tax laws, coverage for the domestic partner and the domestic partner's children can only be purchased with after-tax dollars; and
 - The cost of supplemental life insurance coverage can only be purchased with after-tax dollars.
 - The cost of LTD buy-up coverage can only be purchased with after-tax dollars.
- To establish a dependent care flexible spending account (Dependent Care FSA) and/or, if not enrolled in the Savings Advantage medical plan, a health care flexible spending account (Health Care FSA) funded from the eligible employee's pay. The accounts may be used to fund eligible dependent care expenses and eligible health care expenses, respectively, on a pre-tax basis. The accounts may not be used to fund expenses incurred on behalf of the eligible employee's domestic partner or the child of a domestic partner (unless that child is your tax-qualified dependent).

Section 2. Benefits Eligibility

2.1 *How do I know if I am eligible to receive benefits?*

Eligibility requirements and waiting periods for the individual health and welfare plans differ by employer. Appendix A lists the participating employers, the classes of workers eligible for coverage, the waiting periods, the number of hours employees must work to qualify for coverage, and the coverage options available to them.

Employees whose employment is covered by a collective bargaining agreement are only covered to the extent the collective bargaining agreement provides for participation in Component Programs of this Plan.

2.2 *What are some of the classes of workers ineligible to participate in the Plan?*

You are not eligible to participate in the Plan if you are 1) a temporary or on-call employee; 2) a “leased employee,” including an employee engaged through a third-party service agency; or 3) classified as an independent contractor or in any way as a third-party service provider.

If, for some reason, you later are classified as a regular employee, your eligibility to participate in the Plan will be prospective only.

2.3 *May I purchase benefits for my federal spouse and eligible dependents?*

Yes. You may purchase certain benefits for you, your federal spouse or your domestic partner, and your eligible dependents and/or eligible dependents of your domestic partner, as further described in this booklet.

For purposes of this plan, your **federal spouse** is a person of the same or opposite sex to whom you are legally married under the laws of any state or foreign country having the legal authority to sanction the marriage, even if you do not currently live in a state that recognizes the validity of your marriage. This definition is required in order for the Plan to comply with federal law. The McClatchy Company recognizes common law marriages entered into in a state allowing such marriages in determining whether you have a federal spouse.

Eligible dependents are:

- For purposes of medical benefits, your married or unmarried children until the end of the month in which they attain age 26, regardless of student status, residency or financial dependency.
- For purposes of the Health Care FSA, your married or unmarried children until the end of the calendar year in which they attain age 26, regardless of student status, residency or financial dependency.
- For purposes of the dental, vision, employee assistance plan, and supplemental life insurance benefits, your unmarried children until the end of the month in

which they turn the maximum age defined by the Plan. Information about the maximum age for children can be found in the Evidence of Coverage booklets available on McClatchy's LiveWell website.

- Your unmarried children of any age who are handicapped before the maximum age limit defined by the individual plans and who are primarily dependent on you for support.

The term "children" includes your natural children, legally adopted children, stepchildren, foster children, children for whom coverage is required through a QMCSO or other court or administrative order and any other children for whom you are the legal guardian or for whom you have legal custody. The term "children" also includes children placed for adoption in your home.

Your participation in the Plan or any Component Program of the Plan includes all coverage that you have elected on behalf of dependents. Accordingly, any dependent coverage will terminate upon the termination of your participation in the Plan or, if earlier, the date when the dependent no longer qualifies to be a dependent under the Plan as specified above.

For purposes of medical, dental and vision coverages, your federal spouse or eligible dependents may only be enrolled in the same coverage option you have selected.

2.4 *Is my domestic partner eligible to receive benefits?*

Yes. Your domestic partner is eligible to receive benefits if the appropriate documentation has been submitted to Human Resources.

A ***domestic partner*** is a committed life partner of the same or opposite sex as you. An eligible domestic partnership exists when you either have a registered domestic partner, a civil union or other similar formal relationship under state or local law. If such a legal registry or union is not available, then or all of the following criteria must be met:

- You and your partner are financially interdependent and jointly responsible for each other's welfare;
- There is an intent to remain in a committed relationship;
- You and your partner have the same permanent address for at least 12 months;
- You and your partner are not so closely related by blood that legal marriage would be prohibited;
- You and your partner are at least 18 years of age and neither of you is married to another individual;
- Neither you nor your partner has been in a different domestic partner relationship or marriage within the last 12 months; and

- The current relationship has been in effect for at least 12 months.

A domestic partner does not include a mere roommate or a sibling, parent or other close relative.

In order to elect benefits under the Plan for your domestic partner, you must submit documentation showing that you are registered as domestic partners in your state or local municipality. If state and local municipality registration are not available, you must declare your domestic partnership to the Company by filling out the Declaration of Domestic Partnership, available on LiveWell website or from Human Resources. This Declaration must be notarized before you submit it. In addition to the Declaration, you must submit two documents evidencing that the relationship has been in existence for at least 12 months. The Company has the right not to accept your Declaration of Domestic Partnership or enroll your domestic partner in benefit coverage if all of the conditions for a domestic partnership listed above are not met.

You are also required to inform the Company, within 31 days, if your domestic partnership ends for any reason. You notify the Company by completing the Declaration of Termination of Domestic Partnership, available on the LiveWell website or from Human Resources. This Declaration must be notarized.

You will not be permitted to enroll a domestic partner if you have had another domestic partner on file in the last 12 months.

For purposes of medical, dental and vision coverages your domestic partner may only be enrolled in the same coverage option you have selected.

The Domestic Partners policy and Domestic Partners forms can be found on McClatchy's LiveWell website.

2.5 *Is the child of my domestic partner eligible to receive benefits?*

Yes. The child of your domestic partner is eligible to receive benefits under the Plan.

The child of your domestic partner includes the domestic partner's natural child, legally adopted child, stepchild, foster child or child in the care of your domestic partner by court or administrative order and any other child for whom your domestic partner is legal guardian or legal custodian.

The child of a domestic partner is eligible to receive benefits until reaching the age of majority as provided under the benefit coverage option. These are the same age limits as apply to children who are eligible dependents. (Please see Section 2.4) In addition, certain unmarried children who are handicapped before the maximum age limit defined by the individual plans and who are incapable of self-support may continue to be eligible for benefits under the Plan.

For purposes of medical, dental and vision coverages, the child of your domestic partner may only be enrolled in the same coverage option you have selected.

2.6 Which companies are “participating employers” and what benefits are offered by the participating employers?

Participating employers are companies within our controlled group and affiliates of the Company that have agreed to take part in this Plan and offer the benefits provided by the Plan. For the list of participating employers and the benefits they offer under the Plan, please see Appendix A.

A newly formed or acquired subsidiary shall only become a participating employer of the Plan as of the date designated to commence participation by the Company, and only as to such Component Programs for which The McClatchy Company authorizes participation.

2.7 Will McClatchy require proof that my enrolled dependent is eligible for coverage?

If you enroll your federal spouse, eligible dependent, domestic partner or domestic partner’s child in a McClatchy health care (medical, dental and/or vision) plan, you will be asked to verify that person’s eligibility for coverage. McClatchy has retained a third-party administrator to handle these verifications. If you do not send in the appropriate required documentation to show your enrolled federal spouse, eligible dependent, domestic partner or domestic partner’s child is eligible for coverage within the required deadlines, coverage for that person will be terminated effective the first of the month following the deadline. If coverage is dropped because you did not send in the documents required to verify eligibility, that person cannot be added to coverage until the next open enrollment period, provided you can demonstrate the person’s entitlement to coverage, and he/she also is not eligible for COBRA. More information about these eligibility verification requirements can be found on McClatchy’s LiveWell website.

2.8 What are the spousal/domestic partner eligibility rules?

If your federal spouse/domestic partner is eligible for medical and/or dental coverage with his/her employer and he/she declines that coverage, he/she is not eligible to enroll in medical or dental coverage with McClatchy. If your federal spouse/domestic partner is eligible for non-HMO medical and/or dental coverage with his/her employer, he/she must be enrolled in that coverage in order to be eligible for secondary medical or dental coverage with McClatchy. If the federal spouse/domestic partner medical and/or dental plan is an HMO, he/she cannot be covered under a McClatchy plan. Spousal/domestic partner eligibility must be certified each year during Open Enrollment in order to retain medical and/or dental coverage for the federal spouse/domestic partner for the next year. More information about the spousal/domestic partner eligibility benefit coverage policy can be found on McClatchy’s LiveWell website.

Section 3. Health Benefits -- Medical, Dental, Vision and Employee Assistance Plan (EAP)

3.1 What health care plan options are available to me?

McClatchy offers medical, dental, vision and EAP plans. Appendix A lists the options for each type of health benefit. More specific information on the health care plan options can be found on McClatchy's LiveWell website. You may also receive this information by contacting your local Human Resources.

Each plan option may have a different cost to you. Some specific rules regarding each option and benefits provided under each option are detailed below.

3.2 Who is eligible?

Each eligible employee may purchase coverage for himself or herself. For any health benefit option you select, you may also enroll your federal spouse/domestic partner, eligible dependents and/or your domestic partner's child(ren) in the same plan option that you are enrolled in.

3.3 What if I am eligible for Medicare or a state medical assistance plan?

Your eligibility for Medicare does not affect your ability to enroll in McClatchy's health care plans except as described below in Section 3.6. McClatchy's health plans will be the primary payer; Medicare will be the secondary payer.

We will coordinate with any state and federal agencies and follow necessary federal and state laws to make sure that payments for your benefits under the Plan are made appropriately.

3.4 How do I enroll?

Enrollment in the EAP program is automatic and fully paid by your employer.

For medical, dental and vision coverage, once you become eligible to participate, you must enroll by a process approved by the Company in order to receive these benefits.

You have the opportunity to enroll in the health care plans when you first become eligible for the coverage. You must actively enroll in coverage by the deadline given when you first become eligible for benefits or you will not have medical, dental or vision coverage for the rest of the year. In addition, if you do not enroll in a timely manner, your federal spouse -- or domestic partner, your eligible dependents and any child of your domestic partner will not be entitled to any health care coverage.

After your initial enrollment period, you will have another opportunity to enroll or change coverage during the annual Open Enrollment period, which is normally held during the fourth quarter of the year. The Company reserves the right to "roll over" elections into the next Plan Year, subject to new Plan costs and the federal spouse/domestic partner eligibility certification requirement described in Section 2.8.

In that case, if you do not make changes to your coverage during Open Enrollment, your current coverage elections will remain the same for the following year but the premium contributions you pay would be adjusted to the new rates.

However, even when elections generally are rolled over, ***health care and dependent care spending accounts must be re-elected annually.***

3.5 *My federal spouse/domestic partner is already enrolled in my health care plans. Does his or her coverage also automatically “roll over” to the next year?*

Medical and/or dental coverage for your federal spouse/domestic partner will only roll over if you certify he/she is eligible for medical and/or dental coverage during the Open Enrollment period. This certification must be done each year. If this certification is not completed during Open Enrollment, your federal spouse/domestic partner will not have coverage for the following year.

If your federal spouse/domestic partner loses medical or dental coverage for the next year because spousal eligibility certification was not completed during the Open Enrollment period, he/she is not eligible for COBRA.

Vision coverage for your federal spouse/domestic partner will automatically roll over to the next year because the spousal eligibility rules do not apply to this coverage.

3.6 *Can I change my health care plan elections during the year?*

In general, the coverage that you choose when you enroll is irrevocable until the next annual enrollment period; however, in certain situations you are allowed to change your coverage during the middle of the year. The situations when you are permitted to make mid-year enrollment changes are described in this section and in Section 5.8. To request special enrollment or obtain more information, contact your local Human Resources.

The Health Insurance Portability and Accountability Act of 1996 (known as “HIPAA”) provides you with special enrollment rights in the event that you acquire a new dependent, or you or your dependent experience a loss of other health coverage, are terminated under a Medicaid or state child health plan as a result of loss of eligibility or become eligible for premium assistance through a Medicaid or state child health plan as further described in this section. These HIPAA special enrollment rights are applied with respect to your medical, dental and vision coverage, but do not apply to your Health Care FSA.

(i) *New Dependent*

HIPAA provides you with special enrollment rights if you acquire a new dependent during the year.

If you acquire a new federal spouse through marriage, or a new eligible dependent through marriage, the birth of a child, adoption or the placement of a child for adoption, you may make the following changes:

- If you are already a participant in the health plan, you may enroll your federal spouse, your newly acquired dependent and other eligible dependents in the same coverage option that you are covered under or you may enroll yourself, your federal spouse, your newly acquired dependent and other eligible dependents in another available coverage option.
- If you are not a participant in the health plan, you must enroll yourself in the applicable health plan if you are adding others as described above.

Note: To take advantage of this special enrollment right, you must contact HR and provide the required documentation regarding the enrollees in the health plan within 31 days of the event that gave rise to the new dependent.

- If the dependent is new due to the birth, adoption of a child or placement for adoption, coverage will be retroactive to the date of the birth, adoption or placement in the home for adoption.
- If the dependent is new due to marriage, coverage shall be effective no later than the first day of the month after enrollment.

(ii) *Loss of Other Health Coverage – Including Medicaid or a State Child Health Plan*

HIPAA gives you special enrollment rights if you experience a “loss of other health coverage.” A loss of other health coverage occurs if you, your federal spouse, or eligible dependents, lose health coverage by (i) exhausting another employer’s COBRA coverage, (ii) ceasing to be covered under another health plan because of a loss of eligibility for that plan, or (iii) ceasing to be covered under another employer plan because the employer stopped contributing to the plan.

- If you are already a participant in the health plan, you may enroll your federal spouse, your newly acquired dependent and other eligible dependents in the same coverage option that you are covered under or you may enroll yourself, your federal spouse, your newly acquired dependent and other eligible dependents in another available coverage option.
- If you are not enrolled in the selected health coverage option, in order to enroll your federal spouse or eligible dependents, you first must enroll yourself.

Note: To take advantage of this special enrollment right, you must contact HR and provide the required documentation regarding the enrollees in the health plan within 31 days of the loss of other health coverage. However, if the loss of coverage results from Medicaid or state child health plan coverage,

you have 60 days to provide the required documentation regarding your enrollees in the health to HR.

- Your coverage will be effective on the first day of the month after enrollment.

(iii) *You Become Eligible for Premium Assistance Through a Medicaid or State Child Health Plan*

Finally, HIPAA also gives you special enrollment rights if you, your federal spouse or eligible dependent become eligible for assistance with respect to coverage under a health plan through a Medicaid or state child health plan.

- If you are already a participant in the health plan, you may enroll your federal spouse, your newly acquired dependent and other eligible dependents in the same coverage option that you are covered under or you may enroll yourself, your federal spouse, your newly acquired dependent and other eligible dependents in another available coverage option;
- If you are not enrolled in the selected health coverage option, in order to enroll your federal spouse or eligible dependents, you first must enroll yourself.

Note: To take advantage of this special enrollment right, you must contact HR and provide the required documentation regarding the enrollees in the health plan within 60 days of being determined to be eligible for assistance with respect to coverage under the health plan through a Medicaid or state child health plan.

- Your coverage will be effective on the first day of the month after enrollment.

(iv) *Qualified Medical Child Support Order*

You may also have the right, or be required by law, to change your coverage during the year if you are subject to a Qualified Medical Child Support Order (known as a “QMCSO”). A QMCSO is a state court or administrative agency order that requires an employer’s medical plan to provide benefits to the child of an employee who is covered, or eligible for coverage, under the employer’s plan. QMCSOs usually apply to a child who is born out of wedlock or whose parents get divorced.

When we receive a QMCSO, we must promptly notify you and the child that the order has been received and what procedures we will use to determine if the order is “qualified.” If we determine the order is qualified and you must provide coverage for your child pursuant to the QMCSO we will enroll you and your child in the coverage specified in the Order. When the Order does not address the type of coverage, your child will be enrolled in your current

medical plan. If you are not currently enrolled, both you and your child will be enrolled in the lowest cost medical plan.

We will deduct from your paycheck the amount necessary to pay for such coverage. We will notify you once we determine whether or not the order is qualified.

A copy of the procedures governing QMCSO determinations is available from Human Resources.

3.7 *Do the HIPAA Special Enrollment Rights Permit the Enrollment of My Domestic Partner or My Domestic Partner's Child?*

No. However, with respect to medical, dental and/or vision coverage, the Plan provides HIPAA-like special enrollment rights to your domestic partner and/or the child of a domestic partner, as follows:

- If you are the affected person in a loss of other health coverage situation or a Medicaid/state plan premium assistance situation, you may enroll yourself, your domestic partner and your domestic partner's child in any health coverage option that is a replacement for the lost coverage.
- If you are currently enrolled in a health plan coverage option, and you newly acquire a domestic partner or child of a domestic partner, you may enroll your domestic partner and any child of a domestic partner in the health plan coverage option in which you are enrolled.
- If you are currently enrolled in a health plan coverage option and your domestic partner or the child of your domestic partner is the affected person in a loss of other health coverage situation or a Medicaid/state plan premium assistance situation, you may enroll your domestic partner and the child of your domestic partner in the health coverage option in which you are enrolled.

3.8 *How are health benefit premiums paid?*

You are required to pay the employee portion of the premiums for your medical, dental, and vision coverage. If you are enrolled in health care coverage, the premium conversion program (described in detail in Section 5 of this booklet) allows you to pay your portion of these premiums with pre-tax dollars. However, the employee premium contributions for a domestic partner's or domestic partner's dependent's medical, dental, and vision insurance must be paid with after-tax dollars. Enrollment in the premium conversion program is automatic if you elect health coverage. The Company will deduct the amount of your health care premium contributions from your paycheck twice a month.

The Company pays a portion of the cost of your health care premiums. We reserve the right to change the amount we contribute at any time. We will announce the amount you must pay for your health care coverage each year at the time of Open Enrollment.

3.9 *How do I file a health benefits claim?*

Each health care insurance provider has different procedures for filing claims. In some cases you simply show your insurance card when using services and your health care provider will file the claim. In other cases, to file a claim you must use the claim form provided by the insurance company providing the health coverage you have selected. These forms are available from Human Resources or may be printed directly from McClatchy's LiveWell website.

You should refer to Section 12 of this booklet for an explanation of certain rights that you have regarding when you will be notified of the decision on your claim.

3.10 *What if my health benefits claim is denied?*

If your claim for benefits under this policy is denied and you want to appeal the decision, you should follow the procedures outlined in Section 12 of this booklet.

3.11 *When will my health coverage end?*

You will cease to be covered under our health care plans if (i) you cease to be an eligible employee, (ii) you fail to pay required premiums on a timely basis or (iii) we discontinue the medical, dental, vision, or EAP insurance programs.

If you cease to be an eligible employee, coverage ends on the last day of the month in which your status changes. For example, if your employment terminates during the month, your active employee benefit coverage will end on the last day of that month.

3.12 *Do I have any special rights when my benefits terminate?*

If certain events, known as "qualifying events," cause you to lose your health care coverage, you may be entitled to continue receiving coverage under COBRA. Section 11 of this booklet includes a detailed explanation of when you become entitled to COBRA and how the COBRA program works.

3.13 *If my coverage terminates, will I receive a certificate of creditable coverage?*

If your health coverage or your COBRA continuation coverage ceases (as described in Section 11), HIPAA requires that a certificate of creditable coverage be automatically sent to you, your federal spouse or domestic partner, and your dependents and/or domestic partner's dependents. The certificate will be sent by first class mail to your last known address (or if different, your dependent's last known address, as applicable) generally within 30 days.

In addition, regardless of whether you have previously received a certificate, you may request (or a request may be made on your behalf) to receive a certificate of creditable coverage at any time while your health coverage is in effect and up to 24 months after your coverage ceases, by contacting the insurance carrier's Member Services. The telephone number is listed on the LiveWell website. Upon receipt of your request, a certificate of creditable coverage will be sent by first class mail to

your last known address (or if different, your dependent's last known address, as applicable) generally within 30 days.

Generally, certificates of creditable coverage are in writing, except that the information may be delivered in another form with your consent under certain narrow circumstances. You may also designate another individual or entity to receive the certificate. Only one certificate of creditable coverage will be provided for you, your federal spouse or domestic partner, and your dependents and/or domestic partner's dependents, if the information is identical for each of you. If the information is not identical, certificates for each party may be provided on one form if the form provides all the required information for each individual and separately states any information that is not identical.

Please be aware that the right to receive a certificate of creditable coverage either automatically or upon request under HIPAA does not apply with respect to your dental or vision coverage or your Health Care FSA.

3.14 *Special rights related to your medical insurance*

Several federal laws provide that your medical insurance must provide specific coverage in certain circumstances. This section describes these special protections.

(i) *Maternity Minimum Stay Provisions*

The Newborns' and Mothers' Health Protection Act generally prohibits group health plans and health insurance carriers offering group insurance coverage from:

- Restricting 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, or
- Requiring that a provider obtain authorization from the plan or the insurance issuer for prescribing a length of stay not in excess of the above periods.

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 the newborn earlier than 48 hours (or 96 hours as applicable). If discharged early, a follow-up visit for the mother and newborn within 48 hours of discharge is covered when prescribed by the treating physician. This visit shall be provided by a licensed health care provider whose scope of practice includes postpartum and newborn care. The treating physician, in consultation with the mother, shall determine whether this visit shall occur at home, the contracted facility, or the physician's office.

(ii) Coverage for Reconstructive Surgery Following Mastectomy

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”). When a person insured for medical benefits under the Plan who has had a mastectomy (at any time) decides to have breast reconstruction, based on consultation between the physician and the patient, coverage will be provided for the following benefits, subject to the same coinsurance and deductibles which apply to other medical and surgical benefits provided under the Plan:

- 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 in all stages of mastectomy, including lymphedema.

(iii) Mental Health Parity and Addiction Equity Act

If the medical coverage option that you choose offers mental health benefits or substance use disorder programs, any annual or lifetime maximum dollar limit for such benefits may not be more restrictive than the annual or lifetime maximum dollar limit for substantially all of the medical and surgical benefits under the coverage option. In addition, any financial or treatment limitations on coverage or reimbursement for such benefits may not be more restrictive than the predominant financial or treatment limitations on coverage or reimbursement that applies to substantially all of the medical and surgical benefits under the coverage option.

These requirements apply separately to the following benefit classifications:

- Inpatient, in-network;
- Inpatient, out-of-network;
- Outpatient, in-network;
- Outpatient, out-of-network;
- Emergency care; and
- Prescription drugs.

In addition, the medical coverage option may not impose a “nonquantitative treatment limitation” with respect to mental health or substance use disorder benefits in a particular classification unless any processes, strategies, evidentiary standards, or other factors used in applying the nonquantitative treatment limitation to mental health or substance use disorder benefits in the classification are comparable to, and are applied no more stringently than, the corresponding processes, strategies, evidentiary standards or other factors used in applying the limitation to medical and surgical benefits in the classification. Nonquantitative treatment limitations include:

- Medical management standards limiting or excluding benefits based on medical necessity or medical appropriateness, or based on whether the treatment is experimental or investigative;
- Formulary design for prescription drugs;
- Standards for provider admission to participate in a network, including reimbursement rates;
- Plan methods for determining usual, customary, and reasonable charges;
- Refusal to pay for higher-cost therapies until it can be shown that a lower-cost therapy is not effective (also known as fail-first policies or step therapy protocols);
- Exclusions based on failure to complete a course of treatment;
- Network tier design for plans with multiple network tiers (such as preferred providers and participating providers); and
- Restrictions based on geographic location, facility type, provider specialty and other criteria that limit the scope or duration of benefits for services provided under the plan or coverage.

(iv) *Genetic Information Non-Discrimination Act*

The Genetic Information Non-Discrimination Act prohibits group health plans and health insurance carriers from requesting genetic information from you or purchasing your genetic information for use in connection with plan enrollment or for any underwriting purpose (such as premium adjustments or contribution amounts). In addition, no group health plan or health insurance carrier may request or require you or a family member to undergo genetic tests.

(v) *Patient Protection and Affordable Care Act*

The Patient Protection and Affordable Care Act prohibits certain health plans from imposing annual or lifetime per beneficiary limits on essential health benefits.

In addition, health plans must provide coverage for, and may not impose any cost sharing requirements for:

- Certain evidence-based items or services;
- Certain immunizations;
- With respect to infants, children and adolescents, certain evidence-informed preventive care and screenings; and
- With respect to women, certain additional preventive care and screenings.

Section 4. Welfare Benefits – Life, Long-Term Disability (LTD) and Accidental Death and Personal Loss Insurance

4.1 Does McClatchy offer life insurance?

We offer group term life insurance to provide financial protection for your designated beneficiary in the event of your death. You have the option to purchase additional supplemental life insurance for yourself, your federal spouse/domestic partner, or your eligible dependents.

We also offer accidental death and personal loss insurance, or AD&PL, to provide you with financial protection in the event of your accidental loss of life, sight, limbs, speech or hearing. Supplemental AD&PL insurance is not available.

Details about these insurance coverages, including Guaranteed Issue and Evidence of Insurability rules, can be found on the McClatchy LiveWell website.

4.2 Who is my beneficiary?

It is important for you to designate who you would like to receive your life and AD&PL benefits in the event that you die. If no named beneficiary survives you or if no beneficiary has been named, payment will be made as follows to those who survive you:

- Your spouse, if any.
- If there is no spouse, in equal shares to your children.
- If there is no spouse or child, to your parents, equally or to the survivor.
- If there is no spouse, child or parent, in equal shares to your brothers and sisters.
- If none of the above survives, to your executors or administrators.

You may designate or change your beneficiary at any time using McClatchy Employee Self Service located on the McClatchy internet and intranet websites or by contacting your local Human Resources.

4.3 *What disability benefits does McClatchy offer?*

McClatchy offers long-term disability (LTD) benefits that are paid after you have been disabled for six months. You receive a percentage of your pay up to a maximum monthly benefit during your disability. You may be eligible to purchase additional LTD buy-up coverage.

More information about these benefits can be found on the LiveWell website or by contacting your local Human Resources.

4.4 *When am I eligible to participate?*

The welfare plans follow the eligibility rules detailed in Appendix A.

4.5 *How do I enroll?*

You are automatically enrolled in basic life and AD&PL, and base LTD insurance when you become eligible. To purchase additional supplemental life insurance and/or LTD buy-up coverage, you must enroll using the same process as your health care plan enrollment, as designated by the employer. If you do not enroll in additional supplemental life insurance or LTD buy-up coverage when you are initially eligible, you will only be enrolled in the basic life and base LTD benefit. You may be eligible to apply for supplemental life and/or LTD buy-up coverage during the next open enrollment period.

4.6 *How are the welfare benefits paid for?*

Basic life, AD&PL, and base LTD insurance coverage premiums are paid for by McClatchy. Basic life and AD&PL benefits are not taxed. However, because the LTD insurance coverage is paid by the employer, any future benefits paid will be taxed.

The premiums for supplemental life insurance and/or LTD buy-up coverage are paid by the employee. Because these premiums are paid with after-tax dollars, any future benefits paid will be tax-free.

4.7 *When will my coverage end?*

Your coverage in any of the welfare programs will end if you cease to be an eligible employee or if we discontinue such program. Supplemental life insurance and LTD buy-up coverage also would end if you fail to pay the required premiums. If coverage ends because you have ceased to be an eligible employee (for example, if you terminate employment), you will cease to be covered by the welfare plans on the last day you are an eligible employee. Thus, if you terminate employment, basic and supplemental life, AD&PL, and base and buy-up LTD coverage will end on the day you terminate employment.

When your life and AD&PL insurance coverage terminates, you may have the option of portability or conversion to an individual policy. Application and payment for

portability and/or conversion of life insurance must be made within 30 days from your termination date. Contact the life insurance carrier for details. Contact information for the carrier can be found on the LiveWell website.

4.8 *How do I file a claim for benefits?*

To file a claim, please contact the appropriate insurance company. Further information is available by contacting your local Human Resources.

4.9 *What if my claim is denied?*

If your claim for benefits under these policies is denied and you want to appeal the decision, you (or your beneficiary) should follow the procedures outlined in Section 12 of this booklet.

Section 5. Premium Conversion Program

5.1 *What is the premium conversion program?*

The premium conversion program is a benefit program that allows you to pay for some Plan benefits on a tax-free basis from your salary. The premium conversion program also allows you to participate in the Health Care FSA and the Dependent Care FSA. More detail about the Health Care FSA and Dependent Care FSA can be found in Section 6 and Section 7, respectively. Through the premium conversion program, you can also contribute a portion of your salary to a health savings account (HSA), which is discussed in detail in Section 8.

5.2 *What benefits may I purchase through the premium conversion program and how do I enroll in the program?*

When you pay for your health care insurance (medical, dental, and vision coverage) under the Plan, the amounts you have to pay for such coverage for yourself, your federal spouse, and your eligible dependents, will be run through the premium conversion program on a pre-tax basis. You may not use the premium conversion program, however, to pay for the cost of coverage for your domestic partner or your domestic partner's child, if any. As a result, domestic partner coverage must be paid for with after-tax dollars.

5.3 *How do the Health Care FSA and the Dependent Care FSA (FSAs) work?*

The FSAs allow you to pay certain health and dependent care expenses (see Section 6 and Section 7) on a pre-tax basis. You redirect a portion of your salary to the accounts, and when you incur eligible health and/or dependent care expenses, you are reimbursed from the applicable account. Following is an outline of the process:

- You estimate your eligible medical or dependent care expenses.
- You set aside funds in your FSA through payroll deduction.
- You receive your normal medical or dependent care services and pay for the expenses.
- You submit for reimbursement for the eligible expenses you have incurred, also submitting substantiating receipts with the reimbursement form.
- The claim administrator reviews your claim, and provides you with reimbursement if the claim satisfies the conditions for reimbursement.

Please see Section 6.9 regarding using an FSA debit card for these expenses, rather than filing for reimbursement.

5.4 *What are some of the guidelines I should consider in establishing a FSA?*

You may not enroll in the Health Care FSA if you are enrolled in the Savings Advantage medical plan. Your medical plan enrollment does NOT affect your ability to enroll in the Dependent Care FSA.

If you elect to participate in either or both the Health Care FSA and Dependent Care FSA, you must follow the following rules:

- Funds may not be transferred from one FSA to another.
- Once you have elected your general contribution amount, you are limited in your ability to change that amount. See Section 5.8.
- Funds may only be used for eligible expenses (please see Section 6 and Section 7 and Appendix B), as determined by the claim administrator.
- Funds not used to pay eligible expenses incurred during the applicable coverage period or disbursed to the employee as a qualified reservist distribution from a Health Care FSA will be forfeited at the end of the applicable coverage run-out period.
- If you submit a claim to your FSA, you may not claim the same expenses as a deduction on your income tax return. In addition, if you receive a reimbursement from a third-party for expenses already reimbursed by your FSA, you will be required to repay the Plan for the FSA reimbursement. Finally, you cannot receive reimbursement from an FSA for an expense paid for by a health care plan.

5.5 *How do I enroll in an FSA and the premium conversion program?*

Once you become eligible to participate, you are automatically enrolled in the premium conversion program when you enroll in certain benefits that require you to pay premiums.

To enroll in an FSA plan, you must follow the same process that is used for your other benefit enrollments. To authorize FSA contributions, you will be required to explicitly set the amount of salary to be withheld from your salary for the year. This amount will be deducted in substantially equal payments twice a month from your paycheck and credited to the applicable FSA.

If you do not enroll when you first become eligible, your next opportunity to enroll is generally the next annual enrollment period established by the Company for the new coverage year. Health Care FSA and Dependent Care FSA elections do not roll-over from year to year. You must actively elect to participate in the Health Care FSA and/or Dependent Care FSA each year at Open Enrollment if you wish to participate in the following year.

5.6 *How do I benefit from participating in the premium conversion program?*

The following example illustrates the federal income tax savings that you may be able to achieve by participating in the premium conversion program.

Cathy and Jim both work full-time and expect to spend \$2,600 for eligible day care in the coming year. Both spend about \$3,000 to purchase health coverage for their families. Cathy pays for her family's health care coverage under the Plan, while Jim elects to purchase health care coverage elsewhere. Cathy also decides to redirect \$2,600 of her salary towards the Dependent Care FSA, while Jim does not elect to redirect any salary towards the Dependent Care FSA. Cathy's estimated tax savings are shown below in comparison to Jim's.

	<u>Cathy's Election</u> (With Premium Conversion)	<u>Jim's Election</u> (Without Premium Conversion)
Salary	\$40,000	\$40,000
Pre-tax Health Care Premium Contributions	\$3,000	0
FSA Account	\$2,600	0
Taxable Pay	\$34,400 (\$40,000 – \$5,600)	\$40,000 (\$40,000 – \$0)
Estimated Tax (20%)	\$6,880	\$8,000
After-Tax Salary	\$27,520 (\$34,400 – \$6,880)	\$32,000 (\$40,000 – \$8,000)
After-Tax Expense	\$0	\$5,600 (for day care, plus health care purchased elsewhere)
Spendable Income	\$27,520	\$26,400 (\$32,000 – \$5,600)

By redirecting salary under the premium conversion plan and the Dependent Care FSA, Cathy has saved \$1,120 (\$27,520 - \$26,400) or 2.8% of her annual salary.

Contributions to the premium conversion program usually are not subject to state taxes.

5.7 *What is the impact of my participation on my Social Security taxes?*

You should note that you also do not pay Social Security tax on amounts deducted from your pay on a pre-tax basis under the premium conversion program (including the FSAs and the HSA). This means your contributions to the premium conversion program may reduce your wages reported for Social Security purposes and could ultimately reduce your Social Security benefit amount.

5.8 *May I change my election during the year?*

Your election to participate in the premium conversion program, including the Health Care FSA and the Dependent Care FSA, is generally irrevocable during the year. ***In other words, once you have decided how much salary you wish to defer in order to pay for benefits under the premium conversion program, you are locked into that salary deferral until the next annual enrollment period.***

Special rules apply to your participation in the HSA and are addressed in Section 8.4.

However, if certain special circumstances occur, you may be permitted to change your election, or to begin or cease participation in the premium conversion program, before the next annual enrollment period. These circumstances are described below.

IMPORTANT: You may not make any change in the amount that you have elected to defer into the Health Care FSA as a result of the circumstances listed below with an *.

(i) Change of Status

You may change your election under the premium conversion program if you experience a change of status and your election change is consistent with that change of status.

A change of status is any of the following events:

- A change in your legal marital status, including marriage, divorce, death of a federal spouse, legal separation from a federal spouse or annulment of a marriage to a federal spouse;
- A change in your number of eligible dependents, including birth, adoption, placement for adoption or death, becoming a foster parent or becoming subject to a court order providing for guardianship or a similar relationship;
- A change in your employment status or in the employment status of your federal spouse or eligible dependent, including:
 - A termination or commencement of employment;
 - A strike or lockout;
 - A commencement of or return from an unpaid leave of absence;
 - A change in worksite; and
 - A change in employment status of you, your federal spouse or eligible dependent resulting in you, your federal spouse or eligible dependent

becoming (or ceasing to be) eligible under this Plan or other cafeteria plan or benefits plan, such as your, your federal spouse's or eligible dependent's employment status changing from part-time to full-time, salaried to hourly, union to non-union or vice versa.

- An eligible dependent satisfies or ceases to satisfy eligibility requirements for coverage on account of attainment of age, or any other similar circumstance;
- A change in your, your federal spouse's or eligible dependent's place of residence; and
- Any other events that may become permissible according to the Internal Revenue Service and that are approved by the plan administrator.

Your election change as a result of a change of status must be consistent with the change of status. For example, if you get divorced in the middle of the coverage year, you may only change your premium conversion program election with respect to your ex-federal spouse. Similarly, if one of your children is no longer eligible for coverage as a result of his age, you may only change your election with respect to that dependent, and not with respect to yourself, your federal spouse or your other dependents who remain qualified for coverage.

(ii) *HIPAA Special Enrollment**

If a HIPAA special enrollment applies, you may make new health coverage option elections, as described in Section 3.6.

(iii) *Automatic cost changes**

If the cost of a coverage option automatically increases or decreases during the year by an insignificant amount, the plan administrator may automatically increase or decrease your contribution under the premium conversion program to take account of such increase or decrease in premium cost.

(iv) *Significant cost increases**

If the premium cost of a coverage option increases significantly during the year, you may make either of the following election changes:

- You may revoke your election of the coverage option that increased in cost and either make a new election to receive coverage under another option providing similar coverage or cease to receive medical coverage if no coverage option providing similar coverage exists; or
- You may increase your salary deferrals in order to correspond with the increased cost of the coverage option.

(v) Significant cost decreases*

If the premium cost of a coverage option for which you are eligible significantly decreases during the year, you may make either of the following election changes:

- If you are already participating in the premium conversion program but you are covered under an option other than the option that decreased in cost, you may cease your current coverage and elect coverage under the option that decreased in cost; or
- If you are not participating in the premium conversion program, you may commence participation and elect the coverage option that decreased in cost.

(vi) Significant curtailment of coverage without loss of coverage*

If you or your dependent has a significant curtailment of coverage under a coverage option that does not amount to a loss of coverage, then you may revoke your election to participate in the coverage option and elect coverage under another coverage option providing similar coverage. Examples of significant curtailments of coverage include a significant increase in the deductible, co-pay or out-of-pocket cost-sharing limit under the coverage option.

(vii) Significant curtailment of coverage that results in a loss of coverage*

If you or your dependent has a significant curtailment of coverage that results in a loss of coverage, then you may revoke your election to participate in the coverage option and elect coverage under another coverage option providing similar benefits. If no similar benefit option exists, you may cease participation in the premium conversion program. A loss of coverage occurs when there is a complete loss of coverage under the benefit option.

(viii) Addition or improvement of a coverage option*

If the Plan adds new coverage options during the year or if coverage under existing options is significantly improved during the year, you may make the following election changes:

- If you are already participating in the premium conversion program, you may change to the newly added or improved coverage option; or
- If you are not participating in the premium conversion program, you may commence participation and elect the new or improved coverage option.

(ix) *Change or loss of coverage under another employer plan*

If you or your dependent has coverage under another employer plan and such coverage changes or is canceled, then you may make a change consistent with the change in that coverage.

(x) *Loss of coverage under other group health plan*

If you or your dependent was previously covered under another group health plan sponsored by a governmental or educational institution and you or your dependent loses such coverage, you may elect coverage for yourself or the affected dependent.

(xi) *QMCSO*

If a QMCSO is issued requiring health coverage for your dependent child, you may change your premium conversion election to:

- Provide coverage for the dependent child and yourself (if necessary); or
- Revoke coverage for the dependent child if the QMCSO requires another individual to provide support under that individual's plan, and that coverage is, in fact, provided.

(xii) *Entitlement to Medicare or Medicaid*

If you or your dependent is enrolled in a health plan and you participate in the premium conversion program, and you or your dependent becomes entitled to Medicare or Medicaid, you may reduce or cancel your coverage under this program for the person becoming entitled to Medicare or Medicaid. Similarly, you may commence or increase coverage under the premium conversion program for yourself or your dependent who has lost coverage under Medicare or Medicaid.

5.9 *If I am allowed to change my election, when must I make the change?*

If you are allowed to change your election before the annual enrollment period because you meet one of the requirements listed above, you must make your new election within 31 days of the event that allowed you to change your election, unless a longer applicable period is described in Section 3.6.

Your election will generally be effective as of the first of the next calendar month. However, elections made with respect to the birth, adoption, or placement for adoption of a child will be effective retroactive to the date of the birth, adoption or placement for adoption of the child.

Your new election will be irrevocable until the next annual enrollment period unless a subsequent event allows a further change.

5.10 *When do my benefits end?*

Your benefits under the premium conversion program will end if you cease to be an eligible employee, if you fail to pay required premiums under the program or if we discontinue the program.

When you terminate employment, you cease to be an eligible employee. When you cease to be an eligible employee, your FSA salary reductions will cease. You may claim reimbursement for all eligible expenses incurred during the period of coverage prior to termination, as long as you file the claim by March 31 of the year following the year the expenses were incurred for the Health Care FSA (except as permitted in Section 6.4), or March 31 of the year following the year expenses were incurred for the Dependent Care FSA.

Section 6. Health Care Flexible Spending Account

6.1 *What is the Health Care FSA?*

The Health Care FSA allows you to elect salary deductions on a pre-tax basis to pay eligible health care expenses directly with a debit card or to reimburse you for health care expenses (which must meet the definition of “medical care” in section 213(d) of the Internal Revenue Code) that are not otherwise covered by your health insurance or reimbursable from any other source, such as co-pays and deductibles. A generalized list of other eligible expenses is provided in Appendix C.

6.2 *Can I enroll in the Health Care FSA if I am enrolled in the Savings Advantage medical plan?*

You cannot enroll in the Health Care FSA if you are enrolled in the Savings Advantage medical plan, which is a high deductible health plan. You can enroll in the Health Care FSA if you are enrolled in the Classic Care medical plan or have waived medical coverage.

6.3 *What is the coverage period under the Health Care FSA?*

When you elect to participate in the Health Care FSA, it is an election to participate until the end of the year. This means that the coverage period generally is the next calendar year, if your election to participate occurs during annual Open Enrollment. Each new calendar year is a new coverage period under the Plan, if you remain continuously enrolled. However, please note that for the 2013 calendar year coverage period, the Plan offers a “grace period” described below in Section 6.4. (See Section 6.5 for the use-it-or-lose-it rule.)

If you terminate employment (unless you are eligible for COBRA), your coverage period will be treated as ending on your termination date and you will no longer be entitled to make salary deduction contributions to the Health Care FSA after your final paycheck from The McClatchy Company.

Your Health Care FSA election ordinarily is irrevocable for the coverage period, which means you generally cannot increase or decrease the amount of your salary deductions during the year. However, under special circumstances described in Section 5.8, you can make a mid-year coverage change, which in some cases would permit late enrollment or early termination of participation during a calendar year.

6.4 *What is the grace period?*

If you are a participant under the Health Care FSA on December 31, 2013, and you have not fully used the amounts set aside in your account for the 2013 calendar year, the Plan allows you to use eligible expenses incurred on or before March 15, 2014 to obtain additional reimbursements from your prior year's Health Care FSA account.

You will have until May 15, 2014 to submit eligible expenses incurred during 2013 and the grace period described above.

For participation in the Health Care FSA during the 2014 calendar year or any subsequent calendar year, the grace period will not apply. All expenses will have to be incurred by December 31 to be eligible for reimbursement and submitted to the FSA third party administrator by March 31 of the following calendar year (see Section 6.10).

6.5 *Why is the coverage period important and what is the “use-it-or-lose-it” rule?*

Amounts you set aside in the Health Care FSA through salary deductions for a coverage period may only be used to pay or reimburse eligible health care expenses *incurred during* the coverage period unless you receive a qualified reservist distribution as described in Sections 6.18 through 6.22. If, when the coverage period ends, you do not have enough eligible expenses to use up the amounts you have set aside by salary deduction, you will forfeit those amounts. In other words, the amounts that are not used will not roll over into the new coverage period or be returned to you.

Claims incurred after your termination date are not eligible to be paid or reimbursed under the Health Care FSA unless you are eligible for and elect COBRA coverage. However, you can continue to submit claims for health care expenses that you incurred during the coverage period prior to your termination date. Those expenses will be paid or reimbursed up to the unused amount that you set aside in the Health Care FSA as of your date of termination.

6.6 *When are health care expenses incurred?*

For eligible health care expenses to be paid directly or reimbursed to you from your Health Care FSA, they must have been incurred during the coverage period. A health care expense is *incurred* when the service is provided, not when the expense is paid, with the exceptions described below. For example, if you pay for health care on the first day of the month for care given on the 15th of that month, the expense has not been incurred until the 15th of that month. In addition, you may not be

reimbursed for any expenses incurred at a time you are not a participant under the Health Care FSA.

There are two exceptions to the general rule that eligible health care expenses may only be reimbursed if they have been incurred during the coverage period. First, you may be reimbursed for durable medical equipment with a useful life extending beyond the coverage period during which the expense is incurred. You may also be reimbursed for orthodontia services before the services are provided, but only to the extent that you have actually made the payments in advance of the orthodontia services in order to receive the services. Such orthodontia services will be deemed to be incurred when you make the advance payment. Orthodontia expenses may also be treated as incurred periodically over the treatment period if the expenses are paid under the service contract.

6.7 *What is the maximum amount that I may contribute to my Health Care FSA?*

The maximum amount you can contribute to your Health Care FSA is \$2,500 per year. If your federal spouse is employed and covered by their own Health Care FSA, then the maximum amount you can each contribute to your respective employer's Health Care FSA is \$2,500 per year.

6.8 *What if I incur a large reimbursable claim early in the year?*

The Health Care FSA is funded through salary deductions taken in substantially equal amounts over 24 pay periods during the year. Thus, for example, if an eligible employee who enrolled during the enrollment period for the upcoming calendar year is paid bi-weekly and elects to contribute \$100 a pay period for the upcoming year, his total election would be \$2,400 for the year. If that employee incurs a significant, and otherwise uncovered, health care expense early in the year, the employee would only have contributed a fraction of the \$2,400 by the time the claim is incurred. Nevertheless, even if the eligible employee submits a \$2,400 claim in March, for example, the whole of the claim will be reimbursed from the account since the annual election is sufficient to cover the reimbursable expense.

On the other hand, if the participant's annualized salary deduction contributions would only have totaled \$2,000, only \$2,000 would be reimbursable from the account at any point during the coverage year. The total aggregate claims reimbursable from a participant's Health Care FSA account cannot exceed the participant's total annual contributions to the Health Care FSA.

6.9 *How can I access my Health Care FSA directly to pay eligible expenses?*

If you contribute to a Health Care FSA, you will receive a limited use Visa® debit card that you can use to pay for your qualified health care expenses and those of your federal spouse and dependents. You cannot use the debit card to pay Dependent Care expenses. The debit card allows you to pay eligible expenses directly from your Health Care FSA, without having to pay out-of-pocket and file for reimbursement. Any expense paid with the card cannot be reimbursed by another source. If the debit card is used to pay an ineligible expense, the card will be

suspended until the participant repays the amount. You may choose not to use the debit card and to instead file for reimbursement for an eligible expense.

The dollar value stored on your debit card will be the same as the contribution amount that you elect when you enroll in the account. When you use the debit card, your eligible expenses will be deducted automatically from your account. The Company has retained the services of an independent third-party administrator, to administer the debit card feature of the account.

In order to reduce abuse of the card, it will only be accepted at approved points of sale, for example, doctors' offices and pharmacies. Some expenses at certain points of sale will be automatically approved. For instance, a \$25 co-pay at a doctor's office will usually be automatically approved without further documentation. Other expenses may require documentation, and the administrator will notify you if such documentation is necessary. You should retain receipts for all of your transactions, even for items that are normally automatically approved.

Additional cards will be available upon request. Your debit card will be cancelled on the date of your termination of employment with The McClatchy Company, as described in Section 6.14.

6.10 *How do I make a claim for reimbursement from my Health Care FSA?*

You may submit a claim for reimbursement from your Health Care FSA as soon as an eligible expense is incurred. Claims forms are available on McClatchy's LiveWell website, through the FSA third-party administrator's website, or by calling the FSA third-party administrator's Customer Service. In addition, you may submit your claim for reimbursement from your Health Care FSA online and upload your receipts through the FSA third-party administrator's website. Contact information for the FSA third-party administrator can be found in Section 16, Plan Administrative Information.

Your claim must include a written statement or bill from an independent party stating that the eligible expenses have been incurred, the date of service, and the amount of such expenses. In addition, you may be required to include an explanation of benefits from any primary medical and/or dental coverage indicating the amounts that you are obligated to pay. You must also attest to the fact that the expense is not reimbursable from any other source.

If you participated in the Health Care FSA and were employed with McClatchy on December 31, 2013, you will have until May 15, 2014 to submit a claim for reimbursement for eligible health care expenses incurred during 2013 or up until and including March 15, 2014.

If you participate in the Health Care FSA in 2014 or any subsequent calendar year, you can submit a claim for reimbursement for eligible health care expenses incurred through December 31. You have until March 31 after the end of the calendar year of participation to submit your claims for reimbursement.

You will be notified in writing within 30 days of the FSA third-party administrator's receipt of your claim if any claim for benefits is denied; however, if special circumstances require a delay, you will be notified that the review may take an additional 15 days. If you have failed to submit the information necessary for the FSA third-party administrator to decide your claim, you will be notified and provided with 45 days to submit such information to the FSA third-party administrator.

The denial will take the form of an Explanation of Benefits ("EOB") form that shows that all or any part of your claim for reimbursement of expenses will not be paid and includes the information listed in Section 12.3. You are assumed to receive the EOB form five days after it is mailed to you.

You have the right to appeal any denial you receive for reimbursement of health care expenses that have submitted. To appeal the decision, you must submit a written request to the FSA third-party administrator within 180 days of receiving the EOB. Be sure to include any additional information that will assist in the review of the claim (such as an itemized billing statement or a physician's statement of medical necessity).

Upon receipt of your appeal request, the FSA third-party administrator will review the information submitted and will respond to you in writing within 60 days.

You either may appeal a denial yourself or you may designate an authorized representative to undertake the appeal on your behalf.

At the appeal level we will review all documents, records and other information submitted that relates to the claim. You may request, free of charge, copies of the documents, records and other information upon which the FSA third-party administrator relied in making its determination. See Section 12.8 for further information about how your appeal will be reviewed.

6.11 *What if the eligible health care expenses I incur during the Plan Year are less than the annual amount that I elected for Health Care FSA benefits?*

Generally, you will forfeit any remaining balance in your Health Care FSA at the end of the annual run-out period, as described in Section 6.4.

There is one exception to this rule. If you meet the eligibility requirements for a qualified reservist distribution as described in Section 6.18, the account balance of your Health Care FSA may be reimbursed to you upon your request.

6.12 *When would I risk forfeiting my Health Care FSA benefits?*

You will forfeit any balance in your Health Care FSA account if that amount has not 1) been disbursed to you through a qualified reservist distribution (as described in Sections 6.18 through 6.22) or 2) a claim is not filed for eligible health care expenses incurred during the coverage period by March 31 following the end of the calendar

year for which the election was effective. The Company may use amounts so forfeited to pay administrative expenses and future costs of the Plan.

6.13 *What expenses are reimbursable and eligible for the Health Care FSA?*

You can use your Health Care FSA to pay a provider directly, or reimburse you for eligible health care expenses not paid or reimbursed in full by another program or plan. In general, eligible expenses include those charges that would be deductible as a health care expense under section 213(d) of the Internal Revenue Code. See Appendix C for a generalized list of eligible and ineligible Health Care FSA expenses.

6.14 *Will I be able to use my debit card after I terminate employment with The McClatchy Company?*

No. If you terminate employment with The McClatchy Company your debit card will be de-programmed as of your date of termination and you will not be able to use it after that date. As a result, you will need to manually submit claims for any eligible expenses that you incur prior to your termination date but you pay for after your termination date.

6.15 *Can I use my Health Care FSA to pay eligible expenses that I incur for my dependents or domestic partner?*

Eligible health care expenses that you incur for your dependents are reimbursable and eligible for debit card use under your Health Care FSA. However, expenses that you incur on account of your domestic partner or the child of your domestic partner who, in either case, does not qualify as your tax dependent, are not eligible for reimbursement or direct debit card payment under your Health Care FSA.

6.16 *Am I eligible to elect COBRA or USERRA coverage for the Health Care FSA?*

If you lose coverage under the Health Care FSA due to a termination of employment or reduction of hours, you may be eligible to elect to continue coverage under the Health Care FSA through COBRA. COBRA premiums are generally paid with after-tax dollars. However, if you pre-pay your entire remaining annual election for COBRA coverage, you may elect to pay with pre-tax dollars if you have sufficient compensation remaining to be paid to cover the election.

You are only allowed to elect COBRA for the Health Care FSA if your Health Care FSA account balance is greater than zero at the time of the qualifying event. Your account balance will be considered to be greater than zero if, as of the date of the qualifying event, you have contributed more to your Health Care FSA account than you have been reimbursed, taking into account all claims submitted before the qualifying event.

For example, if you contribute \$100 per month to your Health Care FSA, the qualifying event occurs on March 1, and you have not received any reimbursements from your account, your balance will be \$200, which is greater than zero. You will be entitled to COBRA and your monthly COBRA premium to continue Health Care

FSA coverage will be \$102 per month (or 102% of \$100). However, if you have already received reimbursements from your account of \$200 or more, you will not have an account balance that is greater than zero and therefore will not be eligible to elect COBRA for the Health Care FSA.

If you go on military leave that qualifies under USERRA, you may elect to continue Health Care FSA coverage for up to 24 months, regardless of whether or not your account balance is positive at the time the leave begins.

6.17 *Will I be taxed on the Health Care FSA benefits I receive?*

Generally, you will not be taxed on your Health Care FSA benefits, as long as the reimbursement or debit card payment for the eligible medical care expenses is valid and substantiated. The Company cannot guarantee this consequence, however. For example, the Plan and the Health Care FSA program are subject to coverage and non-discrimination tests under the Internal Revenue Code. If the tests are not satisfied, then participants who are considered highly compensated employees under the Code may be required to be taxed on the FSA benefits. Accordingly, the Company reserves the right to reduce the benefits payable to highly compensated employees if it believes this action will restore the Plan's compliance with the applicable Internal Revenue Code rules.

6.18 *What is a qualified reservist distribution and who is eligible to request one?*

A qualified reservist distribution is a disbursement to you of all or a portion of the balance of your Health Care FSA account. You are eligible to request a qualified reservist distribution if you are a member of a reserve component who has been called or ordered to active duty for 180 days or more or for an indefinite period during this year. A member of a reserve component is any member of one of the Army National Guard of the United States, the Army Reserve, the Navy Reserve, the Marine Corps Reserve, the Air National Guard of the United States, the Air Force Reserve, the Coast Guard Reserve, or the Reserve Corps of the Public Health Service. Generally, if you are ordered or called to active duty for less than 180 days you are not eligible to request a qualified reservist distribution. However, if subsequent orders or calls to active duty increase your total period of continuous active duty to 180 days or more you will become eligible to request a qualified reservist distribution.

Many employees who are eligible to request a qualified reservist distribution will also qualify to extend their Health Care FSA coverage through COBRA as described in Section 6.16 above. Employees who elect to continue Health Care FSA coverage through COBRA will not be eligible to receive a qualified reservist distribution.

6.19 *How do I request a qualified reservist distribution?*

If you qualify for a qualified reservist distribution and would like to receive your account balance from your Health Care FSA as a disbursement to you, you will need to request the distribution from McClatchy's third-party administrator before the last day of the calendar year during which the order or call to active duty occurred.

You will have to provide third-party administrator with a copy of the order or call to active duty. You can only request a qualified reservist distribution of contributions you have made to your Health Care FSA during the same year in which the call or order to active duty occurred.

6.20 *How will my Health Care FSA account balance be calculated?*

Your Health Care FSA account balance will be calculated by subtracting 1) the amount you have received in reimbursements under the Health Care FSA, and 2) any amount that has been paid directly for qualifying health care expenses by using your Health Care FSA debit card as of the date you request the qualified reservist distribution, from the amount you have contributed to your Health Care FSA as of that date. For example, if you have contributed \$600 to your Health Care FSA at the time that you request a qualified reservist distribution and you have received \$200 in reimbursements for qualifying health care expenses incurred up to that point, you will be eligible to receive up to \$400 as a qualified reservist distribution. If the Health Care FSA has directly paid another \$200 in qualifying expenses through the use of your Health Care FSA debit card, your qualified reservist distribution will be \$200.

The amount of your qualified reservist distribution is capped at the current account balance in your Health Care FSA account. Only your Health Care FSA account balance is eligible for a qualified reservist distribution.

6.21 *Will I be able to continue to submit claims for reimbursement from my Health Care FSA account after I receive a qualified reservist distribution?*

You can continue to submit claims for eligible health care expenses that you incurred prior to the date you requested the qualified reservist distribution but you will not be eligible to receive reimbursement for any health care expenses incurred after the date of your request. For example, if you request a qualified reservist distribution on the first day of a month and subsequently incur a health care expense on the 15th of that month, you will not be reimbursed for that health care expense. Therefore, you should consider carefully when to submit your request for a qualified reservist distribution.

6.22 *Will I be taxed on a qualified reservist distribution if I receive one?*

Yes. The amount of your qualified reservist distribution will be included in your gross income and wages and will be subject to employment taxes. In addition, the amount of your qualified reservist distribution will be included as wages on your Form W-2 for the year in which the qualified reservist distribution is paid. A qualified reservist distribution is optional and you should consider the tax consequences of such a distribution as well as your likely eligible health care expenses before requesting a qualified reservist distribution.

Section 7. Dependent Care Flexible Spending Account

7.1 *What is the Dependent Care FSA?*

The Dependent Care FSA allows you to elect salary deductions on a pre-tax basis to pay for your eligible dependent care expenses. A generalized list of eligible expenses is provided in Section 7.8.

Under the Dependent Care FSA, the amount available for reimbursement is limited to the value of your account at the time the claim is received. If your claim is for an amount that is more than the current balance, the excess unpaid portion will be carried over and paid to you as your account balance becomes adequate. However, there is no carryover of expenses into a new coverage year.

7.2 *What is the coverage period under the Dependent Care FSA?*

When you elect to participate in the Dependent Care FSA, it is an election to participate until the end of the year. This means that the coverage period generally is the next calendar year, if your election to participate occurs during annual Open Enrollment. Each new calendar year is a new coverage period under the Plan, if you remain continuously enrolled. The election ordinarily is irrevocable for the coverage period, which means you generally cannot increase or decrease the amount of your salary deductions during the year. However, under special circumstances described in Section 5.8(i) and Section 7.10, you can make a mid-year coverage change, which in some cases would permit late enrollment or early termination of participation during a calendar year.

If you terminate employment, your coverage period will be treated as ending at the your termination date and you will no longer be entitled to make salary deduction contributions to the Dependent Care FSA after your final paycheck from The McClatchy Company.

Even if you become entitled to and do make a mid-year coverage change under the Dependent Care FSA, you are not allowed to reduce your election of the amount set aside in your Dependent Care FSA account to a point where the annualized contribution is less than the amount already reimbursed.

7.3 *Why is the coverage period important and what is the “use-it-or-lose-it” rule?*

Amounts you set aside in the Dependent Care FSA through salary deductions for a coverage period may only be used to reimburse eligible dependent care expenses *incurred during* the coverage period. If, when the coverage period ends, you do not have enough eligible expenses to use up the amounts you have set aside by salary deduction, you will forfeit those amounts.

7.4 *When are dependent care expenses incurred?*

For eligible dependent care expenses to be reimbursed to you from your Dependent Care FSA, they must be incurred during the coverage period. A dependent care

expense is *incurred* when the service is provided; not when the expense is paid. For example, if you pay for your child's daycare on the first day of the month for care given during the entire month, the expense has not been incurred until the end of that month.

In addition, you may not be reimbursed for any expenses incurred at a time you are not a participant under the Dependent Care FSA. If you terminate employment, you will be treated as having revoked your election for the remainder of the Plan Year and may not be reimbursed for any expense incurred after your date of termination. However, you may continue to submit eligible expenses incurred prior to your date of termination. Those expenses will be reimbursed up to the unused amount that you set aside in the Dependent Care FSA as of the date of your termination.

7.5 *What is the maximum amount that I may contribute to my Dependent Care FSA?*

If you are married and file a joint tax return, the maximum amount is \$5,000 per year or, if less, the lesser of your federal spouse's earned income or your earned income. If your federal spouse is a full-time student, he or she is presumed to have \$250 of earned income if there is only one Qualifying Dependent (defined in Section 7.8) in the household or \$500 per month if you have two or more Qualifying Dependents. (If your federal spouse is a disabled Dependent whose care you would like to treat as eligible dependent care expenses, your federal spouse is treated as having earned income as though he or she is a full-time student.) The \$5,000 per year limit also applies if you are single.

If you are married and you and your federal spouse file separate tax returns, the maximum amount you can contribute to the Dependent Care FSA is \$2,500 per year.

7.6 *How do I make a claim for reimbursement from my Dependent Care FSA?*

You may submit a claim for reimbursement from your Dependent Care FSA as soon as an eligible expense is incurred. Claims forms are available on McClatchy's LiveWell website, through the FSA third-party administrator's website, or by calling the FSA third-party administrator's customer service. In addition, you may submit your claim for reimbursement from your Dependent Care FSA online and upload your receipts through the FSA third-party administrator's website. Contact information for the FSA third-party administrator can be found on the LiveWell website and in Section 16, Plan Administrative Information.

Your claim must include a receipt from the qualified caregiver indicating the dates and types of services provided, the expense incurred, and the tax identification or social security number of the caregiver. You must also attest to the fact that this amount is not being reimbursed from any other source.

You will have until March 31 after the end of the calendar year in which to submit a claim for reimbursement for eligible expenses incurred during that calendar year.

Generally, you will be notified in writing within two days if any claim for benefits is denied. You may call the FSA third-party administrator's customer service to challenge the denial. If your claim is denied, you have the right to request a review of any expenses that have not been paid in full. To request a review, you must submit a written request to the FSA third-party administrator within 60 days of receiving the denial letter. Be sure to include any additional information that will assist in the review of the claim.

Upon receipt of your request, the FSA third-party administrator will review the information submitted and will respond to you in writing within 60 days; however, if special circumstances require a delay, you will be notified that the review may take an additional 60 days.

You may request, free of charge, copies of the Internal Revenue Service documents upon which the FSA third-party administrator relied in making this determination.

You either may request a review of a claim denial yourself or you may designate an authorized representative to undertake the request for review on your behalf.

At the review level we will review all documents, records and other information submitted that relates to the claim.

7.7 *What are eligible dependent care expenses?*

Dependent care expenses are expenses that you pay for the care of a Qualifying Dependent, if such services enable you and your federal spouse, if any, to be working, looking for work or enrolled as a full-time student.

A **Qualifying Dependent** is either of the following:

- An eligible dependent child under age 13 who lives with you for more than one-half of the year; or
- Your federal spouse or eligible dependent who is incapable of caring for him or herself and lives with you more than one-half of the year.

However, expenses incurred for the following services are NOT dependent care expenses:

- Services provided outside of your home for the care of a disabled federal spouse or eligible dependent age 13 or older, unless the dependent regularly spends at least 8 hours each day in your home;
- Services provided outside of your home by a facility which provides care for more than six individuals and which receives a fee, payment or grant for providing services, unless the facility complies with all state and local laws; and

- Services rendered by your child who is under the age of 19 or your federal spouse.

7.8 *What are some examples of covered dependent care expenses and expenses that cannot be reimbursed as a dependent care expense?*

(i) *Some expenses that can be reimbursed include:*

- Preschool, day-care or elder-care centers;
- Non-educational programs for children under age 13 while school is not in session (including summer day camp);
- Salaries for individuals who care for young children in or outside your home;
- Home care, non-medical nursing or nurse's aide services for a dependent parent who lives with you; and
- Special non-medical care for mentally or physically handicapped dependents.

(ii) *Some expenses that are not covered:*

- The cost of food, clothing and education;
- The cost of transportation between your house and the place where dependent services are provided;
- Expenses that are claimed on your federal tax return as either a dependent care tax credit or medical care deduction; and
- The cost of overnight camp.

7.9 *Can I use my Dependent Care FSA to pay eligible expenses that I incur to care for my domestic partner?*

Expenses that you incur to care for your domestic partner or the child of your domestic partner, in either case, who does not qualify as your dependent are not eligible for reimbursement under your Dependent Care FSA.

7.10 *How do the cost change and coverage change rules under Section 5.8 apply the Dependent Care FSA?*

When applying the cost change rules in Sections 5.8(iii) and 5.8(iv) above to the Dependent Care FSA, you may only change your salary deferral election for the Dependent Care FSA if the cost change is imposed by a caregiver who is not your relative.

Under the coverage rules in Sections 5.8(v), 5.8(vi) and 5.8(vii) above, you may change your salary deferral election for the Dependent Care FSA if you terminate one caregiver and hire a new caregiver, or you may cease participation in the Dependent Care FSA if you terminate a dependent care service provider because a relative becomes available to care for your dependent at no cost.

7.11 *If I elect Dependent Care FSA benefits, can I still claim the dependent care tax credit on my federal income tax return?*

You may not claim any other tax benefit for the tax-free amounts received by you for dependent care benefits under this Plan, although the *forfeited balance* of your dependent care expenses may be eligible for the dependent care tax credit under Internal Revenue Code § 21 (“Dependent Care Credit”). Section 7.12 provides a more detailed explanation. Stated differently, the amount of any dependent care credit you may have available will be offset by any dependent care benefits received under the Plan.

7.12 *What is the Dependent Care Credit?*

The Dependent Care Credit is an allowance for a percentage of your annual qualifying dependent care expenses as a credit against your federal income tax liability under the Internal Revenue Code. You will likely want to determine whether maximizing the dependent care tax credit or the Dependent Care FSA is a better alternative for you. To do so, you may wish to consult either IRS Publication No. 503 (“Child and Dependent Care Expenses”) or your personal tax advisor.

Congress frequently changes the rules applicable to the Dependent Care Credit, so you should review your choice annually.

7.13 *Can I receive a qualified reservist distribution of the account balance of my Dependent Care FSA if I am a military reservist called to active duty?*

No. Qualified reservist distributions are limited to the account balance of your Health Care FSA. You cannot receive any portion of your account balance from your Dependent Care FSA as a qualified reservist distribution.

Section 8. Health Savings Account

8.1 What is a health savings account?

A health savings account or HSA is a tax-exempt trust or custodial account established outside of the Plan with a qualified HSA trustee/custodian. A health savings account may be used in conjunction with a high deductible health plan to allow you to set aside amounts on a pre-tax basis to pay for eligible health care expenses (which must meet the definition of “qualified health care expenses” in section 223 of the Internal Revenue Code) that are not otherwise covered by your health insurance or reimbursable from any other source.

8.2 Who is eligible to make contributions to an HSA?

To be eligible to make contributions to an HSA, you must meet the following requirements:

- You are enrolled in the Savings Advantage medical plan;
- You are not enrolled in any other medical coverage that is not a high deductible health plan;
- Neither you nor your spouse is participating in a health care FSA other than a “limited purpose” health care FSA;
- You are not enrolled in Medicare;
- You are not receiving benefits under TRICARE;
- You are not enrolled in a prescription drug plan that provides benefits before the minimum annual deductible of the high deductible health plan is satisfied;
- You are not receiving Veterans Administration benefits within the past 3 months; and
- You are not being claimed as a dependent on another person’s tax return.

If you meet the applicable requirements you will be eligible to contribute to an HSA, even if your federal spouse is covered under a non-high deductible health plan, as long as your federal spouse’s non-high deductible health plan coverage does not cover you.

8.3 Can I contribute to both an HSA and Health Care FSA?

If you are enrolled in the Savings Advantage medical plan, you are not eligible to make contributions or receive benefits under McClatchy’s health care FSA. Your federal spouse also may not make contributions to or receive benefits from a health care FSA of another employer unless your federal spouse’s health care FSA is a

“limited purpose” health care FSA. A limited purpose health care FSA is a health care FSA under which generally only dental and vision care expenses are eligible for reimbursement.

8.4 *If I establish an HSA, can I change my HSA elections during the Plan Year?*

Yes. Unlike many of your other elections under the Plan, you may prospectively increase, decrease or revoke your HSA contribution elections at any time in accordance with the Plan’s and your HSA’s administrative procedures. Your ability to change your HSA elections under the Plan is not conditioned upon the occurrence of special events or circumstances.

8.5 *Is my HSA balance subject to the “use-it-or-lose-it” rule?*

Amounts you set aside in an HSA are nonforfeitable and not subject to the “use-it-or-lose-it” rule applicable to health care and dependent care FSAs. In other words, your HSA balance is yours to keep and will automatically carry forward from Plan Year to Plan Year. These amounts may be used to pay for unreimbursed eligible health care expenses you incur at any time after your HSA is established.

8.6 *Can HSA contributions be deducted from my paycheck?*

You can elect to make pre-tax contributions to your HSA held by a trustee or custodian selected by McClatchy with payroll salary deductions. You may change your pre-tax HSA contributions at any time.

To authorize HSA contributions, you must explicitly set the amount of salary to be withheld from your compensation each pay period and deposited to your HSA held by McClatchy’s trustee or custodian. If you remain in the Savings Advantage medical plan, your HSA salary contributions will be carried over from year to year.

8.7 *Are there any other benefits associated with establishing an HSA?*

If you enroll in the Savings Advantage medical plan and establish an HSA with the trustee or custodian selected by McClatchy, McClatchy may make certain contributions to your HSA in addition to any salary deduction contributions you may make. Any contribution by McClatchy to your HSA is contingent on you being an active employee and eligible to contribute to an HSA.

Contributions by McClatchy to your HSA may be prorated based on the number of months during the year that you were eligible to contribute to the HSA.

8.8 *What is the maximum amount that I may contribute to my HSA?*

Federal law limits the total amount that can be contributed to an HSA during a taxable year, and may change from year to year. Assuming you are eligible to contribute to an HSA each month (or are treated as eligible to contribute to an HSA each month, as discussed below), the maximum amount that may be contributed to your HSA in 2014 is \$3,300 if you have self-only coverage and \$6,550 if you have

family coverage. This maximum includes any amounts contributed by McClatchy. In other words, the maximum amount you may individually contribute to your HSA will be reduced by any amount contributed by McClatchy. If you are age 55 or older, an additional catch-up contribution of \$1,000 may be made regardless of whether you have self-only or family coverage.

Generally, the maximum amount that you may contribute to an HSA is pro-rated for the number of months in which you are eligible to contribute. For instance, if you were 50 years of age and were eligible to contribute to an HSA for the first 3 months of the year, but you lost eligibility for the remainder of the year, the maximum amount that could be contributed to your HSA would equal \$825 if you have self-only coverage (i.e. \$3,300, the annual self-only limit, multiplied by a fraction, the numerator of which is the number of months you were eligible to contribute to your HSA (3) and the denominator of which is the total number of months in the year (12)) and \$1,637.50 if you have family coverage (i.e. \$6,550, the annual family limit, multiplied by 3/12).

Under a special rule, if you are eligible to contribute to an HSA during the last month of your taxable year you will be treated as having been eligible during each month of the taxable year. In other words, if you become eligible to contribute to an HSA during the year and you are eligible to contribute in the last month of your taxable year (typically December), then the statutory maximum amount that may be contributed to your HSA will be the full annual limit, even if you were not eligible to contribute during certain months throughout the year. You will only be permitted to make pre-tax payroll contributions up to the prorated limit based on the number of months you were eligible. Additional contributions made under this special rule must be made by the employee directly to the trustee/custodian. If you make contributions based on this special rule, you must remain eligible to contribute to an HSA for the last month of the taxable year and the entire succeeding taxable year to avoid adverse tax consequences for such contributions.

8.9 *How do I make a claim regarding my HSA?*

Claims to the Plan Administrator will be limited to the administration of your salary deductions under Section 8.6. You may submit a claim to the Plan Administrator. You will be notified in writing within 30 days (but no later than 45 days) of the Plan Administrator's receipt of your claim if your claim is denied. You may call the Plan Administrator to challenge the denial.

Any claims with respect to amounts in or distributions from your HSA must be presented to the trustee or custodian that maintains your HSA. Contact the HSA third-party administrator listed in Section 16, Plan Administrative Information.

8.10 *What if I incur a large reimbursable claim early in the year?*

Under your HSA, the amount available for reimbursement is limited to the value of your account at the time the claim is received. If your claim is for an amount that is more than the current balance, you may request an additional distribution to reimburse you for the excess amount when your account balance becomes adequate.

8.11 *When and under what circumstances can distributions be made from my HSA?*

If you have an HSA, you can generally receive a distribution from your HSA for any purpose and at any time. Only reasonable restrictions on the frequency or timing of distributions will be imposed by your HSA trustee/custodian.

Any HSA distribution that is used to pay for unreimbursed eligible health care expenses for you, your federal spouse or your HSA dependent incurred after the establishment of your HSA will generally be tax-free to you. Your federal spouse or HSA dependent does not need to be eligible to make contributions to an HSA for their unreimbursed eligible health care expenses to be reimbursed tax-free.

Your domestic partner or the child of your domestic partner must rely on you for over 50% of his or her support for the calendar year, and have the same principal residence as you and be a member of your household in order for his or her eligible health care expenses to be eligible to be reimbursed from your HSA.

Any HSA distributions that are not used to pay for unreimbursed eligible health care expenses will generally be included in your gross income and subject to an additional 20% tax. The additional 20% tax does not apply under certain circumstances, such as if payment is made after death, disability or attaining the age of 65 or is in the form of a rollover that meets certain statutory requirements.

8.12 *When is my HSA established?*

To be reimbursable on a tax-free basis, eligible health care expenses must be incurred after your HSA is established. You may need to provide certain documentation to the HSA trustee/custodian before your HSA can be established. Therefore, your HSA may not yet be in place at the time that you commence participation in the Savings Advantage medical plan. You should check with the HSA third-party administrator to determine when your HSA has been established. Contact information for the HSA third-party administrator can be found in Section 16, Plan Administrative Information.

8.13 *What is the period of coverage for an HSA?*

There is no time limit on when an HSA distribution must occur to be tax-free. You can use contributions made to your HSA in one year to offset unreimbursed eligible health care expenses incurred in another year as long as the unreimbursed eligible health care expenses are incurred after your HSA has been established.

It is your responsibility to make sure you have valid qualified health care expenses before requesting payment. Although you do not need to send in any supporting documentation with your reimbursement request, you should keep records that are sufficient to show that (i) the distributions were exclusively to pay or reimburse eligible health care expenses, (ii) the eligible health care expenses have not been previously paid or reimbursed from another source and (iii) the eligible health care

expenses have not been taken as an itemized deduction in any prior taxable year in case you have to justify your reimbursement during an IRS audit.

8.14 *How can I access my health savings account?*

You can check your HSA account balance and make transactions at any time on the HSA third-party administrator's website or by calling the HSA third-party administrator's customer service. Contact information for the HSA third-party administrator can be found in Section 16, Plan Administrative Information.

8.15 *What expenses are eligible health care expenses for purposes of my HSA?*

In general, eligible expenses include those charges that would be deductible as a health care expense under section 213(d) of the Internal Revenue Code and are not reimbursed from any other source. See Appendix C for a generalized list of eligible and ineligible HSA expenses.

In addition to the list in Appendix C, eligible health care expenses for an HSA also include payments for the following coverage:

- Certain long-term care services;
- COBRA or USERRA continuation coverage for you, your federal spouse and/or your HSA dependents;
- Any health plan maintained while you, your federal spouse and/or your HSA dependents, as applicable, are receiving federal or state unemployment compensation; and
- If you are over 65, any deductible health insurance other than a Medicare supplemental policy.

8.16 *Am I eligible to elect COBRA coverage for an HSA?*

You or your dependents enrolled in the Savings Advantage high deductible health plan may become eligible to elect COBRA coverage for the medical plan if you or your dependent experience a qualifying event described in Section 11.3

However, you will not be eligible to elect COBRA continuation coverage for your HSA. Therefore, you will not be eligible to receive any employer contributions relating to any periods after you lose coverage under the high deductible health plan due to a termination of employment or reduction of hours.

As described above, your HSA is yours to keep. Following your termination of employment or reduction of hours, your HSA will be converted to an individual HSA that you can continue to use to reimburse yourself for future eligible health care expenses. However, you will not be able to make any additional contributions to this HSA through McClatchy payroll salary reductions.

You will be responsible for paying the monthly maintenance fees for your individual HSA.

Section 9. Wellness Program

9.1 What is the new Wellness Program offered by the Company?

The McClatchy Company has established a program to promote healthy living and disease prevention. At times, the program may offer the opportunity for you to participate in any of the following voluntary activities:

- A health assessment provided through an online survey to establish health status and lifestyle information.
- A voluntary biometric screening that includes a series of measurements to identify potential health risks.
- An election to work with health coaches by telephone or online to encourage and support healthy lifestyles.
- Team or individual health challenges to reach a goal focused on developing healthy behavior.
- Educational wellness seminars and newsletters designed to encourage fitness and healthy lifestyles.

9.2 How do I know if I am eligible for the Wellness Program?

Just as with the health and welfare plans, consult Appendix A to determine whether you are eligible to participate in the Wellness Program. You do not have to participate in any of the other health and welfare plans listed in Appendix A in order to participate in the Wellness Program.

9.3 May my federal spouse, eligible dependents, domestic partner and the child of my domestic partner participate in the Wellness Program?

Your federal spouse or domestic partner is eligible to participate in the Wellness Program for so long as he or she is enrolled in a McClatchy medical plan identified in Appendix A. Your eligible dependents and the child of your Domestic Partner are not eligible to participate in the Wellness Program.

9.4 How does participation in the Wellness Program begin?

The Company will automatically enroll you in the Wellness Program when you become eligible to participate. Your federal spouse or domestic partner will be enrolled in the Wellness Program when he or she becomes enrolled in a McClatchy medical plan identified in Appendix A.

9.5 How does participation in the Wellness Program end?

You will no longer be eligible to participate in the Wellness Program when you no longer meet the eligibility requirements in Appendix A or, if earlier, the date that you terminate employment with the Company. Your federal spouse or domestic

partner will no longer be eligible to participate in the Wellness Program when he or she is no longer enrolled in a McClatchy medical plan identified in Appendix A or, if earlier, the date that he or she ceases to be your federal spouse or Domestic Partner.

9.6 *Will there be an opportunity to earn awards through participation in the Wellness Program?*

The Company has discretion to elect to offer awards for participation in the Wellness Program. Any awards offered may result in taxable income to the recipient. When awards are offered, the Company will provide information regarding eligibility for the awards, the form and amount of awards, standards for earning awards and information about alternative opportunities for earning awards when those standards are based on health status.

Section 10. Leaves of Absence

The rules outlined in this section are summarized in the table found in Appendix B of this SPD and do not apply to your HSA election, described in Section 8.

10.1 What happens to my benefits when I go on a Family and Medical Leave Act (FMLA) Leave of Absence?

If you are absent from work because of a leave under the Family and Medical Leave Act (FMLA) of 1993, you are entitled to maintain the coverage you have under the Plan. Leave to care for a domestic partner or the child of a domestic partner will be treated as giving rise to FMLA leave to the same extent as if the domestic partner was your federal spouse and the child of your domestic partner was your child. This Section 10.1 also applies if your workers' compensation leave occurs during the same period as your FMLA leave.

(i) Unpaid FMLA leave

If the FMLA leave is unpaid, you may revoke or change your existing elections for coverage under the Plan, provided that the election change is consistent with the event. Keep in mind that for the Health Care FSA and the Dependent Care FSA, you are not eligible for the reimbursement of any eligible expense incurred while you are not a participant in the applicable FSA.

If you maintain coverage, you must pay the contributions for the coverage during your absence using one of the following methods:

- You may prepay your contributions from your pre-FMLA compensation by increasing your salary reduction(s) for one or more pay periods in an amount sufficient to cover contributions you anticipate missing while on leave, so long as the leave does not straddle two Plan Years.
- You may pay contributions directly to the Company on a monthly basis throughout your leave with after-tax dollars. Payments must be made within 30 days of their due date. If you do not pay within the grace period, you will be given 15 days' advance notice and then your participation in the Plan will be terminated.

(ii) Paid FMLA Leave

If your FMLA leave is paid, you may not change or revoke your elections under the Plan unless you also experience an eligible change in status event or in accordance with the normal open enrollment period.

10.2 What happens to my benefits when I go on a non-Family and Medical Leave Act (Non-FMLA) Leave of Absence?

If you are absent from work because of a non-FMLA leave or absence, your participation may be affected by your pay status.

(i) Unpaid Non-FMLA Leaves of Absence

Except to the extent described in the paragraph below, if you go on unpaid leave that is not an FMLA leave or military leave (discussed in Section 10.4), you will cease to be eligible to participate in the Plan effective the end of the month that your unpaid non-FMLA or non-military leave began.

If required by applicable law (e.g., you are on pregnancy disability leave or California Family Rights Act (CFRA) leave), you will continue to be eligible to participate in the Plan. Therefore, when your unpaid leave of absence begins, it is considered a change in status event. As a result, you may be able to change or revoke your elections under the Plan, provided that the election change is consistent with the event.

Keep in mind that for the Health Care FSA and the Dependent Care FSA, you are not eligible for the reimbursement of any eligible expense incurred while you are not a participant in the applicable FSA. Also, even if you remain a participant in the Dependent Care FSA, dependent care expenses that you incur during your leave may not be eligible for reimbursement if your leave is more than a short duration.

If you maintain coverage and your leave is unpaid, you must pay the contributions for the coverage during your absence using one of the following methods:

- You may prepay your contributions from your pre-leave compensation by increasing your salary reduction(s) for one or more pay periods in an amount sufficient to cover contributions you anticipate missing while on leave, so long as the leave does not straddle two Plan Years.
- You may pay contributions directly to the Company on a monthly basis throughout your leave with after-tax dollars. Payments must be made within 30 days of their due date. If you do not pay within the grace period, you will be given 15 days' advance notice and then your participation in the Plan will be terminated.

(ii) Paid Non-FMLA Leaves of Absence

You may not change or revoke your election unless you experience a qualified change in status event or in accordance with the normal open enrollment period.

If your leave will be more than a short duration and results in a Change in Status Event, you will be eligible to change your Dependent Care FSA election. Keep in mind that, even if you continue to make contributions during your leave, the dependent care expenses that you incur during the leave may not be eligible for reimbursement.

10.3 When can I re-enter a plan after returning from leave?

If your coverage under any of the Component Programs other than the Health Care FSA or the Dependent Care FSA is discontinued while on leave, upon returning from leave to a position eligible to participate in the Plan, you will be allowed to re-enroll in the Plan. Your coverage elections will take effect the first day of the calendar month following your return from leave.

If your participation in the Health Care FSA or the Dependent Care FSA is discontinued while on leave, upon returning from leave, you will be allowed to re-enter the Plan on the same basis that you were participating prior to leave. Your coverage elections will take effect the first day of the calendar month following your return from leave. If you re-enter the plan(s) in the same plan year (upon returning from leave), a new account will be established for you. The dates that services are incurred will determine the accounts from which reimbursements will be made. Furthermore, services incurred during the lapse in coverage will not be eligible for reimbursement.

10.4 What happens if I go on a military leave of absence?

If you take a leave of absence from employment with the Company by reason of “service in the uniformed services” (determined in accordance with the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA)), you may elect to continue to participate in the Plan after your active coverage ends pursuant to any written military leave policy to the extent required by USERRA. You will be required to pay for your coverage in accordance with the requirements of USERRA. Your coverage under the Plan shall end on the earlier of: (1) the last day of the 24 month period beginning on the date on which your absence begins; or (2) the day after the date on which you fail to apply for or return to a position in employment with the Company (as determined in accordance with USERRA).

Section 11. COBRA

11.1 What is COBRA and to what benefits does it apply?

COBRA refers to the extended health coverage that is available to you by the Consolidated Omnibus Budget Reconciliation Act of 1985 at certain times you otherwise would lose coverage. You must, however, pay the required premium for coverage to be effective. COBRA premiums are paid by you on an after-tax basis.

The COBRA continuation coverage described in this Section 11 applies only to your medical, dental, vision and employee assistance program options under the Plan. The COBRA rules applicable to the Health Care FSA are described in Section 6.16 and not in this section.

Furthermore, COBRA does not apply to any life insurance, disability or accident insurance program, the dependent care flexible spending account program or the health savings account.

11.2 Who is eligible for COBRA coverage?

COBRA coverage may be extended to the following Plan participants who lose their regular group health coverage because of certain qualifying events:

- An enrolled active employee;
- The employee's enrolled federal spouse and eligible dependents; or
- The employee's enrolled domestic partner and the enrolled domestic partner's children.

In addition, a child born to a former employee covered by COBRA, adopted by such former employee, or placed for adoption with such employee, will become eligible for continuation of coverage for the remainder of the applicable coverage period.

11.3 When am I eligible for COBRA coverage?

You are eligible for COBRA coverage if you experience a qualifying event that results in a loss of your health coverage option. A qualifying event occurs when you experience a voluntary or involuntary termination of employment (other than for gross misconduct) or a reduction in your work hours to less than the number of hours required to be eligible for the applicable health coverage. Someone who is eligible for COBRA coverage is referred to as a "qualified beneficiary."

Your enrolled dependents may become qualified beneficiaries if they lose health coverage as a result of one of the following qualifying events:

- Your termination of employment (other than for gross misconduct) or reduction in your work hours to less than the number of hours required to be eligible for the applicable health coverage;

- Your death;
- Your divorce or legal separation from your federal spouse;
- The cessation of your child's eligibility as an eligible dependent under a health plan; or
- Your qualification for Medicare benefits under Title XVIII of the Social Security

11.4 *When does COBRA coverage start?*

If elected, COBRA continuation coverage is effective on the date coverage under the Plan terminates.

11.5 *How long does COBRA coverage last?*

COBRA coverage generally lasts for 18 months. However, there are several situations in which COBRA coverage may be shorter or longer than 18 months. These situations are described in the next two questions and answers.

11.6 *When will the maximum COBRA coverage period be longer than 18 months?*

(i) *Determination of Disability*

If a qualified beneficiary is determined to have been disabled under Title II or XVI of the Social Security Act at the time of the qualifying event or during the first 60 days of the start of COBRA coverage, then he or she may receive an 11-month extension of COBRA coverage beyond the initial 18-month coverage period – for up to 29 months. Note that the Social Security Administration (“SSA”) does not have to make the determination during the first 60-days of COBRA coverage. The SSA simply needs to reach the conclusion (and notify the applicable qualified beneficiary before the end of the initial 18-month period) that you, or the applicable beneficiary, are disabled and that the disability occurred on a date during the first 60 days of the person's COBRA coverage.

If you are determined to have been disabled, and you wish to receive the additional 11-months of COBRA coverage described in this Section 11.6(i), it is your responsibility to notify McClatchy's COBRA third-party administrator of the disability determination within certain time periods. Please refer to Section 11.11 for a discussion of these time periods and for other information on how to provide the required notice.

(ii) *36-Month Coverage Period for Your Dependents in Certain Circumstances*

If you have health coverage and you die or get divorced or separated and your death, divorce or separation causes a loss of coverage for your dependents, then your dependents who were covered under the health program option

plan as of the date of your death, divorce or separation may elect COBRA coverage for a period of up to 36 months after the date of your death or after the end of the month in which your divorce or separation occurs.

If your child loses coverage because he or she is no longer a dependent, then he or she may elect COBRA coverage for a period of up to 36 months after the date that he or she stopped being an eligible dependent.

(iii) *Second Qualifying Event*

If your federal spouse or eligible dependent is receiving COBRA coverage due to your reduction in hours or loss of employment and during the original 18-month period of coverage a “second qualifying event” occurs, then the federal spouse or eligible dependent may elect an additional 18 months of coverage, for a total of 36 months of COBRA coverage. A “second qualifying event” is your death, divorce or separation, or the dependent’s loss of eligible dependent status.

11.7 *When will COBRA coverage cease before the expiration of the applicable maximum COBRA coverage period?*

If any of the following events occurs, COBRA coverage will end immediately:

- A qualified beneficiary fails to pay premiums on a timely basis;
- A qualified beneficiary becomes covered under any other group health plan, unless that coverage excludes or limits coverage of a pre-existing condition that the qualified beneficiary has;
- A qualified beneficiary becomes entitled to Medicare benefits;
- Continuation of coverage was extended to twenty-nine (29) months and there has been a final determination that the enrollee is no longer disabled;
- The McClatchy Company ceases to sponsor any group health plans; or
- A qualified beneficiary’s coverage is terminated for “gross misconduct.”

11.8 *How much does COBRA cost?*

The cost of COBRA coverage is equal to 102 percent of the cost of coverage under the health plan(s) that the qualified beneficiary is enrolled in. However, if the qualifying beneficiary is disabled, the cost of coverage for the 19th month through the 29th month of COBRA coverage equals 150 percent of the cost of coverage under the respective health plan(s). Your otherwise applicable cost of COBRA coverage may be reduced, to the extent required under applicable law, by any federal or state subsidy requiring direct offset.

11.9 How does a qualified beneficiary elect COBRA coverage?

A qualified beneficiary must complete and file the COBRA election form in order to receive COBRA coverage. The election form must be received no later than 60 days after the later of (1) the date notice of COBRA coverage rights was sent to the qualified beneficiary or (2) the date on which the qualified beneficiary was scheduled to lose health benefits coverage as a result of the qualifying event.

COBRA coverage will not become effective until you file a completed COBRA election form by the filing due date. If you do not file a completed COBRA election form by the due date, COBRA coverage will be completely lost, and you will be ineligible for such coverage.

Of course, your first COBRA premium payment may accompany your COBRA election. However, as described in Section 11.10, you have 45 days from electing COBRA to pay the first premium. If your first premium becomes past due, your COBRA coverage will be revoked retroactively, and your COBRA election will be entirely voided.

11.10 When and how must payment for COBRA coverage be made?

(i) First payment for COBRA coverage

If a qualified beneficiary elects COBRA coverage, he or she does not have to send any payment for COBRA coverage with the COBRA election form. However, the qualified beneficiary must make the first payment for COBRA coverage within 45 days after the date of the COBRA election. (This is the date the COBRA election notice is post-marked, if mailed.) If the qualified beneficiary does not make the first payment for COBRA coverage within the 45 days, he or she will lose all COBRA coverage rights under the Plan.

A qualified beneficiary whose check is returned for non-sufficient funds will not be considered to have made his or her first payment. Following the return of a check for non-sufficient funds, the qualified beneficiary must still make his or her first payment prior to the expiration of the 45-day period. If the qualified beneficiary does not make a payment following the return of the check for insufficient funds within the 45-day period, he or she will not have any COBRA coverage rights under the Plan.

The first payment must cover the cost of COBRA coverage from the time coverage under the Plan would have otherwise terminated up to the time the qualified beneficiary makes the first payment. The qualified beneficiary is solely responsible for making sure that the amount of the first payment is enough to cover this entire period. A qualified beneficiary may contact McClatchy's COBRA third-party administrator to confirm the correct amount of the first payment and the address to which to send such payment. Contact information for the COBRA third-party administrator can be found in Section 16, Plan Administrative Information.

(ii) *Periodic payments for COBRA coverage*

After the qualified beneficiary makes the first payment for COBRA coverage, he or she will be required to pay for continuation coverage for each such subsequent month of coverage, by sending payment to McClatchy's COBRA third-party administrator. All subsequent premium payments are due on the first day of the calendar month and the qualified beneficiary will be notified of the payment schedule. There is a 30-day grace period for each periodic payment due date. However, if a qualified beneficiary fails to make a periodic payment before the end of the grace period for that payment, he or she will lose all rights to COBRA coverage under the Plan.

(iii) *Retroactive Loss of Coverage*

If a qualified beneficiary fails to pay the initial premium or a subsequent periodic premium, then once the premium becomes past due COBRA coverage will retroactively terminate. The retroactive COBRA coverage termination date is the first day of the coverage period for which the past due premium was to relate.

11.11 *Do I have to notify someone when a qualifying event occurs?*

You will receive a notice from McClatchy's COBRA third-party administrator of your eligibility for COBRA continuation of coverage if your employment is terminated or your number of work hours is reduced.

You are required to notify us, in the form of a written letter addressed to McClatchy's COBRA third-party administrator, if you get divorced or separated or if your child ceases to be an eligible dependent. If we do not receive this notice within 60 days of the divorce, separation or eligible dependent change, your qualified beneficiary will lose his or her right to COBRA coverage. This notice must come from you or your qualified beneficiary. You may contact the COBRA third-party administrator (see contact information provided in Section 16, Plan Administrative Information) for more information regarding this notice.

You are also required to notify us of any determination that you are disabled or that you are no longer disabled for purposes of Title II and XVI of the Social Security Act. In order to be eligible for the 11-month extension of COBRA coverage (described in Section 11.6(i)), we must receive notice that you were disabled as of the date of the qualifying event or that you have been declared disabled as of a date during the first 60 days of continuation coverage. This notice must be received within the initial 18-month period of continuation coverage. In addition, we must receive this notice no later than 60 days after the latest of (1) the date you receive your disability determination from the Social Security Administration; (2) the date on which the qualifying event occurs; (3) the date on which you lose coverage; or (4) the date on which you were informed of your obligation to provide the disability notice.

As an example of how these two timing rules work together, assume that you begin COBRA coverage on January 1, 2014. You receive a disability determination from

the SSA on March 1, 2014, stating that you were disabled as of January 1, 2014. You have 60 days from March 1, 2014 (the date on which you received the disability notice) to notify us that you have been declared disabled if you wish to take advantage of the 11-month extension of COBRA coverage. Under this example you are within both the original 18-month period of continuation coverage and the 60-day rules described above.

Alternatively, assume that you do not receive a disability determination from the SSA until June 1, 2015, stating that you were disabled as of January 1, 2014. Under the 60-day rule above, you would have ordinarily have 60 days from June 1, 2015 (the date on which you received the disability notice) to provide us with notice that you have been declared disabled. However, the end of the initial 18-month period of continuation coverage is July 1, 2015, only 30 days after the determination was issued. Because you must provide notice within both the original 18-month period of coverage and the 60-day period, the 60-day period is shortened to 30 days in this instance.

The information regarding disability notices applies to you, or to the qualified beneficiary, as applicable. Such disability notice should take the form of a written letter addressed to McClatchy's COBRA third-party administrator and include a copy of the determination notice from the SSA. Contact information for the COBRA third-party administrator can be found in the Section 16, Plan Administrative Information.

If any other qualifying event results in your eligibility for COBRA coverage, we will notify you.

11.12 How do the COBRA rules work in connection with Medicare?

(i) Medicare Entitlement, Then COBRA Coverage

When any qualified beneficiary is entitled to Medicare on or before the date that COBRA coverage is elected, he or she still has the right to elect COBRA coverage. The COBRA offer cannot be withheld because of Medicare entitlement, and the COBRA coverage may not be terminated early because of Medicare entitlement.

In addition, when a covered employee's termination occurs within the 18-month period after the employee becomes entitled to Medicare, the employee's federal spouse and dependent children (but not the employee) become entitled to COBRA coverage for a maximum period that ends 36 months after the covered employee becomes entitled to Medicare.

(ii) COBRA Coverage, Then Medicare Entitlement

When any qualified beneficiary first becomes entitled to Medicare after electing COBRA coverage, his or her COBRA coverage will terminate as of the date of entitlement. Thus Medicare entitlement while on COBRA will result in termination of your COBRA coverage before the end of the

maximum coverage period. This rule only affects the individual who becomes Medicare-entitled. It does not affect the COBRA coverage rights of other qualified beneficiaries in a family unit who are not yet entitled to Medicare.

(iii) Medicare Entitlement

These guidelines depend on the timing of “Medicare entitlement.” To be entitled to Medicare under COBRA, an individual must be both (1) eligible for Medicare and (2) enrolled in either Part A or Part B, whichever occurs earlier. While an individual who is age 65 or older is generally eligible for certain Medicare benefits, enrollment may be automatic or a separately-required application depending on the individual’s circumstances. For example, Medicare enrollment is automatic for those who are already receiving Social Security benefits when they attain age 65. Upon turning age 65, such an individual becomes both eligible and enrolled, and thus entitled to Medicare under COBRA. Other individuals become eligible for Medicare but must file an application in order to become entitled to benefits. An example is a working individual who attains age 65 and is eligible for Medicare benefits but has not yet applied for them. Under COBRA, such individuals will not be entitled to Medicare until they file an application for enrollment.

Section 12. Claims Procedure

12.1 *Generally speaking, how do I make a claim for benefits?*

You should check your health and welfare plan's Evidence of Coverage booklet for that plan's deadlines for the filing of claims.

For information about FSA claim reimbursement, see Section 6.10 for the Health Care FSA rules and Section 7.6 for the Dependent Care FSA rules. For information about HSA claims, see Section 8.9.

The rest of this section describes the rules regarding when you must be informed whether or not your claim for benefits is approved or denied. It also sets out the basic rules for filing an appeal if your benefit claim is denied.

12.2 *When must I receive a decision on my initial claim?*

The timing of the decision on your claim will depend on whether your claim is a health plan claim (i.e. a claim for medical, dental or vision benefits or under the Health Care FSA), a disability claim or any other claim.

(i) *Health Plan Claims*

You are entitled to notification of the decision on your claim as described below and based on the type of claim.

a. *Urgent Care Claims*

An urgent care claim is any claim for a medical benefit where the normal review period could seriously jeopardize the life or health of the claimant. The claim administrator will defer to the attending provider's determination of whether a claim involves urgent care. You are entitled to written or electronic notification of the determination of your urgent care claim within 72 hours after the Plan receives the claim, unless you fail to provide sufficient information for the claim administrator to determine whether or not benefits are available under the Plan. If additional information is needed, the claim administrator must notify you of the specific information needed to complete the claim within 24 hours after the original claim is received. You are entitled to notice of the determination of your claim within 48 hours after the Plan has received the additional information or the end of your time period to provide the additional information, whichever is earlier.

b. *Concurrent Care Decisions*

If the Plan has approved an on-going course of treatment to be provided over a period of time or a number of treatments, any reduction or termination of treatments is an adverse benefit

determination. You are entitled to be told of such determination with sufficient time to appeal the decision and obtain a determination on your appeal before the benefit is reduced or terminated. If you request to extend the course of treatment beyond a period of time or number of treatments and your request is a claim involving urgent care, then the claim shall be decided as soon as possible, taking into account the medical exigencies, and the claim administrator shall notify you of the decision on the claim within 24 hours of the receipt of the claim by the Plan, provided that the claim is made at least 24 hours before the course of treatment or number of treatments were set to expire.

c. *Pre-Service Claims*

A pre-service claim is any claim for a benefit under the Plan that requires you to obtain approval of the benefit prior to obtaining the medical care. The claim administrator is required to notify you of its determination for pre-service claims within 15 days of receiving the claim. The 15-day period may be extended by an additional period of up to 15 days if the extension is necessary due to conditions beyond the control of the claim administrator. The claim administrator is required to notify you of the need for the extension and when you will receive the determination on your claim. If the extension is necessary because you failed to follow the required procedures for submitting a pre-service claim, the Plan must notify you within 5 days of receipt of your claim of the additional information you are required to submit, and you will be given at least 45 days to submit the information.

d. *Post-Service Claims*

The claim administrator must notify you of its determination for a post-service claim within 30 days of its receipt of the claim. This 30-day period may be extended up to another 15 days if the extension is necessary due to conditions beyond the control of the claim administrator. The claim administrator is required to notify you of the need for the extension and when you will receive the determination on your claim. If the extension is necessary because you failed to follow the required procedures for submitting a pre-service claim, the notice of extension will specifically describe the information you are required to submit, and you will be given at least 45 days to submit the information.

(ii) *Disability Claims*

You are entitled to notification of the determination of your disability claim within 45 days after the Plan receives the claim. The 45-day period may be extended by an additional period of up to 30 days if the extension is necessary due to conditions beyond the control of the claim administrator and the claim administrator notifies you of the extension before the end of the original 45-

day period. The extended period may again be extended for up to another 30 days provided that the extension is due to matters beyond the control of the claim administrator and the claim administrator notifies you of the extension before the end of the first 30-day extension.

(iii) *Other Claims*

The claim administrator is required to notify you of the denial of your claim within 90 days after the filing of the claim. The 90-day period may be extended for up to 90 additional days if there are special circumstances requiring an extension and the claim administrator notifies you of the extension before the end of the original 90-day period.

If you have not received a written denial of your claim or a notice of a delay of the decision within 90 days after you file your claim, you may assume it has been denied.

12.3 *What information will a notice of denial of a claim contain?*

If your claim is denied, the written or electronic notice that you receive from the claim administrator will include:

- The denial code, if any, and its corresponding meaning;
- The specific reason(s) for the denial;
- A reference to the specific plan provision(s) or standard(s) on which the denial is based;
- A description of any additional material or information necessary for you to perfect your claim, accompanied by an explanation of why such material or data is being requested; and
- A description of the Plan's review procedures (including for health plan claims, internal appeals and external review processes) and the time limits applicable to such procedures.

If your claim is a health plan or disability claim, the notice that you receive from the claim administrator will also include:

- If the claim administrator relied on an internal rule, guideline, protocol or similar criteria in making its determination, either the specific rule, guideline or protocol, or a statement that such a rule, guideline, protocol, or similar criterion was relied upon in making the determination and that a copy of such rule, guideline, protocol or similar criterion will be provided to you free of charge upon request;

- If the claim administrator's decision is based upon a medical necessity or experimental treatment limit, either an explanation of the scientific or clinical judgment applied for the determination or a statement that such explanation will be provided free of charge upon request; and
- If the determination involves a claim for urgent care, a statement describing the expedited review process applicable to such claims.

Further, if your claim is a health plan claim, the notice that you receive from the claim administrator will also include:

- Information sufficient to identify the claim involved (including date of service, the health care provider, the claim amount (if applicable) and either the diagnosis code and/or the treatment code and their corresponding meanings or a statement that those codes and meanings are available upon your request);
- The availability of, and contact information for, any applicable office of health insurance consumer assistance or ombudsman established to assist in individuals with internal claims and appeals and external review processes; and
- A statement of your right to bring a civil action under ERISA section 502(a) following a denial on review.

12.4 Do I have the right to receive diagnosis and treatment codes?

If not provided in the notice, upon your request to the claim administrator, you will be provided with the diagnosis and treatment codes, and their corresponding meanings, associated with your denied claim. Your request for diagnosis and treatment information will not be considered a request for internal appeal or external review.

12.5 Do I have the right to appeal a denied claim?

If you or your beneficiary does not receive benefits from the Plan that you believe you should receive, you should contact the Plan Administrator to submit a formal internal appeal. You may make a claim by writing to the Plan Administrator at the address provided in the Plan Administration section of this booklet. If your claim is denied, you or your authorized representative may request that:

- The Plan Administrator undertake a review of the claim denial; and
- Pertinent documents related to this specific request be made available to you for review.

No person may take legal action against the Plan until all administrative remedies provided under the Plan are exhausted.

12.6 *What procedures and deadlines must I follow to appeal a claim?*

Your request for review must be in writing. If your claim is a health plan or disability claim, you or your authorized representative will have a 180-day period to request a review after your claim is denied. Otherwise, you or your authorized representative will have a 60-day period to request a review after your claim is denied. The request for review should be sent to the Plan Administrator at the address specified in the “Plan Administration” section of this booklet.

12.7 *What information must be included in my internal appeal?*

This written request must contain:

- Your name and address.
- The date of your appeal petition.
- The date of the notice that informed you of the denied claim.
- The fact that you are disputing a denial of a claim or act or omission.
- The statement of the grounds on which the request for review is based.
- The reasons or arguments in favor of the claim and the evidence supporting those reasons.
- Any other relevant documents or comments to support the request for review.

12.8 *How will my internal appeal be reviewed?*

Any time before the internal appeal deadline you may submit copies of all relevant documents, records, written comments and other information to the claim administrator. The Plan is required to provide you with reasonable access to, and copies of, all documents, records and other information related to the claim. When reviewing your appeal, the claim administrator will take into account all relevant documents, records, comments and other information that you have provided with regard to the claim, regardless of whether or not such information was submitted or considered in the initial determination.

If the claim administrator considers, relies upon or generates new or additional information (including information generated by another party at the claim administrator’s direction) relating to your claim, this information will be provided to you free of charge as soon as possible. Any new or additional information will be provided to you sufficiently in advance of the date on which the claim administrator considers a new rationale relating to your claim, this rationale will be provided to you free of charge as soon as possible and sufficiently in advance of the date on which the claim administrator must inform you of its final determination.

If your claim is a health plan or disability claim, then your claim will also be subject to the following procedures. The appeal determination will not afford deference to the initial determination and will be conducted by a fiduciary of the Plan who is neither the individual who made the original determination nor an individual who is a subordinate of the individual who made the initial determination.

When deciding an appeal which is based in whole or in part on medical judgment, including determinations with regard to whether a particular treatment, drug or other item is experimental, investigational, or not medically necessary or appropriate, the claim administrator shall consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment. Further, the Plan will identify the medical or vocational experts whose advice was obtained on behalf of the Plan in connection with the initial determination, without regard to whether the advice was relied on in making the determination.

Any health care professional engaged by the Plan for purposes of this review shall be someone who was not consulted in connection with the original determination, and who is not a subordinate of someone who was consulted in connection with the original determination.

If your claim is a health plan claim that involves urgent care, an expedited appeal may be submitted orally or in writing and all of the information necessary for the appeal may be submitted by telephone, facsimile or other similarly expeditious method.

12.9 When will I be notified of the decision on my internal appeal?

The timing of the decision on your claim will depend on whether your claim is a health plan claim (i.e. a claim for medical, dental or vision benefits or under the Health Care FSA), a disability claim or any other claim.

(i) Health Plan Claims

You will be notified of the decision on your appeal within the following time frames:

- *Urgent care claims* – The claim administrator must notify you of the decision on your appeal of an urgent care claim within 72 hours of receipt of your request for review.
- *Pre-Service claims* – The claim administrator must notify you of the decision on your appeal of a pre-service claim within 30 days of receipt of your request for review.
- *Post-Service claims* – The claim administrator must notify you of the decision on your appeal of a post-service claim within 60 days of receipt of your request for review.

(ii) *Disability Claims*

You will be notified of the decision on your appeal within 45 days after the claim administrator's receipt of your request for review. However, where special circumstances make a longer period for decision necessary or appropriate, the decision may be postponed for an additional 45 days, provided that you are given written notice of such postponement. The notice is required to explain to you why such postponement is necessary and when the claim administrator expects to render the decision on your claim. In no event, shall the claim administrator notify you of your decision on appeal more than 90 days after receipt of your request for review.

(iii) *Other Claims*

You will be notified of the decision on your appeal within 60 days after the claim administrator's receipt of your request for review. However, where special circumstances make a longer period for decision necessary or appropriate, the decision may be postponed for an additional 60 days, provided that you are given written notice of such postponement. The notice is required to explain to you why such postponement is necessary.

12.10 *What information is included in the notice of the denial of my internal appeal?*

You will receive a written or electronic notice of the Plan Administrator's decision. The notice will be culturally and linguistically appropriate and include the following information:

- The denial code, if any, and its corresponding meaning;
- The specific reason(s) for the denial, if applicable, and a discussion of the decision;
- A reference to the specific plan provision(s) or standard(s) on which the decision is based;
- A description of the Plan's review procedures (including for health plan claims, internal appeals and external review processes) and the time limits applicable to such procedures; and
- A statement that you are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records and other information relevant to the claim for benefits.

If your claim is a health plan or disability claim, the notice that you receive from the claim administrator will also include:

- If the claim administrator relied on an internal rule, guideline, protocol or similar criteria in making its determination, either the specific rule, guideline or protocol, or a statement that such a rule, guideline, protocol, or similar criterion was relied upon in making the determination and that a copy of such rule, guideline, protocol or similar criterion will be provided to you free of charge upon request; and
- If the claim administrator's decision is based upon a medical necessity or experimental treatment limit, either an explanation of the scientific or clinical judgment applied for the determination or a statement that such explanation will be provided free of charge upon request.

Further, if your claim is a health plan claim, the notice that you receive from the claim administrator will also include:

- Information sufficient to identify the claim involved (including date of service, the health care provider, the claim amount (if applicable) and either the diagnosis code and/or the treatment code and their corresponding meanings or a statement that those codes and meanings are available upon your request); and
- The availability of, and contact information for, any applicable office of health insurance consumer assistance or ombudsman established to assist in individuals with internal claims and appeals and external review processes.

12.11 What external review processes are available for my health plan claim if my internal appeal has been denied or if the initial denial of my claim is eligible for external review?

Generally, if your internal appeal of your health plan claim is denied or if the initial denial of your health plan claim is eligible for external review, you have the right to a review of your claim by an independent review organization (“IRO”) with health care professionals that have no conflict of interest with respect to the internal benefit determination. However, if your claim is regarding a denial, reduction, termination or a failure to provide payment for a benefit based on a determination that you do not meet the requirements for eligibility under the terms of the Plan then your claim is not eligible for the external review process.

If a State external review process applies to and is binding on the claim administrator and the State external review process meets certain minimum requirements established by law, your external review will be conducted in accordance with the applicable State external review process. In addition, if a State expands the coverage of its State external review process to include plans that are not subject to the State external review process under applicable State law but have voluntarily opted to be subject to the State external review process, your claim may be subject to the applicable State external review process.

If your claim is not subject to a State external review process it will be subject to the Federal external review process described below. *Please note, the details of your*

external review process may differ substantially from those described below if your claim is subject to a State external review process.

12.12 *What are the requirements of my request for external review?*

Generally, you must deliver your request for external review to the claim administrator within 123 calendar days of your receipt of notice of adverse benefit determination or final internal adverse benefit determination, as applicable. If the last day for filing your request falls on a Saturday, Sunday or Federal holiday, your last filing date is extended to the next day that is not a Saturday, Sunday or Federal holiday. *If you do not deliver your request for external review prior to the applicable deadline, you lose your right to external review.*

12.13 *When am I eligible for an expedited external review?*

You may request an expedited external review at the time you receive:

- An adverse benefit determination if the adverse benefit determination involves a medical condition for which the timeframe for completion of an expedited internal appeal would seriously jeopardize the claimant's life or health or would jeopardize the claimant's ability to regain maximum function and you have filed a request for an expedited internal appeal; or
- A final internal adverse benefit determination, if the claimant has a medical condition where the timeframe for completion of a standard external review would seriously jeopardize the claimant's life or health or would jeopardize the claimant's ability to regain maximum function, or if the final internal adverse benefit determination concerns an admission, availability of care, continued stay, or health care item or service for which the claimant received emergency services, but has not been discharged from the facility.

12.14 *How will the claim administrator determine whether my claim should be referred to an IRO?*

The claim administrator will complete a preliminary review within 5 business days following its receipt of your external review request to determine whether your request is eligible for external review based on the following factors:

- The claimant is or was covered under the Plan at the time the health care item or service was requested or provided (in the case of a retrospective review);
- The adverse benefit determination or the final adverse benefit determination does not relate to the claimant's ineligibility under the terms of the Plan;
- You have exhausted your internal appeal process (unless not required to do so); and

- You have provided all of the information and forms required to process your request for external review.

The Plan will issue a written notice to you within 1 business day following the completion of this preliminary review. If your request is complete but is not eligible for external review, this notification will include the reason(s) your request is not eligible for external review and contact information for the Employee Benefits Security Administration. If your request for external review is not complete, your notification will describe the information or materials you must provide to complete your request. You will have until the later of the expiration of the remaining 4-month filing period or 48 hours from your receipt of this notification to perfect your request for external review.

If your request is for an expedited external review, the claim administrator will complete the preliminary review immediately upon receipt of your request and immediately send the applicable notice.

12.15 If my claim is complete and is eligible for external review, how will it be referred to an IRO?

If your claim is complete and eligible for external review, the claim administrator will use unbiased methods to assign an IRO to your claim. The IRO assigned to your claim will be accredited by a nationally-recognized accrediting organization to conduct external reviews.

12.16 How will the IRO review my claim?

Your assigned IRO must utilize legal experts where appropriate to make coverage determinations under the Plan. In addition, your assigned IRO will timely notify you in writing of your request's eligibility and acceptance for external review. This notice will include a statement that you may submit in writing to the assigned IRO within 10 business days following the date of receipt of the notice any additional information that the IRO must consider when conducting the external review.

Within 5 business days after assignment of the IRO, the claim administrator will provide the assigned IRO with the documents and information it considered in making the adverse benefit determination or final internal adverse benefit determination. If the plan fails to timely provide the documents and information, the assigned IRO may terminate the external review and make a decision to reverse the adverse benefit determination or final internal adverse benefit determination. If such a decision is made, you and the Plan will be notified within 1 business day of any the decision. If your claim is for expedited external review, the claim administrator will provide the documents and information electronically, by telephone, by facsimile or by any other available expeditious method.

The assigned IRO will send any information it receives from you to the claim administrator within 1 business day of receiving such information. The claim administrator may then reconsider its adverse benefit determination or final internal adverse benefit determination. However, reconsideration by the claim

administrator will not delay the external review and the claim administrator may only terminate the external review as a result of this reconsideration if it decides, upon completion of its reconsideration, to reverse its adverse benefit determination or final internal adverse benefit determination and provide coverage or payment. If the claim administrator reverses its decision, it will provide written notice to you and the assigned IRO within 1 business day after making its decision and the assigned IRO will terminate the external review upon receipt of this notice.

The assigned IRO will review the claim de novo and will not be bound by any decisions or conclusions reached during the internal claim and appeals process. The assigned IRO will review all of the information and documents timely received. The assigned IRO may also consider the following:

- The claimant's medical records;
- The claimant's attending health care professional's recommendation;
- Reports from appropriate health care professionals and other documents submitted by you, the claimant's treating provider or the claim administrator;
- The terms of the Plan and the applicable benefit option to ensure that the IRO's decision is not contrary to the terms of the Plan or the applicable benefit option (unless the terms of the Plan or the applicable benefit option are inconsistent with applicable law);
- Appropriate practice guidelines, which must include applicable evidence-based standards;
- Any applicable clinical review criteria developed and used by the Plan, unless the criteria are inconsistent with the terms of the Plan, the applicable benefit option or applicable law; and
- The opinion of the IRO's clinical reviewer or reviewers after considering the information provided.

12.17 When will I be notified of the assigned IRO's decision regarding my external review?

The assigned IRO will provide written notice of its final external review decision within 45 days after it receives the request for external review. If your request is for expedited external review, you will receive notice of the final external review decision as expeditiously as your medical condition or circumstances require, but in no event more than 72 hours after the assigned IRO receives the request for an expedited external review. If this notice is not in writing, the assigned IRO will provide written confirmation to you within 48 hours after the date the IRO provides its notice of final external review decision.

12.18 What information is included in the notice of my final external review decision?

The notice that you receive from the assigned IRO will include the following information:

- A general description of the reason for the request for external review, including information sufficient to identify the claim (including the date or dates of service, the health care provider, the claim amount (if applicable), the diagnosis code and treatment code and their corresponding meanings and the reason for the previous denial);
- The date the IRO received the assignment to conduct the external review and the date of the IRO's decision;
- References to the evidence or documentation, including the specific coverage provisions and evidence-based standards, considered in reaching its decision;
- A discussion of the principal reason or reasons for its decision, including the rationale for its decision and any evidence-based standards that were relied on in making its decision;
- A statement that the determination is binding except to the extent that other remedies may be available under State or Federal law to either you or the Plan;
- A statement that judicial review may be available to you; and
- Current contact information, including phone number, for any applicable office of health insurance consumer assistance or ombudsman.

12.19 If the assigned IRO reverses the claim administrator's decision, how will my claim be handled?

Upon receipt of a final external review decision reversing your adverse benefit determination or final internal adverse benefit determination, the Plan will immediately provide coverage or payment (including immediately authorizing or immediately paying benefits) for the claim.

Section 13. Other Things You Should Know

13.1 Circumstances That Can Reduce or Result in the Loss of Your Benefit

There are numerous circumstances under which you may be disqualified from receiving Plan benefits. In general, with respect to benefits other than the FSA benefit options under the Plan, the circumstances will be outlined in the appropriate Evidence of Coverage booklet. In addition, this summary has set forth a number of situations in which you would not be entitled to benefits. For example:

- If you are ineligible for a particular benefit, you will not be entitled to receive that benefit. In addition, if we pay the benefit to or for you mistakenly, you will be required to repay the Plan.
- Once your coverage terminates, you are ineligible for benefits under the Plan.
- Under the FSA(s), if you do not have sufficient eligible expenses to use up your entire account accumulated for the coverage period, you are required to forfeit the unused amounts.
- If the Plan or any coverage option under the Plan is terminated, you will no longer be entitled to receive benefits under the Plan or coverage option, as applicable.
- If you fail to pay required premiums, you will be ineligible to receive coverage under the benefit option for which premiums or other payments are past due.

13.2 Non-Discrimination Testing

In exchange for favorable tax treatment, the IRS requires plans such as The McClatchy Company Flexible Spending Accounts Plan to pass certain fairness tests. The tests are designed to assure a fair mix of participation in the Plan among employees at various income levels and to prevent discrimination in favor of highly compensated employees. If these tests are not met, it may be necessary for the Company to reduce or stop your contributions or to refund the contributions to you. Refunded contributions would then be taxable. If you are affected, the Company will inform you.

13.3 Forfeitures

It is very important that you estimate your eligible expenses carefully under the Dependent Care FSA and Health Care FSA. If your eligible expenses are less than the amount you contribute to your FSA(s), you will not be entitled to receive any payment of any amount that you are unable to claim for reimbursement and you will lose the excess money in your plan(s) at the end of the claim-filing period (see Section 6.10 and Section 7.6 for the applicable deadline). You should also remember that the IRS does not allow you to transfer funds from one plan to another.

13.4 Plan Administration

The Plan is administered by The McClatchy Company, which in general, is the Plan Administrator. However, The McClatchy Company has delegated the day-to-day administration of the individual health and welfare plans to the human resources staff at the participating papers.

The McClatchy Company has the discretionary authority to interpret the provisions of the Plan, supply omissions and resolve inconsistencies, including, but not limited to, determining eligibility, granting or denying reimbursement requests, and appointing third-party administrators to administer and process claims reimbursements. The authority to resolve inconsistencies also applies if the Plan Administrator determines that a provision of the Plan or this summary is inconsistent with the requirements of the Internal Revenue Code. The Plan Administrator's determinations in this regard are binding on all Plan participants, their covered dependents and beneficiaries.

13.5 Future of the Plan

The McClatchy Company intends to continue the Plan indefinitely, but has reserved the right to amend, modify or terminate it at any time. The authority to make any such plan changes rests with the Board of Directors of the Company or any officer delegated by the Board of Directors. You will be notified of any material changes as required by law.

13.6 Assignment of Benefits

You cannot use the value of your Plan(s) as collateral for a loan, nor can it be pledged to another person or organization in any way, except as provided under a QMCSO made pursuant to state domestic relations law (a description of which is provided in Section 3.6(iv)).

13.7 Right of Recovery

Every effort is made to ensure that benefit payments are correct. If a mistake is made when your claim is paid or reimbursed, the Company, as Plan Administrator, reserves the right to correct the error.

13.8 Plan Expenses/Funding

Employee contributions and employer contributions are used to pay plan premiums.

The Company will pay the administrative expenses of the FSA plans and the HSA during the period that you are employed with the Company. However, participants may have to pay fees for special services such as direct deposit, etc.

Section 14. Your ERISA Rights

As a participant in The McClatchy Company Comprehensive Welfare Benefit and Cafeteria Plan, you are entitled to certain rights under the Employee Retirement Income Security Act of 1974, commonly referred to as ERISA. ERISA provides that all Plan participants shall be entitled to:

- Examine, without charge, at the principal office of The McClatchy Company and at other specified work locations, all documents governing the Plan, including insurance contracts, and a copy of the latest annual report (Form 5500 series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.
- Obtain, upon written request to the Plan Administrator, copies of all documents governing the operation of the Plan, including insurance contracts, and copies of the latest annual report (Form 5500 Series) and updated summary plan description. The Plan Administrator may make a reasonable charge for the copies.
- Continue group health care coverage for yourself, federal spouse or dependent if there is a loss of coverage under the Plan as a result of a qualifying event. You or your dependents may have to pay for such coverage. Make sure that you review Section 11 of this booklet and the Plan for the rules governing your COBRA continuation coverage rights.
- Reduction or elimination of exclusionary periods of coverage for preexisting conditions under your group health plan, if you have creditable coverage from another plan. You should be provided a certificate of creditable coverage, free of charge, from your group health plan or health insurance issuer when you lose coverage under the Plan, when you become entitled to elect COBRA continuation coverage, when your right to elect COBRA continuation coverage ceases, if you request it before losing coverage, or if you request it up to 24 months after losing coverage. Without evidence of creditable coverage, you may be subject to a preexisting condition exclusion for 12 months (18 months for late enrollees) after your enrollment date in your coverage.

14.1 *Prudent Actions by Plan Fiduciaries*

In addition to creating rights for Plan participants, ERISA imposes duties upon the people who are responsible for the operation of the Plan. The people who operate your Plan, called “fiduciaries” of the plan, have a duty to do so prudently and in the interest of you and other Plan participants and beneficiaries. No one, including your employer or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a benefit under the Plan or exercising your rights under ERISA.

14.2 *Enforce Your Rights*

If your claim for a welfare benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to this decision without charge, and to appeal any denial, all within certain time schedules.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request materials from the Plan and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the Plan Administrator to provide the materials and to pay you up to \$110 per day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator. If you have a claim for benefits, which is denied or ignored, in whole or in part, you may file suit in a state or federal court. In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a domestic relations order or medical child support order, you may file suit in federal court. If it should happen that Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

14.3 *Assistance with Your Questions*

If you have any questions about your Plan, you should contact your human resources department or the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor (listed in your telephone directory) or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

Section 15. Your Additional HIPAA Rights

15.1 *HIPAA Non-Discrimination Rule*

This Plan will not deny group health benefits (medical, dental or vision benefits) otherwise provided for treatment of the injury if the injury results from an act of domestic violence or medical condition (including both physical and mental health conditions). For example, the group health benefits will not exclude coverage for self-inflicted injuries due to a suicide attempt by a person who suffers from depression.

15.2 *Use and Disclosure of Protected Health Information*

Except for certain permitted uses and disclosures, the Privacy Rule issued by the federal government prohibits the Plan from using or disclosing any health information about you that is created or received by a health program, the Health Care FSA and the HSA without your written authorization (“Protected Health Information” or “PHI”). For additional information about your privacy rights, please refer to either the Plan’s Privacy Notice or contact the Director, Employee Benefits, who is the Plan’s Privacy Officer.

If you wish to authorize the Plan to use or disclose your PHI in a manner that is not otherwise permitted, submit a signed and completed authorization form to the Plan. You may request a copy of the authorization form from Human Resources.

The “**Privacy Rule**” means the regulations that were issued by the Department of Health and Human Services in accordance with the requirements of the Health Insurance Portability and Accountability Act of 1996 (“HIPAA”).

“**PHI**” includes all information, whether written or oral, in connection with a health program, the Health Care FSA or the HSA that (1) is created or received by the Plan; (2) relates to your past, present or future physical or mental health, the provision of health care to you, or the past, present or future payment for the provision of health care; and (3) identifies you or could be used to identify you.

(i) Permitted Uses and Disclosures

The Plan is permitted under the Privacy Rule to use or disclose your PHI without your authorization only for purposes related to:

- Health care treatment;
- Payment for health care;
- Health care operations; and
- Other specifically permitted exceptions, such as disclosures to assist disaster relief, disclosures to lessen serious health or safety threats or disclosures to business associates.

For a complete list of permitted exceptions, please refer to the Plan's Privacy Notice or contact the Plan's Privacy Officer.

(ii) Disclosures to the Company

After the Company has certified to the Plan that it is in compliance with the Privacy Rule, the Plan may disclose PHI to the Company without your authorization to the extent the PHI is necessary for the Company to perform Plan administration functions. The Plan may not disclose any more PHI to the Company than is necessary for the Company to fulfill its administration functions, and the Plan may not disclose PHI to the Company for purposes of any employment related actions or in connection with any other employee benefit provided by the Company.

To the extent that your PHI is disclosed to the Company, the Company will:

- Not use or further disclose PHI other than as permitted or required by the official Plan document or as required by law;
- Ensure that any agents, including subcontractors, to whom the Company provides PHI received from the Plan agree to the same restrictions and conditions that apply to the Company with respect to the PHI;
- Not use or disclose PHI for employment-related actions and decisions unless authorized by you;
- Not use or disclose PHI in connection with any other benefit provided by the Company unless authorized by you;
- Report to the Plan's Privacy Officer any misuse or improper disclosure of PHI;
- Make PHI available to you in accordance with the requirements of the Privacy Rule;
- Make PHI available to you for amendment and incorporate any amendments to PHI in accordance with the requirements of the Privacy Rule;
- Make available to you the information required to provide an accounting of disclosures in accordance with the requirements of the Privacy Rule;
- Make internal practices, books and records relating to the Company's use and disclosure of PHI received from the health program, the Health Care FSA or the HSA available to the Secretary of Health and Human Services for the purposes of determining the Plan's compliance with HIPAA; and

- If feasible, return or destroy all PHI received from the health program, the Health Care FSA or the HSA that the Company still maintains in any form, and retain no copies of the PHI, when the PHI is no longer needed for the purpose for which the disclosure was made (or if return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction infeasible).
- Ensure that adequate separation is established between the Plan and the Company.
- Regarding electronic PHI, implement administrative, physical, and technical safeguards to reasonably and appropriately protect the electronic PHI's confidentiality, integrity, and availability; ensure that reasonable and appropriate security measures support the adequate separation between The McClatchy Company and the health program, the Health Care FSA and the HSA; ensure that any agent, including a subcontractor, to whom the Company provides such electronic PHI agrees to implement reasonable and appropriate security measures to protect such information; and report to the health program, the Health Care FSA or the HSA, as applicable, any security incident of which the Company becomes aware.

The Company may only disclose your PHI to the following Company employees and may only do so to the extent that the Company employees perform Plan administration functions:

- The Privacy Officer;
- Employees in the Company's Human Resources Department;
- Employees in the Company's Office of General Counsel;
- Employees in the Company's Finance Department;
- Employees in the Company's IT Group; and
- Any other class of employees designated in writing by the Privacy Officer.

If a Company employee does not comply with the requirements of the Privacy Rule, the Company's Privacy Officer shall seek appropriate resolution of the issue. Unresolved issues will be escalated to the Vice President, Human Resources, who shall have the authority to apply appropriate sanctions to the employee in order to ensure compliance with the Privacy Rule, including termination of the non-complying employee's employment. If you become aware of any inappropriate use or improper disclosure of PHI, contact the Privacy Officer immediately.

Section 16. Plan Administrative Information

Name of Plan: The McClatchy Company Comprehensive Welfare Benefit and Cafeteria Plan

Plan Sponsor: The McClatchy Company

Employer Identification Number: 52-2080478

Plan Number: 005

Plan Administrator: The McClatchy Company
2100 Q Street (95816)
P.O. Box 15779
Sacramento, CA 95852-0779

(The day-to-day administration of the individual health and welfare plans has been delegated to the human resources staffs at the individual papers.)

Agent for Service of Legal Process: Corporate Secretary
The McClatchy Company
2100 Q Street (95816)
P.O. Box 15779
Sacramento, CA 95852-0779

HIPAA Privacy Officer: Director, Employee Benefits
The McClatchy Company
2100 Q Street (95816)
P.O. Box 15779
Sacramento, CA 95852-0779

FSA Third-Party Administrator: PayFlex Systems USA, Inc.
P.O. Box 3039
Omaha, NE 68103-3039
(888) 678-8242
(800) 450-0016 (fax)
www.payflexdirect.com

HSA Third-Party Administrator: PayFlex Systems USA, Inc.
P.O. Box 3317
Carol Stream, IL 60132-3317
(888) 678-8242
www.payflexdirect.com

COBRA Third-Party Administrator:

PayFlex Systems USA, Inc.
P.O. Box 2239
Omaha, NE 68103-2239
(800) 359-3921
www.payflexdirect.com

Dependent Eligibility Audit Third-Party Administrator:

Budco Health Service Solutions
P.O. Box 8072
Royal Oaks, MI 48068
(888) 349-2301
(888) 546-7382 (fax)
www.dependentverification.budco.com/user/mni

List of Insurance Carriers:

Please see McClatchy's LiveWell website for the list of insurers for a particular benefit option.

Type of Welfare Plan:

This Plan is a comprehensive welfare plan providing coverage for health, life, accident and disability claims. The Plan includes a cafeteria plan component under Section 125 of the Internal Revenue Code (the "Code") (referred to under the Plan as the premium conversion program), and includes a health care flexible spending account, as described under Section 105(b) of the Code, a dependent care flexible spending account, as described under Section 129 of the Code, and a health savings account, as described under Section 223 of the Code.

Funding:

Employee contributions, and, as determined by the Company, employer contributions are used to pay premiums.

Benefit Year:

January 1 through December 31.

LiveWell Website:

<http://www.mcclatchy.com/LiveWell>

Wellness Website:

<https://mcclatchy.livehealthier.com>

Date of SPD:

January 1, 2014

**APPENDIX A
ELIGIBILITY REQUIREMENTS FOR COMPONENT PROGRAMS**

Non-union and union* Employees of the identified Employers who are scheduled and regularly work at least 30 hours per week are eligible to participate in the Component Programs listed below commencing as of the first day of the month following 30 days of employment. Employees who work variable hours but average 30 hours per week in their first 12 months of employment are also eligible to participate in the Component Programs commencing as of the first of the month following one year of employment.

Employer	Component Programs
The McClatchy Company Aboard Custom Publishing Anchorage Daily News** The Beaufort Gazette Belleville News-Democrat The Bellingham Herald Bradenton Herald Centre Daily News (State College)* The Charlotte Observer Columbus Ledger-Enquirer The (Cass County) Democrat El Nuevo Herald The Fresno Bee* Florida Keys Keynoter The Herald (Rock Hill) The Idaho Statesman* The Island Packet The Kansas City Star* Lexington Herald-Leader* Lee's Summit Journal McClatchy Interactive TruMeasure McClatchy-Tribune Info Svcs. Services Merced Sun Star The Miami Herald The Modesto Bee* The News & Observer Publishing Co. News Tribune The Olympian*	Medical (Classic Care and Savings Advantage) Health Savings Accounts (if enrolled in Savings Advantage) Dental (Comprehensive and Basic) Vision (Comprehensive and Basic) Long Term Disability (Base and Buy-Up) Basic Life and AD&PL Supplemental Life (self, spouse/domestic partner and children) Flexible Spending Accounts (Health Care & Dependent Care) Premium Conversion Wellness Program

Olympic Cascade The Peninsula Gateway The Reporter The Sacramento Bee* Shared Services Center Sierra Star Star Telegram The State Sun Herald The Sun News The Telegraph Tri-City Herald The Tribune Washington Bureau The Wichita Eagle*	
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EAP Eligibility. All regular employees of the employers listed in this Schedule A participate in the Employee Assistance Program commencing as of the first day of the calendar month following 30 days of employment.

*Eligibility and Component Plan offering or design is defined by the Collective Bargaining Agreement for employees represented by a union.

**Until May 4, 2014

**APPENDIX B
LEAVES OF ABSENCE**

Plan	FMLA – Paid	FMLA - Unpaid	Non-FMLA - Paid	Non-FMLA – Unpaid
Component Programs other than the HSA	Cannot change or revoke coverage election on account of leave unless Change in Status Event.	<p>Can continue, change or revoke coverage election due to leave (Change in Status Event).</p> <p>If you continue or change your coverage election, premiums can be made as follows:</p> <ul style="list-style-type: none"> • Can pre-pay premiums with before-tax contributions out of pre-FMLA compensation. If leave crosses plan years, then payment will be with after-tax dollars. • Can make monthly payments with after-tax dollars during FMLA leave. <p>If coverage is discontinued while on FMLA, can re-enter plan on same basis as</p>	Cannot change or revoke coverage election on account of leave unless Change in Status Event.	<p>Except for certain leaves specified in Section 10.2(i), your coverage will be discontinued as of the end of the month that your unpaid leave began.</p> <p>For certain leaves specified in Section 10.2(i) only, you can continue, change or revoke coverage election due to leave (Change in Status Event).</p> <p>If you continue or change your coverage election, premiums can be made as follows:</p> <ul style="list-style-type: none"> • Can pre-pay premiums with before-tax contributions out of pre-leave compensation. If leave crosses plan years, then payment will be with after-tax

Plan	FMLA – Paid	FMLA - Unpaid	Non-FMLA - Paid	Non-FMLA – Unpaid
		<p>prior participation in plan upon return from FMLA leave.</p>		<p>dollars.</p> <ul style="list-style-type: none"> • Can make monthly payments with after-tax dollars during leave. <p>If coverage is discontinued while on leave, can re-enter plan on same basis as prior participation in plan upon return from leave.</p>

APPENDIX C

ELIGIBLE AND INELIGIBLE HSA AND HEALTH CARE FSA EXPENSES

Eligible Expenses include the following, if prescribed by a treating physician or other approved health provider:

- Acupuncture;
- Alcoholism and drug dependency treatment;
- Charges above the reasonable and customary charge not covered by a Company-sponsored plan;
- Chiropractor;
- Counseling for learning disabilities, psychiatric care, and other counseling expenses;
- Dental expenses, including orthodontic and prosthetic expenses;
- Dermatology;
- Fertility enhancement, including in-vitro fertilization expenses, egg and sperm storage costs, and the cost of procuring a donor and harvesting eggs;
- Hearing expenses, including hearing aids and exams;
- Hospice care;
- Medical deductibles and co-payments;
- Orthopedic expenses;
- Orthodontic expenses;
- Over-the-counter medicines or drugs, such as allergy medicines and cold remedies, with a prescription;
- Oxygen;
- Physical exams;
- Physical therapy;
- Prescription drugs and medicines;
- Psychologist;

- Reasonably necessary transportation to and from medical treatment;
- Surgery, including cosmetic surgery following an operation that causes disfigurement or cosmetic surgery that is needed to correct a defect caused by a disease or that interferes with the normal functioning of a body are deductible. Examples include expenses paid for breast reconstruction surgery following a mastectomy for cancer or LASIK and radial keratotomy vision correction surgery;
- Weight-loss programs or treatments prescribed for a medical condition such as obesity;
- Vaccinations and immunizations;
- Vision expenses, including eye exams, glasses, contacts and seeing eye dogs;
- Vitamin and food supplements;
- X-ray fees; and
- Other expenses that qualify, in total or in part, under provisions of Internal Revenue Code section 213(d).

Eligible Expenses also include the following, even if not prescribed by a treating physician or other approved health provider:

- Automobile improvement that is necessary to enable a disabled person to drive;
- Home improvement that is necessary to enable a disabled person to access or maneuver through the home;
- Non-prescription birth control drugs or devices;
- Ovulation monitoring devices;
- Pregnancy test kits;
- Smoking cessation products, such as smoking cessation patches and gum; and
- Smoking cessation programs.

Ineligible Expenses include the following expenses that you cannot use your HSA or Health Care FSA to reimburse:

- Expenses already paid by any medical or dental program;
- Premiums paid for convalescent or disability income insurance;
- Medical supplies not related to a disease or defect;

- Cosmetic surgery expenses or other procedure or services that are cosmetic in nature, unless the surgery or procedure follows an operation that causes disfigurement or is needed to correct a defect caused by disease or that interferes with the normal functioning of the body;
- Over-the-counter medicines or drugs, such as allergy medicines and cold remedies, without a prescription;
- Funeral and burial expenses;
- Household and domestic help;
- Teeth whitening procedures;
- Expenses for weight-loss programs or treatments, unless the service is a weight loss program prescribed for a medical condition, such as obesity;
- Custodial care;
- Costs for sending a problem child to a special school for benefits the child may receive from the course of study and disciplinary methods;
- Health club or fitness program dues;
- Social activities, such as dance lessons (even though recommended by a physician for general health improvement);
- Bottled water;
- Maternity clothes;
- Diaper service or diapers;
- Cosmetics, toiletries, toothpaste, shaving cream, lotion, etc.;
- Vitamins and food supplements, if not prescribed by a physician;
- Automobile insurance premiums;
- Marijuana and other controlled substances that are in violation of federal laws, even if prescribed by a physician; and
- Any expense that does not qualify under Internal Revenue Code section 213(d).

Ineligible Expenses that you **cannot** use your **HealthCare FSA** to reimburse, but **may** be able to use your **HSA** to reimburse as provided in Section 8.15:

- Long-term care services;

- COBRA or USERRA continuation coverage; and
- Insurance premiums.