Kimball International

BENEFITS GUIDE 2027

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CORE+

KIMBALL INTERNATIONAL BENEFITS

2027 Benefits Enrollment

ANNUAL BENEFITS ENROLLMENT

Each year, you have the chance to review your needs and make choices for your healthcare, dental, vision, disability, life, accident, hospital indemnity, and critical illness insurance.

IMPORTANT DATES

Open Enrollment runs from October 26, through November 6, at 11:59 PM ET.

- Health Savings Account (HSA): Your HSA election will not carry over into 2027. To continue contributing, log into MyADP and enter your annual contribution amount.
- All other benefits will roll over automatically unless you make changes.
- Review all your 2027 benefits details by visiting MyADP > Benefits > View Forms and Documents.
- Be sure to review and update all your dependents during Open Enrollment. This supports traditional benefits (like medical coverage) in addition to special Kimball International benefits such as:
  - Kimball International Health Center eligibility (also applies to dependents not on a Kimball International health plan)
  - Children's holiday gifts
  - Member family events

HOW ENROLLMENT WORKS

Just like in past years, enrollment is completely online and paperless. You'll receive an email at the address listed in MyADP letting you know when your enrollment is available.

YOUR BENEFITS GUIDE

This Benefits Guide provides an overview of all benefit plans offered for 2027. Use it as a resource to:

- Compare plan options
- Make confident, informed decisions during enrollment
- Refer back throughout 2027 to get the most out of your benefits

WELCOME NEW HIRES!

When you're ready to enroll, be sure to review the step-by-step instructions.

View How to Enroll PDF

HELPING US MANAGE COSTS FOR EVERYONE

Our medical, prescription drug, dental, and short-term disability plans are self-insured, meaning Kimball International pays the claims and works with vendors to process and manage them.

Your premiums cover only a small portion of the total cost—Kimball International funds the rest. As healthcare costs continue to rise, it's more important than ever that we all focus on preventive care and making the most of your benefits.

Here's how you can make the most of your benefits:

- **Preventive Care:** Take advantage of annual screenings and immunizations, which are covered at 100% under our plan.
- **Smart Care Choices:** Use a Kimball International Health Center, your primary care doctor, or Sydney Virtual Care telemedicine for non-emergencies—rather than visiting the ER for conditions that aren't life-threatening.

By using your benefits wisely and focusing on prevention, you'll help protect your health and keep costs down for everyone.

WHO'S ELIGIBLE?

Members:

- Full-time members
- Part-time members working an average of at least 30 hours per week for the past 12 months (for medical plan only, along with children)

Dependents:

- Your legal spouse or legal domestic partner—coverage varies based on if your spouse/partner has coverage available through their employer:
  - Medical: You cannot cover your spouse/partner in a Kimball International medical plan if they are eligible for their employer's medical plan.
  - All Other Benefits: You can cover your spouse/partner.
- Your children **up to the age of 26** for medical, dental, vision, dependent life, and supplemental plans
- Your children **over age 26** who are not able to support themselves due to a physical or mental disability

Medical, dental, and vision are COBRA-eligible benefit plans.

KIMBALL INTERNATIONAL HEALTH CENTER

$0 SERVICES FOR KII HEALTH PLAN MEMBERS

Preventive Care

- Adult Immunizations
- Annual Physicals (PHA)
- Lab Work/Tests
- Generic Medications on Formulary
- Men's Health Exams
- Women's Health Exams

Health Condition Programs

- Depression/Anxiety
- Diabetes
- Heart Disease
- High Blood Pressure
- High Cholesterol
- Weight Management

Additional Services

- Mental Health Counseling
- Nutrition Counseling
- Lifestyle Coaching
- RN Care Coordination

$30 SERVICES FOR KII HEALTH PLAN MEMBERS

Urgent Care / Primary Care

- Asthma / Emphysema
- Colds / Flu / Congestion
- Diarrhea / Constipation
- Headache / Migraine
- Muscle / Joint Pain
- Nausea / Vomiting
- Seasonal Allergies
- Sinus Infection
- Skin Cut / Rash
- Sore Throat
- Sprain / Strain
- Thyroid Conditions
- Urinary Tract Infection

Physical Therapy Sessions

- 10 Sessions for $30

$50 SERVICES FOR KII NON-HEALTH PLAN MEMBERS

- Labs and Primary Care (PHA)
- Mental Health
- Nutrition Counseling
- Physical Therapy

STAY UP TO DATE ON YOUR PREVENTIVE SCREENINGS

Preventive screenings can help detect health concerns early, when they're often easier to treat. Ask your CareATC provider if you're eligible for a no-cost preventive screening through your health plan.

Common Preventive Screenings Include

- ➔ Colonoscopy
- ➔ Prostate Cancer Screening
- ➔ Mammogram
- ➔ Lung Cancer Screening
- ➔ Pap Test/HPV Screening
- ➔ Skin Cancer Screening

ACTIVATE YOUR PATIENT ACCOUNT

Activate your patient account in minutes to easily schedule appointments, your view medical records, request Rx refills, message your provider, and more!

Each eligible member over the age of 18 must create their own account

DOWNLOAD THE CAREATC APP

Scheduling appointments and accessing your medical, prescription and appointment information has never been easier or more convenient.

Download the mobile app to:

- ➔ Schedule in-person or virtual care appointments.
- ➔ Message your primary care team.
- ➔ Complete and review forms and documents.
- ➔ View your medical record.
- ➔ Submit prescription refill requests.
- ➔ View your Personal Health Assessment (PHA) results.
- ➔ Locate health centers near you.
- ➔ View the Health Education Library.

THREE EASY SCHEDULING OPTIONS

You can schedule at our five convenient locations using the three options below:

- www.careatc.com/kimballinternational
- 812-772-4485
- Care ATC Mobile App (Scan the QR Code below to download)

HEALTH CENTER LOCATIONS

Kimball International Health Center - Jasper
1620 Cherry St, Ste A, Jasper, IN 47546

Kimball International Health Center - Danville
259 Stewarts Ln, Danville, KY 40422

Kimball International Health Center - Fordsville
16968 KY-69, Fordsville, KY 42343

Kimball International Health Center - Salem
200 Kimball Blvd, Salem, IN 47167

Kimball International Health Center - Santa Claus
116 Burch Drive, Santa Claus, IN 47579

Kimball International HEALTH CENTER

provided by CareATC

MEDICAL AND PRESCRIPTION DRUGS

You have two Consumer Driven Health Plans (CDHPs) to choose from:

- 1750 Plan
- 2400 Plan

The plans both:

- Use Anthem Blue Cross Blue Shield network
- Offer prescription drugs through Northwind
- Cover the same treatments and medications, including free preventive care (such as annual wellness exams, routine immunizations, and health screenings based on age and gender)
- Provide a way for you to save for your medical and prescription drugs with a Health Savings Account (HSA)
- Provide access to an online/mobile app called Sydney that includes virtual care for medical and behavioral health

However, there are some key differences. If you choose the 1750 Plan, you will:

- Pay more in paycheck deductions
- Have a lower deductible and out-of-pocket max when you need care during the year
- Receive HSA dollars from Kimball International to use for your care

DOWNLOAD THE **SYDNEY APP TODAY!**

Before you make your medical plan decision, review the table below to see how the plans compare.

	1750 PLAN		2400 PLAN	
	IN-NETWORK	OUT-OF-NETWORK	IN-NETWORK	OUT-OF-NETWORK
Annual Deductible				
Individual (Member Only)	$1,750	$3,500	$2,400	$4,800
Family (Member and Dependents)	$3,500	$7,000	$4,800	$9,600
Coinsurance	YOU PAY 20% AFTER DEDUCTIBLE	YOU PAY 40% AFTER DEDUCTIBLE	YOU PAY 10% AFTER DEDUCTIBLE	YOU PAY 40% AFTER DEDUCTIBLE
Company HSA Contribution				
Individual (Member Only)	$400 Annually		No company contribution	
Family (Member and Dependents)	$700 Annually			
Out-of-Pocket Maximum				
Individual (Member Only)	$3,500 Only in-network expenses apply to the in-network out-of-pocket limit.	$7,000	$5,800 Only in-network expenses apply to the in-network out-of-pocket limit.	$11,600
Family (Member and Dependents)	$7,000 Only in-network expenses apply to the in-network out-of-pocket limit.	$14,000	$11,600 Only in-network expenses apply to the in-network out-of-pocket limit.	$23,200

CHART CONTINUED	1750 PLAN		2400 PLAN	
	IN-NETWORK	OUT-OF-NETWORK	IN-NETWORK	OUT-OF-NETWORK
Office Visits				
Preventive Visits	$0 — PLAN PAYS 100%		$0 — PLAN PAYS 100%	
Primary Care (PCP)	YOU PAY 20% AFTER DEDUCTIBLE	YOU PAY 40% AFTER DEDUCTIBLE	YOU PAY 10% AFTER DEDUCTIBLE	YOU PAY 40% AFTER DEDUCTIBLE
Specialists				
Urgent Care				
Virtual Visits — Sydney				
Diagnostic Lab and X-Ray				
Hospital				
Emergency Room	$200 COPAY + COINSURANCE AFTER DEDUCTIBLE IS MET			
Inpatient	YOU PAY 20% AFTER DEDUCTIBLE	YOU PAY 40% AFTER DEDUCTIBLE	YOU PAY 10% AFTER DEDUCTIBLE	YOU PAY 40% AFTER DEDUCTIBLE
Outpatient				
Emergency Medical Transportation				
Imaging (CT/PET Scans, MRIs)				
Infertility Treatment	YOU PAY 20% AFTER DEDUCTIBLE $10,000 LIFETIME MAXIMUM	YOU PAY 40% AFTER DEDUCTIBLE $10,000 LIFETIME MAXIMUM	YOU PAY 10% AFTER DEDUCTIBLE $10,000 LIFETIME MAXIMUM	YOU PAY 40% AFTER DEDUCTIBLE $10,000 LIFETIME MAXIMUM

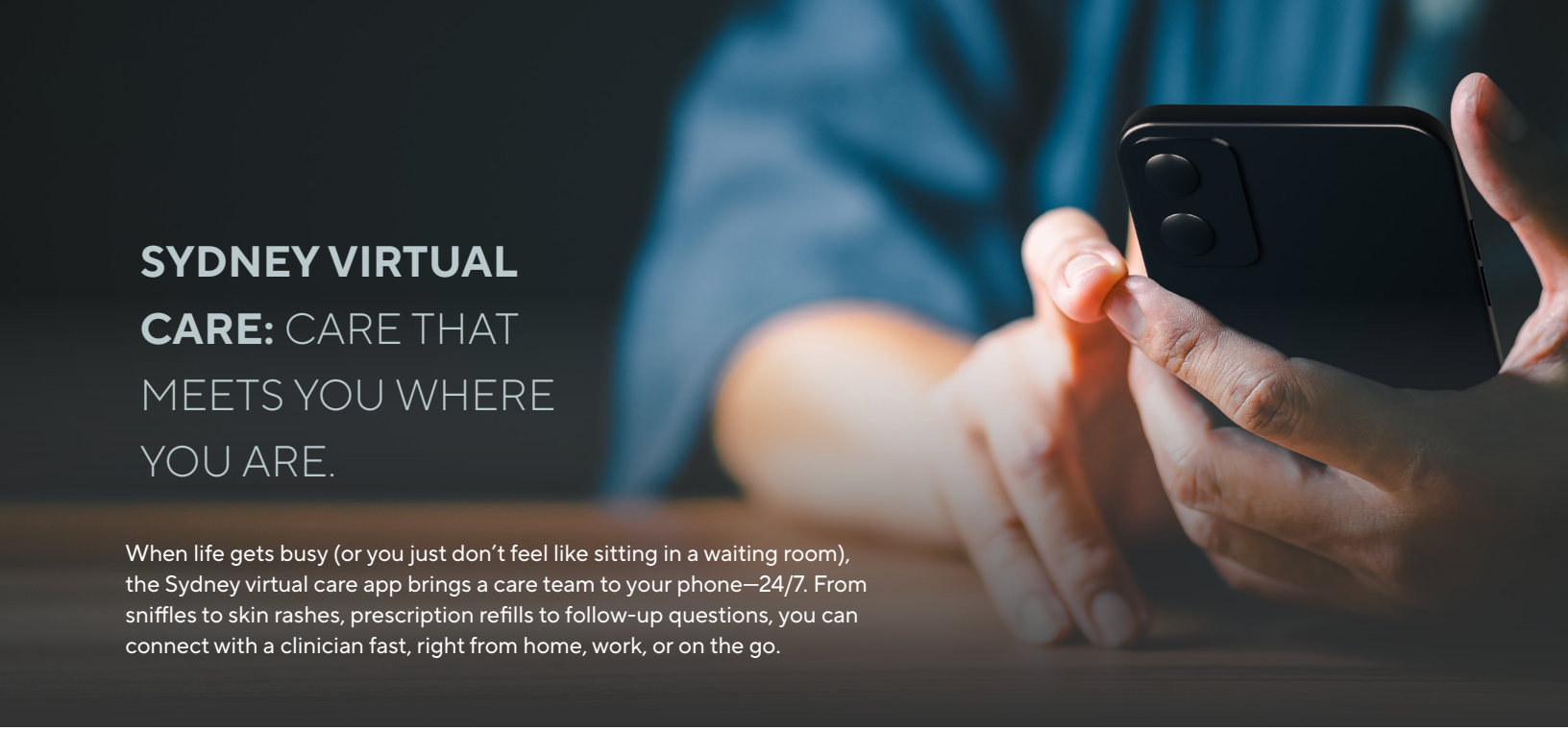
Prescription (Rx) Drugs - Moving to Northwind	
Rx Drug on Preventive List	Retail and mail order: Deductible does not apply. You pay 10%, 20%, or 40%.
Rx Drug Not on Preventive List	Member pays full cost of the drug until deductible is met. Once met, you pay 10%, 20% or 40%. Once out of pocket is met, member pays $0.
Rx Specialty Drugs	
Infertility Drugs	Member pays full cost of the drug until deductible is met. Once met, you pay 10%, 20% or 40%. Once out of pocket is met, member pays $0. **$10,000 LIFETIME MAX. FOR MEDICAL AND RX**

You are responsible for obtaining precertification for certain services. Please call Member Services on the back of your Anthem ID card for more information.

PRESCRIPTION DRUG COVERAGE:

90-day supply: Available at network pharmacies in addition to mail order

2027 HEALTHCARE (Medical and Prescription) **COSTS**	WEEKLY PAYCHECK COSTS		BIWEEKLY PAYCHECK COSTS	
	1750 PLAN	2400 PLAN	1750 PLAN	2400 PLAN
Employee	$26.47	$11.01	$52.94	$22.01
Employee + Spouse	$72.13	$32.22	$144.27	$64.43
Employee + Child(ren)	$60.65	$27.19	$121.31	$54.39
Employee + Family	$104.35	$46.67	$208.70	$93.33



SYDNEY VIRTUAL CARE: CARE THAT MEETS YOU WHERE YOU ARE.

When life gets busy (or you just don't feel like sitting in a waiting room), the Sydney virtual care app brings a care team to your phone—24/7. From sniffles to skin rashes, prescription refills to follow-up questions, you can connect with a clinician fast, right from home, work, or on the go.

WHY YOU'LL LOVE IT

- Anytime access: Video or chat with board-certified doctors and licensed clinicians—days, nights, weekends, and holidays.
- Quick answers, real care: Get help for common issues such as colds and flu, allergies, pinkeye, UTIs, stomach bugs, skin concerns, and more.
- Prescriptions made simple: If medically appropriate, prescriptions can be sent to your preferred local pharmacy.
- No surprises: See visit options and estimated costs up front based on your health plan.
- Follow-ups made easy: Message your virtual care team with questions after your visit.
- For the family: Use the app to access care for covered dependents on your plan.

WHEN TO USE VIRTUAL CARE

Choose Sydney virtual care for non-emergency needs when you want fast, convenient help. It's perfect for:

- Minor illnesses and infections
- Skin issues (share photos for a quick review)
- Medication refills and treatment questions
- Care guidance—"Should I see a doctor, or can this be handled virtually?"

HOW TO GET STARTED (IT'S EASY)

1. Download the Sydney Health app from the App Store or Google Play.
2. Register using your member ID and create a secure login.
3. Tap Care → Virtual Care to choose video or chat. Pick a time (often within minutes) and share a few details about your symptoms.
4. Join your visit and get a care plan—often in under 20 minutes.

GET IT ON Google Play

Download on the App Store

EMPLOYEE ASSISTANCE PROGRAM

Life can be full of challenges. That's why Kimball International has **an Employee Assistance Program available to help you and your family when you need it most**. The ComPsych EAP program is free and offers a wide range of support services and resources.

EAP SERVICES:

CONFIDENTIAL COUNSELING

- Anxiety, depression, stress
- Grief, loss, life adjustments
- Relationship/marital conflicts

WORK AND LIFESTYLE SUPPORT

- Child, elder, and pet care
- Moving and relocation
- Shelters, government assistance

LEGAL GUIDANCE

- Divorce, adoption, family law
- Wills, trusts, estate planning
- Free consultation and discounted local representation

FINANCIAL RESOURCES

- Financial planning, retirement, taxes
- Relocation, mortgages, insurance
- Budgeting, debt, bankruptcy

DIGITAL TOOLS AND SUPPORT

- Immediate connection to counseling, work-life support, and more
- Personalized guided behavioral health and well-being programs
- Interactive articles, videos, on-demand trainings, digital self-care tools
- Accessible resources for anxiety, stress, mindfulness, sleep, and more

SCAN THE QR CODE FOR MORE RESOURCES:

CONFIDENTIAL 24/7 SUPPORT, WHEN AND WHERE YOU NEED IT.

- Call 866-899-1367 to speak to a highly trained, caring professional.
- Go to guidanceresources.com and enter your company ID: MAP4HNI
- Assistance is always confidential. View the privacy notice at guidanceresources.com/privacy

HEALTH SAVINGS ACCOUNT

HEALTH SAVINGS ACCOUNT (HSA)

An HSA is a great way to save money tax-free for healthcare expenses when you're enrolled in one of KII's two Consumer Driven Health Plans.

- **Opening your account:** You'll need to provide a little paperwork to get started, but once it's open, it's yours to keep—even if you change jobs. Kimball International covers the monthly bank fee for active members.
- **You can add money:** You can contribute through pre-tax payroll deductions or by making your own deposits.
- **Kimball International will add money:** Kimball International also contributes each pay period if you're enrolled in the 1750 plan. **You must have an active, open account within 90 days of initiation to avoid forfeiting any contributions**.
- **Accessing funds:** You'll receive a debit card when your account is opened, and you can also access your funds through the Anthem member portal.
- **Rollover:** Any unused money stays in your account, as long as the account is open, and rolls over year to year—it's your money to grow and use in the future.

Important to know:

- You'll need to open and activate your account within 90 days to receive company contributions.
- If your account isn't open by day 90, you won't be able to contribute, and your contributions already deducted from your paycheck will be returned. All company contributions will be forfeited.

PLEASE NOTE:

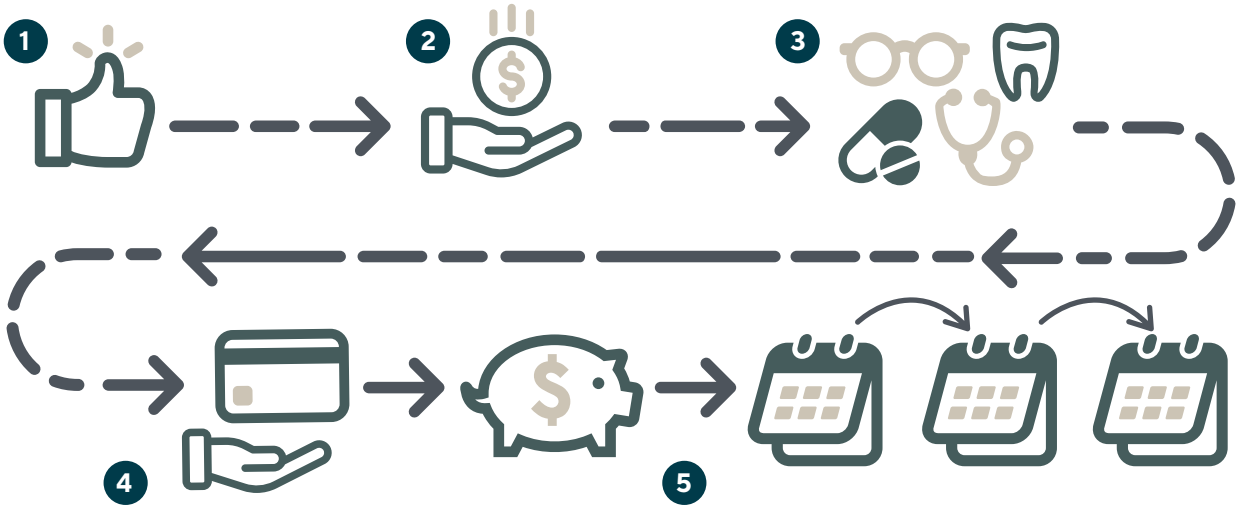
If you are on **Medicare**, or within 6 months of enrolling in Medicare, you cannot contribute to an HSA. If you need assistance in learning more about Medicare coverage, you can reach out to a free counselor in your area at **shiphelp.org**

	1750 PLAN	2400 PLAN
Company Contribution	$400 Annually Employee Only $700 Annually Other Tiers (Employee + Spouse, Employee + Child(ren), or Employee + Family)	No Company Contribution
Catch-up Contribution (after age 55)	$1,000	$1,000
IRS Maximum Annual Contribution	SINGLE: $4,500 FAMILY: $9,000	SINGLE: $4,500 FAMILY: $9,000
Maximum you may Contribute Based upon Company Contribution	SINGLE: $4,100 FAMILY: $8,300	SINGLE: $4,500 FAMILY: $9,000

** You must open and activate your HSA within 90 days of account initiation. Kimball International will deduct your HSA deferrals from your paycheck and deposit that amount in addition to your Kimball International contributions (if in the 1750 Plan) from the date you enroll to the end of the 90-day period.* ***If you join as a new hire during the plan year, the Kimball International contribution will be prorated based on your date of hire.*** *If you fail to open your account by the 90th day, you will be deemed not eligible to contribute to an HSA, your deferrals will be returned, and any employer contribution will be forfeited.*

HOW A HEALTH SAVINGS ACCOUNT WORKS

You contribute on a pre-tax basis and can change how much you contribute from each paycheck up to the IRS maximum of $4,500 if you enroll only yourself, or $9,000 if you enroll in family coverage. You can make an additional $1,000 catch-up contribution if you are age 55 or older.



1 ELIGIBILITY

You must be enrolled in one of our medical plans with HSA and complete the necessary paperwork to open your account.

2 CONTRIBUTIONS

You contribute on a pre-tax basis and can change how much you contribute from each paycheck up to the IRS maximum of $4,500 if you enroll only yourself, or $9,000 if you enroll in family coverage. You can make an additional $1,000 catch-up contribution if you are age 55 or older.

3 ELIGIBLE EXPENSES

You may use your HSA funds to cover eligible medical, dental, vision, and prescription drug expenses incurred by you and your eligible family members.

4 USING YOUR ACCOUNT

Use your HSA debit card linked to your HSA to cover eligible expenses or pay for expenses out of your own pocket and save your HSA money for future healthcare expenses.

5 HSA FOREVER

YOUR HSA IS ALWAYS YOURS — NO MATTER WHAT. One of the best features of an HSA is that any money left in your HSA account at the **end of the year rolls over so you can use it next year** or sometime in the future. And if you leave Kimball International or retire, your HSA goes with you so you can continue to pay for or save for future eligible healthcare expenses.

Anthem is the administrator of the Health Savings Account and can be reached by calling Member Services on the back of your card or by visiting **www.anthem.com**.

DENTAL

You have two dental plans to choose from:

- **1000 Plan:** Comes with a $1,000 maximum annual benefit per member per year
- **2000 Plan:** Comes with a $2,000 maximum annual benefit per member per year

Both plans are administered by Delta Dental of Indiana. You can see any dentist you choose; however, the dentist you visit will impact how much you will pay when you receive care:

- **PPO dentist:** You'll receive the biggest discount and pay less out of your pocket.
- **Premier dentist:** You'll still receive a discount but will pay more than a PPO dentist.
- **Dentist that isn't in the Delta Dental network:** You'll pay the most for your care.

Before you make your dental plan decision, review the table below to see how the plans compare.

	PPO Dentist	Premier Dentist	Non-Participating Dentist
Calendar-Year Deductible	**$50 Single / $150 Family Does not apply to Diagnostic and Preventive or Orthodontic Services**		
Calendar-Year Maximum Benefit You Will Receive	**$1,000 per person or $2,000 per person Does not apply to Preventive Services**		
Diagnostic and Preventive Services – exams, full mouth x-rays, cleanings, fluoride treatments up to age 19, space maintainers	**You pay 0% Plan pays 100%**	**You pay 0% Plan pays 100%**	**You pay 10% Plan pays 90%**
Basic Services – posterior composite resins, fillings, root canals, extractions, oral surgery	**You pay 20% Plan pays 80%**	**You pay 40% Plan pays 60%**	**You pay 60% Plan pays 40%**
Major Services – crowns, bridges, dentures	**You pay 40% Plan pays 60%**	**You pay 50% Plan pays 50%**	**You pay 70% Plan pays 30%**
Orthodontic Services for children up to age 19	**You pay 40% Plan pays 60%**	**You pay 50% Plan pays 50%**	**You pay 70% Plan pays 30%**
Orthodontic Services – Lifetime Maximum	**$1,000 or $2,000 per covered child up to age 19**		

2027 DENTAL COSTS	WEEKLY PAYCHECK COSTS		BIWEEKLY PAYCHECK COSTS	
	1000 PLAN	2000 PLAN	1000 PLAN	2000 PLAN
Employee	**$1.47**	**$1.94**	**$2.94**	**$3.88**
Employee + Spouse	**$7.22**	**$8.21**	**$14.44**	**$16.42**
Employee + Child(ren)	**$11.56**	**$14.53**	**$23.12**	**$29.06**
Employee + Family	**$18.32**	**$23.37**	**$36.64**	**$46.74**

VISION

Kimball International's Vision Plan is offered through VSP and includes eye exams, frames, lenses, and contacts every 12 months. Benefits renew on January 1st of each year.

You'll save money when you go to a network provider. If you choose benefits outside of the VSP network, just pay in full at the time of service, obtain an itemized receipt, and file a claim for reimbursement up to your maximum out-of-network allowance.

Before you make your vision plan decision, review the table below to see what you'll pay when you need care.

	IN-NETWORK	OUT-OF-NETWORK
Exam (once every calendar year)	**$10 copay**	**Up to $45**
Frames/Lenses, once every calendar year	**$180 ALLOWANCE, THEN 20% OFF ANY REMAINING BALANCE** **$200 ALLOWANCE FOR FEATURED FRAMES**	**UP TO $50**
Lenses (once every calendar year) **Single Vision** **Bifocal** **Trifocal** **Lenticular** **Standard Progressive** **Premium/Custom Progressive** **Polycarbonate** **Factory Scratch Coating**	 **$20 copay** **$20 copay** **$20 copay** **$20 copay** **$20 copay** **$95-175 copay** **$0 copay** **$0 copay**	 **Up to $30** **Up to $50** **Up to $60** **Up to $75** **Up to $50** **No allowance** **No allowance** **No allowance**
Contact Lenses – (once per calendar year) in lieu of Frames/Lenses		
Elective	**$180 allowance; no additional discount**	**Up to $100**
Medically Necessary	**Covered in full**	**Up to $210**

Plan covers glasses lenses or contact lenses each year (not both).

2027 VISION COSTS	WEEKLY PAYCHECK COSTS	BIWEEKLY PAYCHECK COSTS
Employee	**$1.60**	**$3.20**
Employee + Spouse	**$2.70**	**$5.40**
Employee + Child(ren)	**$2.75**	**$5.50**
Employee + Family	**$4.35**	**$8.70**

DISABILITY COVERAGE

SHORT-TERM DISABILITY

Life can be unpredictable. Short-term disability insurance provides peace of mind by replacing part of your income if you're unable to work due to an illness or injury that happens outside of work. This benefit is administered by MetLife.

It's designed to help protect your financial stability and support you while you recover—so you can focus on getting better, not worrying about lost pay.

Base Plan: Kimball International will replace and pay for 35% of your pre-disability wages.

Supplemental Protection: You can buy and add another 25% replacement on top of the 35% provided by Kimball International for a total of 60% replacement of your pre-disability wages.

Benefit payments commence on the 8th day of disability (accident/injury/sickness). The maximum benefit payment duration is 26 weeks.

LONG-TERM DISABILITY

Long-Term Disability (LTD) helps protect your income if you're unable to work due to an illness or injury for an extended period.

- **What's covered:** Both work-related and non-work-related disabilities.
- **When benefits begin:** After 26 weeks of disability (this lines up with when short-term disability ends).
- **Benefit amount:** Choose 50% or 60% of your pre-disability earnings.
- **Payment range:** Minimum of $100/month, up to a maximum of $15,000/month.
- **How long benefits last:** Until you reach Social Security Normal Retirement Age (see chart on next page).
- **Pre-existing conditions:** Excluded for up to 1 year from your hire date, or for 1 year after enrolling in Option 2 if you switched from another option or previously declined coverage.

Kimball International offers two plan options to choose from:

- **Option 1:** 50% replacement of your pre-disability earnings
- **Option 2:** 60% replacement of your pre-disability earnings

Plan rates are calculated by your age and pre-disability earnings when you enroll in MyADP.

MAXIMUM DURATION OF LTD BENEFITS TABLE

AGE WHEN DISABLED	MAXIMUM BENEFIT PERIOD
Age 62 or younger	To SSNRA, or 3 years 6 months, whichever is longer
Age 63	To SSNRA, or 3 years, whichever is longer
Age 64	2 years 6 months
Age 65	24 months
Age 66	21 months
Age 67	18 months
Age 68	15 months
Age 69 and over	12 months

LIFE INSURANCE

No one can predict the future, but you can plan for it. That's why Kimball International offers you benefits to help protect your income and give you peace of mind. Life insurance pays a benefit if you or a covered family member dies. It is paid to your beneficiary if you die or to you if a dependent dies. This benefit is administered by MetLife.

TERM LIFE INSURANCE Kimball International provides **$25,000 in basic life insurance coverage**—at no cost to you.

Supplemental Coverage

- You can buy extra coverage of 1x, 2x, 3x, or 4x your annual salary (up to **$250,000** without EOI).
- The $25,000 provided by Kimball International is **in addition** to any supplemental coverage you choose.
- During **Annual Enrollment**, you can increase your coverage by one level (1x salary) without EOI, up to the guarantee issue amount of $250,000.
- Keep in mind: IRS rules require you to pay taxes on the value of coverage over $50,000.

NOTE:

More information about EOI on the next page.

Policy Highlights

- **Waiver of Premium:** If you become totally disabled before age 60, you may qualify to keep your supplemental coverage without paying premiums. (You must request the waiver form and submit medical documentation before your coverage ends.)
- **Accelerated Benefits:** If diagnosed with a terminal illness (life expectancy of 12 months or less), you may receive up to 75% of your coverage (maximum $500,000 when basic + supplemental are combined).
- **Conversion and Portability:** If your coverage ends (due to leaving the company or reduced hours), you can extend or convert your policy. You must request a Portability Conversion Kit from MetLife at 800-638-5433 within 60 days.

LIFE INSURANCE *(continued)*

DON'T FORGET: Be sure to keep your beneficiary information up to date in MyADP—this applies to both your basic and supplemental life coverage.

EVIDENCE OF INSURABILITY (EOI)

EOI is a brief health questionnaire MetLife uses to confirm eligibility for supplemental life insurance. You'll be asked to complete EOI if you enroll for the first time and elect over $250,000 or increase coverage to over $250,000.

- **What to do:** Watch for instructions from MetLife via email and submit your information by the stated deadline.
- **What to expect:** MetLife—not Kimball International—reviews your answers and will notify you of approval or denial. Coverage and payroll deductions for the requested amount begin only after approval.
- **Privacy:** Your health information is kept confidential by MetLife.
- **If not approved:** You'll keep any coverage up to the guaranteed issue amount of $250,000.

DEPENDENT LIFE INSURANCE

You may also purchase dependent life insurance coverage for your spouse and eligible dependent children.

Supplemental Coverage — You can buy extra coverage of:

$10,000 spouse/$5,000 child

$20,000 spouse/$10,000 child

$30,000 spouse/$10,000 child — **To cover your spouse for $30,000, you must have at least $30,000 of supplemental life insurance coverage for yourself.**

Policy Highlights

- **Eligibility:** Children are covered from live birth through age 26.
- **Enrollment reminder:** If you don't elect coverage when first eligible, you will qualify for the first coverage level at your next enrollment.
- **Beneficiary:** You (the member) are always the beneficiary of this policy.
- **Automatic extension:** Coverage for dependents continues free of charge for five months if you pass away.
- **Dual coverage:** If both you and your spouse work at Kimball International, you can each elect dependent life coverage.
- **Taxes:** IRS rules require you to pay taxes on the value of this benefit.
- **Evidence of Insurability (EOI):** Is required if you enroll your spouse and have previously waived coverage. During annual enrollment, new entrants and current participants can elect or increase by one level of coverage without EOI.

2027 DEPENDENT LIFE COSTS	WEEKLY PAYCHECK COSTS	BIWEEKLY PAYCHECK COSTS
$10,000/$5,000	$0.71	$1.42
$20,000/$10,000	$1.57	$3.14
$30,000/$10,000	$2.11	$4.23

AD&D INSURANCE

ACCIDENTAL DEATH AND DISMEMBERMENT (AD&D) INSURANCE

Kimball International provides $25,000 in basic AD&D coverage at no cost to you. If you become injured, benefits are paid directly to you. If you pass away, benefits are paid to your beneficiary. This benefit is administered by MetLife.

Supplemental Coverage — You can buy extra coverage of $25,000, $50,000, $100,000, $150,000, $200,000, or $250,000.

Policy Highlights

- **Seat Belt Benefit:** If death occurs in an automobile accident while wearing a seat belt, an extra benefit equal to the AD&D coverage amount ($25,000) is paid.
- **Air Bag Benefit:** If death occurs in an airbag-equipped vehicle (with proper seat belt use), an additional benefit up to $5,000 is paid.
- **Education Benefit:** Provides 6% of your benefit (up to $6,000/year, max $24,000) to help with a dependent child's college education.
- **Exclusions:** Coverage does not apply to death caused by voluntary use of alcohol, drugs, or chemicals unless prescribed or directed by a physician.

You can view the details of this policy in MyADP within Benefits under Plan Forms and Documents.

DON'T FORGET: Be sure to keep your beneficiary information up to date in MyADP. You'll need to make two beneficiary designations if you choose both basic and supplemental AD&D.

2027 SUPPLEMENTAL AD&D COSTS	WEEKLY PAYCHECK COSTS	BIWEEKLY PAYCHECK COSTS
$25,000	$0.12	$0.23
$50,000	$0.23	$0.46
$100,000	$0.46	$0.92
$150,000	$0.69	$1.38
$200,000	$0.92	$1.85
$250,000	$1.15	$2.31

SUPPLEMENTAL PLAN OPTIONS

ACCIDENT INSURANCE

Accidents happen when you least expect them. Accident insurance helps protect you and your family by providing a cash benefit to help cover costs from an injury. This coverage is offered on a **post-tax basis**. This benefit is administered by MetLife.

Who Can Enroll

- Active members
- Spouses—members must enroll in coverage to include their spouse.
- Children under age 26—members must enroll in coverage to include child(ren).

Policy Highlights

- Portable coverage—you can keep it if you change jobs or retire (with certain conditions).
- Cash benefits—paid directly to you for both inpatient and outpatient accident care.

NOTE: Please be sure to designate a beneficiary.

What's Covered

- Major injuries: fractures, dislocations
- Specific injuries: lacerations, ruptured disc, tendon/ligament injuries, torn knee cartilage, concussion, emergency dental care
- Burns: second- and third-degree

Additional Benefits:

- Daily hospital confinement
- Emergency room care
- Blood/plasma
- Physical therapy
- Follow-up accident treatment
- Exploratory surgery (without repair)
- Medical appliances
- Transportation
- Family member lodging

2027 ACCIDENT INSURANCE COSTS	WEEKLY PAYCHECK COSTS	BIWEEKLY PAYCHECK COSTS
Employee	$0.91	$1.82
Employee + Spouse	$1.45	$2.90
Employee + Child(ren)	$1.49	$2.98
Employee + Family	$2.36	$4.72

SUPPLEMENTAL PLAN OPTIONS

GROUP CRITICAL ILLNESS

A serious illness can bring unexpected medical and financial stress. Critical illness insurance helps by paying you a lump-sum cash benefit if you're diagnosed with a covered condition—money you can use for co-pays, deductibles, or even everyday expenses. This benefit is administered by MetLife.

Who Can Enroll

- Members
- Spouses (member must be enrolled and is automatically covered for up to 50% of the member's coverage amount at no extra cost)
- Children under 26 (automatically covered for up to 50% of the member's coverage amount at no extra cost)

Policy Highlights

- $10,000 guaranteed coverage for members—no medical questions required.
- Family coverage available—spouses and dependents can be covered up to 50% of the member's benefit amount.
- Portable coverage—take it with you if you change jobs or retire (with certain conditions).
- $50 per year/per covered member when completing an approved health screening.
- Direct payments—benefits are paid to you (unless you assign them).
- Quick claims—lump-sum payments are made fast, tax-free.

NOTE: Please be sure to designate a beneficiary.

What's Covered

- Cancer
- Heart attack (myocardial infarction)
- Stroke
- Kidney failure (end-stage renal failure)
- Major organ transplant
- Bone marrow/stem cell transplant
- Sudden cardiac arrest
- Coronary artery bypass surgery
- Non-invasive cancer
- Skin cancer
- Coma
- Paralysis
- Loss of sight, hearing, or speech

CRITICAL ILLNESS COSTS

Rates will increase due to a change in age. Rates will not change due to changes in health status or individual claims. Rates below reflect $10,000 of coverage.

	WEEKLY PAYCHECK COSTS			
Age	EMPLOYEE ONLY	EMPLOYEE + SPOUSE	EMPLOYEE + CHILD(REN)	EMPLOYEE + FAMILY
18–24	$0.44	$0.67	$0.62	$0.88
25–29	$0.55	$0.83	$0.72	$1.02
30–34	$0.62	$0.95	$0.78	$1.13
35–39	$0.83	$1.25	$1.02	$1.45
40–44	$1.18	$1.78	$1.36	$1.98
45–49	$1.82	$2.75	$1.98	$2.95
50–54	$2.58	$3.95	$2.77	$4.15
55–59	$3.65	$5.63	$3.83	$5.82
60–64	$5.19	$8.01	$5.35	$8.19
65–69	$7.02	$10.80	$7.18	$10.98
70–74	$9.37	$14.45	$9.55	$14.63
75–79	$12.58	$19.29	$12.74	$19.50
80–84	$14.52	$22.27	$14.70	$22.45

	BIWEEKLY PAYCHECK COSTS			
Age	EMPLOYEE ONLY	EMPLOYEE + SPOUSE	EMPLOYEE + CHILD(REN)	EMPLOYEE + FAMILY
	$0.88	$1.34	$1.25	$1.75
25–29	$1.11	$1.66	$1.43	$2.03
30–34	$1.25	$1.89	$1.57	$2.26
35–39	$1.66	$2.49	$2.03	$2.91
40–44	$2.35	$3.55	$2.72	$3.97
45–49	$3.65	$5.49	$3.97	$5.91
50–54	$5.17	$7.89	$5.54	$8.31
55–59	$7.29	$11.26	$7.66	$11.63
60–64	$10.38	$16.02	$10.71	$16.38
65–69	$14.03	$21.60	$14.35	$21.97
70–74	$18.74	$28.89	$19.11	$29.26
75–79	$25.15	$38.58	$25.48	$39.00
80–84	$29.03	$44.54	$29.40	$44.91

HOSPITAL INDEMNITY

HOSPITAL INDEMNITY

Hospital stays—whether from an illness, pregnancy, or accident—can come with unexpected costs. Hospital indemnity insurance helps by paying you a cash benefit that you can use however you need. This benefit is administered by MetLife.

Who Can Enroll:

- Members
- Spouses (member must be enrolled)
- Children under 26 (member must be enrolled)

Policy Highlights:

- Portable coverage—take it with you if you change jobs or retire (with some conditions).
- Covers both illness and injury—including pregnancy.
- Pays in addition to other insurance—benefits are yours regardless of other coverage.
- No pre-existing condition limitations—coverage starts right away.

NOTE: Please be sure to designate a beneficiary.

BENEFITS	BENEFIT AMOUNT
Hospital Admission (per admission; up to 4 admissions per covered sickness per calendar year for each insured)	$1,000
Hospital Confinement (per day; max of 31 days per confinement for each covered sickness or accident for each insured)	$100
Hospital Intensive Care (per day; max of 31 days per confinement for each covered sickness or accident for each insured)	$200

HOSPITAL INDEMNITY COSTS	WEEKLY PAYCHECK COSTS	BIWEEKLY PAYCHECK COSTS
Employee	$2.35	$4.70
Employee + Spouse	$4.90	$9.79
Employee + Child(ren)	$3.62	$7.24
Employee + Family	$6.33	$12.67

RETIREMENT PLANNING

YOU SAVE TODAY, SECURE TOMORROW: YOUR 401(K) PLAN

Planning for the future starts now—and your 401(k) plan through Fidelity makes it easy to save for retirement while getting extra support from the company.

How it Works

- You choose how much to contribute to your 401(k) each paycheck through Fidelity.
- Contributions are made before taxes, helping lower your taxable income.
- You can also contribute after-tax with Roth contributions for tax-free withdrawals in retirement.

Company Match—Free Money for Your Future

To help grow your savings, the company matches **dollar for dollar up to 2% of your pay**.
That means if you contribute 2%, the company will contribute an additional 2%.

Example:

- You earn $30,000 annually.
- You contribute 2% ($600).
- The company adds another 2% ($600).
- Total annual contribution to your retirement account = **$1,200**.

Why Enroll?

- **Boost your savings faster** with the company match.
- **Tax advantages now** (traditional 401k) or later (Roth 401k).
- **Convenient payroll deductions** make saving automatic.
- **Your money is yours**—and your account grows with investment earnings over time.

Take Action

Log into my401k.com or access Netbenefits.com to set your contribution percentage, designate or update your beneficiary, and start building your financial future today. **Remember: contributing at least 2% ensures you get the full company match—don't leave free money on the table!**

CONTACTS

Benefit plan details are in MyADP within Benefits under Plan Forms and Documents. If you need help accessing this information, have questions, or want a print copy of any Benefits content, contact the **MCR Service Center at 800-481-6123, option 2** or email **MCRServiceCenter@kimballinternational.com**.

Benefit	Carrier	Phone Number	Website
Medical	Anthem Blue Cross Blue Shield Group #213039	888-523-5918	Anthem.com
Prescription Drugs	Northwind Health Group # VRX0466	866-331-6161	northwindhealth.com/kimball
Health Savings Accounts (HSA)	Anthem Health Savings Account	888-523-5918	Anthem.com
Kimball International Health Centers	CareATC	812-772-4485	patients.careatc.com
Dental	Delta Dental of Indiana Group #0154	800-524-0149	Deltadentalin.com
Vision	VSP Group # 40168654	800-877-7195	vsp.com
Short-Term Disability	MetLife Policy #281325-1-G	800-300-4296	metlife.com
Long-Term Disability	MetLife Policy # 281325-1-G	800-300-4296	metlife.com
Life Insurance and AD&D	MetLife Policy # 281325-1-G	800-523-2894	metlife.com
Supplemental Accident, Critical Illness & Hospital Indemnity Insurance	MetLife Policy #281325-1-G	800-438-6388	metlife.com
401k	Fidelity	800-835-5091	401k.com
Employee Assistance Program	Compsych	866-899-1367	guidanceresources.com

HEALTH COVERAGE NOTICES

This guide contains legal notices for participants in group health plan(s) sponsored by Kimball International.

THE NOTICES INCLUDED IN THIS GUIDE ARE:

- Premium Assistance Under Medicaid and the Children's Health Insurance Program (CHIP)
- Health Insurance Marketplace Coverage Options and Your Health Coverage that describes the Health Insurance Marketplace and eligibility and tax credit information.
- Notice of Privacy Practices that explains how the health care plan(s) protect your personal medical information.
- Medicare Part D Notice that provides information about how your current prescription drug coverage under the health care plan(s) is affected—and your options for coverage—when you become eligible for Medicare
- COBRA Rights Notice that explains when you and your family may be able to temporarily continue coverage under the health care plan(s) if coverage would otherwise end for you.
- 60-Day Special Enrollment Period that describes a special 60-day timeframe to elect or discontinue coverage.
- Notice of Special Enrollment Rights that explains when you can enroll in the health care plan(s) due to special circumstances.
- Newborn & Mothers Health Protection Notice that describes federal laws that govern benefits for hospital stays for mothers following the birth of child.
- Women's Health and Cancer Rights Act that summarizes the benefits available under your medical plan if you have had or are going to have a mastectomy.
- Your Rights and Protections Against Surprise Medical Bills

IMPORTANT: If you or your dependents have Medicare or will become eligible for Medicare in the next 12 months, the Medicare Prescription Drug program gives you more choices about your prescription drug coverage. Please see pages below for more details.

CHIP Notice

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

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

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

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

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

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of July 31, 2026. Contact your State for more information on eligibility –

State	Website	Phone
Alabama (Medicaid)	http://www.myalhipp.com/	1-855-692-5447
Alaska (Medicaid)	The AK Health Insurance Premium Payment Program: myakhipp.com Email: customerservice@myakhipp.com Medicaid Eligibility: health.alaska.gov/dpa/Pages/default.aspx	1-866-251-4861
Arkansas (Medicaid)	http://myarhipp.com/	1-855-692-7447
California (Medicaid)	HIPP Website: www.dhcs.ca.gov/services/health-insurance-premium-payment-program-cost-avoidance/ Email: hipp@dhcs.ca.gov	Phone: 916-445-8322 Fax: 916-440-5676
Colorado Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)	Health First Colorado Website: healthfirstcolorado.com CHP+: hcpf.colorado.gov/child-health-plan-plus Health Insurance Buy-In Program (HIBI): mycohibi.com	Health First Colorado: 800-221-3943 Relay 711 CHP+: 800-359-1991 Relay 711 HIBI: 855-692-6442
Florida (Medicaid)	https://www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html	1-877-357-3268

CHIP Notice *(cont.)*

State	Website	Phone
Georgia (Medicaid)	**GA HIPP: medicaid.georgia.gov/health-insurance-premium-payment- program-hipp** **GA CHIPRA: medicaid.georgia.gov/programs/third-party-liability/childrens-health-insurance-program-reauthorization-act-2009-chipra**	**GA HIPP: 678-564-1162, press 1** **GA CHIPRA: 678-564-1162, press 2**
Illinois Medicaid	**Illinois Medicaid Premium Assistance Information Medicaid applicaiton website: abe.illinois.gov** **HIPP Email: mhfs.boc.hipp@illinois.gov**	**217-524-8268**
Indiana (Medicaid)	HIPP: https://www.in.gov/fssa/dfr/ All other Medicaid: in.gov/medicaid	Family & Social Services: 800-403-0864 Member Services: 800-457-4584
Iowa Medicaid and CHIP (Hawki)	Medicaid: hhs.iowa.gov/programs/welcome-iowa-medicaid Hawki: hhs.iowa.gov/programs/welcome-iowa-medicaid/iowa-health-link/hawki HIPP: hhs.iowa.gov/programs/welcome-iowa-medicaid/fee-service/hipp	Medicaid: 800-338-8366 Hawki: 800-257-8563 HIPP: 888-346-9562
Kansas (Medicaid)	https://www.kancare.ks.gov/	Medicaid: 800-792-4884 HIPP: 800-967-4660
Kentucky (Medicaid and CHIP)	KI-HIPP: chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx KI-HIPP Email: KIHIPP.PROGRAM@ky.gov KCHIP: kynect.ky.gov Medicaid: chfs.ky.gov/agencies/dms	KI-HIPP: 855-459-6328 KCHIP: 877-524-4718
Louisiana (Medicaid)	Medicaid website: ldh.la.gov/healthy-louisiana Medicaid email: healthy@la.gov LaHIPP website: www.ldh.la.gov/lahipp LaHIPP email: La.HIPP@la.gov LaHIPP Mailing Address: 100 Crescent Centre Parkway, Suite 1000, Tucker, GA 30084	Medicaid: 888-342-6207 LaHIPP Phone: 877-697-6703 LaHIPP Fax: 888-716-9787
Maine (Medicaid)	Enrollment: www.mymaineconnection.gov/benefits/s/?language=en_US Private health insurance premium: maine.gov/dhhs/ofi/applications-forms	Enroll: 800-442-6003 Private HIP: 800-977-6740 TTY: Maine Relay: 711
Massachusetts (Medicaid and CHIP)	https://www.mass.gov/masshealth/pa Email: masspremassistance@accenture.com	1-800-862-4840 TTY: 711
Minnesota (Medicaid)	https://mn.gov/dhs/health-care-coverage/	1-800-657-3672
Missouri (Medicaid)	http://www.dss.mo.gov/mhd/participants/pages/hipp.htm	573-751-2005
Montana (Medicaid)	Website: dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Email: HHSHIPPProgram@mt.gov	1-800-694-3084
Nebraska (Medicaid)	http://www.ACCESSNebraska.ne.gov	1-855-632-7633 Lincoln: 402-473-7000 Omaha: 402-595-1178
Nevada (Medicaid)	http://dhcfp.nv.gov/	1-800-992-0900
New Hampshire (Medicaid)	https://www.dhhs.nh.gov/programs-services/medicaid/health-insurance-premium-program Email:DHHS.ThirdPartyLiabi@dhhs.nh.gov	Phone: 603-271-5218 Toll Free HIPP: 800-852-3345, ext. 15218
New Jersey (Medicaid and CHIP)	Medicaid: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ CHIP: http://www.njfamilycare.org/index.html	Medicaid: 800-356-1561 CHIP Premium Assist: 609-631-2392 CHIP: 800-701-0710 TTY: 711
New York (Medicaid)	https://www.health.ny.gov/health_care/medicaid/	1-800-541-2831
North Carolina (Medicaid)	https://medicaid.ncdhhs.gov/	919-855-4100
North Dakota (Medicaid)	https://www.hhs.nd.gov/healthcare	1-844-854-4825
Oklahoma (Medicaid and CHIP)	http://www.insureoklahoma.org	1-888-365-3742

CHIP Notice (cont.)

State	Website	Phone
Oregon (Medicaid)	http://healthcare.oregon.gov/Pages/index.aspx	1-800-699-9075
Pennsylvania (Medicaid and CHIP)	Medicaid: https://www.pa.gov/en/services/dhs/apply-for-medicaid-health-insurance-premium-payment-program-hipp.html CHIP: https://www.pa.gov/en/agencies/dhs/resources/chip.html	Medicaid: 1-800-692-7462 CHIP: 1-800-986-KIDS (5437)
Rhode Island (Medicaid and CHIP)	http://www.eohhs.ri.gov/	1-855-697-4347 or 401-462-0311 (Direct Rite Share Line)
South Carolina (Medicaid)	https://www.scdhhs.gov	1-888-549-0820
South Dakota (Medicaid)	http://dss.sd.gov	1-888-828-0059
Texas (Medicaid)	https://www.hhs.texas.gov/services/financial/health-insurance-premium-payment-hipp-program	1-800-440-0493
Utah (Medicaid and CHIP)	UPP Website: medicaid.utah.gov/upp/ UPP Email: upp@utah.gov Adult Expansion Website: medicaid.utah.gov/expansion/ Utah Medicaid Buyout Program Website: medicaid.utah.gov/buyout-program/ CHIP: chip.utah.gov	UPP: 877-222-2542
Vermont (Medicaid)	https://dvha.vermont.gov/members/medicaid/hipp-program	1-800-250-8427
Virginia (Medicaid and CHIP)	Website: coverva.dmas.virginia.gov/learn/premium-assistance/famis-select HIPP Website: coverva.dmas.virginia.gov/learn/premium-assistance/health-insurance-premium-payment-hipp-programs	Medicaid/CHIP: 800-432-5924
Washington (Medicaid)	https://www.hca.wa.gov/	1-800-562-3022
West Virginia (Medicaid)	bms.wv.gov/mywvhipp.com/	Medicaid: 304-558-1700 CHIP: 855-MyWVHIPP (855-699-8447)
Wisconsin (Medicaid and CHIP)	https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm	1-800-362-3002
Wyoming (Medicaid)	https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/	1-800-251-1269

To see if any other states have added a premium assistance program since January 31, 2026, 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.

Health Insurance Marketplace Coverage Options and Your Health Coverage

PART A: General Information

Even if you are offered health coverage through your employment, you may have other coverage options through the Health Insurance Marketplace ("Marketplace"). To assist you as you evaluate options for you and your family, this notice provides some basic information about the Health Insurance Marketplace and health coverage offered through your employment.

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 in your geographic area.

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

You may qualify to save money and lower your monthly premium and other out-of-pocket costs, but only if your employer does not offer coverage, or offers coverage that is not considered affordable for you and doesn't meet certain minimum value standards (discussed below). The savings that you're eligible for depends on your household income. You may also be eligible for a tax credit that lowers your costs.

Does Employment-Based Health Coverage Affect Eligibility for Premium Savings through the Marketplace?

Yes. If you have an offer of health coverage from your employer that is considered affordable for you and meets certain minimum value standards, you will not be eligible for a tax credit, or advance payment of the tax credit, for your Marketplace coverage and may wish to enroll in your employment-based health plan. However, you may be eligible for a tax credit, and advance payments of the 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 is considered affordable for you or meet minimum value standards. If your share of the premium cost of all plans offered to you through your employment is more than 10.22%1 of your annual household income, or if the coverage through your employment does not meet the "minimum value" standard set by the Affordable Care Act, you may be eligible for a tax credit, and advance payment of the credit, if you do not enroll in the employment-based health coverage. For family members of the employee, coverage is considered affordable if the employee's cost of premiums for the lowest-cost plan that would cover all family members does not exceed 10.22% of the employee's household income.1 2

Note: If you purchase a health plan through the Marketplace instead of accepting health coverage offered through your employment, then you may lose access to whatever the employer contributes to the employment-based coverage. Also, this employer contribution -as well as your employee contribution to employment-based coverage- is generally excluded from income for federal and state income tax purposes. Your payments for coverage through the Marketplace are made on an after-tax basis. In addition, note that if the health coverage offered through your employment does not meet the affordability or minimum value standards, but you accept that coverage anyway, you will not be eligible for a tax credit. You should consider all of these factors in determining whether to purchase a health plan through the Marketplace.

When Can I Enroll in Health Insurance Coverage through the Marketplace?

You can enroll in a Marketplace health insurance plan during the annual Marketplace Open Enrollment Period. Open Enrollment varies by state but generally starts November 1 and continues through at least December 15.

Outside the annual Open Enrollment Period, you can sign up for health insurance if you qualify for a Special Enrollment Period. In general, you qualify for a Special Enrollment Period if you've had certain qualifying life events, such as getting married, having a baby, adopting a child, or losing eligibility for other health coverage. Depending on your Special Enrollment Period type, you may have 60 days before or 60 days following the qualifying life event to enroll in a Marketplace plan.

There is also a Marketplace Special Enrollment Period for individuals and their families who lose eligibility for Medicaid or Children's Health Insurance Program (CHIP) coverage on or after March 31, 2023, through July 31, 2024. Since the onset of the nationwide COVID-19 public health emergency, state Medicaid and CHIP agencies generally have not terminated the enrollment of any Medicaid or CHIP beneficiary who was enrolled on or after March 18, 2020, through March 31, 2023. As state Medicaid and CHIP agencies resume regular eligibility and enrollment practices, many individuals may no longer be eligible for Medicaid or CHIP coverage starting as early as March 31, 2023. The U.S. Department of Health and Human Services is offering a temporary Marketplace Special Enrollment period to allow these individuals to enroll in Marketplace coverage. In addition, if you or your family members are enrolled in Medicaid or CHIP coverage, it is important to make sure that your contact information is up to date to make sure you get any information about changes to your eligibility.

To learn more, visit HealthCare.gov or call the Marketplace Call Center at 1-800-318-2596. TTY users can call 1-855-889-4325.

What about Alternatives to Marketplace Health Insurance Coverage?

If you or your family are eligible for coverage in an employment-based health plan (such as an employer-sponsored health plan), you or your family may also be eligible for a Special Enrollment Period to enroll in that health plan in certain circumstances, including if you or your dependents were enrolled in Medicaid or CHIP coverage and lost that coverage. Generally, you have 60 days after the loss of Medicaid or CHIP coverage to enroll in an employment-based health plan, but if you and your family lost eligibility for Medicaid or CHIP coverage between March 31, 2023 and July 10, 2023, you can request this special enrollment in the employment-based health plan through September 8, 2023. Confirm the deadline with your employer or your employment-based health plan.

Alternatively, you can enroll in Medicaid or CHIP coverage at any time by filling out an application through the Marketplace or applying directly through your state Medicaid agency. Visit healthcare.gov/medicaid-chip/getting-medicaid-chip for more details.

How Can I Get More Information?

For more information about your coverage offered through your employment, please check your health plan's summary plan description or contact the MCR Service Center at 800-481-6123. 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.

1. Indexed annually; see irs.gov/pub/irs-drop/rp-22-34.pdf for 2023.

2. An employer-sponsored or other employment-based health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60% of such costs. For purposes of eligibility for the premium tax credit, to meet the "minimum value standard," the health plan must also provide substantial coverage of both inpatient hospital services and physician services.

Kimball International, Inc. Master Welfare Benefits Plan Notice Of Privacy Practices

This notice describes how medical information about you may be used and disclosed, and how you can get access to this information. Please review it carefully.

OUR COMPANY'S PLEDGE TO YOU

This notice is intended to inform you of the privacy practices followed by the Kimball International, Inc. Master Welfare Benefits Plan (the Plan) and the Plan's legal obligations regarding your protected health information under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). The notice also explains the privacy rights you and your family members have as participants of the Plan. It is effective on 10/1/2026.

The Plan often needs access to your protected health information in order to provide payment for health services and perform plan administrative functions. We want to assure the participants covered under the Plan that we comply with federal privacy laws and respect your right to privacy. Kimball International requires all members of our workforce and third parties that are provided access to protected health information to comply with the privacy practices outlined below.

Protected Health Information

Your protected health information is protected by the HIPAA Privacy Rule. Generally, protected health information is information that identifies an individual created or received by a health care provider, health plan or an employer on behalf of a group health plan that relates to physical or mental health conditions, provision of health care, or payment for health care, whether past, present or future.

How We May Use Your Protected Health Information

Under the HIPAA Privacy Rule, we may use or disclose your protected health information for certain purposes without your permission. This section describes the ways we can use and disclose your protected health information.

Payment. We use or disclose your protected health information without your written authorization in order to determine eligibility for benefits, seek reimbursement from a third party, or coordinate benefits with another health plan under which you are covered. For example, a health care provider that provided treatment to you will provide us with your health information. We use that information in order to determine whether those services are eligible for payment under our group health plan.

Health Care Operations. We use and disclose your protected health information in order to perform plan administration functions such as quality assurance activities, resolution of internal grievances, and evaluating plan performance. For example, we review claims experience in order to understand participant utilization and to make plan design changes that are intended to control health care costs.

However, we are prohibited from using or disclosing protected health information that is genetic information for our underwriting purposes.

Treatment. Although the law allows use and disclosure of your protected health information for purposes of treatment, as a health plan we generally do not need to disclose your information for treatment purposes. Your physician or health care provider is required to provide you with an explanation of how they use and share your health information for purposes of treatment, payment, and health care operations.

As permitted or Required by Law. We may also use or disclose your protected health information without your written authorization for other reasons as permitted by law. We are permitted by law to share information, subject to certain

KII Master Welfare Benefits Plan *(cont.)*

requirements, in order to communicate information on health-related benefits or services that may be of interest to you, respond to a court order, or provide information to further public health activities (e.g., preventing the spread of disease) without your written authorization. We are also permitted to share protected health information during a corporate restructuring such as a merger, sale, or acquisition. We will also disclose health information about you when required by law, for example, in order to prevent serious harm to you or others.

Pursuant to Your Authorization. When required by law, we will ask for your written authorization before using or disclosing your protected health information. Uses and disclosures not described in this notice will only be made with your written authorization. Subject to some limited exceptions, your written authorization is required for the sale of protected health information and for the use or disclosure of protected health information for marketing purposes. If you choose to sign an authorization to disclose information, you can later revoke that authorization to prevent any future uses or disclosures.

To Business Associates. We may enter into contracts with entities known as Business Associates that provide services to or perform functions on behalf of the Plan. We may disclose protected health information to Business Associates once they have agreed in writing to safeguard the protected health information. For example, we may disclose your protected health information to a Business Associate to administer claims. Business Associates are also required by law to protect protected health information.

To the Plan Sponsor. We may disclose protected health information to certain employees of Kimball International for the purpose of administering the Plan. These employees will use or disclose the protected health information only as necessary to perform plan administration functions or as otherwise required by HIPAA, unless you have authorized additional disclosures. Your protected health information cannot be used for employment purposes without your specific authorization.

Your Rights

Right to Inspect and Copy. In most cases, you have the right to inspect and copy the protected health information we maintain about you. If you request copies, we will charge you a reasonable fee to cover the costs of copying, mailing, or other expenses associated with your request. Your request to inspect or review your health information must be submitted in writing to the person listed below. In some circumstances, we may deny your request to inspect and copy your health information. To the extent your information is held in an electronic health record, you may be able to receive the information in an electronic format.

Right to Amend. If you believe that information within your records is incorrect or if important information is missing, you have the right to request that we correct the existing information or add the missing information. Your request to amend your health information must be submitted in writing to the person listed below. In some circumstances, we may deny your request to amend your health information. If we deny your request, you may file a statement of disagreement with us for inclusion in any future disclosures of the disputed information.

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

Your request for an accounting must be submitted in writing to the person listed below. You may request an accounting of disclosures made within the last six years. You may request one accounting free of charge within a 12-month period.

Right to Request Restrictions. You have the right to request that we not use or disclose information for treatment, payment, or other administrative purposes except when specifically authorized by you, when required by law, or in emergency circumstances. You also have the right to request that we limit the protected health information that we disclose to someone involved in your care or the payment for your care, such as a family member or friend. Your request for restrictions must be submitted in writing to the person listed below. We will consider your request, but in most cases are not legally obligated to agree to those restrictions.

KII Master Welfare Benefits Plan *(cont.)*

Right to Request Confidential Communications. You have the right to receive confidential communications containing your health information. Your request for restrictions must be submitted in writing to the person listed below. We are required to accommodate reasonable requests. For example, you may ask that we contact you at your place of employment or send communications regarding treatment to an alternate address.

Right to be Notified of a Breach. You have the right to be notified in the event that we (or one of our Business Associates) discover a breach of your unsecured protected health information. Notice of any such breach will be made in accordance with federal requirements.

Right to Receive a Paper Copy of this Notice. If you have agreed to accept this notice electronically, you also have a right to obtain a paper copy of this notice from us upon request. To obtain a paper copy of this notice, please contact the person listed below.

Our Legal Responsibilities

We are required by law to maintain the privacy of your protected health information, provide you with this notice about our legal duties and privacy practices with respect to protected health information and notify affected individuals following a breach of unsecured protected health information.

We may change our policies at any time and reserve the right to make the change effective for all protective health information that we maintain. In the event that we make a significant change in our policies, we will provide you with a revised copy of this notice. You can also request a copy of our notice at any time. For more information about our privacy practices, contact the person listed below.

If you have any questions or complaints, please contact:

Louise Rickelman

Kimball International

1600 Royal Street, Jasper, Indiana 47546

812-482-1600

Complaints

If you are concerned that we have violated your privacy rights, or you disagree with a decision we made about access to your records, you may contact the person listed above. You also may send a written complaint to the U.S. Department of Health and Human Services — Office of Civil Rights. The person listed above can provide you with the appropriate address upon request or you may visit www.hhs.gov/ocr for further information. You will not be penalized or retaliated against for filing a complaint with the Office of Civil Rights or with us.

Important Notice From KII About Your Prescription Drug Coverage & Medicare

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with Kimball International 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. Kimball International has determined that the prescription drug coverage offered by Kimball International plan 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 15th to December 7th.

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 Kimball International coverage will not be affected. If you do decide to join a Medicare drug plan and drop your current Kimball International 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 Kimball International and don't 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.

Prescription Drug Coverage & Medicare *(cont.)*

For More Information About This Notice Or Your Current Prescription Drug Coverage...

Contact the person listed below 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 Kimball International changes. You also may request a copy of this notice at any time.

For More Information About Your Options Under Medicare Prescription Drug Coverage...

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

For more information about Medicare Prescription drug coverage:

- Visit www.medicare.gov
- Call your State Health Insurance Assistance Program (see the inside back cover of your copy of "Medicare & You" handbook for their telephone number) for personalized help
- Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

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

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

Date: 10/1/2026

Name of Entity/Sender: Kimball International
Contact/Office: MCR Service Center
Address: 1600 Royal Street, Jasper, Indiana 47546
Phone Number: 812-481-6123, option 2

COBRA Rights Notice

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

The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to you and other members of your family when group health coverage would otherwise end. For more information about your rights and obligations under the Plan and under federal law, you should review the Plan's Summary Plan Description or contact the Plan Administrator.

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

WHAT IS COBRA CONTINUATION COVERAGE?

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

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

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

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

- Your spouse dies;
- Your spouse's hours of employment are reduced;
- Your spouse's employment ends for any reason other than his or her gross misconduct;
- Your spouse becomes entitled to Medicare benefits (under Part A, Part B, or both); or
- You become divorced or legally separated from your spouse.

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

- The parent-employee dies;
- The parent-employee's hours of employment are reduced;
- The parent-employee's employment ends for any reason other than his or her gross misconduct;
- The parent-employee becomes entitled to Medicare benefits (Part A, Part B, or both);
- The parents become divorced or legally separated; or
- The child stops being eligible for coverage under the Plan as a "dependent child."

COBRA Rights *(cont.)*

When Is COBRA Coverage Available?

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

- The end of employment or reduction of hours of employment;
- Death of the employee;
- The employee's becoming entitled to Medicare benefits (under Part A, Part B, or both).

For all other qualifying events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), you must notify the Plan Administrator within 60 days after the qualifying event occurs. You must provide this notice to the MCR Service Center.

HOW IS COBRA CONTINUATION COVERAGE PROVIDED?

Once the Plan Administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered employees may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation coverage on behalf of their children.

COBRA continuation coverage is a temporary continuation of coverage that generally lasts for 18 months due to employment termination or reduction of hours of work. Certain qualifying events, or a second qualifying event during the initial period of coverage, may permit a beneficiary to receive a maximum of 36 months of coverage. There are also ways in which this 18-month period of COBRA continuation coverage can be extended:

Disability Extension of 18-Month Period of Continuation Coverage

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

Second Qualifying Event Extension of 18-Month Period of Continuation Coverage

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

ARE THERE OTHER COVERAGE OPTIONS BESIDES COBRA CONTINUATION COVERAGE?

Yes. Instead of enrolling in COBRA continuation coverage, there may be other coverage options for you and your family through the Health Insurance Marketplace, Medicaid, or other group health plan coverage options (such as a spouse's plan) through what is called a "special enrollment period." Some of these options may cost less than COBRA continuation coverage. You can learn more about many of these options at www.healthcare.gov.

COBRA Rights *(cont.)*

IF YOU HAVE QUESTIONS

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

KEEP YOUR PLAN INFORMED OF ADDRESS CHANGES

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

For More Information About Your Options Under Medicare Prescription Drug Coverage...

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

For more information about Medicare Prescription drug coverage:

- Visit www.medicare.gov.
- Call your State Health Insurance Assistance Program (see the inside back cover of your copy of "Medicare & You" handbook for their telephone number) for personalized help
- Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

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

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

Date: 10/1/2026
Name of Entity/Sender: Kimball International
Contact/Office: MCR Service Center
Address: 1600 Royal Street, Jasper, Indiana 47546
Phone Number: 812-481-6123, option 2

Other Notices

60-DAY SPECIAL ENROLLMENT PERIOD

In addition to the qualifying events listed in the enrollment guide, you and your dependents will have a special 60-day period to elect or discontinue coverage if:

- You or your dependent's Medicaid or Children's Health Insurance Program (CHIP) coverage is terminated as a result of loss of eligibility; or
- You or your dependent becomes eligible for a premium assistance subsidy under Medicaid or CHIP.

NOTICE OF SPECIAL ENROLLMENT RIGHTS

If you decline enrollment in medical coverage for yourself or your dependents (including your spouse) because of other health insurance coverage, you may be able to enroll yourself or your dependents in Kimball International medical coverage if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing toward your or your dependents' other coverage). However, you must request enrollment no more than 60 days after your or your dependent's other coverage ends (or after the employer stops contributing to the other coverage). In addition, if you have a new dependent as a result of marriage, birth, adoption or placement for adoption, you can enroll yourself and your dependents in Kimball International medical coverage as long as you request enrollment by contacting the benefits manager no more than 60 days after the marriage, birth, adoption or placement for adoption. For more information, contact Kimball International, MCR Service Center at 812-481-6123, option 2.

NEWBORN & MOTHERS HEALTH PROTECTION NOTICE

For maternity hospital stays, in accordance with federal law, the Plan does not restrict benefits, for any hospital length of stay in connection with childbirth for the mother or newborn child, to less than 48 hours following a vaginal delivery or less than 96 hours following a Cesarean delivery.

However, federal law generally does not prevent the mother's or newborn's attending care provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours, as applicable).
The plan cannot require a provider to prescribe a length of stay any shorter than 48 hours (or 96 hours following a Cesarean delivery).

WOMEN'S HEALTH AND CANCER RIGHTS ACT OF 1998

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

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

These benefits will be provided subject to the same deductibles, copays and coinsurance applicable to other medical and surgical benefits provided under your medical plan. For more information on WHCRA benefits, contact your medical plan administrator.

YOUR RIGHTS AND PROTECTIONS AGAINST SURPRISE MEDICAL BILLS

When you get emergency care or get treated by an out-of-network provider at an in-network hospital or ambulatory surgical center, you are protected from surprise billing or balance billing.

What is "balance billing" (sometimes called "surprise billing")?

When you see a doctor or other health care provider, you may owe certain out-of-pocket costs, such as a copayment, coinsurance, and/or a deductible. You may have other costs or have to pay the entire bill if you see a provider or visit a health care facility that isn't in your health plan's network.

"Out-of-network" describes providers and facilities that haven't signed a contract with your health plan. Out-of-network providers may be permitted to bill you for the difference between what your plan agreed to pay and the full amount charged for a service. This is called "balance billing." This amount is likely more than in-network costs for the same service and might not count toward your annual out-of-pocket limit.

"Surprise billing" is an unexpected balance bill. This can happen when you can't control who is involved in your care—like when you have an emergency or when you schedule a visit at an in-network facility but are unexpectedly treated by an out-of-network provider.

YOU ARE PROTECTED FROM BALANCE BILLING FOR:

Emergency services

If you have an emergency medical condition and get emergency services from an out-of-network provider or facility, the most the provider or facility may bill you is your plan's in-network cost-sharing amount (such as copayments and coinsurance). You can't be balance billed for these emergency services. This includes services you may get after you're in stable condition, unless you give written consent and give up your protections not to be balanced billed for these post-stabilization services.

Certain services at an in-network hospital or ambulatory surgical center

When you get services from an in-network hospital or ambulatory surgical center, certain providers there may be out-of-network. In these cases, the most those providers may bill you is your plan's in-network cost-sharing amount. This applies to emergency medicine, anesthesia, pathology, radiology, laboratory, neonatology, assistant surgeon, hospitalist, or intensivist services. These providers can't balance bill you and may not ask you to give up your protections not to be balance billed.

If you get other services at these in-network facilities, out-of-network providers can't balance bill you, unless you give written consent and give up your protections.

You're never required to give up your protections from balance billing. You also aren't required to get care out-of- network. You can choose a provider or facility in your plan's network.

WHEN BALANCE BILLING ISN'T ALLOWED, YOU ALSO HAVE THE FOLLOWING PROTECTIONS:

- You are only responsible for paying your share of the cost (like the copayments, coinsurance, and deductibles that you would pay if the provider or facility was in-network). Your health plan will pay out-of-network providers and facilities directly.
- Your health plan generally must:
  - Cover emergency services without requiring you to get approval for services in advance (prior authorization).
  - Cover emergency services by out-of-network providers.
  - Base what you owe the provider or facility (cost-sharing) on what it would pay an in network provider or facility and show that amount in your explanation of benefits.
  - Count any amount you pay for emergency services or out-of-network services toward your deductible and out-of-pocket limit.

If you believe you've been wrongly billed, you may contact the number on the back of your Anthem of Indiana ID card.

Visit https://www.anthem.com/no-surprise-billing/for more information about your rights under federal law.

Kimball International

2027 Benefits Guide | Kimball International, Inc.

This guide highlights the main features of many of the benefit plans sponsored by Kimball International. Full details of these plans are contained in the legal documents governing the plans. If there is any discrepancy between the plan documents and the information described here, the plan documents will govern. In all cases, the plan documents are the exclusive source for determining rights and benefits under the plans. Participation in the plans does not constitute an employment contract. Kimball International reserves the right to modify, amend, or terminate any benefit plan or practice described in this guide. Nothing in this guide guarantees that any new plan provisions will continue in effect for any period of time. This guide serves as a summary of material modifications as required by the Employee Retirement Income Security Act of 1974 (ERISA), as amended.