2018 EBSCO BENEFITS GUIDE

The information in this guide provides a summary of the benefits available to you as an employee of EBSCO Industries.

It is designed to help you understand your options and make the benefit elections that are right for you and your family.

After you have reviewed the information provided, please refer to page 3 of this guide for important information on how to complete your 2018 enrollment.

If you have questions after reviewing this guide, please contact the EBSCO Benefits Office at benefits@ebsco.com or your local Human Resources Coordinator.

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This document is a guide. It only briefly describes the employee benefits available to benefits eligible employees. The plans and benefits described herein are sponsored by EBSCO Industries for employees who are part of the EBSCO benefits system. If there are any differences between the information contained in this guide and the master plan documents, the plan documents, hospital policies and procedures, and any applicable federal and state laws will govern. The benefits described in this guide may be changed, modified, or eliminated at any time and without advanced notice.

BENEFITS ENROLLMENT

New Employees
If you are enrolling as a newly eligible employee, you must complete your elections within 30 days of you becoming eligible for coverage, and your coverage will begin on your date of eligibility.

Current Employees
Open Enrollment is September 5 – October 16, 2017. This is the time of year to review your benefit elections, make changes, and enroll in flexible spending accounts for the upcoming calendar year. If you are electing new benefits, or making changes to your current benefits, your new elections will become effective January 1, 2018.

If you are not making any changes to your 2017 benefits, you do not need to do anything; your current benefit elections will carry over to 2018. The only exception to this is your participation in flexible spending accounts. However, we encourage all employees to log into *my*EBSCO and verify their elections and dependent information.

You must enroll every year during Open Enrollment to participate in the Medical and Dependent Care Flexible Spending Accounts or the Limited Purpose Flexible Spending Account.

Change in Status Events
Benefit elections can only be changed during the annual Open Enrollment period or within 30 days of experiencing a qualified change in status event. If you elect coverage due to a qualified change in status event, your coverage will begin on your date of eligibility.

Qualifying change in status events include:

1. Marriage, divorce, or legal separation
2. Death of a dependent
3. Birth, adoption, or placement of a child into your home for adoption, or you become responsible for a child's coverage through a Qualified Medical Support Order
4. A change in employment status for you or your spouse which results in a loss of coverage
5. Change in your worksite or residence that affects benefit eligibility
6. Coverage of you, your spouse, or a dependent child by Medicare or Medicaid
7. Involuntary loss of medical coverage for you, your spouse, or your dependent child
8. Dependent satisfying or ceasing to satisfy the dependent requirements
9. Significant coverage curtailment as determined by the Plan Administrator
10. Loss of coverage under another group health plan
11. Change in coverage due to Open Enrollment of employer's plan

In addition to the ability to make changes because of a qualified change in status event, participants on approved Family Medical Leave Act (FMLA) leave may change their medical, dental, vision, and flexible spending account coverages. If coverage is cancelled, the participant, at his or her own option, may re-elect coverage upon return from FMLA leave.

INFO AT A GLANCE

New Employees:

- You must complete your elections within 30 days of becoming eligible for coverage.

Current Employees:

- Open Enrollment is September 5 - October 16, 2017.
- You must enroll every year during Open Enrollment to participate in the Medical, Limited Purpose, or Dependent Care Flexible Spending Accounts.

STEPS TO ENROLL

The following information will assist you in enrolling in EBSCO benefits. **You must enter all dependent and beneficiary information in *my*EBSCO BEFORE you elect coverage.**

Current Employees:

Step 1. Access enrollment through *my*EBSCO
Self-Services > My Services > Benefits and Payments > Open Enrollment > Terms and Conditions

Step 2. Review your current information in *my*EBSCO
- Personal Profile: To verify and update your permanent residence, if needed.
- Dependents and Beneficiaries: To add or edit your dependents and beneficiaries.
- Benefits Summary: To review current coverages.

Step 3. Add, edit, or remove benefit plans
- Health Plans: To add, edit, or remove Medical, Dental, or Vision plans. (Remember, you must select the dependents you wish to be enrolled in each plan.)
- Insurance Plans: To add, edit, or remove Life and Disability Insurance plans.
- Flexible Spending Accounts: To add Dependent Care and Medical Spending Accounts. When selecting Flexible Spending Account options, you must indicate the amount you wish to have deducted over the course of the calendar year.

Step 4. Review and save
Your enrollment is not complete until you review all of your elections and click *Save*. Be sure to print a copy of your benefit elections summary for your records.

New Employees:

Step 1. Update personal and dependent information in *my*EBSCO
Dependent information must be entered prior to electing coverage. Self-Services > My Services > Personal Information > Personal Profile

Step 2. Access enrollment in *my*EBSCO
Self-Services > My Services > Overview > New Hire Enrollment > Terms and Conditions

Step 3. Review and verify Personal Profile > Dependents and Beneficiaries

Step 4. Add benefit plans
- *Health Plans:* To add Medical, Dental, or Vision plans. (You must select the dependents you wish to be enrolled in each plan.)
- *Insurance Plans:* To add Life and Disability Insurance plans.
- *Flexible Spending Accounts:* To add Dependent Care and Medical Spending Accounts. When selecting Flexible Spending Account options, you must indicate the amount you wish to have deducted over the course of the calendar year.

Step 5. Review and save
Your enrollment is not complete until you review all of your elections and click *Save*. Be sure to print a copy of your benefit elections summary for your records.

INFO AT A GLANCE

- You must enter all dependent and beneficiary information in *my*EBSCO BEFORE you elect coverage.

MEDICAL, DENTAL, AND VISION COVERAGES

MEDICAL PLANS OVERVIEW

At EBSCO, our commitment to continuous improvement extends beyond the products and services we offer our customers. We are equally committed to improving our employees' experience, and our benefits are at the heart of that experience.

That is why we now offer three health insurance plan options:

- **Platinum**
- **Gold**
- **Silver**

The Platinum Plan is the medical plan EBSCO has offered in previous years. We have added two additional options, because we want everyone on our diverse team to be able to choose medical insurance coverage that best fits their unique needs and the needs of their families.

In order to make the best decision possible, it is important that you begin by thinking critically about your existing medical conditions and the annual healthcare expenses you can anticipate. While the monthly premium is an important element that differs between the plans, it should not be the only factor you take into account when making your health insurance decision.

Consider the amount of coverage you and your family need to be medically and financially secure as you review plan elements, such as:

- Annual Deductible
- Coinsurance
- Copays
- Prescription Drug Expenses

All three of EBSCO's medical plans are administered by Blue Cross Blue Shield (BCBS) of Alabama, one of the largest physician and hospital networks in the country. Employees who are enrolled in our plans pay less for health care provided by professionals and hospitals in the BCBS of Alabama network.

BlueCross BlueShield of Alabama

INFO AT A GLANCE

- EBSCO's medical plans are administered by Blue Cross Blue Shield (BCBS) of Alabama.
- To learn more about the plans we offer and watch our benefits video, visit www.EBSCOChoice.com.

Apps to Download:

- Alabama Blue
- Baby Yourself
- Alabama Blue Health Handbook
- myRx Planner

COMPARE MEDICAL PLANS

	Platinum Plan	Gold Plan	Silver Plan
EBSCO's 2018 HSA Contribution	N/A	N/A	$500
Annual Deductible (Single / Family)	$200 / $600	$1,000 / $3,000	$2,000 / $4,000
Out-of-Pocket Maximum Including Deductible (Single / Family)	$1,200 / $3,600	$3,000 / $9,000	$4,500 / $9,000
Coinsurance	30% after deductible	10% after deductible	20% after deductible
Office Visit Copay (Primary Care Provider / Specialist)	$30 / $30	$30 / $40	20% after deductible
Emergency Room Copay	$150	10% after deductible	20% after deductible
Outpatient Surgery Copay	$150	10% after deductible	20% after deductible
Inpatient Stay Copay	$350 copay per admit, $50 copay days 2-5	10% after deductible	20% after deductible
Prescription Drugs (Retail)	$10 generic / $25 preferred / $55 non-preferred	$10 generic / $25 preferred / $55 non-preferred	20% after deductible
Prescription Drugs (Mail Order)	$25 generic / $62.50 preferred / $137.50 non-preferred	$25 generic / $62.50 preferred / $137.50 non-preferred	20% after deductible

COMPARE MEDICAL PLAN PREMIUMS

Platinum Plan Premiums		0-5th Year	6th Year	7th Year	8th Year	After 8th Year
2018 Platinum Plan Insurance Tiers	Full Premium	Employee Pays	Employee Pays	Employee Pays	Employee Pays	Employee Pays
Employee Only	$669.37	$160.58	$132.86	$116.30	$94.16	$62.40
Employee +1 (Spouse)	$1,150.70	$322.55	$280.54	$239.56	$198.57	$156.48
Employee +1 (No Spouse)	$1,101.97	$276.78	$234.79	$193.81	$152.82	$110.72
Employee +2 or More (No Spouse)	$1,822.02	$415.25	$353.20	$290.06	$229.19	$166.07
Employee +2 or More (Spouse)	$1,870.74	$460.99	$398.96	$335.82	$274.96	$211.83

Gold Plan Premiums		All Employees
2018 Gold Plan Insurance Tiers	Full Premium	Employee Pays
Employee Only	$597.90	$55.22
Employee + Spouse	$1,034.37	$110.91
Employee + Children	$956.64	$104.92
Employee + Family	$1,674.12	$176.72

Silver Plan Premiums		All Employees
2018 Silver Plan Insurance Tiers	Full Premium	Employee Pays
Employee Only	$516.24	$10.00
Employee + Spouse	$893.10	$20.50
Employee + Children	$825.98	$19.00
Employee + Family	$1,445.47	$32.00

**Please note that the premium rates provided in the charts above are paid monthly, with employees paying the smaller amount and EBSCO paying the remainder of the full premium.*

PLATINUM PLAN

The Platinum Plan is EBSCO's current medical plan. There will be no changes to this plan's coverage. It will remain a Preferred Provider Organization plan, and it will continue to be grandfathered under the Affordable Care Act.

Under the Platinum Plan, most eligible services are covered by a copay and are not applied toward the deductible or out-of-pocket maximum. Only out-of-network services and Other Covered Services have to meet the deductible before the plan will begin paying for eligible expenses. Other Covered Services include:

- Ambulance services
- Chiropractic care
- Physical therapy
- Durable medical equipment

Copays will not be applied toward the annual deductible or out-of-pocket maximum on the Platinum Plan. The only expenses that go toward the out-of-pocket maximum are the deductible and coinsurance.

Therefore, employees who participate in this plan will rarely reach their out-of-pocket maximum.

Platinum Plan Overview	
Monthly Premium	Based on years of coverage (See chart on page 7)
Annual Deductible (Single / Family)	$200 / $600
Out-of-Pocket Maximum Including Deductible (Single / Family)	$1,200 / $3,600
Coinsurance	30% after deductible
Office Visit Copay (Primary Care Provider / Specialist)	$30
Emergency Room Copay	$150
Outpatient Surgery Copay	$150
Inpatient Stay Copay	$350 copay per admit, $50 copay days 2-5
Prescription Drugs (Retail)	$10 generic / $25 preferred / $55 non-preferred
Prescription Drugs (Mail Order)	$25 generic / $62.50 preferred / $137.50 non-preferred

GOLD PLAN

The Gold Plan is one of the two new choices being offered for 2018, and it is also a Preferred Provider Organization plan.

The monthly premiums on the Gold Plan are lower than the Platinum Plan, but the annual deductible and out-of-pocket maximum are higher. On this plan, copays, in addition to your deductible and coinsurance, are applied toward the out-of-pocket maximum. That means everything you pay out of pocket, except for your premium, will go toward the out-of-pocket maximum.

On the Gold Plan, office visits and prescriptions are covered by a copay. Other eligible services are subject to the deductible and copay.

For an individual on the Gold Plan, after the deductible ($1,000) is met, the plan will pay for 90% of eligible services. Therefore, the individual will only be responsible for 10% of the expense for those services. Once the individual has met the out-of-pocket maximum ($3,000) in a plan year, the plan will pay for 100% of eligible services for the remainder of the plan year.

For a family, once **three** individuals in the family meet the annual deductible ($1,000 **each**), the deductible is satisfied for the **entire** family for the remainder of the plan year. At that point, the plan will pay for 90% of eligible services for the remainder of the plan year for all family members. Once **three** individuals in the family meet the out-of-pocket maximum ($3,000 **each**), the plan will pay for 100% of eligible services for the **entire** family for the remainder of the plan year.

Gold Plan Overview	
Monthly Premium	See chart on page 7
Annual Deductible (Single / Family)	$1,000 / $3,000
Out-of-Pocket Maximum Including Deductible (Single / Family)	$3,000 / $9,000
Coinsurance	10% after deductible
Office Visit Copay (Primary Care Provider / Specialist)	$30 / $40
Emergency Room Copay	10% after deductible
Outpatient Surgery Copay	10% after deductible
Inpatient Stay Copay	10% after deductible
Prescription Drugs (Retail)	$10 generic / $25 preferred / $55 non-preferred
Prescription Drugs (Mail Order)	$25 generic / $62.50 preferred / $137.50 non-preferred

SILVER PLAN

The Silver Plan is the other new choice available for 2018. Also known as a High-Deductible Health Plan (HDHP), the monthly premium is the lowest on the Silver Plan, but the annual deductible and out-of-pocket maximum are significantly higher.

During the first year the Silver Plan is offered, EBSCO will be providing Critical Illness and Accident Insurance to help participants cover expenses in the case of an unexpected or catastrophic event. With the Silver Plan, participants will also be automatically enrolled in a Health Savings Account (HSA), which will allow them to set aside money to pay for qualified medical expenses on a pre-tax basis. In 2018, EBSCO will contribute $500 to each Silver Plan participant's HSA. More information about the HSA can be found on page 11.

For an individual on the Silver Plan, after the annual deductible ($2,000) is met, the plan will pay for 80% of eligible services. Therefore, the individual will only be responsible for 20% of the expense for those services. Once the individual has met the out-of-pocket maximum ($4,500) in a plan year, the plan will pay for 100% of eligible services for the remainder of the plan year.

For a family, once **two** individuals in the family meet the annual deductible ($2,000 **each**), the deductible is satisfied for the **entire** family for the remainder of the plan year. At that point, the plan will pay for 80% of eligible services for the remainder of the plan year. Once **two** individuals in the family meet the out-of-pocket maximum ($4,500 **each**), the plan will pay for 100% of eligible services for the **entire** family for the remainder of the plan year.

Due to IRS requirements for High-Deductible Health Plans, Birmingham-based employees who choose to participate in the Silver Plan will pay a negotiated rate out of pocket for the services and/or medication provided by the onsite medical clinic at Headquarters.

Silver Plan Overview	
Monthly Premium	See chart on page 7
EBSCO's 2018 HSA Contribution	$500
Annual Deductible (Single / Family)	$2,000 / $4,000
Out-of-Pocket Maximum Including Deductible (Single / Family)	$4,500 / $9,000
Coinsurance	20% after deductible
Office Visit Copay (Primary Care Provider / Specialist)	20% after deductible
Emergency Room Copay	20% after deductible
Outpatient Surgery Copay	20% after deductible
Inpatient Stay Copay	20% after deductible
Prescription Drugs (Retail)	20% after deductible
Prescription Drugs (Mail Order)	20% after deductible

SILVER PLAN: HEALTH SAVINGS ACCOUNT

Because the IRS considers the Silver Plan a High-Deductible Health Plan (HDHP), EBSCO can offer a Health Savings Account (HSA) to employees who elect this plan.

A HSA allows employees to set aside money on a pre-tax basis to help pay for qualified medical, dental, and vision expenses. HSAs also allow employer contributions, unlike a traditional medical flexible spending account.

Employees who choose the Silver Plan can deposit pre-tax deductions from their regular paychecks into the HSA, which will automatically be set up for them by EBSCO. **By contributing pre-tax, the employee's taxable income is reduced.** Employees can also contribute to their HSA on a post-tax basis by mailing a payment directly to the third-party company that administers EBSCO's HSA, HealthEquity.

In 2018, EBSCO will also be contributing $500 to every Silver Plan participant's HSA. Employees' HSAs will be funded on a quarterly basis ($125 per quarter).

The IRS limits the amount that can be contributed to a HSA each year. The 2018 HSA contribution limit (employee + employer) is:

- Individual: $3,450
- Family: $6,900

HSAs also allow catch-up contributions (similar to 401k plans) for participants age 55 or older. The 2018 HSA catch-up contribution limit is $1,000. Please note that catch-up contributions can be made any time during the year in which the participant turns 55.

Even though the HSA is set up through EBSCO, it will always be in the employee's name. The money the employee and EBSCO contribute to the HSA will be deposited into a FDIC-insured, interest-bearing account. Employees will earn interest on the money they and the company contribute to the HSA, and the interest earned is tax free.

Once an employee's HSA has a $1,000 balance, HealthEquity will open an investment portfolio on the employee's behalf, through which the employee can manage his/her HSA investment just as they would a 401(k).

It is the responsibility of the employee to manage his/her HSA. EBSCO cannot make changes to employee accounts. If an employee needs to alter their account in any way, he/she must do so directly through HealthEquity.

If your adult child (up to age 26) is covered under the Silver Plan, but does not qualify as your tax dependent, you cannot use HSA funds to pay for his/her qualified healthcare expenses.

Employees can contact HealthEquity through their website or by phone.

Website: **www.healthequity.com**
Phone Number: **866-346-5800**

ARE YOU ELIGIBLE?

To be eligible for a HSA, you must meet the following requirements:

- You are covered under a High-Deductible Health Plan (such as EBSCO's Silver Plan).
- You have no other health coverage.
- You are not enrolled in Medicare.
- You cannot be claimed as a dependent on someone else's tax return for the prior year.

SILVER PLAN: CRITICAL ILLNESS & ACCIDENT COVERAGE

For those employees who choose to participate in the Silver Plan, EBSCO is providing Critical Illness and Accident Coverage. This coverage is provided at no cost to the employee and is meant to help cover expenses in the case of an unexpected and catastrophic event during the first year the Silver Plan is offered to employees.

This benefit provides up to $5,000 in coverage that an employee can use for any purpose after a critical illness diagnosis, including out-of-pocket medical expenses, treatments, prescription medication, transportation, and everyday living costs, such as utilities and groceries.

In the event of a critical illness or covered accident, the employee must submit a claim through Voya/ReliaStar, the insurance company that is administering the Critical Illness & Accident Coverage. They will determine whether a claim qualifies for coverage. EBSCO has no control over whether a claim is approved or the benefits deemed payable.

Critical Illness Coverage

Critical Illness Coverage pays a lump sum benefit to employees who are diagnosed with a covered condition. The amount paid depends on the illness.

Accident Coverage

Accident Coverage can help relieve an employee of the financial stress associated with an accidental injury. The benefits amount paid depends on the specific type of covered injury incurred and the subsequent care received.

INFO AT A GLANCE

- For those employees who choose to participate in the Silver Plan, EBSCO is providing Critical Illness and Accident Coverage at no cost to the employee.
- Critical Illness & Accident Coverage provides up to $5,000 in coverage that Silver Plan participants can use for any purpose after a critical illness diagnosis or accident.

MENTAL HEALTH AND EMPLOYEE ASSISTANCE PROGRAM (EAP)

EBSCO's Mental Health and Employee Assistance Program (EAP) is administered by Blue Cross Blue Shield (BCBS) of Alabama.

Mental Health Benefits

EBSCO's mental health benefits are available to employees and qualifying dependents who participate in the EBSCO Medical Plan. The mental health benefits address clinical diagnoses such as depression, anxiety, abuse, childhood trauma, chemical dependency, and other serious disorders.

Employee Assistance Program (EAP)

The Employee Assistance Program (EAP) is available to all employees and their dependents, regardless of whether or not they participate in EBSCO's Medical Plan. The EAP provides up to 6 free visits to talk confidentially with a counselor to help work through issues such as marital and family matters, stress, work problems, grief, financial and legal issues, and emotional problems.

To set up an EAP or Mental Health Appointment:

- Go to www.ndbh.com
- Click "Log In" in upper left hand corner of page
- On the Individuals & Families tab, choose "Managed Behavioral Health" or "Employee Assistance Program" from the dropdown menu
- If you choose "Employee Assistance Program," the company code is EBSCO

From there you can schedule appointments, find providers, and access other helpful resources.

Employees can also contact Blue Cross Blue Shield (BCBS) of Alabama directly about mental health or Employee Assistence needs by calling **800-624-5544.**

INFO AT A GLANCE

- With the BCBS network, you have nationwide access to over 194,000 providers.
- EAP benefits are provided at no cost to EBSCO employees and their families, up to 6 free visits.

DENTAL PLAN

EBSCO's dental coverage is administered by Delta Dental.

INFO AT A GLANCE

- Through Delta Dental, employees have access to providers in both the Delta Dental PPO and Delta Dental Premier Networks.

Summary of In-Network Benefits	
Calendar Year Deductible	$25 per individual / $75 per family
Calendar Year Benefit Maximum	$2,000 per individual / $6,000 per family
Basic Diagnostic and Preventive Services	100% of usual and customary charges, no copay or deductible
Basic Restorative Services (fillings, simple extractions, crowns)	80% of usual and customary charges, subject to the deductible
Supplemental Basic (oral surgery to treat fractures, tooth extractions, impactions)	80% of usual and customary charges, subject to the deductible
Prosthetic Benefits (full or partial dentures, bridges, inlays, onlays)	50% of usual and customary charges, subject to the deductible
Periodontic Benefits	50% of usual and customary charges, subject to the deductible
Orthodontic Benefits per member up to age 19	Covered at 50% of the allowance, up to a separate lifetime maximum of $2,000 per member up to age 19

Monthly Dental Rates

Insurance Tier	Full Premium	0-5th Year	6th Year	7th Year	8th Year	After 8th Year
Employee Only	$24.34	$11.44	$9.53	$7.62	$5.71	$3.82
Employee + 1	$60.85	$40.02	$36.58	$33.16	$30.29	$27.43
Employee + 2 or more	$142.01	$93.35	$85.35	$77.36	$73.35	$64.02

To set up an account with Delta Dental:

- Go to www.deltadentalins.com
- Use your Social Security number to set up the account
- From there you can order ID cards, look up providers, and check your claims

VISION PLAN

Vision Service Plan (VSP) provides vision insurance to EBSCO employees.

VSP Benefits

Benefit	VSP Choice	VSP Choice Premier
Eye Exam	$10 copay every 12 months	$10 copay every 12 months
Prescription Glasses	$15 copay	$15 copay
Frames	Included in the $15 copay every 24 months, up to $150	Included in the $15 copay every 12 months, up to $200
Lenses (single vision, lined bifocal, lined trifocal, lenticular, and polycarbonate for children)	Included in the $15 copay every 12 months	Included in the $15 copay every 12 months
Lens Enhancements	Most popular lens options covered with a copay resulting in an average 20-25% savings	
Anti-reflective coating	$41 copay	$25 copay
Polycarbonate	$35 copay	No copay
Progressives	$55 copay	No copay
Scratch resistant coating	$17 copay	No copay
Effective Contact Lenses		
Exam - fitting and evaluation	Copay not to exceed $60	Copay not to exceed $60
Elective lenses	Up to $150	Up to $200
Necessary lenses	Covered in full	Covered in full
Laser Vision Correction	Average 15% discount available only at contracted facilities	

You can access a list of VSP providers at www.vsp.com. No ID cards are required. All you need to do is tell your provider you are a VSP member.

Monthly Vision Rates

Insurance Tier	VSP Choice	VSP Choice Premier
Employee Only	$7.90	$19.73
Family	$17.40	$43.44

INFO AT A GLANCE

- The Choice Premier option allows for frames every 12 months and reduced copays for lens enhancements.
- No ID cards are required.

FLEXIBLE SPENDING ACCOUNTS

FLEXIBLE SPENDING ACCOUNTS

EBSCO offers Medical, Limited Purpose, and Dependent Care Spending Accounts administered by HealthEquity through BCBS of Alabama, to its employees. These Flexible Spending Accounts (FSAs) allow you to set aside money from your paycheck before it is taxed to pay for certain healthcare and dependent care expenses as defined by the IRS. You benefit from planning for upcoming expenses, and you also save on your taxes. **You MUST enroll each year during the annual Open Enrollment period to participate in a flexible spending account for the upcoming year.**

Medical Spending Account (Platinum and Gold Plans)

The Medical Spending Account can be used to get reimbursed for qualified medical, dental, and vision expenses. The maximum you can defer into the Medical Spending Account is $2,600 per household per calendar year. Expenses must be incurred pre-tax between January 1 and December 31 each year, and you have until the following April 15 to submit requests for reimbursement.

There are two ways to file for reimbursement through your Medical Spending Account. Employees can use a flex debit card from HealthEquity to pay for copays, deductibles, and other qualified healthcare expenses. The alternative is to manually submit a request for reimbursement with the appropriate receipts to HealthEquity.

You should estimate your annual out-of-pocket expenses carefully. Any amount under $500 will be rolled to the next plan year. Any amount over $500 will be forfeited.

Limited Purpose Medical Spending Account (Silver Plan)

If an employee elects to participate in the Silver Plan with a HSA, he/she will not be able to participate in EBSCO's traditional Medical Flexible Spending Account or his/her spouse's Medical Flexible Spending Account through their employer.

However, employees who elect the Silver Plan with a HSA will have the opportunity to participate in the Limited Purpose Medical Flexible Spending Account, but reimbursements from this type of account will be limited to qualifying dental and vision expenses.

Dependent Care Spending Account

The Dependent Care Spending Account can be used to get reimbursed for expenses incurred for the care of a qualifying dependent so you can attend work, look for work, or attend school. You elect how much money you want to defer into the Dependent Care Spending Account. The maximum you can defer into the Dependent Care Spending Account is $5,000 per household per calendar year. Qualifying dependents may include a disabled spouse or other dependent, a parent, or any child under the age of 13. Expenses must be incurred between January 1 and December 31 each year, and you have until the following March 31 to submit requests for reimbursement.

To file for reimbursement through the Dependent Care Spending Account, you must file a request for reimbursement with appropriate receipts to HealthEquity.

Employees can contact HealthEquity through their website or by phone.

Website: www.healthequity.com
Phone Number: 866-346-5800

HealthEquity®

INFO AT A GLANCE

- The IRS provides a full list of eligible healthcare expenses on their website at www.irs.gov/publications/p502/ar02.html
- The maximum you can defer into the Medical Spending Account is $2,600 per household per calendar year.
- The maximum you can defer into the Dependent Care Spending Account is $5,000 per household per calendar year.

PAID MATERNITY LEAVE

PAID MATERNITY LEAVE

EBSCO provides Maternity Leave benefits **at no cost** to eligible employees. This benefit will pay 100% of your basic earnings for up to 6 weeks for a normal delivery and up to 8 weeks for a cesarean delivery. The Paid Maternity Leave will run concurrent with the leave you are entitled to under the Family and Medical Leave Act (FMLA) and will not be a part of EBSCO's Paid Short Term Disability Plan.

Overview of EBSCO's Paid Maternity Leave:

- **Eligibility:** Birth mothers who are active EBSCO employees and have worked at least 12 months and 1,250 hours in the prior 12-month period are automatically eligible for Paid Maternity Leave benefits. **You do not have to enroll in the plan** to be eligible for benefits.

  Employees must apply for maternity leave benefits by contacting their local Human Resources Coordinator. Employees will be required to submit certification from a physician and be approved by the EBSCO Benefits Office before benefits are paid.

- **Benefits Paid:** Birth mothers are eligible to receive a benefit equal to 100% of their basic earnings for up to 6 weeks for normal delivery and up to 8 weeks for cesarean delivery.

- **Length of Benefits:** Maternity Leave benefit payments begin the first day of your approved Maternity Leave. The paid benefit will end after 6 weeks for normal delivery and 8 weeks for cesarean delivery. The balance of your leave entitlement under FMLA will be unpaid, or you can use earned vacation or sick time.

For more detailed information, please refer to the Paid Maternity Leave Policy.

INFO AT A GLANCE

- EBSCO pays 100% of basic earnings for up to 6 weeks for normal delivery and up to 8 weeks for cesarean delivery.
- Employees must apply for maternity leave benefits by contacting their local Human Resources Coordinator.

DISABILITY AND LIFE INSURANCE

PAID SHORT TERM DISABILITY

EBSCO provides Short Term Disability salary continuation benefits **at no cost** to eligible employees. This benefit will pay 60% of your basic earnings if you experience a short term, non-work related illness or injury that makes you unable to temporarily perform your job. The paid Short Term Disability will run concurrent with the medical leave you are entitled to under the Family and Medical Leave Act (FMLA).

Overview of EBSCO's Short Term Disability Plan:

- **Eligibility:** All active EBSCO employees who have worked at least 12 months and 1,250 hours in the prior 12-month period are automatically eligible for Short Term Disability benefits. **You do not have to enroll in the plan** to be eligible for benefits.

  Employees who experience an illness or injury that will require them to be out of work more than one week (40 hours) must apply for Short Term Disability benefits by contacting their local Human Resources Coordinator. Employees will be required to have the condition certified by a physician and approved by the EBSCO Benefits Office before benefits are paid.

- **Elimination Period:** The elimination period is the length of time between when an illness or injury begins and the time you are eligible to receive Short Term Disability benefits. The first 40 hours of your illness or disability is the elimination period under EBSCO's plan. You may use sick time during the elimination period. If 40 hours of sick time is not available, you may use vacation or unpaid time.

- **Benefits Paid:** Once the elimination period is met, you are eligible to receive a benefit equal to 60% of your basic earnings, up to a maximum benefit of $2,308 per week.

- **Length of Benefits:** Short Term Disability benefit payments begin after the 40-hour elimination period and continue for the duration of the disability to a maximum of 25 weeks (180 days of total leave).

INFO AT A GLANCE

- EBSCO will pay 60% of basic earnings to eligible employees who experience a short term, non-work related illness or injury.
- Employees must apply for Short Term Disability by contacting their local Human Resources Coordinator.

LONG TERM DISABILITY

EBSCO's Long Term Disability coverage replaces 60% of your monthly income, up to a maximum monthly benefit of $10,000. Benefits are payable once you have been unable to work for a period of 180 days. Your benefits will be reduced by other sources of income. Also note, benefits are not payable if you become disabled from a pre-existing condition within the first 12 months of being insured.

INFO AT A GLANCE

- EBSCO's Long Term Disability coverage replaces 60% of your monthly income, up to a maximum monthly benefit of $10,000.
- To be eligible for Long Term Disability coverage, you must be an active employee working a minimum of 37.5 regularly scheduled hours per week.

Long Term Disability Maximum Benefit Period

Age at Disability	Maximum Benefit Period
Under age 60	To age 65 (but not less than 5 years)
60	60 months
61	48 months
62	42 months
63	36 months
64	30 months
65	24 months
66	21 months
67	18 months
68	15 months
69 and over	12 months

If you do not enroll in Long Term Disability insurance when you first become eligible for coverage, you will be required to complete an Evidence of Insurability (EOI) and be approved by Liberty Mutual before it will go into effect.

Instructions for completing the EOI can be found here:
www.intranet.ebsco.com/wp-content/uploads/2014/04/Online-Filing-for-Evidence-of-Insurability-EBSCO.pdf

Cost:
The monthly cost is $0.21 per $100 of covered benefit. To calculate your monthly premium, use the following formula:

Premium = (Monthly income x $0.21)/100

For example, if you make $1,000 per month,

$1,000 X $0.21 = $210.00
$210.00 / 100 = $2.10

You will be responsible for 50% of the monthly premium until you have completed five (5) years of consecutive plan participation. After five (5) years of consecutive plan participation, EBSCO Industries will increase its contribution by 10% each year of enrollment until the benefit is 100% paid by the company.

LIFE INSURANCE

Employee Basic Life and AD&D Coverage

EBSCO offers Employee Basic Life and Accidental Death & Dismemberment (AD&D) coverage, through Liberty Mutual, in the amount of 1 x your annual base salary up to $100,000. All active employees working a minimum of 20 regularly scheduled hours per week are eligible after 90 days of continuous employment.

Cost:
The monthly cost is $0.06 per $1,000 of covered benefit. To calculate your monthly premium, use the following formula:

Monthly Premium = annual salary (up to $100,000 and rounded to nearest thousand) x $0.06 / 1,000.

Example:
For an employee who makes $35,075 per year,

$35,100 x $0.06 = $2,106
$2,106 / 1,000 = $2.11

You will be responsible for 50% of the monthly premium until you have completed five (5) years of consecutive plan participation. After five (5) years of consecutive plan participation, EBSCO Industries will increase its contribution by 10% each year of enrollment until the benefit is 100% paid by the company.

If you elect Employee Basic Life and AD&D coverage at a time other than your initial eligibility, you must complete an Evidence of Insurability (EOI) with Liberty Mutual within 30 days of your election. You must be approved by Liberty Mutual before your coverage will go into effect.

Instructions for completing the EOI can be found here:
www.intranet.ebsco.com/wp-content/uploads/2014/04/Online-Filing-for-Evidence-of-Insurability-EBSCO.pdf

Liberty Mutual INSURANCE

INFO AT A GLANCE

- After five (5) years of consecutive plan participation, EBSCO Industries will increase its contribution by 10% each year of enrollment until the benefits is 100% paid by the company.
- If you elect Employee Basic Life and AD&D coverage at a time other than your initial eligibility, you must complete an Evidence of Insurability (EOI) with Liberty Mutual within 30 days of your election.

Employee Optional Group Term Life Insurance

If you need more financial protection than EBSCO's Basic Life and AD&D Insurance coverage provides, you may be able to purchase Employee Optional Life Insurance. Employees must elect Basic Life and AD&D Insurance in order to elect Employee Optional Life Insurance.

The Employee Optional Life Insurance options are:

Class	Annual Salary	Optional Coverage
Class 1	less than $40,000	Option 1: increments of $20,000 up to $100,000
Class 2	over $40,000 and less than $60,000	Option 1: increments of $20,000 up to $100,000 Option 2: $200,000
Class 3	$60,000 or more annually	Option 1: increments of $20,000 up to $100,000 Option 2: $200,000 Option 3: $300,000

Cost:
The cost of Employee Optional Life Insurance is based on the employee's age as of January 1 of each year. To determine your monthly cost for optional life coverage:

1. Divide your elected amount by $1,000.
2. Locate your age on the chart below and multiply the resulting number from Step 1 with the rate that corresponds to your age on the chart.
3. The resulting number is your monthly deduction.

Example:
Monthly cost for an employee, age 48, who wants to purchase $80,000 in employee optional life coverage.

$80,000 / 1,000 = $80
$80 x 0.238 = $19.04

The monthly deduction is $19.04.

If you elect Employee Optional Life Insurance at a time other than your initial eligibility, your coverage will not go into effect until you complete an Evidence of Insurability (EOI) and are approved by Liberty Mutual. Instructions for completing the EOI can be found here:
www.intranet.ebsco.com/wp-content/uploads/2014/04/Online-Filing-for- Evidence-of-Insurability-EBSCO.pdf

Optional Employee and Dependent Life Insurance Step Rates

Age*	Rate
<24	0.068
25-29	0.068
30-34	0.076
35-39	0.094
40-44	0.145
45-49	0.238
50-54	0.34
55-59	0.536
60-64	0.765
65+	1.334

**Age as of January 1, 2018.*

Spouse Optional Life Insurance

EBSCO also offers Spouse Life Insurance coverage to protect you against the financial impact of your spouse's death. You may choose increments of $10,000 up to a maximum of $50,000. The amount of Spouse Life Insurance coverage you elect cannot exceed 50% of the amount of Employee Optional Life Insurance you have for yourself. As an employee, you are automatically the beneficiary of the Spouse Life Insurance benefits.

Cost:
The cost of Spouse Life Insurance is based on the employee's age as of January 1 of each year. To determine your monthly cost for spouse life coverage:

1. Divide your elected amount by $1,000.
2. Locate the employee's age on the chart on page 18 and multiply the resulting number from Step 1 with the rate that corresponds to your age on the chart.
3. The resulting number is your monthly deduction.

Example:
Monthly cost for an employee, age 48, who wants to purchase $40,000 in spouse life coverage.

$40,000 / 1,000 = $40
$40 x 0.238 = $9.52

The monthly deduction is $9.52.

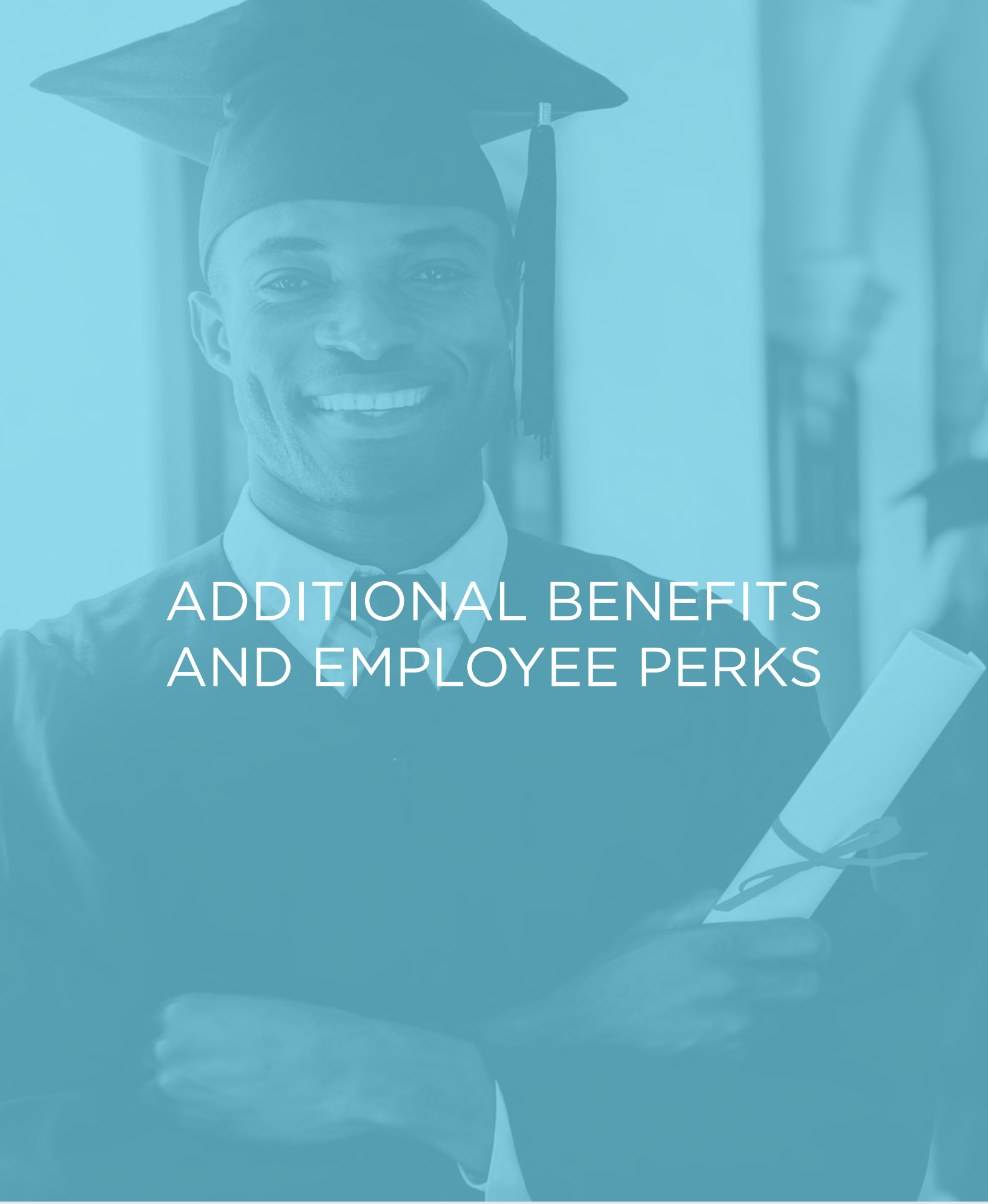
If you elect Spouse Life Insurance at a time other than your initial eligibility, your coverage will not go into effect until your spouse completes an Evidence of Insurability (EOI) and is approved by Liberty Mutual. Instructions for completing the EOI can be found here:
www.intranet.ebsco.com/wp-content/uploads/2014/04/Online-Filing-for-Evidence-of-Insurability-EBSCO.pdf

Child Life Insurance

If you elect Employee Optional Life Insurance for yourself, you may elect Child Life Insurance. The child life benefit is $10,000 ($500 if the child is at least 15 days old but under 6 months of age).

The amount of Child Life Insurance you elect cannot exceed 50% of the amount of Optional Life Insurance you have for yourself. As an employee, you are automatically the beneficiary of the Child Life Insurance benefits.

The monthly cost of Child Life Insurance is $0.39, regardless of the number of children covered.



ADDITIONAL BENEFITS AND EMPLOYEE PERKS

ADDITIONAL BENEFITS

Travel Assistance Services

Travel assistance provides 24/7/365 access to pre-travel, personal, and emergency assistance for travel-related problems and circumstances.

Travel assistance services include:

- **Worldwide Destination Intelligence:** Get weather, currency, culture, embassy, and immunization and vaccination information.
- **Travel:** Receive assistance with lost passports and credit cards, ticket replacement, emergency messages, emergency travel arrangements, translation, legal referral, and emergency cash advances.
- **Medical Evacuation and Repatriation:** Get assistance with emergency medical evacuation, transportation to join a patient, transportation home for unattended minor children, and repatriation of mortal remains.
- **Security and Political Evacuation:** Obtain assistance with security intelligence and evacuation arrangements in the event of a threatening political or security situation.

Employees who are covered under EBSCO's group life insurance policy issued by Liberty Mutual are eligible to use these services. Employees can access these services while traveling for business or personal reasons at least 100 miles from home and for fewer than 90 consecutive days. Dependents traveling with the employee are also eligible.

For more information on travel assistance services, please contact the EBSCO Benefits Office at **benefits@ebsco.com**.

Tuition Reimbursement

Continuous improvement is one of EBSCO's core principles. We strive to offer customers the best solutions available, and we seek to empower our employees by fostering personal development. Our Tuition Reimbursement Program allows full-time employees in good standing and with at least one year of continuous service the opportunity to take single courses or pursue degree programs while getting reimbursed for 75% of the tuition costs and fees.

For more information on the Tuition Reimbursement Program, please refer to the full policy:

www.intranet.ebsco.com/wp-content/uploads/2014/08/Benefits_Tuition-Reimbursement-for-Education-and-Training.pdf

INFO AT A GLANCE

- Travel assistance provides 24/7/365 access to pre-travel, personal, and emergency assistance for travel-related problems and circumstances.
- Our Tuition Reimbursement Program allows full-time employees in good standing and with at least one year of continuous service the opportunity to take single courses or pursue degree programs while getting reimbursed for 75% of the tuition costs and fees.

INFO AT A GLANCE

- Eligible adoption related expenses will be reimbursed up to a maximum of $3,000 for a child, and up to a maximum of $5,000 for a special needs child.

Adoption Assistance Benefits

EBSCO will provide assistance to all eligible employees who are building families through the adoption process. EBSCO recognizes the need to ease the financial and time-consuming aspects of child adoption for its employees and to provide reliable resource and referral services.

All full-time and part-time employees in good standing are eligible for adoption benefits after one full year of continuous service with EBSCO. If both spouses are employed by EBSCO, only one can utilize the benefit.

Eligible adoption related expenses will be reimbursed up to a maximum of $3,000 for a child, and up to a maximum of $5,000 for a special needs child. In addition, eligible employees who undergo the adoption process are eligible for paid leave.

For more information about our adoption assistance benefits, please refer to the full policy, located under the Benefits tab on the EBSCO Intranet.

EMPLOYEE PERKS

In addition to the many insurance coverages available to you, there are also many perks available to you as an EBSCO employee.

SoFi

With the ever-increasing cost of higher education, we understand that many of our employees are burdened with large amounts of student debt. To help our employees tackle this issue, EBSCO proudly partners with SoFi, the market leader in student loan refinancing.

Through this partnership, EBSCO employees and their friends and families are eligible for a $300 welcome bonus if they refinance their student loans through SoFi. Whether you are a parent who has taken out loans for a child or a graduate with student loans, SoFi refinances student loans at low rates, creating meaningful savings.

Benefits include:

- **Bonus:** $300 welcome bonus for employees and their friends and families who refinance through SoFi.
- **Savings:** SoFi borrowers save $19k on average over the life of their loans when they refinance.
- **Rates:** Variable rates as low as 2.15% APR and fixed rates as low as 3.50% APR (with Autopay).
- **Flexibility:** 5 year, 7 year, 10 year, 15 year, and 20 year term loans
- **Simplicity:** Consolidate all student loans into a single loan with one monthly payment.
- **No Fees:** No application fees, no origination fees and no prepayment penalties.

For more information visit: **www.SoFi.com/EBSCO**

PerkSpot

EBSCO has partnered with PerkSpot, a one-stop-shop for exclusive discounts at many of your favorite national and local merchants. PerkSpot is completely free and is accessible from any device: desktops, tablets, and phones.

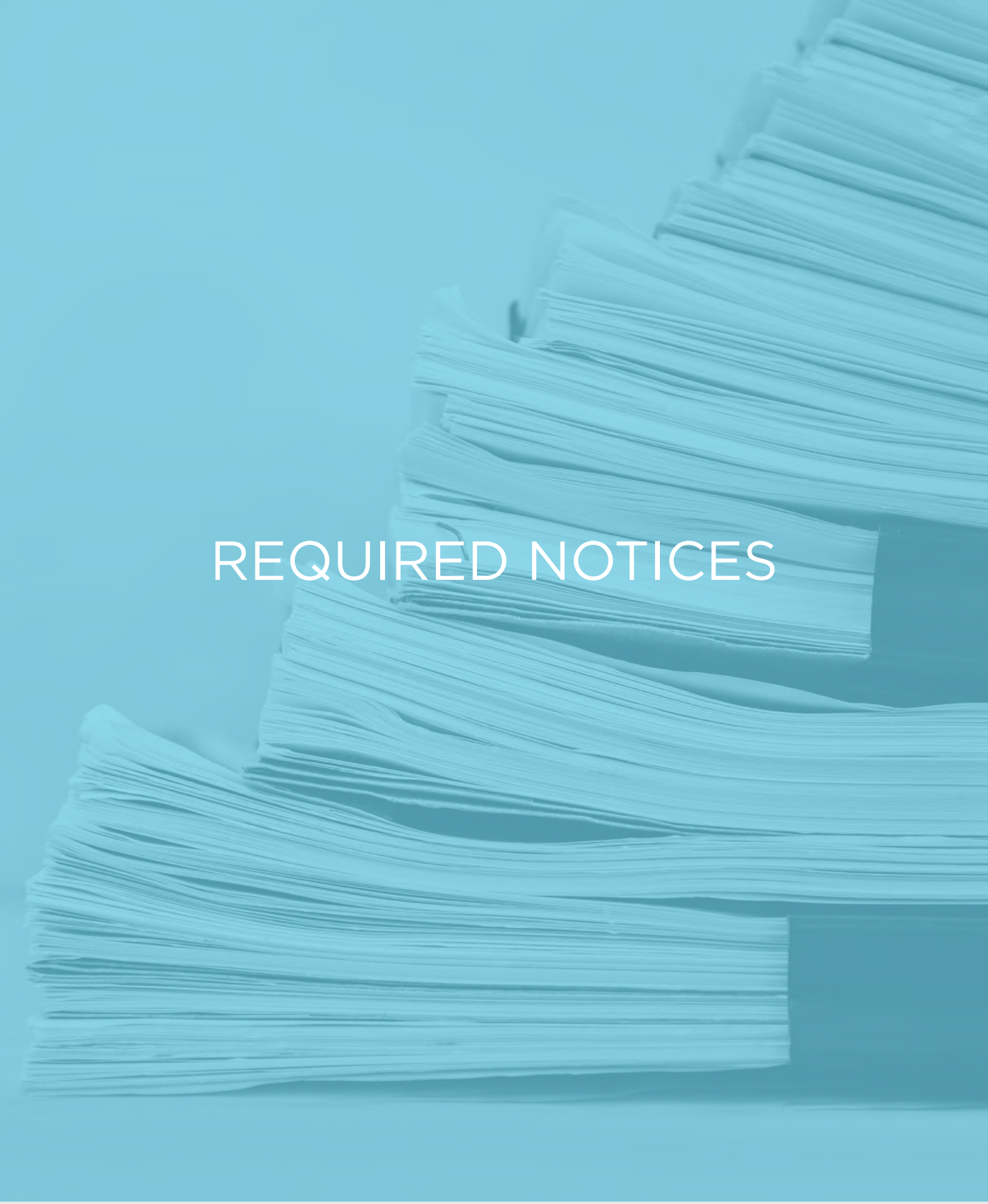
- **Get Started:** Go to **www.EBSCO.Perkspot.com** and follow the simple on-screen instructions to create an account with your personal or work email.

- **Start Saving:** Enjoy access to thousands of discounts in dozens of categories, updated daily. From discounts on pet insurance and Identity Theft protection to travel and recreation, PerkSpot puts all the discounts available to you as an EBSCO employee in one location. Take advantage of online offers from popular national retailers, and discover discounts in your neighborhood with PerkSpot's streamlined local map. Filter your map results by categories like restaurants, health and fitness, retail, and more!

If you don't see the retailer or product you want, you can always request a merchant through your PerkSpot account, and the negotiating experts will work to get it for you. Keep an eye out for new featured discounts in PerkSpot's weekly emails.

INFO AT A GLANCE

- EBSCO employees and their friends and families are eligible for a $300 welcome bonus if they refinance their student loans through SoFi.
- Employees can access thousands of discounts through Perkspot.



REQUIRED NOTICES

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

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

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

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

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

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of January 31, 2017. Contact your State for more information on eligibility –

ALABAMA – Medicaid	FLORIDA – Medicaid
Website: http://myalhipp.com/ Phone: 1-855-692-5447	Website: http://flmedicaidtplrecovery.com/hipp/ Phone: 1-877-357-3268
ALASKA – Medicaid	**GEORGIA – Medicaid**
The AK Health Insurance Premium Payment Program Website: http://myakhipp.com/ Phone: 1-866-251-4861 Email: CustomerService@MyAKHIPP.com Medicaid Eligibility: http://dhss.alaska.gov/dpa/Pages/medicaid/default.aspx	Website: http://dch.georgia.gov/medicaid - Click on Health Insurance Premium Payment (HIPP) Phone: 404-656-4507
ARKANSAS – Medicaid	**INDIANA – Medicaid**
Website: http://myarhipp.com/ Phone: 1-855-MyARHIPP (855-692-7447)	Healthy Indiana Plan for low-income adults 19-64 Website: http://www.in.gov/fssa/hip/ Phone: 1-877-438-4479 All other Medicaid Website: http://www.indianamedicaid.com Phone 1-800-403-0864
COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)	**IOWA – Medicaid**
Health First Colorado Website: https://www.healthfirstcolorado.com/ Health First Colorado Member Contact Center: 1-800-221-3943/ State Relay 711 CHP+: Colorado.gov/HCPF/Child-Health-Plan-Plus CHP+ Customer Service: 1-800-359-1991/ State Relay 711	Website: http://dhs.iowa.gov/ime/members/medicaid-a-to-z/hipp Phone: 1-888-346-9562

KANSAS – Medicaid	NEW HAMPSHIRE – Medicaid
Website: http://www.kdheks.gov/hcf/ Phone: 1-785-296-3512	Website: http://www.dhhs.nh.gov/oii/documents/hippapp.pdf Phone: 603-271-5218
KENTUCKY – Medicaid	**NEW JERSEY – Medicaid and CHIP**
Website: http://chfs.ky.gov/dms/default.htm Phone: 1-800-635-2570	Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ Medicaid Phone: 609-631-2392 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710
LOUISIANA – Medicaid	**NEW YORK – Medicaid**
Website: http://dhh.louisiana.gov/index.cfm/subhome/1/n/331 Phone: 1-888-695-2447	Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831
MAINE – Medicaid	**NORTH CAROLINA – Medicaid**
Website: http://www.maine.gov/dhhs/ofi/public-assistance/index.html Phone: 1-800-442-6003 TTY: Maine relay 711	Website: https://dma.ncdhhs.gov/ Phone: 919-855-4100
MASSACHUSETTS – Medicaid and CHIP	**NORTH DAKOTA – Medicaid**
Website: http://www.mass.gov/eohhs/gov/departments/masshealth/ Phone: 1-800-462-1120	Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/ Phone: 1-844-854-4825
MINNESOTA – Medicaid	**OKLAHOMA – Medicaid and CHIP**
Website: http://mn.gov/dhs/people-we-serve/seniors/health-care/health-care-programs/programs-and-services/medical-assistance.jsp Phone: 1-800-657-3739	Website: http://www.insureoklahoma.org Phone: 1-888-365-3742
MISSOURI – Medicaid	**OREGON – Medicaid**
Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005	Website: http://healthcare.oregon.gov/Pages/index.aspx http://www.oregonhealthcare.gov/index-es.html Phone: 1-800-699-9075
MONTANA – Medicaid	**PENNSYLVANIA – Medicaid**
Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084	Website:http://www.dhs.pa.gov/provider/medicalassistance/healthinsurancepremiumpaymenthippprogram/index.htm Phone: 1-800-692-7462
NEBRASKA – Medicaid	**RHODE ISLAND – Medicaid**
Website: http://dhhs.ne.gov/Children_Family_Services/AccessNebraska/Pages/accessnebraska_index.aspx Phone: 1-855-632-7633	Website: http://www.eohhs.ri.gov/ Phone: 401-462-5300
NEVADA – Medicaid	**SOUTH CAROLINA – Medicaid**
Medicaid Website: https://dwss.nv.gov/ Medicaid Phone: 1-800-992-0900	Website: https://www.scdhhs.gov Phone: 1-888-549-0820

SOUTH DAKOTA - Medicaid	WASHINGTON – Medicaid
Website: http://dss.sd.gov Phone: 1-888-828-0059	Website: http://www.hca.wa.gov/free-or-low-cost-health-care/program-administration/premium-payment-program Phone: 1-800-562-3022 ext. 15473
TEXAS – Medicaid	**WEST VIRGINIA – Medicaid**
Website: http://gethipptexas.com/ Phone: 1-800-440-0493	Website: http://www.dhhr.wv.gov/bms/Medicaid%20Expansion/Pages/default.aspx Phone: 1-877-598-5820, HMS Third Party Liability
UTAH – Medicaid and CHIP	**WISCONSIN – Medicaid and CHIP**
Medicaid Website: https://medicaid.utah.gov/ CHIP Website: http://health.utah.gov/chip Phone: 1-877-543-7669	Website: https://www.dhs.wisconsin.gov/publications/p1/p10095.pdf Phone: 1-800-362-3002
VERMONT– Medicaid	**WYOMING – Medicaid**
Website: http://www.greenmountaincare.org/ Phone: 1-800-250-8427	Website: https://wyequalitycare.acs-inc.com/ Phone: 307-777-7531
VIRGINIA – Medicaid and CHIP	
Medicaid Website: http://www.coverva.org/programs_premium_assistance.cfm Medicaid Phone: 1-800-432-5924 CHIP Website: http://www.coverva.org/programs_premium_assistance.cfm CHIP Phone: 1-855-242-8282	

To see if any other states have added a premium assistance program since January 31, 2017, or for more information on special enrollment rights, contact either:

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

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

Paperwork Reduction Act Statement

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

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

New Health Insurance Marketplace Coverage
Options and Your Health Coverage

PART A: General Information

When key parts of the health care law take effect in 2014, there will be a new way to buy health insurance: the Health Insurance Marketplace. To assist you as you evaluate options for you and your family, this notice provides some basic information about the new Marketplace and employment based health coverage offered by your employer.

What is the Health Insurance Marketplace?

The Marketplace is designed to help you find health insurance that meets your needs and fits your budget. The Marketplace offers "one-stop shopping" to find and compare private health insurance options. You may also be eligible for a new kind of tax credit that lowers your monthly premium right away. Open enrollment for health insurance coverage through the Marketplace begins in October 2013 for coverage starting as early as January 1, 2014.

Can I Save Money on my Health Insurance Premiums in the Marketplace?

You may qualify to save money and lower your monthly premium, but only if your employer does not offer coverage, or offers coverage that doesn't meet certain standards. The savings on your premium that you're eligible for depends on your household income.

Does Employer Health Coverage Affect Eligibility for Premium Savings through the Marketplace?

Yes. If you have an offer of health coverage from your employer that meets certain standards, you will not be eligible for a tax credit through the Marketplace and may wish to enroll in your employer's health plan. However, you may be eligible for a tax credit that lowers your monthly premium, or a reduction in certain cost-sharing if your employer does not offer coverage to you at all or does not offer coverage that meets certain standards. If the cost of a plan from your employer that would cover you (and not any other members of your family) is more than 9.5% of your household income for the year, or if the coverage your employer provides does not meet the "minimum value" standard set by the Affordable Care Act, you may be eligible for a tax credit.[1]

Note: If you purchase a health plan through the Marketplace instead of accepting health coverage offered by your employer, then you may lose the employer contribution (if any) to the employer-offered coverage. Also, this employer contribution -as well as your employee contribution to employer-offered coverage- is often excluded from income for Federal and State income tax purposes. Your payments for coverage through the Marketplace are made on an after-tax basis.

How Can I Get More Information?

For more information about your coverage offered by your employer, please check your summary plan description or contact your Human Resources Department.

The Marketplace can help you evaluate your coverage options, including your eligibility for coverage through the Marketplace and its cost. Please visit **HealthCare.gov** for more information, including an online application for health insurance coverage and contact information for a Health Insurance Marketplace in your area.

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[1] An employer-sponsored health plan meets the “minimum value standard” if the plan’s share of the total allowed costs covered by the plan is no less than 60 percent of such costs.

PART B: Information About Health Coverage Offered by Your Employer

This section contains information about any health coverage offered by your employer. If you decide to complete an application for coverage in the Marketplace, you will be asked to provide this information. This information is numbered to correspond to the Marketplace application.

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3. Employer name EBSCO Industries, Inc.		4. Employer Identification Number (EIN) 63-6014186
5. Employer address P. O. Box 1943		6. Employer phone number (205) 991-6600
7. City Birmingham	8. State AL	9. ZIP code 35201
10. Who can we contact about employee health coverage at this job? Human Resources Department, EBSCO International Headquarters		
11. Phone number (if different from above) Same as above	12. Email address benefits@ebsco.com	

Here is some basic information about health coverage offered by this employer:

- As your employer, we offer a health plan to some employees. Eligible employees are regular status employees working 20 or more hours per week and sales representatives submitting daily reports.

- We offer coverage to eligible dependents. Eligible dependents are spouses and children up to age 26.

The health plan coverage offered by EBSCO Industries, Inc. meets the minimum value standard, and the cost of this coverage to you is intended to be affordable, based on employee wages.

Note: Even if the coverage offered is intended to be affordable, you may still be eligible for a premium discount through the Marketplace. The Marketplace will use your household income, along with other factors, to determine whether you may be eligible for a premium discount. If, for example, your wages vary from week to week (perhaps you are an hourly employee or you work on a commission basis), if you are newly employed mid-year, or if you have other income losses, you may still qualify for a premium discount.

If you decide to shop for coverage in the Marketplace, **HealthCare.gov** will guide you through the process. The information listed above is the initial employer information you'll enter when you visit **HealthCare.gov** to find out if you can get a tax credit to lower your monthly premiums.

CREDITABLE DRUG COVERAGE NOTICE

Important Notice About Your Prescription Drug Coverage and Medicare

The EBSCO pharmacy plan is fully creditable under Medicare guidelines. For any questions regarding the plan, contact EBSCO Human Resources at 205 991-6600.

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with your employer and about your options under Medicare's prescription drug coverage. This information can help you decide whether or not you want to join a Medicare drug plan. If you are considering joining, you should compare your current coverage, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare prescription drug coverage in your area. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

There are two important things you need to know about your current coverage and Medicare's prescription drug coverage:

1. Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.
2. Your employer has determined that the prescription drug coverage offered by your employer is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

When Can You Join A Medicare Drug Plan?

You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15 through December 7. However, if you lose your current creditable prescription drug coverage, through no fault of your own, you will also be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan.

What Happens To Your Current Coverage If You Decide to Join A Medicare Drug Plan?

If you decide to join a Medicare drug plan, your current employer group coverage may be affected. For example, you and your dependents may not be able to keep your current employer coverage if you join a Medicare drug plan.

If you decide to join a Medicare drug plan and drop your current employer group coverage, be aware that you and your dependents may not be able to get this coverage back.

When Will You Pay A Higher Premium (Penalty) To Join A Medicare Drug Plan?

You should also know that if you drop or lose your current coverage with your employer and do not join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.

If you go 63 continuous days or longer without creditable prescription drug coverage, your monthly premium may go up by at least 1% of the Medicare base beneficiary premium per month for every month that you did not have that coverage. For example, if you go nineteen months without creditable coverage, your premium may consistently be at least 19% higher than the Medicare base beneficiary premium. You may have to pay this higher premium (a penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to join. For More Information About This Notice Or Your Current Prescription Drug Coverage contact our office for further information.

NOTE: You'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage through your employer changes. You also may request a copy of this notice at any time.

Need More Information About Your Options Under Medicare Prescription Drug Coverage?

More detailed information about Medicare plans that offer prescription drug coverage is in the "Medicare & You" handbook. If you are eligible for Medicare you'll get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare drug plans.

For more information about Medicare prescription drug coverage visit www.medicare.gov or call your State Health Insurance Assistance Program (see the inside back cover of your copy of the "Medicare & You" handbook for their telephone number) for personalized help. You can always call 1-800-MEDICARE (1-800-633-4227) for answers to your questions. TTY users should call 1-877-486-2048.

If you have limited income and resources, extra help paying for Medicare prescription drug coverage is available. For information about this extra help, visit Social Security on the web at www.socialsecurity.gov, or call them at 1-800-772-1213 (TTY 1-800-325-0778).

REMEMBER, keep this Creditable Coverage notice. If you decide to join one of the Medicare drug plans, you may be required to provide a copy of this notice when you join to show whether or not you have maintained creditable coverage and, therefore, whether or not you are required to pay a higher premium (a penalty).

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

This Joint Notice gives you information required by law about the duties and privacy practices of the EBSCO Industries, Inc. Group Medical Plan and the health flexible spending account component of the EBSCO Industries, Inc. Flexible Benefits Plan (the "Plans") to protect the privacy of your medical information and your legal rights regarding your protected health information held by the Plans under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA").

Among other things, this Notice describes how your protected health information may be used or disclosed to carry out treatment, payment, or health care operations, or for any other purposes that are permitted or required by law. It is effective September 23, 2013. The Plans are required to provide this Notice of Privacy Practices to you.

The HIPAA Privacy Rule protects only certain medical information known as "protected health information." Generally, protected health information is individually identifiable health information, including demographic information, collected from you or created or received by a health care provider, a health care clearinghouse, a health plan, or your employer on behalf of a group health plan, that relates to your past, present or future physical or mental health or condition; the provision of health care to you; or the past, present or future payment for the provision of health care to you.

If you have any questions about this Notice or about our privacy practices, please contact the Plans' HIPAA Privacy Official at (205) 991-6600. You may contact the Plans at 5724 Highway 280 East, Birmingham, Alabama 35242.

Our Responsibilities. The Plans are required by law to maintain the privacy of your protected health information; provide you with certain rights with respect to your protected health information; provide you with a copy of this Notice of our legal duties and privacy practices with respect to your protected health information; and follow the terms of the Notice that is currently in effect. The Plans reserve the right to change the terms of this Notice and to make new provisions regarding your protected health information that it maintains, as allowed or required by law. If this Notice is ever changed in any material way, you will be provided with a copy of the revised Notice of Privacy Practices.

How The Plans May Use and Disclose Your Protected Health Information. Under the law, the Plans may use or disclose your protected health information under certain circumstances without your permission. The following categories describe the different ways that the Plans may use and disclose your protected health information. Not every use or disclosure in a category is listed, but every way the Plans are permitted to use and disclose information will fall within one of the categories.

For Treatment. The Plans may use or disclose your protected health information to facilitate medical treatment or services by providers. The Plans may disclose medical information about you to providers, including doctors, nurses, technicians, medical students, or other hospital personnel who are involved in taking care of you. For example, the Plans might disclose information about your prior prescriptions to determine if prior prescriptions contraindicate a pending prescription.

For Payment. The Plans may use or disclose your protected health information to determine your eligibility for Plan benefits, to facilitate payment for the treatment and services you receive from health care providers, to determine benefit responsibility under the Plans, or to coordinate Plan coverage. For example, the Plans may tell your health care provider about your medical history to determine whether a particular treatment is experimental, investigational, or medically necessary, or to determine whether the Plans will cover the treatment.

For Health Care Operations. The Plans may use and disclose your protected health information for other Plan operations. These uses and disclosures are necessary to run the Plans. For example, the Plans may use medical information in connection with conducting quality assessment and improvement activities; underwriting (except for protected health information that is genetic information), premium rating, and other activities relating to Plan coverage; submitting claims for stop-loss (or excess-loss) coverage; conducting or arranging for medical review, legal services, audit services, and fraud & abuse detection programs; business planning and development such as cost management; and business management and general Plan administrative activities.

To Business Associates. The Plans may contract with individuals or entities known as business associates to perform various functions on behalf of the Plans. In order to perform these functions or to provide these services, business associates will receive, create, maintain, use and/or disclose your protected health information, but only after they agree in writing with the Plans to implement appropriate safeguards regarding your protected health information. For example, the Plans may disclose your protected health information to a business associate to administer claims or to provide support services, such as utilization management, but only after the business associate enters into an agreement with the Plans to safeguard your protected health information.

As Required by Law. The Plans will disclose your protected health information when required to do so by federal, state or local law. For example, the Plans may disclose your protected health information when required by national security laws.

To Avert a Serious Threat to Health or Safety. The Plans may use and disclose your protected health information when necessary to prevent a serious threat to your health and safety, or the health and safety of the public or another person. Any disclosure, however, would only be to someone able to help prevent the threat.

To Plan Sponsors. For the purpose of administering the Plans, the Plans may disclose protected health information to certain authorized employees of the employer sponsoring the Plans. However, those employees will only use or disclose that information as necessary to perform Plan administration functions or as otherwise required by HIPAA, unless you have authorized further disclosures. Your protected health information cannot be used for employment purposes without your specific authorization.

Special Situations. In addition to the above, the following categories describe other possible ways that the Plans may use and disclose your protected health information. Not every use or disclosure in a category will be listed. However, all of the ways the Plans are permitted to use and disclose information will fall within one of the categories.

Organ and Tissue Donation. If you are an organ donor, the Plans may release your protected health information to organizations that handle organ procurement or organ, eye, or tissue transplantation or to an organ donation bank, as necessary to facilitate organ or tissue donation and transplantation.

Military and Veterans. If you are a member of the armed forces, the Plans may release your protected health information as required by military command authorities. The Plans may also release protected health information about foreign military personnel to the appropriate foreign military authority.

Workers' Compensation. The Plans may release your protected health information for workers' compensation or similar programs. These programs provide benefits for work-related injuries or illness.

Public Health Risks. The Plans may disclose your protected health information for public health actions. These actions generally include to prevent or control disease, injury, or disability; to report births and deaths; to report child abuse or neglect; to report reactions to medications or problems with products; to notify people of recalls of products they may be using; to notify a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition; to notify the appropriate government authority if we believe that a patient has been the victim of abuse, neglect, or domestic violence. (The Plans will only make this disclosure if you agree, or when required or authorized by law.)

Health Oversight Activities. The Plans may disclose your protected health information to a health oversight agency for activities authorized by law. These oversight activities include audits, investigations, and licensure. These activities are necessary for the government to monitor the health care system, government programs, and compliance with civil rights laws.

Lawsuits and Disputes. If you are involved in a lawsuit or a dispute, the Plans may disclose your protected health information in response to a court or administrative order. The Plans may also disclose your protected health information in response to a subpoena, discovery request, or other lawful process by someone else involved in the dispute, but only if efforts have been made to tell you about the request or to obtain an order protecting the information requested.

Law Enforcement. The Plans may disclose your protected health information if asked to do so by a law enforcement official in response to a court order, subpoena, warrant, summons or similar process; to identify or locate a suspect, fugitive, material witness, or missing person; about the victim of a crime if, under certain limited circumstances, the Plans are unable to obtain the victim's agreement; about a death that we believe may be the result of criminal conduct; and about criminal conduct.

Coroners, Medical Examiners and Funeral Directors. The Plans may release protected health information to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death. The Plans may also release medical information about patients to funeral directors, as necessary to carry out their duties.

National Security and Intelligence Activities. The Plans may release your protected health information to authorized federal officials for intelligence, counterintelligence, and other national security activities authorized by law.

Inmates. If you are an inmate of a correctional institution or are in the custody of a law enforcement official, the Plans may disclose your protected health information to the correctional institution or law enforcement official if necessary (1) for the institution to provide you with health care; (2) to protect your health and safety or the health and safety of others; or (3) for the safety and security of the correctional institution.

Research. The Plans may disclose your protected health information to researchers when the individual identifiers have been removed; or when an institutional review board or privacy board has reviewed the research proposal and established protocols to ensure the privacy of the requested information, and approves the research.

Required Disclosures

Government Audits. The Plans are required to disclose your protected health information to the Secretary of the United States Department of Health and Human Services when the Secretary is investigating compliance with HIPAA.

Disclosures to You. When you request, the Plans are required to disclose to you the portion of your protected health information that contains medical records, billing records, and any other records used to make decisions regarding your health care benefits. The Plans are also required, when requested, to provide you with an accounting of most disclosures of your protected health information if the disclosure was for reasons other than for payment, treatment, or health care operations, and if the protected health information was not disclosed pursuant to your individual authorization.

Other Disclosures

Spouses and Other Family Members. With only limited exceptions, the Plans will send all mail to the employee. This includes mail relating to the employee's spouse and other family members who are covered under the Plans, and includes mail with information on the use of Plan benefits by the employee's spouse and other family members and information on the denial of any Plan benefits to the employee's spouse and other family members. If a person covered under the Plans has requested Restrictions or Confidential Communications (see below under "Your Rights"), and if one or both of the Plans have agreed to the request, mail will be sent as provided by the request for Restrictions or Confidential Communications.

Authorizations. Other uses or disclosures of your protected health information not described above will only be made with your written authorization. In addition, most uses and disclosures of psychotherapy notes, uses and disclosures of protected health information for marketing, and any sale of protected health information require your authorization. You may revoke written authorization at any time, so long as the revocation is in writing. Once the Plans receive your written revocation, it will only be effective for future uses and disclosures. It will not be effective for any information that may have been used or disclosed in reliance upon the written authorization and prior to receiving your written revocation.

Your Rights

Right to Inspect and Copy. You have the right to inspect and copy certain protected health information that may be used to make decisions about your health care benefits. To inspect and copy your protected health information, you must submit your request in writing to the Plans. If you request a copy

of the information, the Plans may charge a reasonable fee for the costs of copying, mailing, or other supplies associated with your request. The Plans may deny your request to inspect and copy in certain very limited circumstances. If you are denied access to your medical information, you may request that the denial be reviewed by submitting a written request to the Plans.

Right to Amend. If you feel that the protected health information the Plans have about you is incorrect or incomplete, you may ask the Plans to amend the information. You have the right to request an amendment for as long as the information is kept by or for the Plans. To request an amendment, your request must be made in writing and submitted to the Plans. In addition, you must provide a reason that supports your request. The Plans may deny your request for an amendment if it is not in writing or does not include a reason to support the request. In addition, the Plans may deny your request if you ask the Plans to amend information that is not part of the medical information kept by or for the Plans; was not created by the Plans, unless the person or entity that created the information is no longer available to make the amendment; is not part of the information that you would be permitted to inspect and copy; or is already accurate and complete. The Plan will provide a written explanation of a denial within 60 days. If the Plans deny your request, you have the right to file a statement of disagreement with the Plans and any future disclosures of the disputed information will include your statement.

Right to an Accounting of Disclosures. You have the right to request an "accounting" of certain disclosures of your protected health information. The accounting will not include (1) disclosures for purposes of treatment, payment, or health care operations; (2) disclosures made to you; (3) disclosures made pursuant to your authorization; (4) disclosures made to friends or family in your presence or because of an emergency; (5) disclosures for national security purposes; and (6) disclosures incidental to otherwise permissible disclosures.

To request this list or accounting of disclosures, you must submit your request in writing to the Plans. Your request must state a time period of not longer than six years and may not include dates before April 14, 2003. Your request should indicate in what form you want the list (for example, paper or electronic). The first list you request within a 12-month period will be provided free of charge. For additional lists, the Plans may charge you for the costs of providing the list. The Plans will notify you of the cost and you may choose to withdraw/modify your request at that time before any costs are incurred.

Right to Request Restrictions. You have the right to request a restriction or limitation on your protected health information that the Plans use or disclose for treatment, payment, or health care operations. You also have the right to request a limit on your protected health information that the Plans disclose to someone who is involved in your care or the payment for your care, such as a family member or friend. For example, you could ask that the Plans not use or disclose information about a surgery that you had. Except as provided in the next paragraph, the Plans are not required to agree to your request. However, if the Plans do agree to the request, the Plans will honor the restriction until you revoke it or the Plans notify you.

Effective February 17, 2010 (or such other date specified as the effective date under applicable law), the Plans will comply with any restriction request if (1) except as otherwise required by law, the disclosure is to the health plan for purposes of carrying out payment or health care operations (and is not for purposes of carrying out treatment); and (2) the protected health information pertains solely to a health care item or service for which the health care provider involved has been paid out-of-pocket in full.

To request restrictions, you must make your request in writing to the Plans. In your request, you must tell the Plans (1) what information you want to limit; (2) whether you want to limit our use, disclosure, or both; and (3) to whom you want the limits to apply—for example, disclosures to your spouse.

Right to Request Confidential Communications. You have the right to request that the Plans communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that the Plans only contact you at work or by mail. To request confidential communications, you must make your request in writing to Plans. The Plans will not ask you the reason for your request. Your request must specify how or where you wish to be contacted. The Plans will accommodate all reasonable requests if you clearly provide information that the disclosure of all or part of your protected information could endanger you.

Right to Select Personal Representatives. The Plans will disclose your protected health information to individuals authorized by you, or to an individual designated as your personal representative, attorney-in-fact, etc., so long as you provide the Plans with a written notice/authorization and any supporting documents (i.e., power of attorney). Note: under the HIPAA privacy rule, the Plans do not have to disclose information to a personal representative if the Plan administrator has a reasonable belief that you have been, or may be, subjected to domestic violence, abuse or neglect by such person; or treating such person as your personal representative could endanger you; and in the exercise of professional judgment, it is not in your best interest to treat the person as your personal representative.

Right to Be Notified of a Breach. You have the right to be notified in the event that the Plans (or a business associate) discover a breach of unsecured protected health information.

Right to a Paper Copy of This Notice. You have the right to a paper copy of this notice. You may ask the Plans to give you a copy of this notice at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy of this notice. To obtain a paper copy of this notice, contact the Privacy Official.

Complaints. If you believe that your privacy rights have been violated, you may file a complaint with the Plans or with the Office for Civil Rights of the United States Department of Health and Human Services. To file a complaint with the Plan, contact the Privacy Official. All complaints must be submitted in writing. You will not be penalized, or in any other way retaliated against, for filing a complaint with the Office for Civil Rights or with the Plans.

Women's Health and Cancer Rights Act Information

A member who is receiving benefits in connection with a mastectomy will also receive coverage for reconstruction of the breast on which a mastectomy was performed and reconstruction of the other breast to produce a symmetrical appearance; prostheses; and treatment of physical complications at all stages of the mastectomy, including lymphedema. Benefits for this treatment will be subject to the same calendar year deductible and coinsurance provisions that apply for other medical and surgical benefits.