

IMPORTANT NOTICES

MEDICARE PART D NOTICE REQUIREMENTS

Effective January 1, 2006, new prescription drug coverage, Medicare Part D, became available to everyone with Medicare as part of the Medicare Modernization Act of 2003. This act also includes additional notice requirements for employers that provide group medical coverage to their employees and dependents.

We are required to notify employees and dependents who are Medicare entitled and covered under our group medical plan whether or not our plan provides comparable coverage to Medicare Part D. These notices must be provided:

- Annually
- Upon an employee or dependent becoming Medicare entitled, including entitlement due to a disability
- When a Medicare entitled individual enrolls in our group medical plan

We have determined that our group medical plan is creditable and are providing you the following Notice of Creditable Coverage. Please retain this for your records.

In order to assist us with future compliance, please contact the LCS Community LLC immediately upon becoming Medicare entitled.

IMPORTANT NOTICE FROM LCS COMMUNITY EMPLOYMENT LLC ABOUT YOUR PRESCRIPTION DRUG COVERAGE AND MEDICARE – CREDITABLE

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with LCS Community Employment LLC 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. LCS Community Employment LLC has determined that the prescription drug coverage offered by the LCS Community Employment Benefits 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 LCS Community Employment LLC coverage will be affected.

If you do decide to join a Medicare drug plan and drop your current LCS Community Employment LLC coverage, be aware that you and your dependents will 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 LCS Community Employment LLC 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.

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

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

Contact 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 LCS Community Employment LLC 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 <http://www.medicare.gov>
- Call your State Health Insurance Assistance Program (see the inside back cover of your copy of the "Medicare & You" handbook for their telephone number) for personalized help
- Call **800.MEDICARE** (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 them at 800.772.1213 (TTY 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: 10/30/2023

Name of Entity/Sender: LCS Community Employment LLC

Contact-Position/Office: Director of Benefits: Michele Gavin

Address: 400 Locust St., Suite 820; Des Moines, IA 50309

Phone Number: 515.875.4500

CMS Form 10182-CC, Updated April 1, 2011 According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0990. The time required to complete this information collection is estimated to average 8 hours per response initially, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

IMPORTANT NOTICES

WOMEN'S HEALTH & CANCER RIGHTS ACT OF 1988

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

- 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 lymphedema.

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this plan. If you would like more information on WHCRA benefits, call your plan administrator.

NEWBORNS' ACT DISCLOSURE

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

IMPORTANT NOTICES

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

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

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

If you or your dependents are not currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, contact your State Medicaid or CHIP office or dial [877.KIDS.NOW](tel: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 [866.444.EBSA \(3272\)](tel:866.444.EBSA).

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of January 31, 2023. Contact your state for more information on eligibility.

ALABAMA – Medicaid http://myalhipp.com 855.692.5447	GEORGIA – Medicaid GA HIPP Website: https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp 678.564.1162, Press 1 GA CHIPRA Website: https://medicaid.georgia.gov/programs/third-party-liability/childrens-health-insurance-program-reauthorization-act-2009-chipra 678.564.1162, Press 2
ALASKA – Medicaid The AK Health Insurance Premium Payment Program http://myakhipp.com/ 866.251.4861 CustomerService@MyAKHIPP.com Medicaid Eligibility: https://health.alaska.gov/dpa/Pages/default.aspx	INDIANA – Medicaid Healthy Indiana Plan for low-income adults 19-64 http://www.in.gov/fssa/hip/ 877.438.4479 All other Medicaid https://www.in.gov/medicaid/ 800.457.4584
ARKANSAS – Medicaid http://myarhipp.com 855.MyARHIPP	IOWA – Medicaid and CHIP (Hawki) Medicaid: https://dhs.iowa.gov/ime/members 800.338.8366 Hawki: http://dhs.iowa.gov/Hawki 800.257.8563 HIPP: https://dhs.iowa.gov/ime/members/medicaid-a-to-z/hipp 888.346.9562
CALIFORNIA – Medicaid Health Insurance Premium Payment (HIPP) Program http://dhcs.ca.gov/hipp 916.445.8322 Fax: 916.440.5676 Email: hipp@dhcs.ca.gov	KANSAS – Medicaid https://www.kancare.ks.gov/ 800.792.4884 HIPP Phone: 800.766.9012
COLORADO – Medicaid and CHIP Health First Colorado (Colorado's Medicaid Program) https://www.healthfirstcolorado.com Member Contact Center: 800.221.3943 State Relay 711 Child Health Plan Plus (CHP+) https://www.colorado.gov/pacific/hcpf/child-health-plan-plus Customer Service: 800.359.1991 State Relay 711 Health Insurance Buy-In Program (HIBI) https://www.colorado.gov/pacific/hcpf/health-insurance-buy-program HIBI Customer Service: 855.692.6442	KENTUCKY – Medicaid Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP): https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx 855.459.6328 KIHIPP.PROGRAM@ky.gov KCHIP: https://kidshealth.ky.gov/Pages/index.aspx 877.524.4718 Medicaid: https://chfs.ky.gov
FLORIDA – Medicaid www.flmedicaidprecovery.com/flmedicaidprecovery.com/hipp/index.html 877.357.3268	LOUISIANA – Medicaid www.medicaid.la.gov or www.ldh.la.gov/lahipp 888.342.6207 (Medicaid hotline) or 855.618.5488 (LaHIPP)

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MAINE – Medicaid

Enrollment: https://www.mymaineconnection.gov/benefits/s/?language=en_US
800.442.6003 | TTY: Maine relay 711
Private Health Insurance Premium: <https://www.maine.gov/dhhs/ofl/applications-forms>
800.977.6740 | TTY: Maine relay 711

MASSACHUSETTS – Medicaid and CHIP

<https://www.mass.gov/masshealth/pa>
800.862.4840 | TTY: 617.886.8102

MINNESOTA – Medicaid

<https://mn.gov/dhs/people-we-serve/children-and-families/health-care/health-care-programs/programs-and-services/other-insurance.jsp>
800.657.3739

MISSOURI – Medicaid

<http://www.dss.mo.gov/mhd/participants/pages/hipp.htm>
573.751.2005

MONTANA – Medicaid

<http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP>
800.694.3084 | Email: HSHIPPProgram@mt.gov

NEBRASKA – Medicaid

<http://www.ACCESSNebraska.ne.gov>
Phone: 855.632.7633 | Lincoln: 402.473.7000 | Omaha: 402.595.1178

NEVADA – Medicaid

<http://dhcfp.nv.gov>
800.992.0900

NEW HAMPSHIRE – Medicaid

<https://www.dhhs.nh.gov/programs-services/medicaid/health-insurance-premium-program>
603.271.5218 | Toll free number for the HIPP program: 800.852.3345, ext. 5218

NEW JERSEY – Medicaid and CHIP

Medicaid: <http://www.state.nj.us/humanservices/dmahs/clients/medicaid> 609.631.2392
CHIP: <http://www.njfamilycare.org/index.html>
800.701.0710

NEW YORK – Medicaid

https://www.health.ny.gov/health_care/medicaid/
800.541.2831

NORTH CAROLINA – Medicaid

<https://medicaid.ncdhhs.gov/>
919.855.4100

NORTH DAKOTA – Medicaid

<http://www.nd.gov/dhs/services/medicalserv/medicaid>
844.854.4825

OKLAHOMA – Medicaid and CHIP

<http://www.insureoklahoma.org>
888.365.3742

OREGON – Medicaid

<http://healthcare.oregon.gov/Pages/index.aspx>
<http://www.oregonhealthcare.gov/index-es.html>
800.699.9075

PENNSYLVANIA – Medicaid and CHIP

<https://www.dhs.pa.gov/Services/Assistance/Pages/HIPP-Program.aspx>
800.692.7462
CHIP Website: <https://www.dhs.pa.gov/CHIP/Pages/CHIP.aspx>
CHIP Phone: 800.986.KIDS (5437)

RHODE ISLAND – Medicaid and CHIP

<http://www.eohhs.ri.gov>
855.697.4347 or 401.462.0311 (Direct Rlite Share Line)

SOUTH CAROLINA – Medicaid

<http://www.scdhhs.gov>
888.549.0820

SOUTH DAKOTA – Medicaid

<http://dss.sd.gov> 888.828.0059

TEXAS – Medicaid

<http://gethipptexas.com>
800.440.0493

UTAH – Medicaid and CHIP

Medicaid: <https://medicaid.utah.gov> CHIP:
<http://health.utah.gov/chip> 877.543.7669

VERMONT – Medicaid

<http://www.greenmountaincare.org>
Health Insurance Premium Payment (HIPP) Program | Department of
Vermont Health Access
800.250.8427

VIRGINIA – Medicaid and CHIP

<https://www.coverva.org/en/famis-select>
<https://www.coverva.org/hipp/>
Medicaid and Chip: 800.432.5924

WASHINGTON – Medicaid

<https://www.hca.wa.gov/>
800.562.3022

WEST VIRGINIA – Medicaid

<https://dhhr.wv.gov/bms/> or <http://mywvhipp.com/>
Medicaid: 304.558.1700
CHIP Toll-free: 855.MyWVHIPP (855.699.8447)

WISCONSIN – Medicaid and CHIP

<https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm>
800.362.3002

WYOMING – Medicaid

<https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/> 800.251.1269

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To see if any other states have added a premium assistance program since January 31, 2023, or for more information on special enrollment rights, contact either:

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

U.S. Department of Health and Human Services
Centers for Medicare & Medicaid Services
www.cms.hhs.gov
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.

OMB Control Number 1210-0137 (expires 1/31/2026)

IMPORTANT NOTICES

HIPAA NOTICE OF PRIVACY PRACTICES

Your Information. Your Rights. Our Responsibilities.

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 LCS Community Employment LLC. It also explains the federal privacy rights afforded to you and the members of your family as plan participants covered under a group health plan.

As a plan sponsor LCS Community Employment LLC often needs access to health information in order to perform plan administrator functions. We want to assure the plan participants covered under our group health plan that we comply with federal privacy laws and respect your right to privacy. We require all members of our workforce and third parties that are provided access to health information comply with the privacy practices outlined below.

Your Rights

When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you.

Get an electronic or paper copy of your medical record

- You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. Ask us how to do this.
- We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee.

Ask us to correct your medical record

- You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this.
- We may say "no" to your request, but we'll tell you why in writing within 60 days.

Request confidential communications

- You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address.
- We will consider all reasonable requests, and must say "yes" if you tell us you would be in danger if we do not..

Ask us to limit what we use or share

- You can ask us not to use or share certain health information for treatment, payment, or our operations.
- We are not required to agree to your request, and we may say "no" if it would affect your care.

Get a list of those with whom we've shared information

- You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why.
- We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

Get a copy of this privacy notice

You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

Choose someone to act for you

- If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.
- We will make sure the person has this authority and can act for you before we take any action.

IMPORTANT NOTICES

File a complaint if you feel your rights are violated

- You can complain if you feel we have violated your rights by contacting us using the information on page 1.
- You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling [877.696.6775](tel:877.696.6775), or visiting www.hhs.gov/ocr/privacy/hipaa/complaints/.
- We will not retaliate against you for filing a complaint.

Your Choices

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to:

- Share information with your family, close friends, or others involved in your care
- Share information in a disaster relief situation

If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.

In these cases we never share your information unless you give us written permission:

- Marketing purposes
- Sale of your information

Our Uses and

Disclosures

How do we typically use or share your health information?

We typically use or share your health information in the following ways. Help manage the health care treatment you receive

We can use your health information and share it with professionals who are treating you.

Example: A doctor sends us information about your diagnosis and treatment plan so we can arrange additional services.

Run our organization

- We can use and disclose your information to run our organization and contact you when necessary.
- We are not allowed to use genetic information to decide whether we will give you coverage and the price of that coverage. This does not apply to long term care plans.

Example: We use health information about you to develop better services for you. Pay for your health services

We can use and disclose your health information as we pay for your health services.

Example: We share information about you with your dental plan to coordinate payment for your dental work..

Administer your plan

We may disclose your health information to your health plan sponsor for plan administration.

Example: Your company contracts with us to provide a health plan, and we provide your company with certain statistics to explain the premiums we charge.

How else can we use or share your health information?

We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html.

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Help with public health and safety issues

We can share health information about you for certain situations such as:

- Preventing disease
- Helping with product recalls
- Reporting adverse reactions to medications
- Reporting suspected abuse, neglect, or domestic violence
- Preventing or reducing a serious threat to anyone's health or safety

Do research

We can use or share your information for health research.

Comply with the law

We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.

Respond to organ and tissue donation requests and work with a medical examiner or funeral director

- We can share health information about you with organ procurement organizations.
- We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

Address workers' compensation, law enforcement, and other government requests

We can use or share health information about you:

- For workers' compensation claims
- For law enforcement purposes or with a law enforcement official
- With health oversight agencies for activities authorized by law
- For special government functions such as military, national security, and presidential protective services

Respond to lawsuits and legal actions

We can share health information about you in response to a court or administrative order, or in response to a subpoena. Our

Responsibilities

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html. Changes to

the Terms of this Notice

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, on our web site, and we will mail a copy to you.

IMPORTANT NOTICES

Other Instructions for Notice

Plan contact information

- 10/30/2023
- Name of Entity/Sender: LCS Community Employment LLC
- Privacy Officer: Kat Kilbane
- Email Address: kilbanekat@lcsnet.com
- Address: 400 Locust St., Suite 820; Des Moines, IA 50309
- Phone Number: 515.875.4500

HIPAA SPECIAL ENROLLMENT NOTICE

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 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). However, you must request enrollment within 30 days after your or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage).

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 30 days after the marriage, birth, adoption, or placement for adoption. To request special enrollment or obtain more information, contact LCS Community Employment LLC.

IMPORTANT INFORMATION ABOUT THE NOTICE ON HEALTH INSURANCE MARKETPLACE COVERAGE OPTIONS AND EMPLOYER-PROVIDED BENEFITS

We are required to provide you with information about your Health Insurance Marketplace Coverage options. You are currently eligible to receive health benefits through the Company, but if you are interested in learning more about the Marketplace, please read the information below and Part A of the enclosed notice for general information. If you're interested in applying for coverage through the Marketplace, Part B of the notice provides important information you will need to know.

Why Am I Receiving This Notice?

This notice provides you with instructions on how to access information about the Health Insurance Marketplace, which offers health plans to you through either your state or the U.S. Department of Health and Human Services.

LCS Community Employment LLC is required to send the enclosed notice to every U.S. employee to comply with rules under the federal Patient Protection and Affordable Care Act (ACA).

What Do I Need to Do?

You don't need to do anything, unless you're interested in Marketplace coverage. As you know, you're currently eligible to participate in the LCS Community Employment LLC group health plan.

How Does My LCS Community Employment LLC Coverage Compare to Marketplace Coverage?

The LCS Community Employment LLC group health plan intends to provide more coverage at a lower cost to you than a Marketplace health plan. If you buy insurance in the Marketplace, you will not receive any contribution from LCS Community Employment LLC. LCS Community Employment LLC already meets government standards for providing minimum, affordable coverage.

If you want to continue health coverage through LCS Community Employment LLC you don't need to take further action.

What if I'm Interested in Marketplace Coverage?

Go to [HealthCare.gov](https://www.healthcare.gov) to review the plans available in your state.

Keep the enclosed notice because it has information you'll need to enroll in Marketplace coverage. Compare your LCS Community Employment LLC coverage costs to those of the Marketplace during enrollment.

IMPORTANT NOTICES

NEW HEALTH INSURANCE MARKETPLACE COVERAGE OPTIONS AND YOUR HEALTH COVERAGE

PART A: General Information

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

What is the Health Insurance Marketplace?

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

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

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

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

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

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

How Can I Get More Information?

For more information about your coverage offered by your employer, please check your summary plan description or contact LCS Community Employment LLC at [515.875.4500](tel:515.875.4500) or benefits@lcsnet.com

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

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PART B: Information About Health Coverage Offered by Your Employer

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

3. Employer name LCS Community Employment LLC		4. Employer Identification Number (EIN) 45-4590615	
5. Employer address 400 Locust St., Suite 820		6. Employer phone number 515.875.4500	
7. City Des Moines	8. State IA	9. ZIP code 50309	
10. Who can we contact about employee health coverage at this job? Michele Gavin			
11. Phone number (if different from above) 515.875.4500		12. Email address benefits@lcsnet.com	

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

- As your employer, we offer a health plan to:
 - ☐ All employees. Eligible employees are:

 - X Some employees. Eligible employees are:
Regular full-time employees working 30 hours or more per week. Employees are eligible the first of the month following date of hire.

- With respect to dependents:
 - X We do offer coverage. Eligible dependents are:
 - Your lawful spouse (or domestic partner if required by State law)
 - Children who meet the following criteria: Your natural child, stepchild, adopted child (including a child legally placed with you for adoptions, or foster child)
 - Under Age 26 (the age 26 limit does not apply to eligible children who can't support themselves because of a physical or mental disability that existed and was certified before the child reached age 26)
 - Your Child (under age 30) who meets certain requirements
 - ☐ We do not offer coverage.

 - X If checked, this coverage meets the minimum value standard, and the cost of this coverage to you is intended to be affordable, based on employee wages.

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

If you decide to shop for coverage in the Marketplace, [HealthCare.gov](https://www.healthcare.gov) will guide you through the process. Here's the employer information you'll enter when you visit [HealthCare.gov](https://www.healthcare.gov) to find out if you can get a tax credit to lower your monthly premiums.

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The information below corresponds to the Marketplace Employer Coverage Tool. Completing this section is optional for employers, but will help ensure employees understand their coverage choices.

13. Is the employee currently eligible for coverage offered by this employer, or will the employee be eligible in the next 3 months?

☒ Yes (Continue)

13a. If the employee is not eligible today, including as a result of a waiting or probationary period, when is the employee eligible for coverage? First of the month following the first date of employment (Continue)

☐ No

14. Does the employer offer a health plan that meets the minimum value standard*?

☒ Yes (Go to question 15)

☐ No (STOP and return form to employee)

15. For the lowest cost plan that meets the minimum value standard offered only to the employee (don't include family plans): If the employer has wellness programs, provide the premium that the employee would pay if he/she received the maximum discount for any tobacco cessation programs, and didn't receive any other discounts based on wellness programs.

a. How much would the employee have to pay in premiums for this plan?

b. How often? ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Monthly ☐ Quarterly ☐ Yearly

If the plan year will end soon and you know that the health plans offered will change, go to question 16. If you don't know, STOP and return form to employee.

16. What change will the employer make for the new plan year?

☐ Employer won't offer health coverage

☒ Employer will start offering health coverage to employees or change the premium for the lowest-cost plan available only to the employee that meets the minimum value standard.* (Premium should reflect the discount for wellness programs. See question 15.)

a. How much would the employee have to pay in premiums for this plan?

b. How often? ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Monthly ☐ Quarterly ☐ Yearly

*An employer-sponsored 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 percent of such costs (Section 36B(c)(2)(C)(ii) of the Internal Revenue Code of 1986)

IMPORTANT NOTICES

Model General Notice of COBRA Continuation Coverage Rights

** Continuation Coverage Rights Under COBRA**

Introduction

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."

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When is COBRA continuation 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 after the qualifying event occurs.

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 COBRA 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, Medicare, Medicaid, Children's Health Insurance Program (CHIP), 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.

Can I enroll in Medicare instead of COBRA continuation coverage after my group health plan coverage ends?

In general, if you don't enroll in Medicare Part A or B when you are first eligible because you are still employed, after the Medicare initial enrollment period, you have an 8-month special enrollment period to sign up for Medicare Part A or B, beginning on the earlier of

- The month after your employment ends; or
- The month after group health plan coverage based on current employment ends.

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If you don't enroll in Medicare and elect COBRA continuation coverage instead, you may have to pay a Part B late enrollment penalty and you may have a gap in coverage if you decide you want Part B later. If you elect COBRA continuation coverage and later enroll in Medicare Part A or B before the COBRA continuation coverage ends, the Plan may terminate your continuation coverage. However, if Medicare Part A or B is effective on or before the date of the COBRA election, COBRA coverage may not be discontinued on account of Medicare entitlement, even if you enroll in the other part of Medicare after the date of the election of COBRA coverage.

If you are enrolled in both COBRA continuation coverage and Medicare, Medicare will generally pay first (primary payer) and COBRA continuation coverage will pay second. Certain plans may pay as if secondary to Medicare, even if you are not enrolled in Medicare.

For more information visit <https://www.medicare.gov/medicare-and-you>. 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.

Plan contact information

Name of Entity/Sender: LCS Community Employment LLC

Contact-Position/Office: Director of Benefits: Michele Gavin

Address: 400 Locust St., Suite 820; Des Moines, IA 50309

Phone Number: 515.875.4500

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

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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 balance 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.

In certain states, you may also have related state protections:

Visit The Commonwealth Fund website for updated state balance-billing protections at <https://www.commonwealthfund.org/publications/maps-and-interactives/2021/feb/state-balance-billing-protections>.

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 Customer Service number on the back of your Medical/Rx card. Visit <https://www.cms.gov/nosurprises> for more information about your rights under federal law.

Visit <https://www.commonwealthfund.org/publications/maps-and-interactives/2021/feb/state-balance-billing-protections> for more information about your rights under each state's laws.

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ILLINOIS CONSUMER COVERAGE DISCLOSURE ACT – FOR ILLINOIS PLANS ONLY

Written List of Covered Benefits

A Comparison of Your Group Health Insurance Coverage to Coverage Under Individual Health Insurance in Illinois

Aetna PPO \$1,000; PPO \$1,500; PPO \$2,000; PPO-PA \$2,000; PPO-PA \$3,000; PPO-PA \$4,000; HDHP \$3,500; HDHP \$4,500; HMO; HDHP \$5,000; HDHP \$5,500 HDHP \$6,500

Benefit Coverage Category [Illinois Essential Health Insurance Benefits]	Benefit Covered under Individual Health Insurance Policy in Illinois?	Benefit Covered under Employer's Group Health Insurance Coverage Policy: Yes / No and Any Limits?
Primary Care Visit to Treat an Injury or Illness	Yes	Yes
Specialist Visit	Yes	Yes
Other Practitioner Office Visit (Nurse, Physician Assistant)	Yes	Yes
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	Yes	Yes
Outpatient Surgery Physician / Surgical Services	Yes	Yes
Hospice Services	Yes	Yes
Infertility Treatment	Yes [Limitations vary based upon procedure]	Yes [Limitations vary based upon procedure]
Private-Duty Nursing	Yes [IP private duty nursing is not covered]	No
Urgent Care Centers or Facilities	Yes	Yes
Emergency Room Services	Yes	Yes
Emergency Transportation / Ambulance	Yes	Yes
Inpatient Hospital Services (e.g., Hospital Stay)	Yes	Yes
Inpatient Physician and Surgical Services	Yes	Yes
Bariatric Surgery	Yes	Yes
Cosmetic Surgery (for the correction of the congenital deformities or for conditions resulting from accidental injuries, scars, tumors or disease.)	Yes	Yes
Skilled Nursing Facility	Yes	Yes 60 day maximum per year
Prenatal and Postnatal Care	Yes	Yes
Delivery and All Inpatient Services for Maternity Care	Yes	Yes
Mental / Behavioral Health Outpatient Services	Yes	Yes
Mental / Behavioral Health Inpatient Services	Yes	Yes
Substance Abuse Disorder Outpatient	Yes	Yes
Substance Abuse Disorder Inpatient Services	Yes	Yes
Generic Drugs	Yes	Yes
Preferred Brand Drugs	Yes	Yes
Non-Preferred Brand Drugs	Yes	Yes

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Specialty Drugs	Yes	Yes
Outpatient Rehabilitation Services	Yes [Maintenance therapies not covered]	Yes
Habilitation Services	Yes [Treatment must be medically necessary and therapeutic and not investigational]	Yes
Chiropractic Care	Yes [Limited to 25 visits per benefit period]	Yes
Durable Medical Equipment	Yes	Yes
Hearing Aids	Yes [Bone anchored hearing aids; quantity limit for hearing aids for children is 2 per 3 years]	Yes TO AGE 18 YEARS 1 BENEFIT MAXIMUM PER EAR AND \$2,500 MAXIMUM PER 24 MONTHS FOR HEARING AID PAY AS BILLED.
Preventive Care / Screening / Immunization	Yes	Yes
Routine Foot Care (for persons diagnosed with diabetes)	Yes	Yes
Routine Eye Exam for Children	Yes [Limited to 1 exam per benefit period]	No
Eye Glasses for Children	Yes [Limited to 1 item per benefit period]	No
Dental Check-Up for Children	Yes	No
Rehabilitative Speech Therapy (When rendered for the treatment of psychosocial speech delay, behavioral problems (including impulsive behavior and impulsivity syndrome) attention disorder, conceptual handicap or mental retardation, except as may be provided under this Certificate for Autism Spectrum Disorder(s).)	Yes [Maintenance speech therapy not covered]	Yes
Rehabilitative Occupational and Rehabilitative Physical Therapy	Yes [Maintenance occupational and physical therapy are not covered]	Yes [Maintenance occupational and physical therapy are not covered]
Well Baby Visits and Care	Yes	Yes
Laboratory Outpatient and Professional Services (for outpatient services and when these services are related to surgery or medical care.)	Yes	Yes
X-rays and Diagnostic Imaging (for outpatient services and when these services are related to surgery or medical care.)	Yes	Yes
Basic Dental Care – Child	Yes	No
Orthodontia – Child	Yes [Limitations vary based upon procedure]	No
Major Dental Care – Child	Yes [Limitations vary based upon procedure]	No
Transplant	Yes	Yes
Accidental Dental	Yes	Yes
Dialysis	Yes	Yes
Allergy Testing	Yes	Yes

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Chemotherapy	Yes	Yes
Radiation	Yes	Yes
Diabetes Education (rendered by a physician, or duly certified, or licensed health care professional with expertise in diabetes management.)	Yes	Yes
Prosthetic Devices	Yes	Yes
Infusion Therapy	Yes	Yes
Treatment for Temporomandibular Joint Disorders	Yes	No
Nutritional Counseling	Yes	Yes
Reconstructive Surgery for mastectomy-related services	Yes	Yes
Other Benefits		
Topical anti-inflammatory medication, including but not limited to Ketoprofen, Diclofenac, or another brand equivalent approved by the FDA for acute and chronic pain	Yes	Yes
Opioid prescriptions for acute pain are provided for no more than 7 days	Yes	Yes
Prohibition on prior authorization, dispensing limits, and fail first policies for buprenorphine or brand equivalent products for medication assisted treatment of opioid use disorder	Yes	No – have formulary quantity limits
At least one intranasal spray opioid reversal agent when initial prescriptions of opioids are dosages of 50MME or higher	Yes	Yes
Tele-psychiatry	Yes	Yes