2016 Employee
Benefits Guide

MolinaHealthcare.com

Welcome

At Molina Healthcare, we recognize our achievements are created by our people. Every employee contributes to the success of the company, and our employees are considered "family."

In recognition of your efforts, Molina Healthcare provides employees with a competitive and comprehensive benefits package –your total rewards– designed to meet your needs and those of your family. It's our goal to ensure that you have the resources to develop and succeed in both your career and your personal life.

This guide provides an overview of the Molina Healthcare employee benefits program. We encourage you to review the information in this guide before making decisions about your benefits.

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This document only provides highlights of the benefits offered at Molina Healthcare. If there are inconsistencies between this document and the official plan documents, the plan documents will govern. Molina Healthcare may modify, amend or terminate any of the benefit plans at any time, with or without notice. This document does not serve as a contract or offer of employment.

Benefits Overview

Who Is Eligible

All regular employees scheduled to work 30 or more hours each week are eligible for benefits. You are eligible for most benefit-plan coverage on the first of the month following 30 days of employment.

You may enroll your eligible dependents for medical, dental, vision and dependent life insurance coverage. They are also eligible to receive Employee Assistance Program (EAP) services. Your eligible dependents generally include:

- Your legal spouse or domestic partner (with domestic partner affidavit.)

  Note: Health care coverage provided to domestic partners through a company-sponsored benefits program is considered taxable by the IRS. Participants should consult a tax advisor for specific tax advice related to domestic partner benefits.

- Your children up to age 26 (married or unmarried)
- Any dependent child who is incapable of self-support because of a physical or mental disability

Spouse/Domestic Partner Affidavit

To help enable us to continue to provide exceptional benefits, we encourage that spouses and domestic partners who have access to workplace coverage enroll in their own employers' health plans. Doing so will help us manage the cost of benefits paid by Molina and, in turn, the costs that you share with us through your payroll contributions.

Employees who choose coverage for spouses or domestic partners, will complete an online affidavit with a few short questions that relate to your spouse's access to coverage through his/her employer.

Making Changes To Your Benefits

You may make changes to your benefit choices once a year during Molina Healthcare's Open Enrollment period. All coverages you select will be effective for a full calendar year, unless you have a qualified change in status or terminate employment.

Because many of your benefits are available on a pre-tax basis, the IRS requires that you have a qualified change in status in order to make changes to your benefit elections during the year. Examples of a qualified change in status include:

- Marriage, legal separation or divorce,
- Disability,
- Birth, adoption, or custody change of an eligible dependent,
- Death of a spouse/qualified domestic partner or dependent,
- Dependent ceases to satisfy dependent eligibility requirements,
- Beginning or ending of spouse's/qualified domestic partner's employment,
- A change in employment (either yours or your spouse's/qualified domestic partner's) from part-time to full-time or full-time to part-time, or
- A significant increase in the cost of Molina Healthcare's healthcare benefits.

Benefits Overview

If you have a qualified change in status and wish to make changes to your benefits, you must email the MHI Benefits Help Mailbox within 30 days of the change. The change to your benefits must be consistent with the change in family status. For example, if you have a new baby, you can enroll the child as a dependent under your current health plan, but you may not remove another dependent that is already covered.

Your health is important and access to affordable, quality healthcare is one of the most-valued benefits you have as a Molina Healthcare employee. The company makes a significant contribution toward the premium costs of the healthcare benefits coverage we offer you and your dependents. You, then, pay the remaining portion of the premium costs on a pre-tax basis through convenient payroll deductions. Please take the time to understand your options and consider them in terms of your personal situation.

Medical

Molina Healthcare offers you a choice of three medical plan options – the Exclusive Network, Select and Premier plans – which we outline for you on pages 7-9. All three plans are self insured by Molina Healthcare, which means that the company pays for the actual cost of care and services but hires a third party to administer the plan.

If you are enrolled in one of the health plans, you and your covered dependents can use Molina Healthcare clinics for primary care and there will be no copay.

Dental

The company offers you two PPO plan options through Delta Dental, a Low PPO plan and a High PPO plan. The High PPO plan offers a higher level of benefits than the Low PPO plan, which has lower premiums. Both plans allow you to select a Delta Dental dentist or see any dentist you want. These plans are outlined for you on page 10.

Vision

Molina Healthcare offers all eligible employees vision coverage through VSP.
For more information, please see the table on page 11.

Health Assessment

There's an easy way to get a snapshot of your health and help you save on medical contributions. Take Anthem's Health Assessment. It only takes a few minutes to complete and helps you understand your risk factors.

1. Register with Anthem at **anthem.com/ca** by clicking on **Register Now**. You will need your Anthem ID number from your ID card, including the three preceding letters.
2. Once your registration it is processed, (it may take up to 24 hours), go to **anthem.com/ca** and click on **Health and Wellness**.
3. Select **Take My HA Now**.
4. Before starting, you should know your waist size, body mass index (BMI), blood pressure, and other key information and lab results from the last time you had preventive care services.
5. For technical assistance with registering, or completing the health assessment, contact Anthem's Help Desk at **866-755-2680**.
6. Once Molina receives reporting from Anthem that you have completed the Health Assessment, you will start the discounted contributions. Please keep in mind that due to lag time in reporting this well-being discount may take more than 3 pay dates. There will be no retros or refunds.

Molina offers an on-line tool to help you understand your prescription drug costs, your formulary, which pharmacies to use, and how to save money on your prescriptions. The tool is available even before you enroll in one of Molina's health plans.

You can go to: **https://www.express-scripts.com/molina**.

Medical Coverage

Molina Healthcare offers all eligible employees three medical plan options to choose from. All use Blue Cross Blue Shield, a nationwide Preferred Provider Organization (PPO) network. While each plan covers most of the same services, your out-of-pocket expenses vary with each plan.

Exclusive Network Plan

With this plan you must use physicians and facilities from the Blue Cross Blue Shield provider network. Office visits are covered at 100% after a $25 copay for primary care doctors and $40 for specialists. Most other services are covered at 80% after the deductible. Network providers must be used in order to receive benefits. There are no benefits when you go out of the network. Employees living outside of California may locate Blue Cross Blue Shield providers at **www.bcbs.com**, or by calling **1-800-810-2583**. Employees living in California can locate providers at **www.anthem.com/ca**, or by calling **1-888-212-0276.**

Select Plan

This option allows you to receive covered services from any provider you wish. When you obtain services from providers who participate in the Blue Cross Blue Shield PPO network, your benefits are greater. If you obtain services from providers who do not participate in the Blue Cross Blue Shield PPO network, you incur higher out-of-pocket expenses. If you choose a network provider, you pay a $25 copay for primary care physician office visits, $40 for specialist visits, and most other services are covered at 90% after you satisfy the calendar year deductible. Most out-of-network services are covered at 50% after the deductible. Employees living outside of California may locate Blue Cross Blue Shield providers at **www.bcbs.com**, or by calling **1-800-810-2583**. Employees living in California may locate providers at **www.anthem.com/ca**, or by calling **1-888-212-0276.**

Premier Plan

This option is similar to the Select PPO plan. When you obtain services from providers who participate in the BCBS PPO network, you pay a $25 copay for primary care physician visits, or $40 for specialist visits. Most other services in-network are covered at 100% after the deductible. Most non-network services are covered at 60% after the deductible. Employees living outside of California may locate Blue Cross Blue Shield providers at **www.bcbs.com**, or by calling **1-800-810-2583**. Employees living in California may locate providers at **www.anthem.com/ca**, or by calling **1-888-212-0276.**

Please review the charts on the following pages to help you select the medical plan that is right for you and your family. Benefit claims information is also available online at **www.deltahealthsystems.com**.

Summaries of Benefits and Coverage (SBCs) are available on the intranet.

Medical Coverage

Well-Being Resources

Complex Care: Complex Care manages healthcare costs starting with helping those who need it the most. Complex Care is staffed by nurse case managers trained in helping higher-risk patients. The nurse care manager will work with you and the treating doctor to make a personal nursing care plan.

Members who sign up for this program may have major orthopedic, heart, nerve or cancer-related issues. Members will have a nurse care manager who will offer the following:

- Personal attention, goal planning and health and lifestyle coaching
- Ways to aid self-management skills and drug adherence
- Resources to answer health-related questions for certain treatments
- Access to other needed medical management programs
- Depression screening with referral to our behavioral health services if needed
- Coordination of care between many providers and services

Please call **1-800-522-5560** to speak with a nurse.

Condition Care: With Condition Care, members get personalized, one-on-one support straight from a nurse to help them better manage chronic conditions. They also get information and tools to help them avoid unnecessary emergency room visits, hospital stays and time away from the job. Condition Care Nurse Care Managers are supported by a team of dieticians, social workers, pharmacists, health educators and other health professionals. Condition Care helps employees deal with the following.

- Asthma
- Diabetes
- Chronic obstructive pulmonary disease (COPD)
- Coronary artery disease
- Heart failure

Please call **1-800-522-5560** to speak with a nurse.

Future Moms: Having a healthy baby is every mom's goal and it starts with a health pregnancy. Future Moms is a program that can answer questions, help make good choices and follow the members health care providers plan of care. Members just need to call the toll free number and our registered nurses will help get member started. Future Moms includes:

- A toll free number to talk to a nurse coach at any time, any day, about pregnancy A nurse may also call the member from time to time to check and see how everything is going
- A book that shows changes the member can expect to happen during the next nine months
- A screening to check for depression or early delivery
- The member's doctor and Future Moms nurse keep track of the pregnancy and help the member make healthier choices
- Free phone calls with the pharmacists, nutritionists and other specialist if needed

Please call **1-866-664-5404** to speak with a nurse.

Medical Coverage

24/7 NurseLine

Call the 24/7 NurseLine to talk with a registered nurse about your health concerns. We all know health concerns can happen when you least expect them. You may be on vacation or even on a business trip. Or your child may have a fever in the middle of the night. You can turn to the 24/7 Nurseline any time day or night. Nurses are there to provide support and peace of mind when you need them. Whether it's a question about allergies, fever, types of preventive care or any other topic, our nurses are there for you. Nurses are also there to help you choose the right place if your doctor is not available. Do you need the emergency room? Is urgent care best? Or do you need to see your doctor? Making the right call can help save time and money.

Please call **1-800-700-9184** to speak with a nurse.

Live Health Online

Live Health Online is a convenient way for you to interact with a doctor via live, two-way video on your computer or mobile device. You'll have 24/7 access to in-network doctors at the same copay of a regular doctor visit. Doctors can ePrescribe to local pharmacies (when applicable). This service provides a convenient way to access care, without waiting, from anywhere you have an internet connection. To access, go to **www.livehealthonline.com**.

Medical Coverage

Exclusive Network Medical Plan – Available Nationwide

The table below provides summaries of the coverage available from the Exclusive Network Plan. The Exclusive Network Plan utilizes BCBS's PPO network. There are no benefits when you go out of network. For further coverage details, please refer to the Summary Plan Descriptions on the Molina Intranet and **www.deltahealthsystems.com**.

	Exclusive Network Plan[1]
	In-Network Only
Calendar Year Deductible	$500 per individual; $1,500 per family
Calendar Year Out-of-Pocket Maximum *(includes deductible)*	$4,000 per individual; $8,000 per family
Lifetime Maximum Benefit	Unlimited
Medical Benefits	
Doctor's Office Visits	Covered at 100% after $25 copay for primary; $40 for specialist
Well-Baby Care *(birth through age 6)*	Covered at 100%
Preventive Care	Covered at 100%
X-Ray and Laboratory Services	Covered at 80% after deductible
Complex Imaging	Covered at 80% after deductible
Chiropractic	Covered at 100% after $40 copay; Limited to 20 visits per year
Prescription Drug Benefits	
Retail Pharmacy [2, 3, 4, 5] **Express Scripts** (30 day supply)	$15 copay for **generic**; 20% for **brand name formulary**; $35 minimum – $60 maximum 20% for **non-formulary;** $50 minimum – $75 maximum $75 copay for **injectibles**
Mail Order [2, 3, 4, 5] **Express Scripts** (90 day supply)	$30 copay for **generic**; 20% for **brand name formulary**; $70 minimum – $120 maximum 20% for **non-formulary;** $100 minimum – $150 maximum
Hospital Benefits	
Inpatient Hospitalization	Covered at 80% after deductible
Outpatient Surgery	Covered at 80% after deductible
Emergency Room *(waived if admitted)*	Covered at 100% after $155 copay
Urgent Care	Covered at 100% after $40 copay
Mental Health Benefits	
Outpatient	Covered at 100% after $40 copay
Inpatient	Covered at 80% after deductible
Substance Abuse Benefits	
Outpatient	Covered at 100% after $40 copay
Inpatient	Covered at 80% after deductible

[1] *Subject to the deductible; paid at negotiated rates.*

[2] *Generic contraceptives will be covered at $0 copay if filled at an in-network pharmacy or by mail order. Brand contraceptives will be covered at the brand copays listed above.*

[3] *All plans are "Generics Preferred", meaning if you receive a brand name drug when a generic is available, you will pay the coinsurance plus the difference in cost between the brand and generic.*

[4] *This plan includes Limited Step Therapy, so you may be asked to try a "Step 1" drug before the drug you are taking.*

[5] *If you are taking a maintenance drug, you should be using mail order. After 2 fills at retail, the 3rd fill will be denied until you contact Express Scripts.*

Medical Coverage

Select PPO Medical Plan – Available Nationwide

The table below provides a summary of the coverage available from the Select PPO Plan. For further coverage details, please refer to the Summary Plan Description on the Molina Intranet and **www.deltahealthsystems.com**.

	Select PPO Plan	
	In-Network Providers [1]	**Out-of-Network Providers** [2]
Calendar Year Deductible	$500 per individual; $1,500 per family	$1,500 per individual; $4,500 per family
Calendar Year Out-of-Pocket Maximum *(includes deductible)*	$4,000 per individual; $8,000 per family	$8,000 per individual; $16,000 per family
Lifetime Maximum Benefit	Unlimited	
Medical Benefits		
Doctor's Office Visits	Covered at 100% after $25 copay for primary; $40 for specialist	Covered at 50% after plan deductible
Well-Baby Care *(birth through age 6)*	Covered at 100%	Covered at 50% after plan deductible
Preventive Care	Covered at 100%;	Covered at 50% after plan deductible
X-Ray and Laboratory Services	Covered at 100%	Covered at 50% after plan deductible
Complex Imaging	Covered at 100% after $40 copay	Covered at 50% after plan deductible
Chiropractic	Covered at 100% after $40 copay; Limited to 20 visits per year	Covered at 50% after plan deductible; Limited to 20 visits per year
Prescription Drug Benefits		
Retail Pharmacy [3, 4, 5, 6] **Express Scripts** (30 day supply)	$15 copay for **generic**; 20% for **brand name formulary**; $35 minimum – $60 maximum 20% for **non-formulary;** $50 minimum – $75 maximum $75 copay for **injectibles**	Responsible for any amount over what the Network price would have been
Mail Order [3, 4, 5, 6] **Express Scripts** (90 day supply)	$30 copay for **generic**; 20% for **brand name formulary**; $70 minimum – $120 maximum 20% for **non-formulary;** $100 minimum – $150 maximum	No coverage
Hospital Benefits		
Inpatient Hospitalization	Covered at 90% after deductible	Covered at 50% after plan deductible
Outpatient Surgery	Covered at 90% after deductible	Covered at 50% after plan deductible
Emergency Room (*waived if admitted)*	Covered at 100%; after $155 copay	Covered at 100% after $155 copay
Urgent Care	Covered at 100% after $40 copay	Covered at 100% after $40 copay
Mental Health Benefits		
Outpatient	Covered at 100% after $40 copay	Covered at 50% after plan deductible
Inpatient	Covered at 90% after deductible	Covered at 50% after plan deductible
Substance Abuse Benefits		
Outpatient	Covered at 100% after $40 copay	Covered at 50% after plan deductible
Inpatient	Covered at 90% after deductible	Covered at 50% after plan deductible

[1] *Subject to the deductible; paid at negotiated rates*

[2] *Subject to the deductible; Out-of-Network benefits are paid at Usual, Customary and Reasonable (UCR) rates*

[3] *Generic contraceptives will be covered at $0 copay if filled at an in-network pharmacy or by mail order. Brand contraceptives will be covered at the brand copays listed above.*

[4] *All plans are "Generics Preferred", meaning if you receive a brand name drug when a generic is available, you will pay the coinsurance plus the difference in cost between the brand and generic.*

[5] *This plan includes Limited Step Therapy, so you may be asked to try a "Step 1" drug before the drug you are taking.*

[6] *If you are taking a maintenance drug, you should be using mail order. After 2 fills at retail, the 3rd fill will be denied until you contact Express Scripts.*

Medical Coverage

Premier PPO Medical Plan – Available Nationwide

The table below provides a summary of the coverage available from the Premier PPO Plan. For further coverage details, please refer to the Summary Plan Description on the Molina Intranet and **www.deltahealthsystems.com**.

	Premier PPO Plan	
	In-Network Providers [1]	**Out-of-Network Providers [2]**
Calendar Year Deductible	$500 per individual; $1,500 per family	$1,500 per individual; $3,000 per family
Calendar Year Out-of-Pocket Maximum *(includes deductible)*	$2,500 per individual; $5,000 per family	$5,000 per individual; $10,000 per family
Lifetime Maximum Benefit	Unlimited	
Medical Benefits		
Doctor's Office Visits	$25 primary; $40 specialist	Covered at 60% after plan deductible
Well-Baby Care *(birth through age 6)*	Covered at 100%	Covered at 60% after plan deductible
Preventive Care	Covered at 100%	Covered at 60% after plan deductible
X-Ray and Laboratory Services *(includes complex imaging)*	Covered at 100%	Covered at 60% after plan deductible
Chiropractic	Covered at 100% after $40 copay; Limited to 20 visits per year	Covered at 60% after plan deductible; Limited to 20 visits per year
Prescription Drug Benefits		
Retail Pharmacy [3, 4, 5, 6] **Express Scripts** (30 day supply)	$10 copay for **generic**; 20% for **brand name formulary**; $30 minimum – $50 maximum 20% for **non-formulary;** $45 minimum – $65 maximum $75 copay for **injectibles**	Responsible for any amount over what the Network price would have been
Mail Order [3, 4, 5, 6] **Express Scripts** (90 day supply)	$20 copay for **generic**; 20% for **brand name formulary**; $60 minimum – $100 maximum 20% for **non-formulary;** $90 minimum – $130 maximum	No coverage
Hospital Benefits		
Inpatient Hospitalization	Covered at 100% after $500 copay	Covered at 60% after plan deductible
Outpatient Surgery	Covered at 100% after $250 copay	Covered at 60% after plan deductible
Emergency Room (*waived if admitted*)	Covered at 100% after $155 copay	Covered at 100% after $155 copay
Urgent Care	Covered at 100% after $40 copay	Covered at 100% after $40 copay
Mental Health Benefits		
Outpatient	Covered at 100% after $40 copay	Covered at 60% after plan deductible
Inpatient	Covered at 100% after $500 copay	Covered at 60% after plan deductible
Substance Abuse Benefits		
Outpatient	Covered at 100% after $40 copay	Covered at 60% after plan deductible
Inpatient	Covered at 100% after $500 copay	Covered at 60% after plan deductible

[1] *Subject to the deductible; paid at negotiated rates*

[2] *Subject to the deductible; Out-of-Network benefits are paid at Usual, Customary and Reasonable (UCR) rates*

[3] *Generic contraceptives will be covered at $0 copay if filled at an in-network pharmacy or by mail order. Brand contraceptives will be covered at the brand copays listed above.*

[4] *All plans are "Generics Preferred", meaning if you receive a brand name drug when a generic is available, you will pay the coinsurance plus the difference in cost between the brand and generic.*

[5] *This plan includes Limited Step Therapy, so you may be asked to try a "Step 1" drug before the drug you are taking.*

[6] *If you are taking a maintenance drug, you should be using mail order. After 2 fills at retail, the 3rd fill will be denied until you contact Express Scripts.*

Dental Coverage

Delta Dental Plans

Molina Healthcare offers a choice of two dental PPO plans through Delta Dental. Under the PPO plans, you may access dental care services from any dentist you wish. However, if you obtain services from a dentist in Delta's nationwide PPO dental provider network, you will save money on your out-of-pocket expenses, and your benefits will be greater.

All participating PPO dentists agree to provide services at discounted, negotiated fees. If you use out-of-network dental providers, your charges will be based on the reasonable and customary (R&C) rates for your area, as determined by Delta Dental.

You may locate a network dentist near you at **www.deltadentalins.com** or by calling **1-800-765-6003**.

	Low PPO Dental Plan	
	In-Network Providers [1] (Delta PPO network)	Out-of-Network Providers [2] (Includes Delta's Premier network)
Calendar Year Deductible	$50 per individual; $150 per family	$75 per individual; $225 per family
Annual Benefit Maximum	$1,000	
Preventive and Diagnostic Services		
Oral Exams, X-Rays, Cleanings	Covered at 100%	Covered at 80%
Basic Services		
Basic Restorative, Extractions, Oral Surgery	Covered at 80% after deductible	Covered at 60% after deductible
Major Services		
Inlays, Onlays, Crowns and Prosthetics	Covered at 50% after deductible	Covered at 50% after deductible
Orthodontia		
Orthodontic Services *(up to age 19)*	Not covered	
Orthodontia Lifetime Maximum	Not applicable	

	High PPO Dental Plan	
	In-Network Providers [1] (Delta PPO network)	Out-of-Network Providers [2] (Includes Delta's Premier network)
Calendar Year Deductible	$50 per individual; $150 per family	
Annual Benefit Maximum	$1,500	
Preventive and Diagnostic Services		
Oral Exams, X-Rays, Cleanings	Covered at 100%	Covered at 100%
Basic Services		
Basic Restorative, Extractions, Oral Surgery	Covered at 80% after deductible	Covered at 80% after deductible
Major Services		
Inlays, Onlays, Crowns and Prosthetics	Covered at 50% after deductible	Covered at 50% after deductible
Orthodontia		
Orthodontic Services *(up to age 19)*	Covered at 50%	Covered at 50%
Orthodontia Lifetime Maximum	$1,500 (In- and Out-of-Network combined)	

[1] *In-Network providers agree to accept payment based on contracted rates, which may reduce your out-of-pocket expenses*

[2] *Out-of-Network providers are paid based on Reasonable and Customary rates (R&C). If the amount billed is higher than R&C, you will be responsible for paying the difference between R&C and the billed amount. Note: Delta Premier dentists have negotiated rates with Delta and therefore you will not be billed if their fees are above R&C amounts.*

Vision Care and EAP Coverage

Vision Service Plan

Molina Healthcare offers employees vision coverage through Vision Service Plan (VSP).

VSP is the largest provider of vision care services in the United States with more than 22,000 network doctors nationwide. You may choose to obtain your vision care services from any provider you wish. However, when you receive care from doctors in VSP's network, your benefits are greater and your out-of-pocket costs are less.

Vision care received from out-of-network providers is subject to a schedule of allowance, as shown below. Also, when you use out-of-network providers, you must pay the entire amount for the services and then file a claim for reimbursement. You may locate providers in VSP's network at **www.vsp.com** by calling **1-800-877-7195**.

	Vision Service Plan (VSP)	
	VSP Providers	**Out-of-Network Providers**
Eye Exams *(once every 12 months)*	Covered at 100% after $25 copay (for exam and materials) 15% off contact lens exam services. Member's copay will not exceed $60.	Covered up to $50 after $25 copay
Eyeglass Lenses *(once every 12 months)*	Covered at 100%	Covered up to $50 for single vision, $75 for lined bifocals, $100 for lined trifocals
Frames *(once every 24 months)*	Covered up to $130; 20% discount off amounts over $130	Covered up to $70 (retail)
Contact Lenses *(once every 12 months in lieu of frames and lenses)* *Medically Necessary:* *Elective:*	Covered at 100% Covered up to $105	Covered up to $210 Covered up to $105
Laser Vision Correction	Up to 15% off the regular price or 5% off the promotional price at contracted centers	Not covered

Ceridian LifeWorks Employee Assistance Program

Molina Healthcare provides an Employee Assistance Program (EAP) to all eligible employees through Ceridian LifeWorks. The EAP offers free and confidential counseling and assistance in resolving situations that may come up in your personal or professional life, such as:

- Financial and legal issues
- Loss and grief issues
- Family and personal conflicts
- Child care referrals
- Stress and emotional management
- Elder care referrals
- Substance abuse (alcohol and drugs)
- Health concerns
- Referrals for educational opportunities

EAP counselors are available to assist you 24 hours a day, seven days a week by calling **1-888-267-8126**. When you or a family member contacts the EAP, your call will be answered by a trained professional who will discuss your personal concerns with you, and make sure you have access to appropriate resources.

EAP offers you and your family members up to six counseling sessions per incident every year. If more sessions are needed, the EAP professionals will work with you to explore other outside resources. You can also receive discounts for face-to-face services related to legal and financial issues. For more information, visit **www.lifeworks.com** or scan the QR code above. When prompted for User ID, type in "**molina**". The Password is "**healthcare**".

Flexible Spending Accounts

Molina Healthcare offers you two flexible spending accounts (FSAs) through Delta Health Systems – Health Care and Dependent Care – that allow you to use pre-tax dollars to pay for certain health and dependent care expenses. You can participate in one or both of the accounts. Each year, you decide how much to contribute on a pre-tax basis. The annual amount you elect is deducted from your paycheck in equal amounts each pay period. As you incur eligible expenses during the year, you can request reimbursement with your untaxed money from the appropriate account.

Health Care Flexible Spending Account (FSA)

The Health Care FSA allows you to pay for certain healthcare expenses that are not covered or only partially covered by your healthcare plans (medical, dental, vision and prescription drug). Examples of eligible expenses include copays for office visits and prescription drugs, coinsurance, deductibles, and fees for acupuncture, chiropractic care, laser eye surgery and orthodontia.

Eligible expenses can be incurred by you, or any of the eligible dependents that you claim on your federal income tax return. You can contribute between $100 and $2,550 per year to the Health Care FSA.

Dependent Care Flexible Spending Account (FSA)

A Dependent Care Flexible Spending Account (FSA) provides tax-exempt funds you can use to pay for eligible expenses related to the care and supervision of your child or elder dependent. Whether you're a single parent or you and your spouse work or attend school full-time, providing supervised care for your dependents is essential to your livelihood. Expenses such as day care, before and after-school care or even day camps can amount to significant costs paid directly from your pocket. Dependents must live with you and be claimed as a dependent on your federal income tax return. You can contribute between $100 and $5,000 per year to the Dependent Care FSA.

Important IRS Rules

1. Plan carefully! Any money remaining in your FSAs that you do not use during the plan year will be forfeited.
2. Molina Healthcare's Health Care FSA allows a grace period for healthcare claims, so you have 14.5 months to incur expenses that can be reimbursed. For example: the dollars you set aside for the 2016 plan year can be used to reimburse for eligible expenses incurred between January 1, 2016 (or your 2016 benefits effective date) and March 15, 2017. You will then have until March 31, 2017 to submit these claims. This only applies to the Health Care FSA, not the Dependent Care FSA.
3. You cannot change or stop your contributions to the FSAs during the year unless you have a qualifying change in status *(see page 2 for more information on status changes).*
4. Money cannot be transferred between accounts. For example, you cannot use your Dependent Care FSA to reimburse yourself for healthcare expenses and vice versa.

Life and Accidental Death and Dismemberment Insurance

Basic Life Insurance
Accidental Death and Dismemberment (AD&D) Insurance
Voluntary Life Insurance

Molina Healthcare provides all eligible employees who work 30 hours or more each week with Basic Life and Accidental Death & Dismemberment (AD&D) Insurance at no cost to you through The Standard. You are automatically enrolled for these coverages on the first of the month following 30 consecutive days of employment. You may also purchase Voluntary Employee and Dependent Life Insurance for yourself and your family members.

Basic Life Insurance

In the event of your death, this plan pays your beneficiary a benefit equal to two times your annual base salary to a maximum of $300,000. The Executive Class has a maximum up to $750,000.

AD&D Insurance

In the event of your accidental death, this plan pays your beneficiary an additional benefit equal to two times your annual salary to a maximum of $300,000. If you are seriously injured as the result of an accident (e.g., lose your eyesight, paralysis), this plan will pay a partial benefit to you.

Voluntary Life Insurance

You have the opportunity to supplement your Basic Life and AD&D Insurance by purchasing Voluntary Life Insurance through The Standard for yourself and your eligible dependents. Rates are shown on the next page.

Employees

You may purchase additional life insurance in increments of $10,000 to a maximum amount of $300,000, not to exceed 6 times earnings. Coverage amounts over $50,000 require proof of good health and are subject to approval by The Standard.

Spouses/Domestic Partners

You may purchase life insurance for your spouse/ domestic partner in increments of $10,000 to a maximum amount of $300,000, not to exceed 100% of employee's coverage amount. Coverage amounts over $10,000 require proof of good health.

Special Note: If you or your spouse/domestic partner do not enroll in the Voluntary Life Insurance plan when you are first eligible, you may enroll at a later date. However, ALL Voluntary Life coverage amounts require proof of good health and are subject to approval by The Standard.

In addition, requests for increases in coverage beyond initial eligibility, require proof of good health and are subject to approval by The Standard.

In order to enroll in spousal or child coverage, you must also enroll in voluntary employee life insurance for yourself.

Children

You may purchase life insurance for your child(ren) from ages birth to 21 years (or age 25 if full-time student). Coverage elections are available at $2,000, $5,000 and $10,000 per child.

Life and Accident Insurance

Voluntary Life Insurance Rates

Voluntary Life Insurance Costs – Employee/Spouse (Monthly Cost Per $10,000 of Coverage)		
Covered Employee's Age	**Tobacco**	**Non-Tobacco**
0 – 29	$ 1.32	$ 0.86
30 – 34	$ 1.41	$ 0.91
35 – 39	$ 1.86	$ 1.19
40 – 44	$ 3.00	$ 1.94
45 – 49	$ 5.10	$ 3.40
50 – 54	$ 7.86	$ 5.24
55 – 59	$ 13.00	$ 8.97
60 – 64	$ 15.50	$ 10.67
65 – 69	$ 28.78	$ 20.56
70 – 74	$ 49.96	$ 37.00
75 – 79	$ 72.08	$ 55.45
80 – 89	$128.01	$ 102.46
90 and up	$323.49	$ 258.79

Voluntary Life Insurance Costs – Child(ren)		
Covered Child's Age	**Coverage Amount**	**Monthly Cost of Coverage**
Birth to 21 years (25, if full-time student)	$2,000	$ 0.40
	$5,000	$ 1.00
	$10,000	$ 2.00

Income Protection Benefits

If you become ill or injured (not work-related) and are unable to work, Molina Healthcare provides income protection benefits at no cost to you through The Standard. These benefits have been designed to protect your income for both short term and longer periods of disability. Please note that specific restrictions apply to these benefits. Please review the Summary Plan Description on Molina Healthcare's intranet for complete details.

Short-Term Disability (STD) Coverage

Short-Term Disability (STD) coverage provides benefits if you are unable to work for a limited period of time due to an illness or injury. You are automatically provided this coverage the first of the month following 30 consecutive days of employment and work 30 hours or more per week.

- Weekly benefits may replace up to 66.67% of your salary to a maximum benefit of $2,500 per week.
- Your STD benefits will be offset by any federal or state disability benefits, so that the total benefit amount is not greater than 66.67% of your weekly earnings.
- Benefits begin on the eighth day of disability due to an illness or pregnancy.
- Benefits begin on the first day of disability due to an accidental injury.
- Benefits can continue for up to 90 days.

Long-Term Disability (LTD) Coverage

Long-Term Disability (LTD) coverage provides financial assistance if you are not able to return to work after 90 days of disability due to an illness or injury. You are automatically provided this coverage on the first of the month following 30 consecutive days of employment and work 30 hours or more per week.

- LTD benefits can replace up to 60% of your salary. The maximum benefit is defined by your insurance class.
- LTD benefits are offset by any income from other sources including Social Security or Workers' Compensation so that the maximum monthly benefit you receive is not greater than 60% of your monthly earnings.
- LTD benefits begin after you have been continuously disabled for 90 days and have been approved.
- LTD benefits can continue until you are able to return to work (or you reach the normal retirement age for Social Security benefits).

Retirement Savings Plan

401(k) Plan

Molina Healthcare's 401(k) Salaried Savings Plan provides employees with the opportunity to save toward long-term goals such as retirement. Employees make pre-tax contributions to their 401(k) plan accounts through automatic payroll deductions.

You are eligible to participate in the plan:

- Age Requirement: 21 years of age
- Service Requirement: 30 days
- Entry Date: first day of each month

You will automatically be enrolled in the 401(k) plan at 4% of your eligible compensation. If you do not want to be enrolled in the plan, you may opt out of the plan.

Important features of the plan include:

- You can contribute between 1% and 90% of your eligible compensation, pre tax, up to the IRS annual maximum. For 2016, the annual maximum is $18,000. If you are age 50 or older, you may make additional "catch-up" contributions. For 2016, the IRS "catch-up" contribution maximum is $6,000.
- The Company intends to match 100% of the first 4% of the pay you contributed to the plan, vested immediately.
- Your contributions are deducted from your eligible compensation before federal (and most state) income taxes are withheld from your paycheck. As a result, your taxable income is reduced, so you pay less in taxes and have more take-home pay.
- You can invest your contributions in a variety of investment funds offered by the plan. Each has a varying level of investment risk.
- You may enroll on a monthly basis. Increases or decreases to contribution percentages are made as soon as administratively possible. Rollovers from other qualified retirement accounts including Individual Retirement Accounts (IRAs) are permitted.
- You can change your investment choices or stop contributing at any time.
- The percentage of pay you contribute to the plan will automatically increase by 1% each year, up to a maximum of 8% of pay, unless you opt out of this feature.

Employee Stock Purchase Plan (ESPP)

You can purchase Molina Healthcare stock at a 15% discount through after-tax payroll deductions. You may enroll twice a year during the offering periods that begin on January 1 and July 1.

Educational Reimbursement

You can receive up to $2,500 per year (upon 6 months of service as a full-time employee) for course work that relates to your current, or a likely future position.

Paid Time Off

Molina Healthcare offers paid time off benefits so that you can enrich your life both at work and at home. Please refer to the HR intranet site for specific policies and limitations regarding each of these benefits.

Paid Time Off (PTO)

All eligible, full-time employees working a minimum of 30 hours per week accrue PTO each pay period. Paid time off covers vacation, sick and personal time off.

PTO accrual is based on an employee's classification, length of service and active employment status.

Paid Holidays

Molina Healthcare provides eight paid holidays and one floating holiday in 2016, as indicated below.

- New Year's Day
- Martin Luther King Jr. Day
- Memorial Day
- Independence Day
- Labor Day
- Thanksgiving Day
- The Day After Thanksgiving Day
- Christmas Day

2016 Employee Cost Sharing

Employee Payroll Contributions

Molina Healthcare and its employees share the cost of health plan premiums. Molina pays a majority of the cost. Employee contributions are deducted on a pre-tax basis each payroll period. Per-pay-period contribution rates for 2016 are shown below.

	Well-Being Participation		No Well-Being Participation		Annual Savings with Well-Being
	2016 Per Pay Period	2016 Annual	2016 Per Pay Period	2016 Annual	Annual Difference
Exclusive Network Plan					
Employee Only	$26.28	$683.25	$39.42	$1,024.85	$341.59
Employee + Spouse/Domestic Partner	$70.52	$1,833.55	$105.78	$2,705.35	$916.81
Employee + Child(ren)	$65.77	$1,709.99	$98.65	$2,565.02	$855.03
Employee + Family	$143.41	$3,728.58	$215.11	$5,592.84	$1,864.26
Select PPO Plan					
Employee Only	$38.62	$1,004.15	$57.93	$1,506.25	$502.11
Employee + Spouse/Domestic Partner	$101.92	$2,649.79	$152.87	$3,974.65	$1,324.86
Employee + Child(ren)	$94.01	$2,444.16	$141.01	$3,666.30	$1,222.14
Employee + Family	$188.89	$4,911.19	$283.34	$7,366.79	$2,455.60
Premier PPO Plan					
Employee Only	$183.16	$4,762.15	$219.79	$5,714.58	$952.43
Employee + Spouse/Domestic Partner	$384.64	$10,000.72	$461.57	$12,000.86	$2,000.14
Employee + Child(ren)	$348.01	$9,048.22	$417.61	$10,857.86	$1,809.64
Employee + Family	$586.12	$15,239.11	$703.34	$18,286.94	$3,047.82
Delta Dental Low PPO Dental Plan					
Employee Only	$4.62	$120.12			
Employee + Spouse/Domestic Partner	$9.23	$239.98			
Employee + Child(ren)	$11.08	$288.08			
Employee + Family	$16.62	$432.12			
Delta Dental High PPO Dental Plan					
Employee Only	$12.69	$329.94			
Employee + Spouse/Domestic Partner	$25.38	$659.88			
Employee + Child(ren)	$25.38	$659.88			
Employee + Family	$39.23	$1,019.98			
VSP Vision Care Plan					
Employee Only	$1.38	$35.88			
Employee + Spouse/Domestic Partner	$2.65	$68.90			
Employee + Child(ren)	$2.65	$68.90			
Employee + Family	$2.65	$68.90			

Well-Being Participation

Once you are enrolled as an Anthem member, you may complete the confidential on-line health assessment so that **your 2016 payroll contributions will be lower** than if you chose not to participate.

You will not be able to take the health assessment until you receive your medical ID card, however, you will be able to receive the discount once you complete the health assessment.

PLEASE NOTE: The payroll contribution amount for medical benefits that you see on your enrollment confirmation statement will not reflect the discounted “Well-Being Participation” rate; however, the wellness rate will be applied to your payroll deductions the first pay date in 2016. The Well-Being participation rates will only be applied once the Company receives confirmation from Anthem that the Health Assessment has been taken. Reduced participation rates will only apply on a go-forward basis. There are no retro reimbursements. We encourage everyone to take the Health Assessment as soon as they are able in order to participate in the reduced rates as soon as administratively possible.

Q & A

How To Use Your Plans Effectively and Save Money

When should I use urgent care instead of the emergency room benefit?

The emergency room benefit covers life-threatening emergencies only. The urgent care benefit allows you to visit an urgent care facility – in the event of an injury or illness that is not life-threatening – at a much lower cost than an emergency room visit.

When should I use the emergency room benefit instead of urgent care?

The emergency room benefit should be used in the case of a life-threatening situation only. You should go to the nearest facility to receive treatment. The claim will be paid at the in-network level regardless of where the services are received.

How does the medical-plan out-of-pocket maximum work?

Your deductible, co-payments and Rx co-payments for essential benefits, and co-insurance are counted when calculating the out-of-pocket maximum.

What is the difference between a network provider and a non-network provider?

The PPO plan has entered into an agreement with a Preferred Provider Organization (PPO). The PPO network is a group of physicians and hospitals contracted to accept negotiated rates in an effort to reduce the effect of rising healthcare costs while providing you with quality care. Therefore, when a participant (in a plan that has both in-network and out-of-network options) uses a network provider, that participant will receive a higher payment from the plan than when they use a non-network provider. It is the participant's choice as to which provider to use.

What are the other advantages of staying in-network?

If you are enrolled in the Premier or Select plans, staying in network means no balance billing and no claims to file (your physician will do this) in addition to lower out-of-pocket costs for you. In fact, staying in network can significantly reduce monthly costs.

How can I find an in-network physician?

If you already have a family physician, call his/her office and ask if they are contracted with Blue Cross Blue Shield's network. Employees living outside of California may locate Blue Cross Blue Shield providers at **www.bcbs.com**, or by calling **1-800-810-2583**. Employees living in California may locate providers at **www.anthem.com/ca**, or by calling **1-888-212-0276.**

Under what circumstances will payment be made at the higher network payment level for non-network services?

The higher network payment will be made for non-network services in these two situations:

- When there is no choice of provider. If, while receiving treatment at a network facility, a participant receives ancillary services or supplies from a non-network provider or is in a situation in which they have no control over provider selection (such as in the selection of an emergency room physician, an anesthesiologist, or a provider for diagnostic services), these non-network services or supplies will be covered at network benefit levels.
- When a non-network provider is used because a network provider is not reasonably accessible to the member due to geographic constraints (e.g., they are over 35 miles from the participant's location.)

Q & A

What procedures do I need to get pre-certified?

Pre-certification is required for any outpatient surgery that is not performed in the physician's office or for any hospital confinement. There are financial penalties for not pre-certifying these procedures:

- All hospital admissions, except maternity admissions
- Inpatient substance-abuse/mental-disorder treatments
- Skilled nursing facility stays
- Rehabilitation and treatment in a sub-acute facility
- Hospice care
- All transplants

For emergency admissions (subject to extenuating circumstances), such authorization must be obtained within forty-eight hours of admission or the first working day following the admission.

Once I get a procedure pre-certified, doesn't that mean it's covered and it's in-network?

No. Pre-certification only determines medical necessity. It does not guarantee coverage. If your physician orders an inpatient or outpatient procedure, you need to contact Delta Health Systems to confirm that it's a covered service according to your plan document. You should also verify the services are going to be performed using in-network physicians and facilities.

How do Molina Healthcare's medical plans treat pre-existing conditions?

After January 1, 2014, Molina's medical plans no longer have any pre-existing condition limitations.

What is a pended claim?

A pended claim is one where payment is put on hold for any of a number of reasons.

What are some of the reasons for pending a claim?

Generally, claims are pended because additional information – such as duplicate coverage information (necessary for coordination of benefits), or accident details – needs to be provided. Here is a closer look at each of these key reasons:

- Coordination of benefits/duplicate coverage is a factor when you or your dependents are eligible for coverage under a Molina Healthcare plan as well as another plan such as your spouse's employer's plan or a government program. Because reimbursement cannot exceed 100% of medical expenses, there are rules that govern which plan would be primary and to what extent reimbursement should be made. Each year you will receive a form asking you to confirm the existence of other coverage. If this form is not returned or is returned incomplete, your claims may be pended until that information is received.
- Duplicate coverage due to an accident is another factor as a third party may be responsible for your expenses due to negligence. For claims that include a diagnosis that indicates a possible injury, a letter and form will be sent to you asking you to confirm the details of the injury. If the form is not returned or returned incomplete, claims may be pended until the information is received.

What happens if I see a provider outside of the network service area? Will payment be made at the higher network level?

If non-network providers are used because a network provider is not reasonably accessible to the participant due to geographic constraints (e.g., they are over thirty-five miles from the participant's location), such non-network care will be covered at the network benefit levels. Claims will be reviewed and adjusted upon notification from the participant.

Q & A

Prescription Plans

How can I save money on my prescription drug copays?

The first way to save is to ask your doctor for generic versions of your drugs as all three plans have lower copays for generic prescriptions and require generics when available or you pay the difference in cost. Some physicians instruct pharmacists to "dispense as written." If you discuss a generic alternative that can be used, however, the physician can write the prescription appropriately to allow for a generic. If your physician tells you there isn't a generic equivalent or that he/she wants you to take the brand name, follow their orders.

I'm on a maintenance medication for the long term. How can I save money on my copays?

Use the prescription plan's mail order benefit. If you are on a maintenance drug (one that you take regularly to treat an ongoing medical condition) you can get a 90 day supply for an amount equal to what you would pay for a 60 day supply at a retail pharmacy. For more information visit **www.express-scripts.com**.

How do I know if my prescription is on the formulary?

Molina offers employees an on-line tool to help you understand your prescription drug costs, your formulary, which pharmacies to use, and how to save money on your prescriptions. The tool is available both before you enroll in one of Molina's employee health plans and while you are enrolled. Go to **https://www.express-scripts.com/molina**.

Employee Assistance Plan

I didn't know we had an employee assistance program (EAP). What is it and how can I use it?

The EAP is a benefit that provides counseling services for family conflicts, drug and alcohol, depression/stress, relationship or marital issues. Visit Ceridian LifeWorks at: **www.lifeworks.com**.

Miscellaneous

How do I obtain duplicate ID cards for my medical, dental and vision plans?

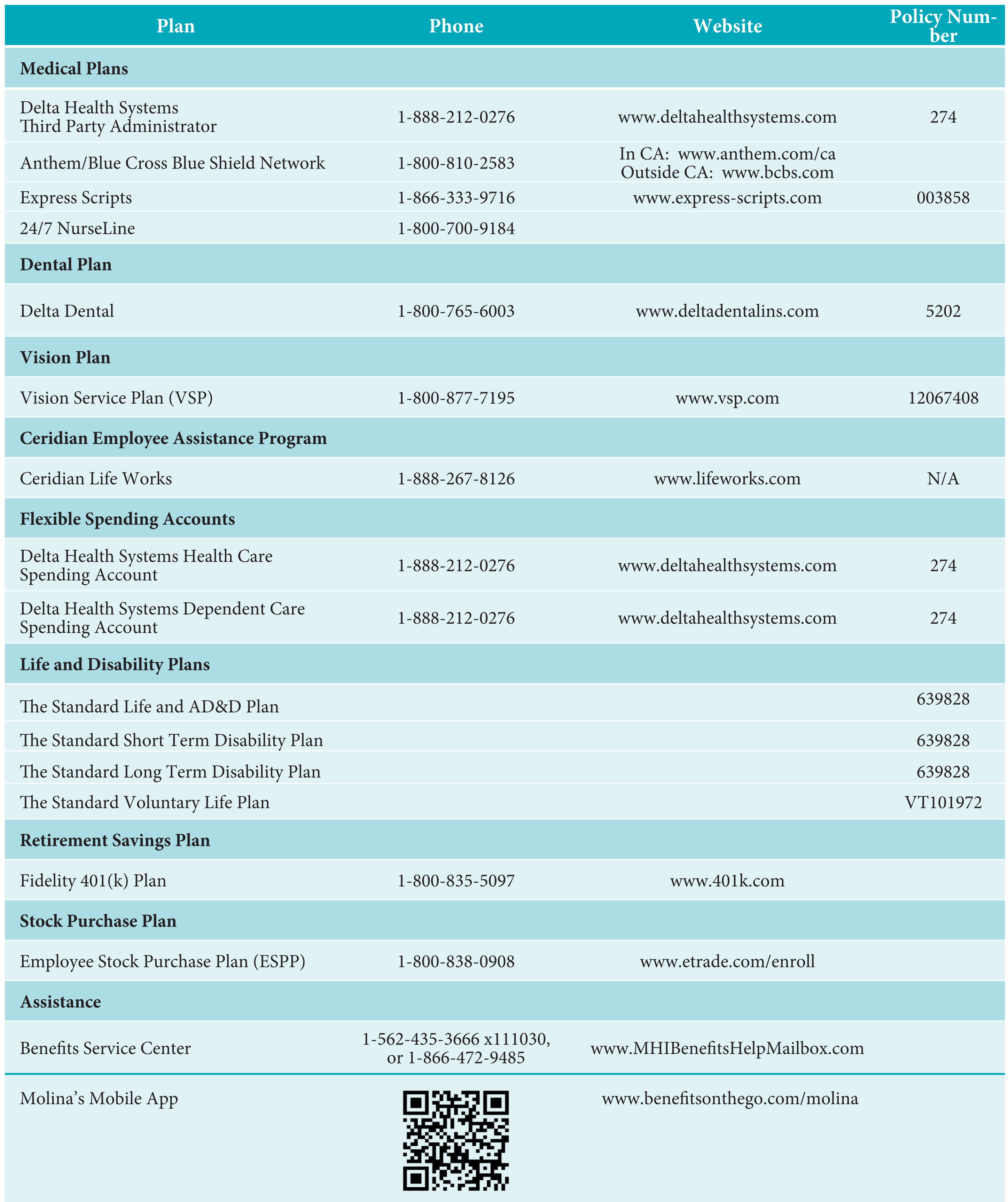
Please contact the plan vendors directly for duplicate ID cards:

- Medical – Delta Health Systems **1-888-212-0276**, Group number: 274
- Dental – Delta Dental **1-800-765-6003 (PPO)**, Group Number: 5202
- Vision care is handled in a paperless manner. The company does not send out ID cards. However, if you like, you may log onto the plan's website (www.vsp.com) to print a generic ID card and additional information.

Whom can I call if I have an eligibility issue with my insurance?

You can contact the Benefits Service Center at **1-562-435-3666 extension 111030**, **1-866-472-9485**, or email the MHI Benefits Help Mailbox.

Benefit Contacts



Plan	Phone	Website	Policy Number
Medical Plans			
Delta Health Systems Third Party Administrator	1-888-212-0276	www.deltahealthsystems.com	274
Anthem/Blue Cross Blue Shield Network	1-800-810-2583	In CA: www.anthem.com/ca Outside CA: www.bcbs.com	
Express Scripts	1-866-333-9716	www.express-scripts.com	003858
24/7 NurseLine	1-800-700-9184		
Dental Plan			
Delta Dental	1-800-765-6003	www.deltadentalins.com	5202
Vision Plan			
Vision Service Plan (VSP)	1-800-877-7195	www.vsp.com	12067408
Ceridian Employee Assistance Program			
Ceridian Life Works	1-888-267-8126	www.lifeworks.com	N/A
Flexible Spending Accounts			
Delta Health Systems Health Care Spending Account	1-888-212-0276	www.deltahealthsystems.com	274
Delta Health Systems Dependent Care Spending Account	1-888-212-0276	www.deltahealthsystems.com	274
Life and Disability Plans			
The Standard Life and AD&D Plan			639828
The Standard Short Term Disability Plan			639828
The Standard Long Term Disability Plan			639828
The Standard Voluntary Life Plan			VT101972
Retirement Savings Plan			
Fidelity 401(k) Plan	1-800-835-5097	www.401k.com	
Stock Purchase Plan			
Employee Stock Purchase Plan (ESPP)	1-800-838-0908	www.etrade.com/enroll	
Assistance			
Benefits Service Center	1-562-435-3666 x111030, or 1-866-472-9485	www.MHIBenefitsHelpMailbox.com	
Molina's Mobile App		www.benefitsonthego.com/molina	

Additional Information

Notice of Special Enrollment Rights

Molina's Initial Notice of Your HIPAA Special Enrollment Rights

Our records show that you are eligible to participate in the Molina Healthcare Health Plan (to actually participate, you must complete an enrollment form and pay part of the premium through payroll deduction). A federal law called HIPAA requires that we notify you about an important provision in the plan – your right to enroll in the plan under its "special enrollment provision" if you acquire a new dependent, or if you decline coverage under this plan for yourself or an eligible dependent while other coverage is in effect and later lose that other coverage for certain qualifying reasons.

Loss of Other Coverage (Excluding Medicaid or a State Children's Health Insurance Program). If you decline enrollment for yourself or for an eligible dependent (including your spouse) while other health insurance or group health plan coverage is in effect, 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 dependent's other coverage). However, you must request enrollment within 30 days after your or your dependent's other coverage ends (or after the employer stops contributing toward the other coverage).

Loss of Coverage for Medicaid or a State Children's Health Insurance Program. If you decline enrollment for yourself or for an eligible dependent (including your spouse) while Medicaid coverage or coverage under a state children's health insurance program is in effect, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage. However, you must request enrollment within 60 days after your or your dependents' coverage ends under Medicaid or a state children's health insurance program.

New Dependent by Marriage, Birth, Adoption, or Placement for Adoption. 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 new dependents. However, you must request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption.

Eligibility for Medicaid or a State Children's Health Insurance Program. If you or your dependents (including your spouse) become eligible for a state premium assistance subsidy from Medicaid or through a state children's health insurance program with respect to coverage under this plan, you may be able to enroll yourself and your dependents in this plan. However, you must request enrollment within 60 days after your or your dependents' determination of eligibility for such assistance.

To request special enrollment or to obtain more information about the plan's special enrollment provisions, contact the Benefits Service Center at 866-472-9485.

Continuation of Coverage Rights

Your group health plan may contain certain options to continue your and or your dependent's health benefits following termination of coverage. These continuation options may include federal COBRA rights, conversion rights, and/or state mandated continuation rights. State and Federal Marketplace exchanges can also provide medical coverage with no health questions plus you may be eligible to qualify for a subsidy to make the coverage affordable to you. Additionally, your group life insurance certificates or booklets may also include and describe certain continuation options that may be available to you. Please examine your options carefully before declining this coverage. You should be aware that companies selling individual health insurance typically require a review of your medical history that could result in a higher premium or you could be denied coverage entirely.

Notice of Women's Health and Cancer Rights Act (WHCRA)

Our medical plan, as required by the Women's Health and Cancer Rights Act of 1998, provides benefits for mastectomy-related services including all states of reconstruction and surgery to achieve symmetry between the breasts, prostheses, and complications resulting from a mastectomy.

If you have had or are going to have a mastectomy, you may be entitled to certain benefits under the Women's Health and Cancer Rights Act of 1998 (WHCRA). 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
- 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. Please review the plan option you elected to determine the actual deductible and coinsurance provisions. Contact the Benefits Service Center for more information.

Additional Information

Notice Regarding the Newborns' and Mothers' Act

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). For plans subject to state law, you will need to review the insurance booklets or certificates describing any additional state law requirements.

If you would like more information, please visit
www.dol.gov/EBSA.

Notice of Availability of Privacy Practices

The Company provides health care benefits and related benefits to its eligible employees and their eligible dependents. By so doing, it creates, receives, uses, and maintains health information about plan participants which is protected by federal law (protected health information or PHI). The Health Insurance Portability and Accountability Act (HIPAA) requires health plan(s) to provide plan participants and others with a notice of the plan's privacy practices with regard to the health information it creates and maintains in the course of providing benefits (Notice of Privacy Practices). This Notice of Privacy Practices describes the ways the plan uses and discloses PHI. To obtain a copy of the plan's Notice of Privacy Practices, you should contact the member services department for your health coverage. Their contact information is located on your ID card. This is also generally available on their respective websites. Additionally, you may contact the Benefits Service Center.

Children's Health Insurance Program (CHIP)

If you lose our company health coverage and if you or your children are eligible for Medicaid or CHIP, your State may have a premium assistance program that can help pay for coverage. Some States use funds from their Medicaid or CHIP programs to help people who are eligible for these programs, but also have access to health insurance through their employer. If you or your children are not eligible for Medicaid or CHIP, you will not be eligible for these premium assistance programs.

To learn about programs that may be available in your state:
www.dol.gov/ebsa/chipmodelnotice.doc or
www.insurekidsnow.gov.

Summary of Benefits and Coverage

As an employee, the medical benefits available to you represent a significant part of your compensation package. They also provide important protection for you and your family in the case of illness or injury. Choosing a health coverage option is an important decision. To help you make an informed choice, your plan provides a Summary of Benefits and Coverage (SBC), which summarizes information about the medical coverage in a standard format. The SBCs are available during Open Enrollment or contact the Benefits Service Center as needed.

For More Information About Your Rights

More information about your rights can be found in your Summary Plan Description, insurance certificates or booklets, as well as any required notices that are sent to you separately regarding these rights. If you would like more information about any of these notices, please contact the Benefits Service Center.

200 Oceangate, Suite 100
Long Beach, CA 90802

MolinaHealthcare.com

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