2022 | HNI healthcare™

Annual Benefits Enrollment
Highlight Guide

Make your HNI Healthcare benefits work for you. This guide will go over: when you are able to enroll, who you are able to cover, medical and prescription drug benefits, dental benefits, vision benefits, income protection benefits, voluntary benefits, and more.

Know About Enrollment

When Can I Enroll?

As a new employee, you become eligible for benefits 1st of the month following or coinciding with your date of hire of full-time employment and must enroll within 30 days to have coverage for the remainder of the current plan year. If you start on the first day of the month, you are eligible to participate in our benefits program effective that date. You may also need to enroll for the next plan year during Annual Enrollment.

Who Can I Cover?

You can enroll yourself and your eligible dependents in Medical, Dental, Vision and/or Life AD&D benefits. Eligible dependents include your:

- Spouse or domestic partner
- Child(ren) up to age 26 regardless of marital or student status.
- Unmarried child(ren) of any age who can't support themselves due to a disability and who are totally dependent on you.

Coverage	Age
Medical	Up to Age 26
Dental	Up to Age 25 (26 if Full-Time Student)
Vision	Up to Age 25 (26 if Full-Time Student)
Voluntary Life	14 Days to Age 25

What if Things Change?

You can't change your coverage during the plan year unless you have a qualified life event. You must make any eligible changes within 30 days of the event. Qualified life events include, but are not limited to:

- Marriage, legal separation, or divorce
- Birth or legal adoption of a child
- Death of your spouse, domestic partner or a dependent child

After a qualified life event, your new coverage options will be effective 1st of the month following the eligible change.*

When Your Employment Terminates

Life, Voluntary Life, Short Term Disability and Long Term Disability end on your last day of active employment. Your medical, dental and vision plans end on the last day of the same month of your last day worked. You may elect to continue your medical, dental and vision plans for a limited period of time after termination through Federal COBRA rights. You will receive this information via mail after your last day worked.

Know Your Medical & Prescription Drug Benefits

HNI Healthcare offers employees three comprehensive, high-quality medical plan options that include prescription drug coverage through BlueCrossBlueShield of TX. These options each feature a network of doctors and specialists who have agreed to provide services at a discounted price. You can see providers outside of the network, but if you use the in-network providers, you'll pay less. The information below is a summary of coverage only.
Visit bcbstx.com, Text BCBSTXAPP to 33633 to download the app or contact the HR Department at hr@hnihc.com for detailed plan information. You may also login into workforcenow.adp.com and go to Resources-Company Information-Forms Library to view Plan Summaries, Benefit fliers and more.

Medical Benefits Summary

Any deductibles, copays, and coinsurance percentages shown in the chart below are amounts for which you are responsible.

BENEFITS	HDHP HSA		Base PPO Plan		Buy-Up PPO Plan	
	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network
Annual Calendar Year Deductible						
Individual	$3,000	$6,000	$2,500	$5,000	$1,500	$5,000
Family	$6,000	$12,000	$5,000	$10,000	$3,000	$10,000
Out of Pocket Maximum*						
Individual (Includes Deductible)	$6,000	$12,000	$5,000	$10,000	$4,500	$10,000
Family (Includes Deductible)	$12,000	24,000	$10,000	$20,000	$9,000	$20,000
Coinsurance (Portion You Pay)	10%	50%	30%	50%	0%	30%
Physician Services						
Office Visit	10% AD	50% AD	$30	50% AD	$20	30% AD
Specialist Visit	10% AD	50% AD	$60	50% AD	$40	30% AD
Preventative Care	Covered 100%	50% AD	Covered 100%	50%	Covered 100%	30%
Lab and X-Ray Services	10% AD	50% AD	$0	50% AD	$0	30% AD
Inpatient Hospital Services (Per Admission)	10% AD	50% AD	30% AD	50% AD	0% AD	30% AD
Emergency Treatment						
Urgent Care Copay	10% AD	50% AD	$75		$75	
Emergency Room Copay (Waived if Admitted)	10% AD		$250 Then 30% AD		$300	
Retail Prescriptions (30-Day Supply)						
Generic	$20 AD	50% AD	$20	50%	$10	50%
Preferred Brand	$35 AD		$35		$30	
Non-Preferred Brand	$70 AD		$70		$50	
Mail-Order Prescriptions (90-Day Supply)						
Generic	$50 AD	Not Covered	$50	Not Covered	$25	Not Covered
Preferred Brand	$98.50 AD		$87.50		$75	
Non-Preferred Brand	$175 AD		$175		$125	
Employee Contributions (per paycheck)	**Semi-Monthly**	**Monthly**	**Semi-Monthly**	**Monthly**	**Semi-Monthly**	**Monthly**
Employee Only	$0.00	$0.00	$72.99	$145.98	$84.07	$168.14
Employee + Spouse / Domestic Partner	$60.15	$120.29	$182.25	$364.49	$209.91	$419.81
Employee + Child(ren)	$62.29	$124.57	$188.72	$377.43	$217.36	$434.72
Employee + Family	$92.21	$184.41	$279.38	$558.75	$321.78	$643.55

AD: After Deductible , *Includes Deductible and All Copays

Know Your Dental Benefits

Dental coverage is important to your overall health and wellness. You can enroll in dental benefits through Cigna for yourself and your family. The dental plans feature a network of dentists and specialists who have agreed to provide services at a discounted price. If you use these in-network providers, you'll pay less. You can see providers outside of the network, but you'll pay more. The information below is a summary of coverage only.

You may go online at www.mycigna.com or contact the HR Department at hr@hnihc.com for plan summaries that offer detailed information about your coverage, limitations, and exclusions.

Dental Benefits Summary

Any deductibles, copays, and coinsurance percentages shown in the chart below are amounts for which **you** are responsible.

BENEFITS	DPPO		DPPO Buy-UP	
Annual Calendar Year Maximum	$1,750		$2,000	
Calendar Year Deductible				
Individual	$50		$50	
Family	$150		$150	
Preventive Services (No Deductible)	Covered in Full		Covered in Full	
Basic Services	20%		20%	
Major Services	50%		50%	
Orthodontia (Children Up to Age 19) - Not Covered	Not Covered		50%	
Employee Contributions (per paycheck)	**Semi-Monthly**	**Monthly**	**Semi-Monthly**	**Monthly**
Employee Only	$0.00	$0.00	$1.63	$3.25
Employee + Spouse / Domestic Partner	$18.02	$36.04	$21.27	$42.53
Employee + Child(ren)	$18.89	$37.77	$22.21	$44.42
Employee + Family	$39.98	$79.95	$45.16	$90.31

Know Your Vision and 401(k) Benefits

HNI Healthcare offers you and your dependents vision coverage through EyeMed. This information below is only a summary of your vision coverage; go to www.eyemed.com for more information about the vision plan.

Vision Benefits Summary

Any deductibles, copays, and coinsurance percentages shown in the chart below are amounts for which **you** are responsible.

Key Features	In-Network	Out-of-Network
Exam	$10	Reimbursed up to $40
Lenses (single vision)	$25	Reimbursed up to $30
Frames	$0 copay; 20% Discount on amount over $130	Reimbursed up to $105
Contact Lenses Instead of Glasses		
Conventional/Disposable	$0 copay, 15% Discount on Amount over $130	Reimbursed up to $105
Medically Necessary	100%; Copay Waived	Reimbursed up to $210
Employee Contributions (per paycheck)	**Semi-Monthly**	**Monthly**
Employee Only	$0.00	$0.00
Employee + Spouse / Domestic Partner	$1.66	$3.31
Employee + Child(ren)	$1.87	$3.73
Employee + Family	$4.14	$8.28

Know Your Terms

- Coinsurance: The percentage of total costs that you pay out of pocket for covered expenses after you meet the deductible.
- Copay (Copayments): The set fee you have to pay out of pocket for certain services, such as a doctor's office visit or prescription drug.
- Deductible: The amount you pay out of pocket before the health plan will start to pay its share of covered expenses.
- Network: The doctors, pharmacists, and/or other health care providers who make up the plan's preferred providers. When you use in-network providers, you pay less because they have agreed to pre-negotiated pricing. Also called in-network.
- Preventive: Services you receive to help you stay healthy (rather than when you're sick or injured). Preventive care services include annual physicals, wellness screenings, and well-baby care.
- Out of Pocket Maximum: The most you pay each year out of pocket for covered expenses. Once you've reached the out-of-pocket maximum, the health plan pays 100% for covered expenses.

Know Your 401(k) Savings Plan

HNI Healthcare provides the 401k Retirement Plan to make saving for your retirement easy and convenient. You are eligible to begin participating in the 401(k) program the first of the month following 90 days of employment. As enrollment eligibility nears, you will receive specific information on how to create an online account and manage your contributions. You can increase, decrease, or opt-out of your enrollment amount as you prefer. HNI will match 100% on the first 1-3% of employee contributions and 50% on the next 2%. The maximum HNI match will be 4% of employee contributions (i.e. if an employee contributes 5%, HNI will only match 4%). You are always 100% vested in any money you contribute directly to your own retirement plan along with HNI's match.

**If you participated in HNI's 401(k) retirement plan prior to 2020, the vesting schedule was over a period of 4 years, at 25% each year. Any amount of match you received prior to 2020 will follow that vesting schedule.

Know Your Income Protection Benefits

HNI Healthcare offers a variety of plans to provide replacement income for you or your beneficiaries in the event of disability, accident, or death. These benefits are provided by HNI through Prudential Financial for 2021.

Basic Life and AD&D

HNI Healthcare automatically provides you with basic life insurance. This is an employer paid benefit. The policy also automatically includes an equal amount of accidental death and dismemberment (AD&D) coverage. Coverage provided is as follows:

Class 1	1 times basic annual earnings up to $300,000 All eligible physicians, nurse practitioners, physician assistants and executive management
Class 2	$50,000 All other eligible employees

Supplemental Life and AD&D

You can purchase supplemental life insurance for yourself, your spouse / domestic partner, and your child(ren). Your needs depend on your personal situation (other income, monthly expenses, short-term and long-term debt, etc.)

Employee Supplemental Coverage: 7x annual salary up to $1,000,000. *Guaranteed issue is $100,000 you must fill out EOI form for anything above that amount.
Spouse Supplemental Coverage: Up to 50% of the employee's elected amount, up to $250,000 max. *Guaranteed issue is $50,000, you must fill out EOI form for anything above that amount.
Child(ren) Supplemental Coverage: $10,000 is available for children 6 month to 25 years of age.

Note: To purchase supplemental coverage for either your spouse / domestic partner or child (ren), you must enroll in employee coverage.

Supplemental Life and AD&D Rates	
Under 30	$0.056
30-34	$0.066
35-39	$0.096
40-44	$0.116
45-49	$0.166
50-54	$0.246
55-59	$0.446
60-64	$0.666
65-69	$1.186
70-74	$2.076
75 and Older	$2.076
Spouse Rate: Based on Employee's Age	
Child(ren) Rate: $0.251 per $1,000	

Short-Term Disability Insurance

Company-Provided STD: If you aren't able to work after 14 consecutive days of disability due to an eligible injury or illness, this benefit pays 60% of your weekly pay up to a maximum benefit of $2,000 per week, for a maximum of 11 weeks. HNI Healthcare pays the full cost of this coverage.

*Short Term Disability may vary state to state. Please reach out to HNI Benefits Manager for information.

Long-Term Disability Insurance

Company-Provided LTD: This benefit pays a portion of your income if you continue to be disabled and your short-term disability benefits end. To qualify, you must be disabled for 90 days. LTD benefits provide you with 60% of your annual base pay up to a $10,000 monthly maximum. HNI Healthcare pays the full cost of this coverage.

Long-Term Disability Buy Up Insurance

To help you increase your disability protection, HNI Healthcare has negotiated a special rate that allows eligible employees to purchase additional voluntary long-term disability coverage at an affordable cost. You can also keep this affordable policy if you leave HNI Healthcare. To qualify, you must be disabled for 90 days. LTD buy up benefits provide you with 60% of your annual base pay up to a $15,000 monthly maximum.

Know Your Additional Benefits

Health Savings Account

If you enroll into the HDHP HSA Plan, you'll have access to a Health Savings Account (HSA). Employees will need to actively open a HSA account with Optum. You can think of your HSA as a personal savings account for your healthcare expenses, with some impressive tax advantages. You can use your HSA to pay for eligible expenses on a tax -free basis.**

**A full list is available at www.irs.gov.

- Copays
- Deductibles
- Prescriptions
- Dental & Vision Expensees

How much can you contribute?	2022 IRS Contribution Limit
Employee Only Coverage	$3,650*
Family Coverage	$7,300*

*If an individual reaches age 55 by the end of the calendar year, he or she can contribute an additional $1000.

Flexible Healthcare Spending Account

A Health Care FSA allows you to set aside dollars from your pay on a pre-tax basis to reimburse yourself for qualified medical, dental, and vision expenses through Optum. The Health Care FSA contribution limit is $2,750 for 2022. Once you enroll and set your annual contribution, you cannot change that amount during the year (except in the case of certain qualified life events). And, with an FSA, you lose any unused money at the end of the year, so it's important that you carefully estimate your anticipated eligible expenses for the coming year.

Limited Flexible Healthcare Spending Account

If you are enrolled in a HDHP and HSA, you are eligible for this Limited Flexible Healthcare Spending Account for Dental and Vision ONLY. Limited FSA contribution limit is $2,750 for 2022.

Dependent Care Flexible Spending Account

A Dependent Care FSA may be used to reimburse yourself for qualified child and dependent care expenses. You may use this account without being enrolled in medical coverage. The Dependent Care FSA contribution limit is $5,000 (or $2,500 if you are married and filing taxes separately for 2022).

Business Travel Accident Insurance

You have access to the AXA Travel Assistance Program, an essential service provided by AXA Assistance USA, Inc. This service offers you and your dependents medical and travel assistance services, 24 hours a day, 365 days a year. Participants have access to assistance services when faced with an emergency while traveling internationally, or domestically when more than 100 miles away from home; you and your dependents (whether traveling together or separately) are eligible to have immediate access to a broad range of travel assistance services for up to 120 consecutive days for any given trip. Through this program, you will be connected to a global network of:

- Over 600,00 service providers
- Air and ground ambulance services
- Trained multilingual personnel who can assist you quickly and professionally in a travel emergency

If you need travel assistance, call 1(800)565-9320 within the U.S. and 1(312)935-3654 outside the U.S. (collect)
email: medassist-usa@axa-assistance.us

Know Your Voluntary Benefits

Critical Illness Insurance - Allstate

Critical illness insurance is designed to protect your income and personal assets when your out-of-pocket expenses increase as a result of an illness. Health insurance is not always enough to cover all of the unforeseen expenses associated with a serious medical condition like a heart attack or cancer. Critical illness insurance pays a lump sum benefit that can be used any way you choose, and benefits are paid in addition to any other insurance coverage you may have.

Covered Illnesses	Payment Percentages
Heart Attack	100%
Stroke	100%
Major Organ Transplant	100%
End Stage Renal (Kidney) Failure	100%
Coronary Artery Bypass Surgery	25%

Plan Features

- You do not have to be terminally ill to receive benefits.
- Coverage options are available for your spouse/domestic partner and children as riders to your coverage.
- Coverage is portable—you can take your policy with you if you change jobs or retire.

The cost of the benefit will vary depending upon factors such as your age, whether you use tobacco, and the dependent coverage you choose.

The policy/certificate of coverage has exclusions and limitations which may affect any benefits payable.

Accident Insurance - Allstate

You don't have to be especially clumsy to experience accidents. These events are all too common, and so are the high medical expenses that come with them.

Accidents are unplanned and unpredictable, but the financial impact that they have on you doesn't have to be either of those things. Voluntary accident insurance pays direct benefits for a range of injuries and accident related expenses such as:

- Fractures
- Dislocations
- Concussion
- Emergency Room Treatment
- Accidental Death

Benefit amounts are based on the type of injury and treatment needed. No matter how great your medical plan is, you will have to share the costs of medical care and rehabilitation that follow an accident. Accident insurance is designed to help you pay for out-of-pocket expenses that insurance doesn't cover, like copays and deductibles, but the benefit pay-out can be used however you'd like.

The policy/certificate of coverage or its provisions may vary or be unavailable in some states. The policy/certificate of coverage has exclusions and limitations which may affect any benefits payable.

Know How to Get More Information

The information in this guide is a summary of coverage only. Refer to your summary plan descriptions (SPDs) or certificates of coverage for full details.

For Questions About	Contact	Call	Visit	Plan/Group ID
Medical/Prescription Drug	BlueCrossBlueShield	1-800-521-2227	bcbstx.com	326570
Dental	Cigna	1-800-244-6224	www.mycigna.com	3344750
Vision	EyeMed	1-844-873-7853	www.eyemed.com	1024915
Life Insurance	Prudential Financial	1-800-524-0542	www.prudential.com/gi	60363
Disability	Prudential Financial	1-800-842-1718	www.prudential.com/gi	60363
Health Savings Account (HSA)	Optum	1-866-234-8913	www.optumbank.com	HN2630703
Flexible Spending Account (FSA)	Optum	1-866-234-8913	www.optumbank.com	H70731
Critical Illness / Accident Insurance	Allstate	1-888-282-2550	www.allstatebenefits.com/mybenefits	TBD
401(k) Savings Plan	ADP Retirement Services	1-866-695-7526	www.mykplan.com	423678

Important Notices

Important Notice from HNI Healthcare About Your Prescription Drug Coverage and Medicare — Medicare Part D Notice of Creditable Coverage

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with HNI Healthcare 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. HNI Healthcare has determined that the prescription drug coverage offered through CIGNA 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.

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 through 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 HNI Healthcare coverage will not be affected. If you do decide to join a Medicare drug plan and drop your current HNI Healthcare 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 HNI Healthcare 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.

Important Notices Continued

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 HNI Healthcare 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 for personalized help. See the inside back cover of your copy of the "Medicare & You" handbook for their telephone number.
- Call (800) MEDICARE (1-800-633-4227). TTY users should call (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: (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: 01/01/2022

Name of Entity/Sender: HNI Healthcare

Contact: HNI Healthcare Privacy Officer

Address: 7500 Rialto Boulevard, Building 1, Suite 140, Austin, TX 78735

Phone Number: 512-730-3060

HIPAA Privacy Notice Reminder

The privacy rules under the Health Insurance Portability and Accountability Act (HIPAA) require HNI Healthcare to periodically send a reminder to participants about the availability of the Plan's Privacy Notices and how to obtain that notice. The Privacy Notice explains participants' rights and the plan's legal duties with respect to protected health information (PHI) and how the plan may use and disclose PHI. You can obtain a copy of the Privacy Notice by contacting HNI Healthcare Please refer to the Summary Plan Description for additional information.

Important Notices Continued

Women's Health and Cancer Rights Notice

CIGNA is required by law to provide you with the following notice:

The Women's Health and Cancer Rights Act of 1998 ("WHCRA") provides certain protections for individuals receiving mastectomy-related benefits. Coverage will be provided in a manner determined in consultation with the attending physician and the patient for:

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

The CIGNA provide(s) medical coverage for mastectomies and the related procedures listed above, subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this plan.

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

Newborns' and Mothers' Health Protection Act of 1996

Group health plans and health insurance issuers generally may not, under federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than:

- 48 hours following a normal vaginal delivery, or
- 96 hours following a cesarean section.

However, federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable).In any case, plans and issuers may not, under federal law, require that a provider obtain authorization from the plan or the insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

Mental Health Parity and Addiction Equity Act (MHPAEA) Compliance Disclosure Notice

HNI Healthcare is complying with recent legislation that removes limits on mental health benefits. For example, there must be equality between medical benefits and mental health benefits as to financial requirements (such as deductibles, co-payments, co-insurance, and out-of-pocket maximums) and quantitative treatment limitations (such as number of treatments, visits, or days of coverage)

General Notice of ERISA Rights and Protections

As a participant in the HNI Healthcare's benefits program, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). If you would like more information about ERISA, or if you have any questions, you may contact the Human Resources Department or the nearest area office of the Pension and Welfare Benefits Administration, U.S. Department of Labor, listed in your telephone directory. You may also contact the Division of Technical Assistance and Inquiries, Pension and Welfare Benefits Administration, U.S. Department of Labor, 200 Constitution Avenue, N.W., Washington, D.C. 20210.

Important Notices Continued

Employee Rights under the Family and Medical Leave Act of 1993 ("FMLA")

Leave Entitlements

Eligible employees who work for a covered employer can take up to 12 weeks of unpaid, job-protected leave in a 12-month period for the following reasons:

- The birth of a child or placement of a child for adoption or foster care;
- To bond with a child (leave must be taken within 1 year of the child's birth or placement);
- To care for the employee's spouse, child, or parent who has a qualifying serious health condition;
- For the employee's own qualifying serious health condition that makes the employee unable to perform the employee's job;
- For qualifying exigencies related to the foreign deployment of a military member who is the employee's spouse, child, or parent.

An eligible employee who is a covered service member's spouse, child, parent, or next of kin may also take up to 26 weeks of FMLA leave in a single 12-month period to care for the service member with a serious injury or illness. An employee does not need to use leave in one block. When it is medically necessary or otherwise permitted, employees may take leave intermittently or on a reduced schedule. Employees may choose, or an employer may require, use of accrued paid leave while taking FMLA leave. If an employee substitutes accrued paid leave for FMLA leave, the employee must comply with the employer's normal paid leave policies.

Benefits & Protections

While employees are on FMLA leave, employers must continue health insurance coverage as if the employees were not on leave. Upon return from FMLA leave, most employees must be restored to the same job or one nearly identical to it with equivalent pay, benefits, and other employment terms and conditions. An employer may not interfere with an individual's FMLA rights or retaliate against someone for using or trying to use FMLA leave, opposing any practice made unlawful by the FMLA, or being involved in any proceeding under or related to the FMLA.

Eligibility Requirements

An employee who works for a covered employer must meet three criteria in order to be eligible for FMLA leave. The employee must:

- Have worked for the employer for at least 12 months;
- Have at least 1,250 hours of service in the 12 months before taking leave;* and
- Work at a location where the employer has at least 50 employees within 75 miles of the employee's worksite.

*Special "hours of service" requirements apply to airline flight crew employees.

Generally, employees must give 30-days' advance notice of the need for FMLA leave. If it is not possible to give 30-days' notice, an employee must notify the employer as soon as possible and, generally, follow the employer's usual procedures. Employees do not have to share a medical diagnosis, but must provide enough information to the employer so it can determine if the leave qualifies for FMLA protection. Sufficient information could include informing an employer that the employee is or will be unable to perform his or her job functions, that a family member cannot perform daily activities, or that hospitalization or continuing medical treatment is necessary. Employees must inform the employer if the need for leave is for a reason for which FMLA leave was previously taken or certified. Employers can require a certification or periodic recertification supporting the need for leave. If the employer determines that the certification is incomplete, it must provide a written notice indicating what additional information is required.

Important Notices Continued

Employer Responsibilities

Once an employer becomes aware that an employee's need for leave is for a reason that may qualify under the FMLA, the employer must notify the employee if he or she is eligible for FMLA leave and, if eligible, must also provide a notice of rights and responsibilities under the FMLA. If the employee is not eligible, the employer must provide a reason for ineligibility.

Employers must notify its employees if leave will be designated as FMLA leave, and if so, how much leave will be designated as FMLA leave.

Enforcement

Employees may file a complaint with the U.S. Department of Labor, Wage and Hour Division, or may bring a private lawsuit against an employer.

The FMLA does not affect any federal or state law prohibiting discrimination or supersede any state or local law or collective bargaining agreement that provides greater family or medical leave rights

For More Information

For more information about FMLA, contact the US Department of Labor at 800-4USWAGE (800-487-9243) or log onto the Department of Labor website at www.dol.gove/esa/whd/fmla.

Notice of Special Enrollment Rights

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to later enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing toward your or your dependents' other coverage).

Loss of eligibility includes but is not limited to:

- Loss of eligibility for coverage as a result of ceasing to meet the plan's eligibility requirements (i.e., legal separation, divorce, cessation of dependent status, death of an employee, termination of employment, reduction in the number of hours of employment);
- Loss of HMO coverage because the person no longer resides or works in the HMO service area and no other coverage option is available through the HMO plan sponsor;
- Elimination of the coverage option a person was enrolled in, and another option is not offered in its place;
- Failing to return from an FMLA leave of absence; and
- Loss of coverage under Medicaid or the Children's Health Insurance Program (CHIP).

Unless the event giving rise to your special enrollment right is a loss of coverage under Medicaid or CHIP, you must request enrollment within 31 days aft your or your dependent's(s') other coverage ends (or after the employer that sponsors that coverage stops contributing toward the coverage).

If the event giving rise to your special enrollment right is a loss of coverage under Medicaid or CHIP, you may request enrollment under this plan within 60 days of the date you or your dependent(s) lose such coverage under Medicaid or CHIP. Similarly, if you or your dependent(s) become eligible for a state-granted premium subsidy toward this plan, you may request enrollment under this plan within 60 days after the date Medicaid or CHIP determine that you or the dependent(s) qualify for the subsidy.

Important Notices Continued

In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents.

However, you must request enrollment within 31 days after the marriage, birth, adoption, or placement for adoption.

To request special enrollment or obtain more information, contact:

HNI Healthcare Privacy Officer
Human Resources Department
7500 Rialto Boulevard, Building 1, Suite 140, Austin, TX 78735 or HR@hnihc.com

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, 2021.

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: 678-564-1162

Important Notices Continued

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 1-800-457-4584
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/hawk-i Phone: 1-800-257-8563 HIPP Website: https://dhs.iowa.gov/ime/members/medicaid-a-to-z/hipp HIPP Phone: 1-888-346-9562
KANSAS – Medicaid	**NEW HAMPSHIRE – Medicaid**
Website: http://www.kdheks.gov/ hcf/ Phone: 1-800-792-4884	Website: https://www.dhhs.nh.gov/oii/hipp.htm Phone: 603-271-5218 Toll free number for the HIPP program: 1-800-852-3345, ext 5218
KENTUCKY – Medicaid	**NEW JERSEY – Medicaid and CHIP**
Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP) Website: https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx Phone: 1-855-459-6328 Email: KIHIPP.PROGRAM@ky.gov KCHIP Website: https://kidshealth.ky.gov/Pages/index.aspx Phone: 1-877-524-4718	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: www.medicaid.la.gov or www.ldh.la.gov/lahipp Phone: 1-888-342-6207 (Medicaid hotline) or 1-855-618-5488 (LaHIPP)	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: 1-800-862-4840	Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/ Phone: 1-844-854-4825
MINNESOTA – Medicaid	**OKLAHOMA – Medicaid and CHIP**
Website: https://mn.gov/dhs/people-we-serve/seniors/health-care/health-care-programs/programs-and-services/other-insurance.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
NEBRASKA – Medicaid	**RHODE ISLAND – Medicaid**
Website: http://www.ACCESSNebraska.ne.gov Phone: (855) 632-7633 Lincoln: (402) 473-7000 Omaha: (402) 595-1178	Website: http://www.eohhs.ri.gov/ Phone: 855-697-4347

Important Notices Continued

NEVADA – Medicaid	SOUTH CAROLINA – Medicaid
Medicaid Website: http://dhcfp.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://mywvhipp.com/ Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)
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 July 31, 2021, 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

Important Notices Continued

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.

Continuation Coverage Rights Under COBRA

You are receiving this notice because you have recently become covered under a group health plan (the Plan). This notice contains important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan.

This notice generally explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect the right to receive it.

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 when you would otherwise lose your group health coverage.

It can also become available to other members of your family who are covered under the Plan when they would otherwise lose their group health coverage. For additional 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 (www.healthcare.gov). 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.

Important Notices Continued

What is COBRA Continuation Coverage?

COBRA continuation coverage is a continuation of Plan coverage when coverage would otherwise end because of a life event known as 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 are an employee, you will become a qualified beneficiary if you lose your coverage under the Plan because either one of the following qualifying events happens:

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

If you are the spouse of an employee, you will become a qualified beneficiary if you lose your coverage under the Plan because any of the following qualifying events happens:

- 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 any of the following qualifying events happen:

- 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."

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. When the qualifying event is the end of employment or reduction of hours of employment, death of the employee, or the employee's becoming entitled to Medicare benefits (under Part A, Part B, or both), the employer must notify the Plan Administrator of the qualifying event.

You Must Give Notice of Some Qualifying Events

For the 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: HNI Healthcare Human Resources.

Important Notices Continued

How is COBRA 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. When the qualifying event is the death of the employee, the employee's becoming entitled to Medicare benefits (under Part A, Part B, or both), your divorce or legal separation, or a dependent child's losing eligibility as a dependent child, COBRA continuation coverage lasts for up to a total of 36 months. When the qualifying event is the end of employment or reduction of the employee's hours of employment, and the employee became entitled to Medicare benefits less than 18 months before the qualifying event, COBRA continuation coverage for qualified beneficiaries other than the employee lasts until 36 months after the date of Medicare entitlement. For example, if a covered employee becomes entitled to Medicare 8 months before the date on which his employment terminates, COBRA continuation coverage for his spouse and children can last up to 36 months after the date of Medicare entitlement, which is equal to 28 months after the date of the qualifying event (36 months minus 8 months). Otherwise, when the qualifying event is the end of employment or reduction of the employee's hours of employment, COBRA continuation coverage generally lasts for only up to a total of 18 months. There are two 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 the Social Security Administration to be disabled and you notify the Plan Administrator in a timely fashion, you and your entire family may be entitled to receive up to an additional

11 months of COBRA continuation coverage, for a total 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 continuation coverage.

Second qualifying event extension of 18-month period of continuation coverage

If your family experiences another qualifying event while receiving 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 notice of the second qualifying event is properly given to the Plan. This extension may be available to the spouse and any dependent children receiving continuation coverage if the employee or former employee dies, becomes entitled to Medicare benefits (under Part A, Part B, or both), or gets divorced or legally separated, or if the dependent child stops being eligible under the Plan as a dependent child, but only if the event would have caused the spouse or dependent child to lose coverage under the Plan had the first qualifying event not occurred.

For More Information

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 ERISA, including COBRA, the Affordable Care Act, the Health Insurance Portability and Accountability Act (HIPAA), 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 the EBSA website at 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 Health Insurance Marketplace, visit www.HealthCare.gov.

Important Notices Continued

Keep Your Plan Informed of Address Changes

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

Plan Contact Information

For further information regarding the plan and COBRA continuation, please contact:

HNI Healthcare
Human Resources Department
7500 Rialto Boulevard, Building 1, Suite 140, Austin, TX 78735

USERRA

Your right to continued participation in the Plan during leaves of absence for active military duty is protected by the Uniformed Services Employment and Reemployment Rights Act (USERRA). Accordingly, if you are absent from work due to a period of active duty in the military for less than 31 days, your Plan participation will not be interrupted. If the absence is for more than 31 days and not more than 12 weeks, you may continue to maintain your coverage under the Plan by paying premiums.

If you do not elect to continue to participate in the Plan during an absence for military duty that is more than 31 days, or if you revoke a prior election to continue to participate for up to 12 weeks after your military leave began, you and your covered family members will have the opportunity to elect COBRA Continuation Coverage only under the medical insurance policy for the 24-month period (18-month period if you elected coverage prior to December 10, 2004) that begins on the first day of your leave of absence. You must pay the premiums for Continuation Coverage with after-tax funds, subject to the rules that are set out in that plan.

NOTICE REGARDING WELLNESS PROGRAM

HNI Healthcare's Wellness Program is a voluntary wellness program available to all employees. The program is administered according to federal rules permitting employer-sponsored wellness programs that seek to improve employee health or prevent disease, including the Americans with Disabilities Act of 1990, the Genetic Information Nondiscrimination Act of 2008, and the Health Insurance Portability and Accountability Act, as applicable, among others. If you choose to participate in the wellness program you will be asked to complete a voluntary health risk assessment or "HRA" that asks a series of questions about your health-related activities and behaviors and whether you have or had certain medical conditions (e.g., cancer, diabetes, or heart disease). You will also be asked to complete a biometric screening, which will include a blood test for [be specific about the conditions for which blood will be tested. You are not required to complete the HRA or to participate in the blood test or other medical examinations.

However, employees who choose to participate in the wellness program may receive incentives for participating in a well-being exam with a physician. Although you are not required to complete the HRA or participate in the biometric screening, only employees who do so will receive an incentive. Additional incentives may be available for employees who participate in certain health-related activities or achieve certain health outcomes. If you are unable to participate in any of the health-related activities or achieve any of the health outcomes required to earn an incentive, you may be entitled to a reasonable accommodation or an alternative standard. You may request a reasonable accommodation or an alternative standard by contacting HNI HR Department. The information from your HRA and the results from your biometric screening will be used to provide you with information to help you understand your current health and potential risks and may also be used to offer you services through the wellness program, such as outreach. You also are encouraged to share your results or concerns with your own doctor.

Important Notices Continued

PROTECTIONS FROM DISCLOSURE OF MEDICAL INFORMATION

We are required by law to maintain the privacy and security of your personally identifiable health information. Although the wellness program and HNI Healthcare may use aggregate information it collects to design a program based on identified health risks in the workplace, HNI Healthcare Wellness Program will never disclose any of your personal information either publicly or to the employer, except as necessary to respond to a request from you for a reasonable accommodation needed to participate in the wellness program, or as expressly permitted by law. Medical information that personally identifies you that is provided in connection with the wellness program will not be provided to your supervisors or managers and may never be used to make decisions regarding your employment.

Your health information will not be sold, exchanged, transferred, or otherwise disclosed except to the extent permitted by law to carry out specific activities related to the wellness program, and you will not be asked or required to waive the confidentiality of your health information as a condition of participating in the wellness program or receiving an incentive. Anyone who receives your information for purposes of providing you services as part of the wellness program will abide by the same confidentiality requirements. The only individual(s) who will receive your personally identifiable health information is (are) registered nurses, doctors or health coaches in order to provide you with services under the wellness program.

In addition, all medical information obtained through the wellness program will be maintained separate from your personnel records, information stored electronically will be encrypted, and no information you provide as part of the wellness program will be used in making any employment decision. Appropriate precautions will be taken to avoid any data breach, and in the event a data breach occurs involving information you provide in connection with the wellness program, we will notify you immediately.

You may not be discriminated against in employment because of the medical information you provide as part of participating in the wellness program, nor may you be subjected to retaliation if you choose not to participate.

If you have questions or concerns regarding this notice, or about protections against discrimination and retaliation, please contact HNI HR Department.

NEW HEALTH INSURANCE MARKETPLACE COVERAGE OPTIONS AND YOUR HEALTH COVERAGE

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 for coverage starting the following January.

Important Notices Continued

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.

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 HNI Healthcare 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.

Notes:

Make Your
HNI Healthcare Benefits
Work for You

HNI healthcare™