Molina Healthcare 2023 Benefits

Protecting What's Important to You

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MEDICARE PART D NOTICE

If you (and/or your dependents) have Medicare or will become eligible for Medicare in the next 12 months, a federal law gives you more choices about your prescription drug coverage. Please see the Important Plan Information section for more details.

MESSAGE FROM MOLINA

As an employee, you play a tremendous part in our company's ultimate success. That's why a core tenet of the Molina Experience is to ensure you are offered an attractive and competitive benefits program where you feel financially rewarded. In addition to your compensation package as a part of your total rewards program, we hope the selection of benefits offered through our program helps guarantee the financial, emotional, and physical security your family needs.

Nothing is more important to our company than keeping our employees engaged, productive, and committed to reaching shared goals and objectives. We also understand being an employee is only part of your story; you have a life outside of our company as well. That is why our benefits program is designed to help you achieve maximum potential at work and at home.

ABOUT **THIS GUIDE**

This guide describes the benefit plans and policies available to you and your family as an employee of Molina. The details of these plans and policies are contained in the official plan and policy documents, including some insurance contracts. It is your responsibility to review and familiarize yourself with the plan coverages and exclusions. This guide is meant only to cover the major points of each plan or policy. It does not contain all the details which are included in your summary plan description (as described by ERISA) located online at The Benefit Center **digital.alight.com/molinahealthcare/.**

If there is ever a question about one of these plans or policies, or if there is a conflict between the information in this guide and the formal language of the plan or policy documents, the formal wording in the plan or policy document will govern.

Adding flexibility to the traditional benefit package gives you more control of your health-related expenses. During open enrollment and in certain circumstances (e.g., qualifying events), you can ensure your personal benefits program is always up-to-date and continuing to meet your needs. As your benefit needs change, you can make new benefit selections during open enrollment to accommodate those changes in a cost-effective manner. Outside of open enrollment, you can change your benefits if you experience a *qualifying life event.*

Molina provides basic protection and benefit options through a core group of benefit plans. The cost of many of the plans are shared between you and Molina. You may add several options to this foundation and purchase them through payroll deduction.

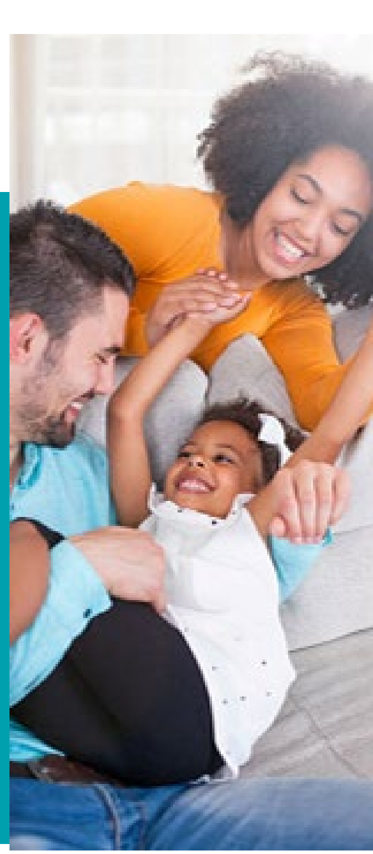
MOLINA **BENEFIT PLANS**

- Medical Insurance
- Dental Insurance
- Vision Insurance
- Health Savings Account (HSA) with Company Contribution
- Flexible Spending Account (FSA) and Limited Purpose Flexible Spending Account (LPFSA)
- Life Insurance and Supplemental Life Insurance
- Short-term and Long-Term Disability Coverage
- Employee Assistance Program (EAP)
- Accident Insurance
- Critical Illness Insurance
- Hospital Indemnity Insurance
- Legal Insurance
- Identity Theft Protection
- Home and Auto Insurance
- Pet Insurance
- 401(k) Retirement Plan
- Employee Stock Purchase Plan (ESPP)
- Paid Holidays, Paid Time Off, Paid Parental Leave and Paid Volunteer Time Off
- Education Reimbursement
- Corporate Banking and Investing
- Employee Discount Program
- Life Care Services
- Health Advocacy Support
- Wellness Program

When You Can Enroll

When you first become eligible for benefits and during open enrollment, you can review all your benefit options and select those which best meet your needs. Your elections will remain in effect throughout the year unless you experience a qualifying life event.

- **New employees must enroll prior to the effective date of their coverage (Coverage begins 1st of the month following 30 days of employment)**
- **Enroll during the open enrollment window**
- **Enroll online at The Benefit Center (digital.alight.com/molinahealthcare/) or through the Alight Mobile App (text "Benefits" to 67426)**
- **If you add dependents to the benefit plan; verification documentation must be submitted within 30 days of your elections in the benefit enrollment portal.**



BENEFIT ELIGIBILITY and **DEPENDENT VERIFICATION**

You are eligible if you are a full-time employee working 30 or more hours per week. Employees with variable hours and seasonal schedules may be considered eligible for benefits. Refer to "Determining Eligibility" later in this guide for details.

Eligible Dependents

- Legally married spouse. (See Spousal Access to Medical Plan Provision)
- Registered Domestic Partner (RDP), are eligible only for supplemental life insurance and the supplemental voluntary plans.
- Natural, adopted or stepchildren, or children in your court-appointed legal guardianship up to age 26.
- Children age 26 or older who are disabled and depend on you for support.
- Children named in a Qualified Medical Child Support Order (QMCSO).

For additional information, please refer to the benefit booklets for each benefit.

Who is Not Eligible

Members who are not eligible for coverage include (but are not limited to):

- Parents, grandparents, and siblings.
- If you and your spouse and/or child work for Molina Healthcare, or your spouse or child becomes employed by Molina Healthcare, you cannot cover them as a dependent if they also have enrolled for coverage through Molina Healthcare. Your dependent children cannot be enrolled for coverage under both employees.

Spousal Access to Medical Plan Provision

If your spouse has access to health insurance coverage through their own employer, they are not eligible to be enrolled in the Molina Medical Plan. Spouses who are not employed or are not eligible for health insurance coverage through their employer can be enrolled in the Molina Medical Plan.

Dependent Verification

It is your responsibility to make sure the proof of eligibility documentation has been provided for each newly enrolled dependent in order to ensure your dependents become covered under the plan. Submit documentation by uploading your documents to digital.alight.com/molinahealthcare.

Type of Dependent

Required Documentation

- **Spouse —Three documents are required**
  - **Section A: Government-Issued Marriage Certificate**
  - **Section B: Federal Tax Return with last 2 years that lists your spouse or Proof of Joint Ownership within the last 6 months.**
    - ***(not required if married in the past 12 months)***
  - **Section C: Spousal Health Affidavit**
- **Child — birth certificate, adoption certificate, or placement agreement**
- **Stepchild — Government-Issued Birth Certificate and one or both documents from Section A and Section B to verify Spouse.**
- **Foster Child — birth certificate and placement letter**
- **Legal Ward — birth certificate and guardianship document**

CHANGING YOUR **BENEFITS**

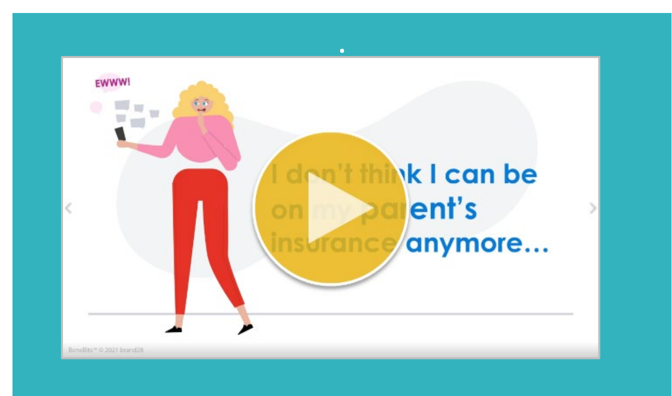
Your elections remain in place for the plan year (runs on a calendar year) unless there is a qualified status change. For an election change to be valid, the change must be consistent with the qualified status change. The following events may be considered a qualified status change:

- Legal marital status: including marriage, divorce, death of a spouse, legal separation, or annulment
- Number of dependents including birth or death of a dependent, adoption, and placement for adoption
- Employment status: termination or commencement of employment of the employee, spouse, or dependent
- Work schedule: reduction or increase in the hours of employment of the employee, spouse, or dependent including changing from full-time to part-time status (or vice versa), a strike or lockout, or commencement or return from an unpaid leave of absence
- Dependent eligibility: satisfying or ceasing to satisfy the eligibility requirement of the plan, such as attainment of limiting age
- Residence of worksite: change in the place of residence or worksite of the employee, spouse, or dependent resulting in a change of health plan access
- Court orders: a court order, judgment or decree, made pursuant to divorce, legal separation, annulment, or change in legal custody requiring coverage for an employee's child
- Medicare/Medicaid: gain or loss of Medicare/Medicaid entitlement of the employee, spouse, or dependent
- Event allowed under the Children's Health Insurance Program (CHIP) Reauthorization Act (you have 60 days to request enrollment due to events allowed under CHIP).

In the event of a divorce, legal separation, or annulment, the ex-spouse is required to be removed from your employer-sponsored coverage. If coverage is mandated by the courts, such coverage is available through COBRA. A qualified status change may allow you to adjust your coverage level for medical, dental, vision, healthcare, and dependent care spending account elections. You must enroll any new dependent into the plan(s) for the new dependent to be covered on the plan(s). All changes must be consistent with the qualified status change and must be made within 31 days of the qualified status change.

Life Happens

A change in your life may allow you to update your benefit choices. Watch the video for a quick take on your options.



Three rules apply to making changes to your benefits during the year:

1. Any change you make must be consistent with the change in status.
2. You must make the change within 31 days of the date the event occurs.
3. All proper documentation is required to cover dependents(marriage certificates, birth certificates, etc.). See page 5 (Benefit Eligibility and Dependent Verification) for more information.

If you wish to make changes to your benefits due to a qualified status change (i.e. getting married, adding a newborn or a newly adopted child), you must do so through the Employee Benefit Center at digital.alight.com/molinahealthcare/ or call the Employee Benefit Center at 1-833-665-4620, Monday through Friday, between the hours of 9:00 am - 6:00 pm EST.

ENROLLMENT **PROCESS**

Before you enroll

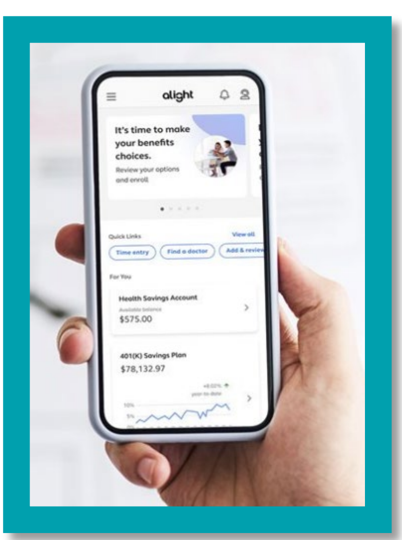
- Know the date of birth, social security number, and address for each dependent you will cover.
- Review your enrollment materials to understand your benefit options and costs for the coming year.

Enroll Online at **digital.alight.com/molinahealthcare/**

(New users see below for account set up instructions)

- *Begin Enrollment*: Click on the Enroll in Your Benefits tile on the home page in the Employee Benefit Center and follow the on-screen prompts to enroll in benefits.
- *Make Your Decisions*: Enroll or waive coverage for each type of benefit. Don’t forget to enter beneficiaries when asked.
- *Review your Choice*: Review and approve your personal information, dependent information, elections and total cost.
- *Confirm*: Your enrollment isn’t complete until you submit your elections.

Enroll via Your Mobile Device



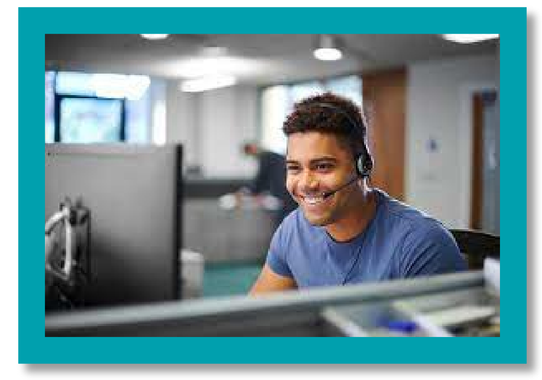
- *Download the Alight Mobile App*: Text “Benefits” to 67426
- *Search for Employer*: Tap Molina Healthcare
- *Login into Account*: Enter username and password. (New users see below for account set up instructions)

Once you are logged into the App you can toggle to the full website to view and change your benefits.

First Time Users

- *Click on New User:* to create your account
- *Enter Personal Information:* (Last four digits of SSN, Date of Birth and Zip Code
- *Create Login Information*: (User Id and Password)
- *Create Security Questions*

If You Need Help Contact, the Employee Benefit Center at 1.833.665.4620



- HOURS OF OPERATION: Monday – Friday 9:00 a.m. – 6:00 p.m. EST

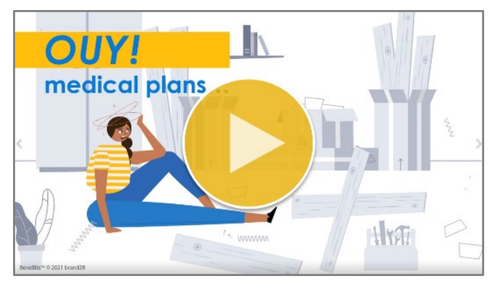
Follow the prompts when calling the Employee Benefit Center to get to Smart-Choice, Dependent Verification Services (DVS), Health and Insurance areas for their specific questions.

Your Options

You have three medical plan options from which to choose. All plans use the Anthem network of healthcare providers and facilities. Visit anthem.com/ca or call Anthem Blue Cross at 1.833.626.4308 to locate in-network providers. All plans offer:

- Coverage for the same services *(like doctor visits, hospital care and lab work)*
- Fully covered in-network preventive care, even before you've met your deductible
- An extensive provider network
- Prescription drug coverage

Learn more about medical plans by watching this video



The High Deductible Health Plans (HDHP) Options:

The HDHP options have **lower premiums** but a higher deductible. This means ***you pay less*** for coverage throughout the year but requires you to meet your deductible before Molina starts sharing in the cost for your medical care.

This plan also partners with a **Health Savings Account (HSA).** Molina contributes to the HSA by providing a $500 contribution for those enrolled in Employee only coverage and $1,000 for those enrolled in Employee+Spouse, Employee+Child(ren) and Family coverage. You can also contribute your own money, pre-tax, to this account to help pay for medical expenses. Some may even save these funds as a **Retirement Savings vehicle.** Molina will match an additional $200 to your HSA if you contribute to the HSA.

Since you are not required to use your HSA contributions each year, like you are with a Flexible Spending Account (FSA), you can grow your money in this account over time and use this for eligible retiree medical expenses down the road.

To learn more about the Triple Tax Advantage of health savings accounts, see page 22.

The PPO Plan Option:

The PPO option has **higher premiums** but a lower deductible. This means ***you pay more*** for coverage throughout the year but does not require you to meet a deductible for many medical services before Molina starts sharing in the cost for your medical care.

This plan will require you to pay a copay for the following medical services:

- Visits to your Primary Care Physician or Specialist
- Visits to a Walk-In Clinic, Urgent Care Clinic and Emergency Room
- Prescription Drugs

This plan allows you to contribute to a **Flexible Spending Account (FSA).** This account allows you to set aside money pre-tax for eligible out of pocket expenses. The trick to using an FSA is figuring out how much to contribute each year. If you contribute **more** than the amount of your eligible medical expenses, you forfeit the extra contributions.

To learn more about the FSA, see page 24.

Covered Expenses

Covered expenses are expenses eligible for reimbursement. Both medical coverage options generally provide benefits for medically necessary services and supplies ordered by a doctor for the treatment of an accidental injury, illness, or pregnancy. Each option also provides benefits for certain routine and preventive services. Under both plans, out-of-network expenses are covered in accordance to the plan, up to the Medicare Maximum Non-Network Reimbursement Plan (MNRP) limitations.

Deductible

The deductible is the amount of your covered expenses you must pay each calendar year before the plan begins to pay. The individual deductible is the amount each covered family member must pay before the plan begins to pay. However, every dollar applied to the individual deductible will also be applied to the family deductible. Once the family deductible is met, the plan will pay benefits for all family members.

Out-of-Pocket Maximum

The maximum limit of all deductible, copay, and coinsurance expenses paid out of a member's pocket in any one calendar year. If you reach the individual out-of-pocket maximum for any covered family member, the plan pays 100% of a person's covered expenses for the remainder of the year. If you reach the family out-of-pocket maximum, the plan pays 100% of your entire family's covered expenses for the remainder of the year.

Coinsurance

After the deductible is met, you and the plan share in the payment of your medical bills. The coinsurance percentage will depend on the plan you choose and whether in-network or out-of-network providers are utilized.

Copayment

Copayment refers to a fixed cost you must pay per occurrence. Copayments are paid directly to the providers (e.g., physician or pharmacy) and count towards your out-of-pocket maximums.

In-Network

These are providers/facilities that are members of the Anthem network. Utilizing these doctors provides you with the **highest** level of coverage and generally you will only need to pay your deductible and any applicable copay or coinsurance. You also cannot be billed for any remaining balance by your provider.

Out-of-Network

These are providers/facilities that are not members of our plan's network. If you utilize an out-of-network provider, you will have a **higher** deductible and out-of-pocket maximum and the plan will cover **less** of your medical expenses.

Locating In-Network Providers

To obtain a listing of providers/facilities participating in the plan's network, visit **anthem.com/ca** or call Anthem Blue Cross at 1.833.626.4308 to locate in-network providers.

The chart below provides an overview of how much you pay when you or your family needs care based on the medical option you choose. This is a summary of benefits for the medical plans. All deductibles and out-of-pocket maximums accumulate in one direction toward in network unless otherwise noted. Any co-pays will accumulate toward your Out-of-Pocket Maximum only. Out-of-network charges accumulate to a separate deductible and out-of-pocket maximum.

	CHOICE PPO PLAN		ESSENTIAL HDHP PLAN		PREMIER HDHP PLAN	
	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network
Your Deductible						
Employee	$500	$1,500	$2,100	$4,200	$1,600	$3,200
Family	$1,500	$4,500	$4,200	$8,400	$3,200	$6,400
HSA Company Contribution*						
Employee	N/A		$500		$500	
Family			$1,000		$1,000	
Matching Contribution			$200		$200	
Your Out-of-Pocket Maximum						
Employee	$4,000	$8,000	$4,200	$10,500	$3,200	$6,400
Family	$8,000	$16,000	$8,400 ($7,900 per individual max)	$21,000	$6,400	$12,800
Coverage for medical services						
Preventative Care Visit	Plan Pays 100%	Plan pays 50% after deductible is met	Plan Pays 100%	Plan pays 50% after deductible is met	Plan Pays 100%	Plan pays 50% after deductible is met
Office Visit						
Primary Care Visit	$25 copay then Plan pays 100%	Plan pays 50% after deductible is met	Plan pays 80% after deductible is met	Plan pays 50% after deductible is met	Plan pays 80% after deductible is met	Plan pays 50% after deductible is met
Specialty Care Visit	$40 copay then plan pays 100%					
Chiropractic (up to 20 visits/year)	Covered	Covered (in-network limitations apply)	Covered	Covered (in-network limitations apply)	Covered	Covered (in-network limitations apply)
Lab and X-ray	$25 copay then Plan pays 100%	Plan pays 50% after deductible is met	Plan pays 80% after deductible is met	Plan pays 50% after deductible is met	Plan pays 80% after deductible is met	Plan pays 50% after deductible is met
Inpatient Hospitalization	Plan pays 80% after deductible is met	Plan pays 50% after deductible is met	Plan pays 80% after deductible is met	Plan pays 50% after deductible is met	Plan pays 80% after deductible is met	Plan pays 50% after deductible is met
Outpatient Surgery	Plan pays 80% after deductible is met	Plan pays 50% after deductible is met (up to $1,000 per surgery)	Plan pays 80% after deductible is met	Plan pays 50% after deductible is met (up to $1,000 per surgery)	Plan pays 80% after deductible is met	Plan pays 50% after deductible is met (up to $1,000 per surgery)
Emergency Room Visit	$200 copay then plan pays 80% after deductible (copay waived if admitted)		$200 copay then plan pays 80% after deductible (copay waived if admitted)		$200 copay then plan pays 80% after deductible (copay waived if admitted)	
Urgent Care Visit	$40 copay then plan pays 100%	Plan pays 50% after deductible is met	Plan pays 80% after deductible is met	Plan pays 50% after deductible is met	Plan pays 80% after deductible is met	Plan pays 50% after deductible is met

HSA Company Contribution Schedule:

- 50% January
- 25% July
- 25% October
- Match will be deposited monthly, following the month in which deductions are posted through payroll

New hires, rehires and newly eligible HSA contributions will be prorated.

PHARMACY **BENEFITS**

Insider tip	Rx expert!
Your medical plan includes prescription drug coverage. You pay a different amount depending on the "tier" or class of drug.	GENERIC drugs are always the least expensive. Get in the habit of asking your doctor or pharmacist if there's a generic alternative.
A FORMULARY is a list of drugs that are preferred by the plan. Plans use formularies to encourage the most cost-effective drugs.	If a generic drug is not available, ask your doctor whether there is an effective brand name medication that is on the plan's preferred drug list.
A PARTICIPATING PHARMACY (one that contracts with your medical plan) will usually offer the best price. You can find a participating (in-network) pharmacy on your plan's website or app.	SHOP AROUND! Even within the same drugstore chain, you may find a better price at a different location. Your medical plan may have an online tool or app to compare prices. Or try websites like goodrx.com or lowestmed.com
You can get a 90-day supply of maintenance medications mailed directly to your home through Anthem's mail order program. You can also get a 90-day supply of your maintenance medications at a CVS retail pharmacy if you prefer not to receive your medications through the mail.	Compare your plan's mail-order copay and shipping costs against your local pharmacy price. If costs are comparable, and mail order is a hassle for you, find out if your plan will cover a 90-day prescription from a local pharmacy.

Preventive Program

This program allows you to obtain preventive medications without reaching the calendar year deductible or copayment from participating pharmacies or home delivery program. The full list is available on the Employee Benefit Center and covers drugs in addition to those required coverage by federal law.

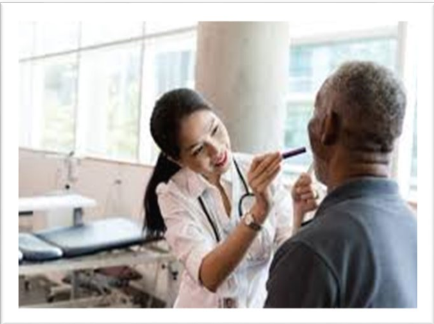
			CHOICE PPO PLAN		ESSENTIAL HDHP PLAN		PREMIER HDHP PLAN	
			In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network
Annual Deductible			Rx costs does not apply toward deductible		Prescriptions subject to medical deductible and out-of-pocket maximums		Prescriptions subject to medical deductible and out-of-pocket maximums	
Annual Out-of-Pocket Maximum			Prescriptions subject to medical out-of-pocket maximums					
Retail Pharmacy Prescription Drug Plan (30 days)								
Tier 1	**$**	**Lower-cost** generics and some brand name drugs	You pay $15 per prescription then plan pays 100%		You pay $15 per prescription after deductible is met		You pay $15 per prescription after deductible is met	
Tier 2	**$$**	**Mid-range** preferred and brand name drugs	You pay $35 or 20% (up to $60) per prescription then plan pays 100%		You pay $35 or 20% (up to $60 max) per prescription after deductible is met		You pay $35 per prescription or 20% (up to $60 max) after deductible is met	
Tier 3	**$$$**	**High-Cost** non-preferred drugs (typically has a more cost-effective generic or preferred brand-name alternative)	You pay 30% (up to $100) per prescription then plan pays 100%		You pay 30% (up to $100 max) per prescription after deductible is met		You pay 30% per prescription (up to $100 max) after deductible is met	
Tier 4	**$$$$**	**High-priced specialty** drug	You pay $125 per prescription then plan pays 100%		You pay $125 per prescription after deductible is met		You pay $125 per prescription after deductible is met	
Mail-Order Pharmacy Prescription Drug Plan (90 days) (Out-of-Network Not Available)								
Tier 1	**$**	**Lower-cost** generics and some brand name drugs	You pay $30 per prescription then plan pays 100%		You pay $30 per prescription after deductible is met		You pay $30 per prescription after deductible is met	
Tier 2	**$$**	**Mid-range** preferred and brand name drugs	You pay $70 or 20% (up to $120) per prescription then plan pays 100%		You pay $70 or 20% (up to $120) per prescription after deductible is met		You pay $70 or 20% (up to $120) per prescription after deductible is met	
Tier 3	**$$$**	**High-Cost** non-preferred drugs (typically has a more cost-effective generic or preferred brand-name alternative)	You pay 30% (up to $200) per prescription then plan pays 100%		You pay 30% (up to $200) per prescription after deductible is met		You pay 30% (up to $200) per prescription after deductible is met	
Tier 4	**$$$$**	**High-priced specialty** drug	You pay $125 per prescription then plan pays 100%		You pay $125 per prescription after deductible is met		You pay $125 per prescription after deductible is met	

HEALTH PLAN **TIPS AND EXAMPLES**

We know it can be confusing when trying to determine what benefits are best for you. Below are some scenarios and tips that will give you some guidance when choosing your benefits.

Current Healthcare Needs

- Any Chronic Conditions needing routine medical appointments
- Ongoing medication needs
- Children in need of orthodontia services
- How much in medical expenses did you experience last year and this year? Did you reach your deductible or out of pocket maximum?
- Is one person in your family the driver of your medical expenses and if so, what were their expenses last year and this year in comparison to your overall family medical expenses?



Anticipated Healthcare Needs

- Family Planning
- Know that you tend to have to seek Urgent Care/ER due to sick or injured children at least once a year
- Upcoming surgeries
- Health issues that you have been putting off but plan on addressing next year

Family Status Changes in the New Year

- Getting married
- Having a baby
- Spouse turning 65 and will enroll in Medicare

Financial Status

- Money left over in checking account after routine household expenses are covered
- Money available in savings account
- Ability to pay for out-of-pocket medical expenses

Goals for the Near Future

- Retirement
- Family planning
- Buying a house
- Paying off student loan

HEALTH PLAN **PERSONAS**

We know it can be confusing when trying to determine what benefits are best for you. Below are some scenarios and tips that will give you some guidance when choosing your benefits.

Graduated with First Job Jake

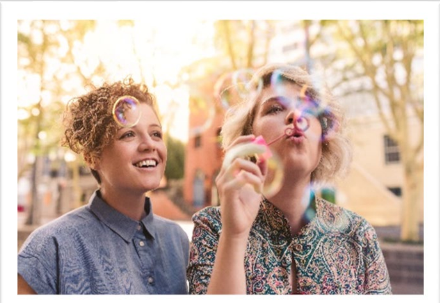
LIFE STAGE: Mid 20s. Single and very active. Rents an apartment with two other people.

GENERAL HEALTH: Jake has no health conditions, lives a healthy lifestyle and tends to only access medical care when he suffers an injury due to his love of basketball and rugby. Jake's father and grandfather, however, do have a history or high blood pressure and heart disease.

HEALTHCARE CONCERNS: Jake rarely thinks about his health but knows that he may need to seek treatment at an Urgent Care or ER when he hurts himself playing his favorite sport. He knows that he should see his Primary Care Physician on a regular basis due to the history of heart disease in his family but does not want to incur medical expenses for a visit that will most likely just confirm that he is healthy.

FINANCIAL STATUS: Jake can cover all his standard household expenses and still be able to pursue his interests.

RECOMMENDED BENEFIT ELECTIONS: Jake can cover all his standard household expenses and still be able to pursue his interests.



Lovin' Married Life Maggie and Melinda

LIFE STAGE: Between mid-20s and early 30s. Married with no children.

GENERAL HEALTH: Both are very healthy, and both do not have family histories of chronic conditions.

HEALTHCARE CONCERNS: They have no current healthcare concerns and only see their health care provider each year for a routine physical.

FINANCIAL STATUS: Maggie and Melinda just bought their first home and are looking for ways to save money because they want to start a family in the next couple of years.

RECOMMENDED BENEFIT ELECTIONS: Like Jake, Maggie and Melinda should consider the HSA plan with the lower premiums and open a health savings account so they can start setting aside money for the future medical expenses they will have when they start their family.

Husband and Girl Dad Sam

LIFE STAGE: Between early 40s and late 50s; Married with 3 children (2, 5, 7).

GENERAL HEALTH: Recently underwent chemotherapy and cancer is currently in remission. His daughter, Samantha, has type 1 diabetes.

HEALTHCARE CONCERNS: Ensuring his daughter's diabetes is controlled and that his cancer remains in remission. Sam knows that next year he will experience high medical expenses due to his need for routine follow-ups to monitor his recovery. Sam worries about how to handle these larger bills next year since he had to use most of his HSA savings this year for his treatment.

FINANCIAL STATUS: Sam worries about his ability to cover the medical expenses he knows he will have next year.

RECOMMENDED BENEFIT ELECTIONS: If Sam is more comfortable with having more money coming out of his check than the uncertainty with his health care expenses, Sam may want to consider the PPO plan. With the PPO plan, Sam will know what his co-pays will be when he visits his physician for follow-up care.

Dreaming of the Beach Life Donna

LIFE STAGE: Between late 50s and early 60s. Recently remarried with adult children. Just became a grandmother.

GENERAL HEALTH: Has a chronic health condition that is managed with medication.

HEALTHCARE CONCERNS: Donna is actively managing her Type 2 Diabetes with medication, diet and exercise. However, she has also noticed in the last couple of years she is also struggling with high blood pressure and chronic pain.

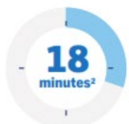
FINANCIAL STATUS: Donna has been aggressively saving for her upcoming retirement. She contributes the most she can each to year to her 401(k) account. She worries about how she will be able to afford healthcare when she retires.

RECOMMENDED BENEFIT ELECTIONS: Donna should consider moving from the PPO to the HSA plan. Instead of contributing to the FSA which requires her to spend those dollars, she could take those contributions and put them in a health savings account each year so that when she retires, she will have money available for her health care expenses.

HELPING YOU CHOOSE **THE BEST CARE OPTIONS FOR YOUR NEEDS**

Services include preventive care (annual wellness visits), common health concerns (cold & flu, pink eye, stomach ailments, seasonal allergies & much more), behavioral health (anxiety and depression), prescriptions request and referrals to a specialist.

In-person: \$\$



Virtual:

Available by appointment only during normal business hours

Connect with a doctor through the Sydney Health App by appointment.
Mon- Fri 9-9 ET and Sat – Sun 9-5 ET

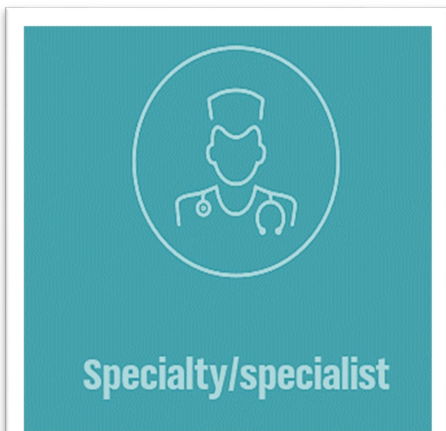
Over 300 common health concerns including:
Bladder issues, chicken pox, cold & flu, ear infections, pink eye, sinus infections, sprains, skin conditions & much more

In-person:

Virtual:

Available by Walk-In or by Appointment
Most are open 7 days a week with extended hours

Available through the Sydney Health app 24/7/365



Specialty care that concentrates on specific health issues such as:
Behavioral Health (stress, anxiety, depression, grief, panic attacks, relationship issues, parenting concerns, dermatology and Allergies

In-person:

Wait times can vary

Virtual:

Available by Appointment only
Available during normal business hours and may also provide medical advice by phone after hours

Connect with a doctor through the Sydney Mobile app by appointment. M-F 9-9 ET

Emergency care for severe abdominal pain, allergic reactions, head injury, chest pains, bone breaks, trouble breathing, or uncontrollable bleeding.

In-person:

Virtual Care Not Available

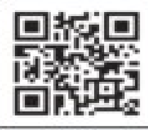
VIRTUAL HEALTHCARE **HAS ITS BENEFITS**

If you have tried virtual care through your primary care doctor or the Sydney mobile app, you know how convenient it is. If you haven't tried it, this may be the right time to try the expanded features that make it even easier to access care when and where you need it.

For example, if you have the flu and can't get to the doctor's office, you can connect through your phone, tablet, or computer with a doctor who can diagnose your symptoms. Or perhaps you wake up on vacation and realize you forgot to bring your medicine. With virtual care, you can contact a doctor through your smartphone to have a prescription called in to a pharmacy near you.

Make the most of your virtual primary care features by always starting with your Sydney Health app to:

- **Schedule appointments** for ongoing condition monitoring for things like diabetes and high blood pressure.
- **Talk with a doctor** through the secure medical chat for on-demand urgent care.
- **Access supportive care services**, including prescription refills, preventive tests, screenings, and labs.
- Use the **Symptom Checker**: it will guide you to have a video visit or chat with a doctor, if needed.
- Receive a **referral for in-office visits** with other doctors and specialists in your plan's network, as needed.



Scan this QR code with your smartphone camera to get more information about virtual care.

Convenience for a busy life

Virtual care offers peace of mind and saves you time and money.

Visits are available at **low or no cost to you** — check your plan for details.

Access virtual care from anywhere through your phone, tablet, or computer.

Find care **24/7, 365 days each year.**

Receive **personalized insights and recommendations** so you can make more-informed decisions about your health.

Help with Chronic Conditions

Complex Care provides a nurse care manager who will help higher-risk patients, such as those with major orthopedic, heart, nerve, or cancer-related issues, with:

- Goal planning and health and lifestyle coaching,
- Ways to aid self-management skills and drug adherence,
- Getting answers to health-related questions about specific treatments,
- Depression screening with referral to behavioral health services, if needed, and
- Coordination of care between many providers and services.

Condition Care offers one-on-one support from a Condition Care Nurse Manager to participants with asthma, diabetes, chronic obstructive pulmonary disorder (COPD), coronary artery disease, and heart failure. With the support of dieticians, social workers, pharmacists, health educators, and other health professionals, the nurse and patient will work together to:

- Better manage chronic conditions, and
- Avoid unnecessary emergency room visits, hospital stays and time away from work.
- To speak with a nurse, call 1-833-626-4308.

Musculoskeletal Program. If you or a covered family member has a musculoskeletal diagnosis — such as spine or joint issues — Anthem's care coordinators can help ensure you receive the best treatment for your condition. A board-certified, leading specialist will review your case and confirm whether your provider's recommended course of treatment is appropriate for your condition. This can help prevent misdiagnosis and may provide effective alternatives to surgery.

- If you qualify (based on claims and diagnosis information Anthem usually receives from your provider), a care team member will proactively reach out to you to coordinate all the details.

Support for Growing Families

Building Healthy Families. Every family grows in its own way. Anthem's all-in-one program, at no extra cost to you, can help your family grow strong whether you are trying to conceive, expecting a child, or in the thick of raising your children.

Building Healthy Families offers personalized, digital support through the Sydney Health mobile app or on anthem.com/ca.

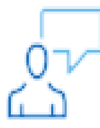
- Digital tools and resources for pregnancy and beyond
    - Track ovulation
    - Monitor prenatal health risks, such as blood pressure and weight.
- Health and wellness expertise for your family and pregnancy
    - Talk to a health coach via chat or phone during pregnancy about your questions and concerns
    - Explore a library of thousands of educational articles and videos

HEALTHCARE THAT **SUPPORTS THE LGBTQIA+ COMMUNITY**

Inclusive Care Program

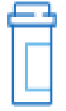
Trusting and feeling comfortable with your doctors is important for everyone. Inclusive Care can connect you to medical and emotional support you or your family member may be seeking.

What Inclusive Care provides beyond traditional healthcare

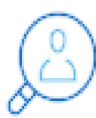


Medical and behavioral health support.
Anthem can locate healthcare professionals who are allies and understand your needs. For your convenience, most visits can be in person or virtual.

Gender affirmation surgery guidance and counseling.
Our Inclusive Care program includes one-on-one guidance from a Nurse Care Manager (NCM). The NCM can set up a virtual second opinion and lead you to world-class hospitals, facilities, and experts.*



Specialty medication support.
This includes educational support for hormone therapy, preexposure prophylaxis (PrEP), and other critical medications you may need.



Community programs and educational resources.
These programs and resources can be used to improve communications; increase understanding; and create a support system for you, a family member, or a friend.

With the Sydney℠ Health app, you can find care, chat with a doctor, and check your benefits 24/7. Download the app today.

We're committed to serving you

Our goal is for every member to feel welcomed, respected, and valued. Healthcare should instill confidence and support your total health. This is why we created Inclusive Care — to offer exceptional healthcare services that suit your individual needs.

ALTERNATIVE **FACILITIES**

If you have time to evaluate your options for non-emergency health treatments, these alternative facilities can provide the same results as a hospital at a fraction of the cost.

Need	Alternative	Features	Savings
Surgery	Ambulatory Surgery Center (ASC)	▪ Specializes in same-day surgeries ▪ Cataracts, colonoscopies, upper GI endoscopy, orthopedic surgery and more ▪ Held to same safety standards as hospitals	Up to 50% over hospital stay*
Physical therapy	Free-standing physical therapy center	▪ Important part of the recovery process after an injury or surgery	40 to 60% over a hospital setting*
Sleep study	Home testing	▪ Diagnoses sleep apnea and other conditions ▪ Cost is often covered by insurance if considered medically necessary	Approx. $4,500*
Infusion therapy	Home or outpatient infusion therapy	▪ For drugs that must be delivered by intravenous injections, or epidurals ▪ Delivered by licensed infusion therapy provider ▪ Maintain normal lifestyle and comfort of home or outpatient center	Up to 90% over hospital stay*

**in-network*

How to find an alternative treatment facility

Ask your doctor if your treatment must be delivered in the hospital. You can also search for surgical centers, physical therapy, etc. on your plan's website; or call member services for assistance.

Online tools such as healthcarebluebook.com and healthgrades.com help you compare costs and doctor ratings. Some alternative services include a facility fee to cover overhead costs. To avoid a surprise on your bill, ask about facility fees before you schedule your appointment.

HEALTH **ADVOCATE**

Provides 24/7 access to a toll-free telephone assistance with any healthcare or insurance related issues. Personal Health Advocates can answer questions about your health plan, explain insurance jargon, help you understand your coverage, find doctors and get support for medical and insurance issues – all to save you time, money and worry.

This benefit provides:

- Hands-on support for a variety of health and well-being issues
- Compassionate, confidential help available 24/7
- Unlimited access for you and your eligible family members
- Interactive mobile app and website

What this benefit can do:

- Find the right doctors
- Explain complex medical conditions
- Coordinate care and schedule follow-up visits
- Arrange specialized treatments and tests
- Offer personal contact with RNs to support treatment decisions
- Clarify benefits
- Resolve insurance claims
- Help locate eldercare services

To get started, **visit www.HealthAdvocate.com/molina** or call 866-695-8622.

UNDERSTANDING **MEDICARE**

Deciding on a Medicare health plan is one of the most important decisions you will make in retirement. Even if you have health insurance through an employer, it is important to be informed about all your insurance options.

Introducing Alliant Medicare Solutions

Alliant Medicare Solutions will bring you and your loved one's access to resources to support you as you navigate various Medicare options. These services are entirely voluntary and are provided at no cost to you or your loved ones.

Some of the items they will review

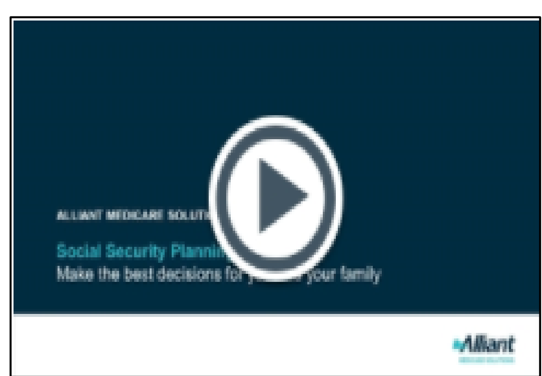
- How does original Medicare work?
- What supplemental coverage options are available?
- What is Medicare Part A, Part B and Part D?
- Is Medicare free?
- When should someone call Medicare?

If you or your loved one is eligible for Medicare or approaching the age of 65, call Alliant today to discuss your options.
(833) 888-1495

Alliant Medicare Solutions is provided by Insuractive LLC, a Nebraska resident insurance agency. Insuractive LLC is wholly owned by Alliant Insurance Services, Inc.

To learn more about Medicare and your options review the guide or watch the video below.

[Your Guide to Medicare]



[Social Security Planning Video]

SAVINGS ACCOUNTS

Molina offers several accounts that enable you to pay for eligible expenses tax-free.

Health Savings Account (HSA)

Available to those enrolled in the High Deductible Health Plan if you are not enrolled in any other health coverage, Medicare, Tricare, or claimed as a dependent on someone else's tax return.

Health Care Flexible Spending Accounts (FSAs)

Your options depend on your medical plan enrollment.

- **Health Care FSA** – If you are not enrolled in the High Deductible Health Plan, you can use this account for medical, pharmacy, dental and vision expenses.
- **Limited Purpose FSA** – If you are enrolled in the High Deductible Health Plan, you can use this account to pay for dental and vision expenses only.

Dependent Care Flexible Savings Account (FSA)

Use for eligible childcare expenses for dependents under age 13 or eldercare.

Comparison of Accounts

	HSA	FSA
Do I have to be enrolled in the Medical Plan?	**YES** Eligibility is limited to employees enrolled in the High Deductible Health Plan only	**NO**
Does the company contribute to the savings account? *Amount for full-year 2023*	**YES** Company Base contribution $500 Employee coverage $1,000 Family Coverage Prorated based on time of enrollment Schedule of deposits: 50% in Janaury, 25% in July and 25% in October Company Match up to $200 (Deposited monthly)	**NO**
Can I contribute my own savings *2023 Contribution Limits*	**YES** Employee: $3,850 Family: $7,750 Those 55 and older can contribute an additional $1,000 annually.	**YES** Health Care or Limited Purpose FSAs : $3,050 Dependent Care FSA: $5,000
Will my savings roll over each year?	**YES** Unlimited	**!** Up to IRS Limits for Health Care and Limited Purpose FSAs; No roll over for Dependent Care FSA
Will I earn interest on my savings?	**YES**	**NO**
Are the savings tax-free?	**YES**	**YES**
Will I get a debit card?	**YES**	**YES**
Do I keep the money if I leave the company?	**YES**	**!** Option to continue Health Care or Limited Purpose FSAs only through COBRA
Can I also have a Flexible Spending Account (FSA)?	**!** Limited Purpose and Dependent Care FSA only	**N/A**

HEALTH SAVINGS ACCOUNTS (HSA) and LIMITED PURPOSE FLEXIBLE SPENDING ACCOUNTS

Eligibility to participate in the health savings account and limited purpose flexible spending accounts is limited to employees enrolled in the High Deductible health plan only. If you enroll in this health plan, you may also enroll in these spending account by electing how much you wish to contribute in the way of pre-tax contributions.

Health Savings Account (HSA)

A Health Savings Account (HSA) is an easy way to pay for healthcare expenses that you have today and save for expenses you may have in the future.

Four reasons to love an HSA

1. **Tax-free.** No federal tax on contributions, or state tax in most states. Withdrawals are also tax-free as long as they're for eligible healthcare expenses.
2. **No "use it or lose it."** Your balance rolls over from year to year. You own the account and can continue to use it even if you change medical plans or leave the company.
3. **Use it now or later.** Use your HSA for healthcare expenses you have today or save it to use in the future.
4. **Boosts retirement savings.** After you retire, you can use your HSA for healthcare expenses tax-free, or for regular living expenses, taxable but no penalties.

HSAs are considered a triple-tax benefit in which you can save funds pre-tax (lowering your taxable income), spend funds tax-free on eligible expenses, and earn interest on your savings tax-free once you reach a specific savings threshold.

Are you Eligible?

The HSA is not for everyone. You're eligible only if you are:

1. Enrolled in the Premier or Essential HDHP Plans.
2. Not enrolled in other non-HDHP medical coverage, including Medicare, Medicaid, or Tricare.
3. Not a tax dependent.
4. Not enrolled in a healthcare Flexible Spending Account (FSA), unless it's a "limited purpose" FSA for dental and vision expenses.

Limited Purpose Flexible Spending Account (LPFSA)

A LPFSA is a spending account, like a traditional flexible spending account, and can work in conjunction with the health savings account.

By establishing a LPFSA, you can set aside pre-tax money to pay for eligible vision and dental expenses, while preserving your HSA funds for your medical expenses. You may contribute up to the annual maximum deferral as determined by the IRS. Contributions are deducted from your pay pre-tax, meaning no federal or state tax on that amount.

During the year, you can use your FSA debit card to pay for services and products. Withdrawals are tax-free as long as they're for eligible healthcare expenses.

Elections cannot be changed during the plan year, unless you experience a qualifying event, and you must enroll in this plan each year (unlike the HSA which continues each year until you change your election).

Like the traditional flexible spending account, if you contribute more than the amount of your actual eligible expenses, you give up the extra money (unlike the HSA). So, it is best to estimate conservatively when deciding how much to contribute.

Expenses must be incurred between January 1, 2023, and March 15, 2024 (2 ½ month "grace period" after the end of the plan year) and claims must be submitted for reimbursement no later than March 31, 2024. If you don't spend all the money in your account, you can rollover up to $570 to use the following year. Any additional remaining balance will be forfeited.

To learn more about High Deductible Health Plans and Health Savings Accounts, click on the videos below.

What can I use my HSA for?

You can use the funds in your HSA:

- To pay for qualified medical, dental, vision and prescription drug expenses, including over-the-counter drugs that have been prescribed by a doctor, as defined in IRS Publication 502.
- As supplemental income after age 65. Once you are 65, you can withdraw funds for any reason without paying a penalty, but they will be subject to ordinary income tax. If you are under age 65 and use your HSA funds for nonqualified expenses, you will need to pay taxes on the money you withdraw, as well as an additional 20 percent penalty.

To review expenses, you can and cannot use with your HSA click the links below:

- **Eligible Expenses**
- **Ineligible Expenses**

Can I use my HSA to pay for qualified medical expenses for a spouse or tax dependent?

Yes, even if your spouse or tax dependent is covered under another health plan. To get personalized details, consult a qualified tax advisor.

How much can I contribute to an HSA?

The IRS sets annual contribution limits each year.

Note that any contributions made to your HSA by family members, your employer or others count toward this limit.

Year	Individual Coverage	Family Coverage
2023	$3,850	$7,750

If you are 55 or older, you can contribute an additional $1,000 each year. Note: The primary account holder must be 55 or older (even if the spouse is of that age).

How can I make contributions?

There are two ways to make a deposit:

- Payroll deductions
- Online through your Smart Choice account using your personal checking account.

Can I consolidate multiple HSA accounts?

Yes. IRS regulations permit the transfer or rollover of funds to an HSA from an existing HSA.

When can contributions be made?

Contributions for a taxable year can be made any time within that year and up until the tax filing deadline for the following year, which is typically April 15.

What happens if my HSA balance exceeds the annual contribution limit?

If you contribute more than the IRS annual contribution limit, you have until the tax-filing deadline to withdraw excess contributions. If excess contributions are not withdrawn by the tax-filing deadline, an annually assessed excise tax of 6 percent will be imposed on any excess contributions.

What happens to my remaining account balance at the end of the year?

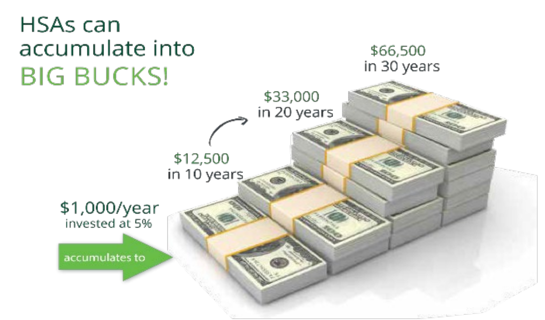
Any remaining balance automatically rolls over year after year.

Is there a time limit for reimbursing myself?

You can reimburse yourself at any time for expenses you paid for out-of-pocket. There is no time limit, but the expenses must have been incurred since you opened your HSA.

Can I invest my HSA dollars?

Yes, you can choose to invest your HSA dollars in mutual funds once you reach your investment threshold.



FLEXIBLE SPENDING **ACCOUNTS**

The healthcare and dependent care flexible spending accounts offer you a great way to save money. These accounts allow you to set aside pre-tax money from each paycheck to pay for eligible out-of-pocket healthcare and dependent care expenses you and your dependents incur throughout the plan year. You may participate in these accounts even if you or your dependents do not participate in the medical, dental, and/or vision plans.

To learn more about Flexible Spending Accounts, click on the video below.

To review expenses, you can and cannot use with your FSA click the links below:

- **Eligible Expenses** – now include more over-the-counter items!
- **Ineligible Expenses**

FSA Debit Card Process

If you enroll in the healthcare FSA, Smart Choice will automatically send you an FSA debit card to your home. Use is limited to qualified locations for eligible products and services. Many eligible transactions can be auto-substantiated at the point of service. However, there are certain purchases which may decline and require you to submit receipts to validate the expense. You will be reimbursed by Smart Choice for these purchases once the expense has been approved.

Healthcare Flexible Spending Account

You may set aside up to the annual maximum deferral as determined by the IRS in the healthcare FSA to reimburse yourself for eligible healthcare expenses not covered under the medical, prescription drug, dental, or vision plans. Reimbursements can be made for most expenses which would qualify for a healthcare deduction on your income tax return. **You don't have to enroll in one of our medical plans to participate in the healthcare FSA. However, if you or your spouse are enrolled in a high deductible health plan (like our Anthem Premier and Essential HDHP plan) you can only participate in the Limited Purpose FSA for dental and vision expenses.**

Eligible Healthcare Expenses

- Deductibles, copayments, coinsurance
- Prescription drugs and medicines
- Over-the-counter medications which are medically necessary (doctor's prescription required)
- Hearing aids, batteries, and exams
- Smoking cessation programs
- Prosthetic, orthopedic, and orthotic devices
- Acupuncture, chiropractic, and physical therapy visits
- Vision care (exams, glasses, contacts, Lasik surgery)
- Dental care (including orthodontia)

Ineligible Healthcare Expenses

- Over-the-counter medications not medically necessary
- Cosmetic expenses
- Massage therapy
- Health club dues and weight loss programs
- Insurance premium

Dependent Care Flexible Spending Account

You may set aside up to the annual maximum per household the IRS allows in the dependent care account to pay for certain child/day care or elder care expenses incurred during the plan year. Your dependent care expenses must be necessary for you and your spouse to work or actively look for work or attend school as a full-time student.

Eligible Dependent Care Expenses

- Childcare provided at a day care center or through a private provider
- Nanny services in the home associated with the care of a dependent
- Day camps associated with the care of a dependent
- Pre-school tuition which is day-care related (price of tuition alone is not eligible)
- Annual registration fees for day care providers
- After-hours care that results from working odd hours or overtime

Ineligible Dependent Care Expenses

- Tuition cost of a pre-school that is not associated with day care services
- Tuition cost of schooling for first grade and above
- Housekeeper/nanny services in the home that is not associated with care of a dependent
- Education-related fees for classes or camps not associated with care of a dependent
- Entertainment-related expenses
- Deposits associated with the inception of childcare
- Materials fee (e.g., books, clothing, food, etc.)
- Late fees for delinquent accounts
- After-hours care not associated with work

FLEXIBLE SPENDING ACCOUNT **CALCULATION**

FSA Reimbursement Runout Period

Expenses must be incurred between January 1, 2023, and March 15, 2024 (2 ½ month "grace period" after the end of the plan year) and claims must be submitted for reimbursement no later than March 31, 2024. If you don't spend all the money in your account, you can rollover up to the IRS allowable amount to use the following year. Any additional remaining balance will be forfeited.

Substantiation and Submission of Claims

If you incur eligible healthcare expenses which cannot be auto-substantiated and/or are declined via debit card, you will be required to submit claim forms to Smart Choice for processing and reimbursement. Dependent care claims will be reimbursed only up to your account's current balance. If a dependent care expense exceeds the dependent care balance, you'll be reimbursed the additional amount as contributions are made to your account through your payroll deductions. Direct deposit reimbursement is available

Saving Money With Flexible Spending Accounts

The example to the right shows how your flexible spending account may save you money. Assume you pay about $1,500 each year on prescriptions, copayments, deductibles, and other medical expenses, and you spend another $4,000 on childcare. As you can see, you can reduce your taxable income and increase your spending money by $1,200.

How Much to Contribute

The trick to using flexible spending accounts is figuring out how much to contribute each pay period. If you contribute less than the amount of your actual eligible expenses, you miss out on some tax savings. If you contribute more than the amount of your actual eligible expenses, you give up the extra money. So, it is best to guess a little low when deciding how much to contribute.

	If you participate	If you don't participate
Annual Salary Before Taxes	$60,000	$60,000
Less		
Healthcare	($1,500)	$0
Dependent Care	($4,000)	$0
Taxable Income	$54,500	$60,000
Less		
Income Taxes and Social Security at 22%	($11,990)	($13,200)
Your Take-Home Pay	$42,510	$46,800
Less		
Healthcare	$0*	($1,500)
Dependent Care	$0*	($4,000)
Net Pay You Can Spend	$42,510	$41,300
Your Tax Savings	$1,210	$0

** You get reimbursed from your health care and dependent care spending accounts*

In an average year, how much do you spend out-of-pocket on…	Amount
Routine Doctor Visits? Hospital Services? X-Rays, Lab Exams, Tests? Eye Doctor Visits? Glasses/Contacts and Cleaning Supplies? Prescriptions? Dental Expenses?	
Total: Regular Expenses *(note: $2,000 is the max. amount you can contribute per year)*	
Divided by Number of Paychecks You Receive Each Year	÷ 52 *(or ÷ 26)*
Amount to Deposit into Your Medical Account Each Pay Period	= __________

In an average year, how much do you spend out-of-pocket on…	Amount
Last Year's Tax Credit-Eligible Day Care Expenses? Day Care/Preschool Programs? After-School Programs? Babysitters? Adult Day Care? Plus Any Fee Increases?	
Total: Regular Expenses *(note: $5,000 is the max. amount you can contribute per year)*	
Divided by Number of Paychecks You Receive Each Year	÷ 52 *(or ÷ 26)*
Amount to Deposit into Your Dependent Care Account Each Pay Period	= __________

Good dental health is critical to your overall health. The Molina dental plans are flexible enough to respond to a variety of dental care needs. Whether you need a checkup, a filling, or major dental work, the dental plan covers you.

WHY SIGN UP FOR DENTAL COVERAGE

It's important to go to the dentist regularly. Brushing and flossing are great, but regular exams catch dental issues early before they become more expensive and difficult to treat.

That's where dental insurance comes in. Dental insurance makes it easier and less expensive to get the care you need to maintain good oral health.

Dental insurance covers three types of treatments:

- **Preventive** care includes exams, cleanings and x-rays
- **Basic** care focuses on repair and restoration with services such as fillings, root canals, and gum disease treatment
- **Major** care goes further than basic and includes bridges, crowns and dentures

DID YOU KNOW?

Keeping your teeth and gums healthy isn't the only reason you should practice preventive dental care. With good dental hygiene, you can greatly reduce your risk of getting cavities, gingivitis, periodontitis, and other dental problems.

You can also reduce your risk of secondary problems caused by poor oral health such as diabetes, heart disease, osteoporosis, respiratory disease and even cancer.

DENTAL PLAN **TERMINOLOGY**

DEDUCTIBLE

The amount of covered expenses you pay each calendar year before benefits become payable by the plan. The deductible does not apply to preventive or diagnostic services.

Learn more by watching this video

COINSURANCE

After the deductible is met, you and the plan share in the payment of your dental bills. The percentage of covered changes depends upon the network option you choose.

ANNUAL MAXIMUM

For all services, other than orthodontia, there is a maximum benefit the plan will pay each calendar year per individual. Once this annual maximum is reached, no further benefits will be payable during the calendar year.

LIFETIME MAXIMUM

For orthodontics, there is a lifetime maximum benefit the plan will pay for each individual. Once this maximum is reached, no further benefits will be payable.

REASONABLE AND CUSTOMARY

The Delta Dental plans will not pay for any charge above the Reasonable and Customary (R&C) limit when you receive services from out-of-network providers. R&C charges are the fees usually charged for comparable services and supplies in your geographic area. Delta Dental will determine the reasonable and customary amount of a charge and keep up to date with the latest dental practices and fees around the country. Because in-network dentists provide services and supplies for agreed rates, you will never exceed R&C charges when you use in network providers.

DENTAL BENEFITS

You always pay the deductible and copayment ($). The coinsurance (%) shows what the plan pays after the deductible.

	Delta Dental PPO - High		Delta Dental PPO - Low	
	In-Network	Out-of-Network	In-Network	Out-of-Network
Annual Deductible	$50 per individual; $150 per family		$50 per individual; $150 per family	$75 per individual (combined with in-network); $225 per family (combined with in-network)
Annual Plan Maximum	$2,000 (applies to basic and major services only)	$2,000 (combined with in-network)	$1,000 (applies to basic and major services only)	$1,000 (combined with in-network)
Diagnostic & Preventive	Plan pays 100%	Plan pays 100%[1]	Plan pays 100%	Plan pays 100%[1]
Basic Services Fillings Root Canals Periodontics	Plan pays 80% after deductible	Plan pays 80% after deductible	Plan pays 80% after deductible	Plan pays 60% after deductible
Major Services	Plan pays 50% after deductible	Plan pays 50% after deductible	Plan pays 50% after deductible	Plan pays 50% after deductible
Orthodontia Children (up to age 19)	Plan pays 50%	Plan pays 50%	Not covered	Not covered
Ortho Lifetime Max	$2,000		Not Applicable	Not applicable

1: The Plan will pay 100% up to the Maximum Plan Allowance (MVA). An Out-of-Network provider may balance bill for the difference between the MPA and the cost of the service. In-Network providers are prohibited from balance billing a patient.

What you need to know about this plan

Features: See any provider, but you'll pay more out of network

Am I restricted to in-network providers? No

Do I have to select a primary dentist? No

Can I use my HSA or FSA? If you participate in a healthcare HSA or FSA, you can use your account to pay for dental expenses.

Where can I get more details? Visit the Delta Dental website deltadentalins.com.

VISION

Your vision is important to your health. Even if you don't need vision correction, an annual eye exam checks the health of your eyes and can even detect more serious health issues such as diabetes, high blood pressure, high cholesterol, and thyroid disease.

The plan provides paid coverage for basic services at a participating provider location for comprehensive eye examination, spectacle lenses contact lenses, in lieu of spectacle lenses and a frame, as long as you do not exceed the plan allowances. For a directory of participating providers, please visit www.vsp.com.

You'll even find discounts on services like LASIK and PRK, rebates on contact lenses, and money off on hearing aids and other related services. Visit the plan's website to check out these extra savings.

	VSP Vision Plan	
	In-Network	**Out-of-Network**
Exams Benefit Materials Frequency	$25 copay then plan pays 100% Once every 12 months	$25 copay then plan pays 100% (reimbursed up to $50) Once every 12 months
Eyeglass Lenses Single Vision Lens Bifocal Lens Trifocal Lens Frequency	Plan pays 100% of basic lens (materials copay applies) Once every 12 months	Reimbursed up to $50 Reimbursed up to $75 Reimbursed up to $100 Once every 12 months
Frames Benefit Frequency	Up to $170 allowance, plus a Plan pays 20% discount from the remaining balance Once every 24 months	Reimbursed up to $70 Once every 24 months
Contacts (Elective) Conventional Medically Necessary Frequency	Fitting & eval exam: up to $60 copay then Plan pays 100%; up to $105 allowance (copay waived; instead of eyeglasses) Once every 12 months	Reimbursed up to $105 (in-network limitations apply) Once every 12 months

Learn more by watching this video

LIFE INSURANCE

Life and AD&D Insurance

Molina provides basic life and AD&D insurance for employees and offers voluntary insurance options for employees and their dependents.

Basic Life and AD&D Insurance

Life insurance is an important part of your financial wellbeing, especially if others depend on you for support. Molina provides basic life and accidental death and dismemberment insurance to all eligible associates at no cost equal to 2 times your base annual earnings, rounded to the next higher $1,000. Up to a maximum benefit of $300,000 for non-executives and $1,000,000 for executives (AVP and above). *The benefit amounts will be reduced if you are age 65 or older. Refer to the plan document for details.*

Coverage is automatic; you do not need to enroll. This benefit includes continuation of basic life insurance while totally disabled, an accelerated benefit option, and an age reductions formula where coverage reduces to 65% at age 65, and to 50% of the original amount at age 70.

Your Beneficiary = Who Gets Paid

Reminder: *Be sure to assign a beneficiary or living trust to ensure your assets are distributed according to your wishes.* If the worst happens, your beneficiary—the person (or people) on record with the life insurance carrier—receives the benefit. Make sure that you name at least one beneficiary for your life insurance benefit, and change your beneficiary as needed if your situation changes.

A Note About Taxes

Company-provided life insurance coverage over $50,000 is considered a taxable benefit. The value of the benefit over $50,000 will be reported as taxable income on your annual W-2 form.

SUPPLEMENTAL **LIFE INSURANCE**

Protecting those you leave behind

Voluntary Life Insurance allows you to purchase additional life insurance to protect your family's financial security. You can also purchase life insurance for your spouse and/or child(ren).

Type	Coverage Amounts
Employee	Increments of $10,000 Maximum of 10× basic annual earnings, not to exceed $1,000,000 Guarantee issue 10x basic annual earnings, up to $300,000
Spouse	Increments of $10,000 up to the lesser of 100% of your coverage amount up to $500,000 Guaranteed Issue: $70,000 (not to exceed 100% of employee amount)
Child(ren)	Increments of $5,000, $10,000 or $20,000 Guaranteed Issue: $20,000
Note: Benefit amount reduces to 65% at age 65.	

Your cost for supplemental life insurance is based on your age and the amount of coverage requested. Payroll deductions for supplemental coverages are deducted on an after-tax basis to generate a tax-free benefit at time of claim.

Benefit Reduction

Benefits are reduced by 35% on the policy anniversary date following the date you attain age 65 and by 50% when you attain age 70. The reduction will apply to the Life Insurance Benefit and Principal Sum (AD&D) in force immediately prior to the first reduction made.

Guarantee Issue (GI)

Guarantee issue is the amount of life insurance you are eligible to purchase on yourself without medical questions being required by the carrier. As a newly eligible employee or spouse you are eligible to elect up to the GI amount in Voluntary life insurance coverage. Amounts above the GI will require you to complete an Evidence of Insurability (EOI).

Evidence of Insurability (EOI)

An EOI is a questionnaire on your health status. If you elect a coverage amount over the Guarantee Issue or outside of being newly eligible for this coverage you will need to complete an EOI form. Once completed, the carrier will review your questionnaire and determine if coverage will be issued.

DISABILITY COVERAGE

Disability insurance provides income replacement should you become disabled and unable to work due to a non-work-related illness or injury. Molina provides eligible employees with Short-Term and Long-Term Disability coverage at no cost as shown below. Coverage is automatic; you do not need to enroll. Employees will be automatically enrolled in the Long-Term Disability Buy-up benefit plan and can choose to waive the buy-up benefit.

Company Paid Short- Term Disability Benefits	
Elimination Period	Sickness—7 days Accident—none
Benefit Percentage	60% of pre-disability earnings
Maximum Weekly Benefit	$1,500
Maximum Period of Payment	13 weeks (Maximum payment period is based on the first day benefits begin, not the first day you are disabled.)

Company Paid Long- Term Disability Benefits	
Elimination Period	After 90 days of disability
Benefit Percentage	50% of pre-disability earnings
Maximum Monthly Benefit	$15,000 for Top Leaders $10,000 for Directors, AVP, VP, SVP and Presidents $8,000 for All Other Employees
Maximum Period of Payment	Until SSNRA

Employee Paid Buy-up Long- Term Disability Benefits	
Elimination Period	After 90 days of disability
Benefit Percentage	60% of pre-disability earnings
Maximum Monthly Benefit	$15,000 for Top Leaders $10,000 for Directors, AVP, VP, SVP and Presidents $8,000 for All Other Employees
Maximum Period of Payment	Until SSNRA

Short-Term Disability (STD) insurance replaces part of your income for limited duration issues such as:

- Pregnancy issues and childbirth recovery
- Prolonged illness or injury
- Surgery and recovery time

STD payments may be reduced if you receive other benefits such as sick pay, workers' compensation, Social Security, or state disability. Molina pays the cost of this core coverage.

Long-Term Disability (LTD) insurance replaces part of your income for longer term issues such as:

- Debilitating illness (cancer, heart disease, etc.)
- Serious injuries (accident, etc.)
- Heart attack, stroke
- Mental disorders

If you qualify, Long-Term Disability benefits begin after short-term disability benefits end. Payments may be reduced by state, federal, or private disability benefits you receive while disabled.

3 Things to know about Long-Term Disability Insurance

1. It can protect you from having to tap into your retirement savings.
2. You can use LTD benefits however you need, for housing, food, medical bills, etc.
3. Benefits can last a long time—from weeks to even years—if you remain eligible.

VOLUNTARY PLANS

You’re unique—and so are your benefit needs

Voluntary benefits are optional coverages that help you customize your benefits package to your individual needs.

Molina offers plans to help:

- replace income if you’re injured or ill
- bridge the gap for special healthcare needs
- secure your identity, and help you manage legal issues
- save money on protection for your pets, home and auto

You pay the entire cost for these plans, but rates may be more affordable than individual coverage. And you get the added convenience of paying through payroll deduction.

Voluntary benefits are just that: voluntary. You have the freedom and flexibility to choose the benefits that make sense for you and your family. Or, you don’t have to sign up for voluntary benefits at all. The choice is yours.

OUR VOLUNTARY PLANS

Accident Insurance

Critical Illness

Hospital Indemnity

Legal Insurance Plan

Identity Theft Protection

Pet Insurance

Home and Auto Insurance

VOLUNTARY **HEALTH RELATED PLANS**

THINGS TO CONSIDER

Your medical plan helps cover the cost of illness, but a serious or long-lasting medical crisis often involves additional expenses and may affect your ability to bring home a full paycheck. These plans provide you with resources to help you get by while there are additional strains on your finances.

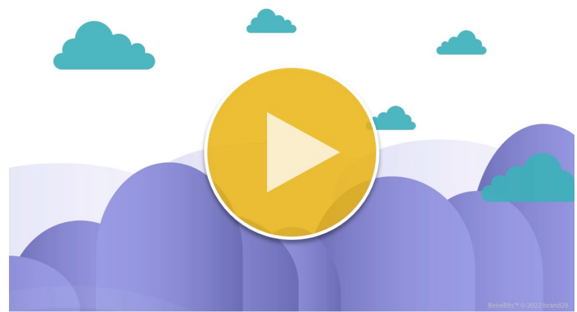
To learn more about these plans click on the videos

Accident Insurance

The Aflac Group Accident Insurance plan provides benefits to yourself, your spouse/ domestic partner, and dependents for those unanticipated events resulting from a covered injury. The plan provides benefits to help cover expenses, such as:

- Surgery and anesthesia
- Stiches
- Casts

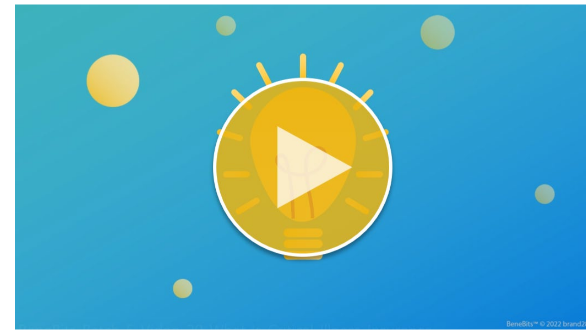
You can enroll at any time. If you enroll in the Premier Medical (HDHP) or Essential Medical (HDHP), you can enroll in employee only coverage at no cost to you or enroll in family coverage at a discount.



Accident Insurance

Critical Illness Insurance

The Aflac Group Critical Illness plan provides a lump sum benefit to help pay for the added costs of treatment for a covered critical illness, such as cancer or heart attack. The plan includes a wellness incentive — receive a cash benefit for getting a wellness exam and/or mammogram. You can use the plan's benefits for anything from ongoing living expenses, such as mortgage payments and childcare or copays and deductibles. Critical Illness Insurance is available to yourself, your spouse/ domestic partner, and dependents.



Critical Illness Insurance

Hospital Indemnity Insurance

The Aflac Group Hospital Indemnity plan provides benefits to yourself, your spouse/ domestic partner, and dependents to help pay for the added costs associated with a hospital stay or medical emergency, including:

- Hospital admission
- Hospital confinement
- Intensive Care unit
- Everyday living expenses, such as utility bills, groceries, rent or mortgage and more.

The plan includes a wellness incentive — receive a cash benefit for getting a wellness exam.

Hospital Indemnity Insurance

Continental American Insurance Company (CAIC), a proud member of the Aflac family of insurers, is a wholly-owned subsidiary of Aflac Incorporated and underwrites group coverage. CAIC is not licensed to solicit business in New York, Guam, Puerto Rico, or the Virgin Islands. For groups with their situs in California, group coverage is underwritten by Continental American Life Insurance Company, Columbia, South Carolina.

PLANS TO KEEP **YOU AND YOUR FAMILY SECURE**

Home and Auto Insurance

Compared with purchasing auto and home insurance on your own, purchasing group auto and home insurance could provide you with up to $562 by making a switch. You get access to a variety of personal insurance policies, including home,* landlord's rental dwelling, condo, mobile home, renters, recreational vehicle, boat and personal excess liability.

Identity Theft Protection

To learn more about these plans click on the videos

Your identity is made up of more than your Social Security number and credit score. That's why the Allstate Identity Protection Pro Plus (InfoArmor) does more than monitor your credit reports. This plan is available to you, your spouse/ domestic partner, and dependents.

This plan looks after your online activity, from financial transactions to what you share on social media. And if fraud occurs, a $1 million identity theft insurance policy and remediation experts have you covered.

Allstate Identity Protection offers proactive monitoring to help stop fraud at its earliest sign and enables quick restoration for minimal damage and stress. In-house experts who are highly trained in identity restoration are available 24/7 to fully restore compromised identities, even if the fraud or identity theft occurred prior to enrollment.

For more information, please visit **myaip.com** or call 1-800-789-2720

Legal Program

Life is full of memorable occasions – like getting married or buying a home. It also comes with some unexpected events, such as a contactor dispute or traffic ticket. Do you have a place to turn if those situations come with legal matters?

That's where legal insurance comes in. It's designed to protect you from legal expenses, much like health insurance helps protect you from healthcare costs.

The ARAG Legal Insurance Plan offers you, your spouse/ domestic partner, and dependents access to 14,000 network attorneys who can work with you in person or over the phone. With legal insurance, network attorney fees are 100% paid in full for most covered matters.

You can enroll in the ARAG Legal Insurance Plan within 30 days of your hire date, or at Open Enrollment. In addition, you can find complete details about the ARAG Legal Plan and cost information at **ARAGLegalCenter.com** with the access code: 18312mhc or by calling 1-800-247-4184.

Pet Insurance

Protect your furry, scaled, or feathered loved ones with healthcare that allows you to use any vet anywhere. Choose between different plans and receive reimbursement on services through Nationwide Pet Insurance. Pre-existing conditions apply for your pet.

Call 1-877-738-7874 and mention you're a Molina Healthcare employee or visit **petinsurance.com/molinahealthcare** for details and a quote.

FINANCIAL BENEFITS

We offer benefits and tools to support your financial goals. We recognize that financial wellness is about the healthy balance between living for today while preparing financially for tomorrow. It's about achieving a state of well-being where you live within your means, feel confident in your future and are prepared for the unexpected.

PLANS TO HELP YOU WITH YOUR FINANCIAL GOALS

Molina Salary Savings Plan

Employee Stock Purchase Plan

Education Reimbursement

Corporate Employee Investing and Banking

Commuter Benefits

Employee Discount Program

RETIREMENT **BENEFIT**

It is never too early to start preparing for retirement. So don't wait. When it comes to saving for your future. The Molina Retirement Plan can help you start saving money to cover your expenses during retirement.

The Retirement plan allows both you and the Company to contribute money towards your retirement. You can choose to invest up to the IRS limits as pre-tax or Roth after-tax dollars. If you are age 50 or older, you can also make a "catch-up" contribution each year. You can change your contributions at any time during the year by logging into your account at **www.401k.com.**

Enrollment

You may participate the first of the month after 30 days of employment. You'll be enrolled automatically at a contribution level of 4% of your eligible compensation. If you do not wish to participate, you may opt out of the plan.

Contributions

You can contribute between 1% and 90% of your eligible compensation. You can contribute on a before-tax basis or Roth after-tax basis up to the IRS limit. Your contribution will increase automatically by 1% each year, up to a maximum of 15% unless you opt out of this feature.

Molina Healthcare matches the first 4% of your employee contributions to the 401(k) plan. These contributions are pre-tax even when we match the Roth after-tax contribution you make to the plan.

Vesting of Company Contributions

You are 100% and immediately vested in your own contributions. You are vested in Molina Healthcare's contributions after one year of service.

The Benefit of Long-Term Saving

Contributing even 1% of your pay today can make a big difference in your savings when you retire. That's because of compounding, which is the ability for any earnings on your savings to be reinvested and earn even more money for you. The earlier you contribute, the more time your earnings have to compound. In the long run, you can save more money for retirement by gradually increasing your contribution over time using the automatic increase feature.

Enrolling in the Plan is Easy

- **Create your account –** log in to **www.401k.com** or call 800-835-5097 to get started
- **Register your account** – Set up your username and password to access your account. Note: if you have/had other employer-sponsored savings account(s) held at Fidelity, you can utilize your existing login credentials to see all of your accounts on the portal.
- **Take Action** – including electing how much you want to contribute to your retirement and which funds to invest your money.

Make the Most of Your Benefits. Download the NetBenefits Mobile App

- **See** all your Fidelity Workplace accounts
- **Monitor** account balances
- **Review** and **Change** investments
- **Update** your contribution amount
- **Access** articles, videos and podcasts in the NetBenefits Library

NetBenefits® smartphone and iPad® app

NetBenefits® Microsoft Surface™ app

EMPLOYEE STOCK **PURCHASE PLAN (ESPP)**

Did you know you can buy company stock at a discount?

What is an ESPP?

An Employee Stock Purchase Plan, or ESPP, gives employees an opportunity to become owners of the company by purchasing shares of stock at a discounted rate.

Contributions

You may enroll twice a year during the offering periods that occur in June and December. You will contribute to the plan through after-tax payroll deductions.

Discount on the Stock Purchase

The discounted purchase price is determined by comparing the Stock price on the date of grant to the Stock price on the date of purchase. Through the ESPP, you can purchase Molina Healthcare stock at a 15% discount and the 15% discount is applied to the lower of those prices to determine the purchase price.

Learn More

To learn more, visit the Human Resources section on the Molina intranet, The Hub.

EDUCATION **REIMBURSEMENT**

Molina believes that continuing one's education has a positive impact on an employee's contribution to the Company and supports its employee's initiative for continuing their education by providing reimbursement towards their education related expenses.

Eligibility

Employees who are employed full-time and have been continuously employed for six (6) months prior to the beginning the eligible curriculum, course or incurring the expense are eligible. Employees must be in an active status at the time of the reimbursement.

Contributions

Molina will reimburse up to $5,250 annually for employees who successfully complete approved courses.

Eligible Courses

All courses and related educational expenses require management approval as the program expenses are reimbursed from your management's fiscal year budget. Eligible courses include college (Associates, Bachelors, Masters of Doctorate) and Certification courses from accredited schools related to the employee's current role or probable future job assignment.

Eligible Expenses

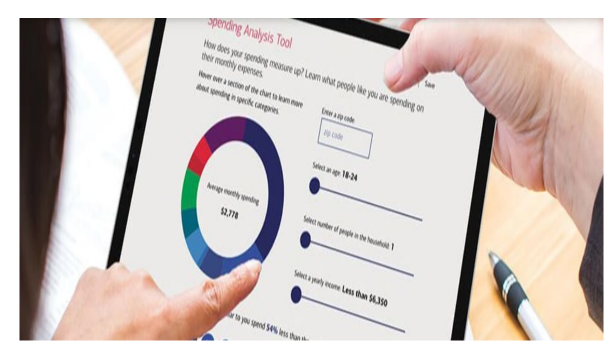
- Tuition for courses offered by educational institutions
- Fees associated with certification courses
- Fees associated with licensure and/or professional memberships

Learn More

To learn more, visit the Human Resources section on the Molina intranet, The Hub.

CORPORATE BANKING with BANK OF AMERICA

Enjoy more ways to pursue financial goals



Through Bank of America employees can get a special bundle of no-fee banking services. All you need to do is set up your payroll direct deposit into your personal eligible Bank of America checking or savings account.

Find out about these special banking benefits, including:

NO Bank of America monthly maintenance fees

NO non-Bank of America ATM fees[2]

NO Bank of America domestic wire transfer fees

Plus, you can:

- Use our free Mobile Banking app,[3] which makes it easy to bank on the go
- Enjoy rewards and benefits personalized for you
- Schedule an appointment to meet with a financial center specialist

TRANSPORTATION SAVINGS ACCOUNT

Do you have out-of-pocket commuting expenses for public transportation, van pooling, or for worksite parking? If so, you can save on taxes by enrolling in our transportation savings account, administered by Smart-choice.

Savings

Save up to $570 per month tax free on commuting expenses.

Contributions

This account lets you set aside money – before it is taxed through payroll deduction. You may enroll in or stop this program at any time. Money in the account can be used in future months or plan year.

Eligible Expenses

You can use commuter benefits for transit, rideshares and qualified paid parking.

Transit Riders

- Bus
- Subway
- Train
- Trolley
- Ferry
- Water Taxi
- Light Rail

Drivers

- Parking Expenses
- Meters
- Garages and Lots

Carpoolers

- Vanpool
- Ridesharing (Lyft Shared)

EMPLOYEE DISCOUNT **PROGRAM**

Great Discounts for Molina Healthcare Employees and their families.

Enjoy health, happiness, and savings with the LifeBalance Program. Molina Healthcare offers thousands of exciting employee discounts through The LifeBalance Program. LifeBalance connects you with great deals on the things you care about most, including family fun, travel, health, fitness, electronics, sports, the arts and above all, a good deal.

How Do I Start Saving?

Visit MolinaHealthcare.LifeBalanceProgram.com to create your free account with the email address of your choice and start saving today! Be sure to sign up for email updates to stay informed about new, seasonal, and time-sensitive discount offers.

Who Is Eligible?

Molina Healthcare employees and their household family members can register at MolinaHealthcare.LifeBalanceProgram.com and use program discounts!

What Can I Save On?

Shop deals on exercise, electronics, apparel, travel, attraction admission, meal delivery, mortgage loans, childcare, gardening, healthcare products, and so much more! Some of LifeBalance's most popular savings include:

*Brands are subject to change at any time

Who Do I Contact with Questions?

The LifeBalance Members Services Team is always happy to assist you! Please call 888.754.5433 or email info@LifeBalanceProgram.com with any questions or feedback!

THE KEY TO KEEPING YOUR BALANCE IS KNOWING WHEN YOU'VE LOST IT

The challenges of daily life can be hard to balance. Whether it's work, school or family obligations, it's no wonder that many of us sometimes have trouble managing the ups and downs of our day-to-day lives.

A Happier, Healthier You

Creating a healthy balance between work and play is a major factor in leading a happy and productive lifestyle, but it's not always easy.

We offer programs to help you:

- Manage stress, chemical dependency, mental health and family issues
- Maximize your physical well-being
- Take time to spend with family and friends, take care of personal business, or just have a little extra "me time".

Taking care of yourself will help you be more effective in all areas of your life. Be sure to take advantage of these programs to stay at your best.

PLANS TO HELP ACHIEVE BALANCE

Employee Assistance Program
Paid Time Off
Paid Parental Leave
Paid Volunteer Time Off
Holiday Pay
Wellness Program
Life Care Services

Help for you and your household members

There are times when everyone needs a little help or advice, or assistance with a serious concern. The EAP through Mutual of Omaha can help you handle a wide variety of personal issue such as emotional health and substance abuse; parenting and childcare needs; financial coaching; legal consultation; and eldercare resources. Best of all, contacting the EAP is completely confidential, free and available to any member of your immediate household.

No cost EAP resources

The EAP is available around the clock to ensure you get access to the resources you need:

- Unlimited phone access 24/7
- In-person or video counseling for short-term issues; up to 6 visits per issue each rolling 12 months.
- Unlimited web access to helpful articles, resources, and self-assessment tools

Counseling Benefits:

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

You and your family members have access to six in-person counseling sessions per issue each rolling 12 months. If more sessions are needed, the counselor can work with you to explore outside resources.

The EAP is 100% paid for by Molina Healthcare. It's available 24 hours a day, 7 days a week and is completely confidential.

PAID **TIME OFF**

There is no perfect, one-size-fits-all balance between work and home. We provide time off so you can take some "me time" to relax, recover from illness, and take care of personal and family business.

Employees classified as full-time and part-time are eligible for PTO benefits. However, only those in active status will continue to accrue PTO. Eligible full-time employees regularly scheduled to work at least 30 hours and part-time employees who work up to 30 hours per week accrue PTO each pay period. You can use PTO for vacation, sick time, and personal time off.

PTO accrual is based on your employment classification, length of service and active employment status.

FULL-TIME EMPLOYEES

Employment Classification	Service Anniversary	Per Day	Per Year	Accrual Cap
Manager & Below	0 through 4	25 Min	18 Days	216 Hours (27 Days)
	5 though 9	31 Min	23 Days	276 Hours (34.5 Days)
	10 and above	37 Min	28 Days	336 Hours (42 days)
Directors, AVPs, State Medical Directors	0 through 4	31 Min	23 Days	276 Hours (34.5 Days)
	5 and above	37 Min	28 Days	336 Hours (42 days)
VPs and Above	Any	37 Min	28 Days	336 Hours (42 days)

PART-TIME EMPLOYEES

Service Anniversary	Per Hour	Per Year (based on 29-hour workweek)	Accrual Cap
0 through 4	.04 Hours	60:20 Hours	90:29 hours
5 though 9	.06 Hours	90:29 Hours	135:45 Hours
10 and above	.075 Hours	113:06 Hours	169:39 Hours

PAID **PARENTAL LEAVE**

We provide eligible employees up to six (6) weeks of Paid Parental Leave to support bonding time for new fathers and mothers after the birth, adoption or foster placement of a child.

To be eligible for Paid Parental Leave, both of the following conditions must be met:

- Childbirth or placement of child via adoption or foster care must have occurred on or after January 1, 2023.
- Employee must qualify for FMLA bonding time for the birth of the child, or placement of a child via adoption or foster care, except for birth mothers who are otherwise eligible for Short-Term Disability following childbirth.

Please review Molina's FMLA and Paid Parental Leave policies to better understand eligibility, terms and conditions.

HOLIDAY **PAY**

Molina provides the following paid holidays and one paid floating holiday for employees. Additional holidays may be designated at the company's discretion.

New Year's Day

Martin Luther King, Jr. Day

Memorial Day

Independence Day

Labor Day

Thanksgiving

Day after Thanksgiving

Christmas Eve (1/2 day)

Christmas Day

New Year's Eve (1/2 day)

Floating Holiday

VOUNTEER **PAID TIME OFF**

Molina understands that community service is important and feels good. Giving our time, support and energy for causes close to our hearts makes a big difference in the lives of employees and collectively makes an even bigger impact in our valued communities. We realize many employees choose to work at Molina for its mission to serve and support the most vulnerable in our diverse communities.

Eligibility

Regular Full-Time employees are eligible for VTO the day following their first pay date. Each calendar year, eligible employees have up to twenty-four (24) hours of paid time off for volunteer activities.

Learn More

To learn more, visit the Human Resources section on the Molina intranet, The Hub.

WELLNESS PROGRAM

Enhance your well-being

Being well involves more than just using your healthcare plans. Wellness is a daily commitment to eating healthy, staying active, managing stress and maintaining balance. We've created an integrated wellness program — Elevate Wellness— to help you create healthy habits and reach your highest level of well-being.
The program consists of support for managing stress, choosing nutritious foods, staying active, maintaining or reaching a healthy weight, avoiding unhealthy habits, and more.

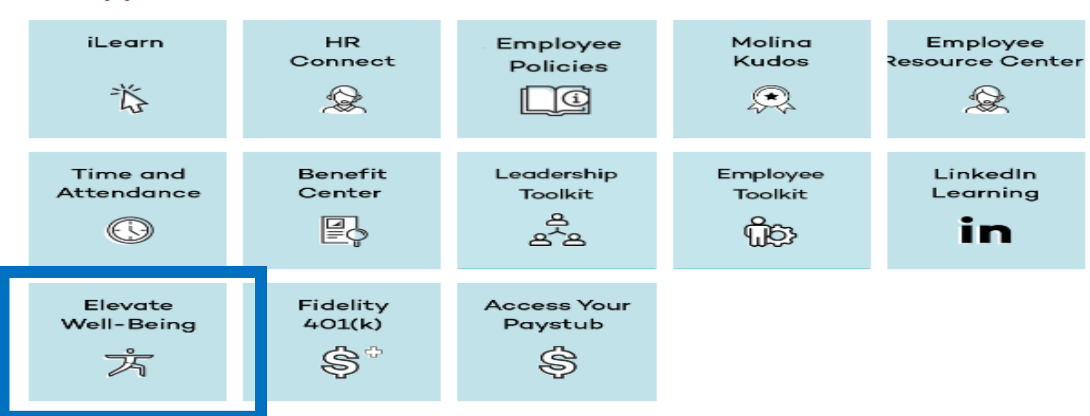
ELEVATE provides a comprehensive suite of tools and support in four areas:

- Physical: fitness activity, healthy eating, nutrition science, fluid intake, sleep
- Emotional: anxiety and stress management, mental health, happiness, compassion, empathy, spirituality
- Financial: managing debt, building a budget, retirement planning, savings goals
- Work: culture, sense of purpose, engagement, feeling connected, liking what you do

Elevate Program Levels

Level	Points	Options 1 (HSA Activated)	Option 2 (No HSA / waived coverage)
1 – Reach	500	5,000 ($50) Molina Kudos Points	5,000 ($50) Molina Kudos Points
2 – Jump	1,500	$100 HSA Contribution	10,000 ($100) Molina Kudos Points
3 – Boost	3,000	$150 HSA Contribution	15,000 ($150) Molina Kudos Points
4 – Soar	5,000	$200 HSA Contribution	20,000 ($200) Molina Kudos Points
Bonus Level – Rocket	7,000	Users who achieve 7,000 points become eligible for entry into a drawing for additional incentives awarded after the program year concludes.	
Biometric Screening Activity	N/A	Employees who complete a Biometric Screening during the applicable dates in the program year receive 10,000 ($100) Molina Kudos Points.	

Access your Elevate Account through The Hub Today to Get Started



LIFECARE **SERVICES**

We know many of our employees are overwhelmed with balancing work and home life. Molina has partnered with LifeCare to help by providing reliable emergency childcare and eldercare, homework and tutoring assistance, and pet care.

Temporary Dependent Care – Ten Back-Up Care Visits Per Year

When your regular care plans are disrupted, LifeCare's **Backup Care Connection** can help you secure and pay for temporary care for your children, aging loved ones, pets or self-recovery. Schedule up to 30 days in advance or even at the last minute via phone, web or mobile app*. You're entitled to up to 10 visits each year and you can choose the care provider that's right for your needs. Options range from center or facility-based care to in-home providers and even your own personal caregiver such as a babysitter, friend or family member. Each visit has a low co-pay of $10. Molina pays the rest.

Access Online Homework Help

Struggling to help with homework? Don't stress! With **Homework Connection** you have 24/7 online access to professional tutors for all subjects, grades K-12, plus college courses and college test prep. Employees have access to online help for up to five hours per child per month at no cost. Your child can safely work with a tutor via voice or chat, or even have a paper proofread. Spanish-speaking tutors also available. Students can learn at their own pace with self-service resources, including study guides, practice tests, lessons, worksheets and videos.

Login anytime, anywhere to get the secure online homework help your kids need, all at no cost to you.

Life Can Be Hard. Getting Help is Easy!

Call 1-833-322-7282 anytime to speak with a specialist about your LifeCare benefits or login at member.lifecare.com with registration code: **Molina**.

IMPORTANT PLAN INFORMATION

In this section, you'll find important plan information, including:

- Your medical, dental and vision benefit contributions for 2023
- A summary of the health plan notices you are entitled to receive annually, and where to find them
- A Benefits Glossary to help you understand important insurance terms
- Contact information for our benefit carriers and vendors

EMPLOYEE **CONTRIBUTIONS**

The total amount that you pay for your benefits coverage depends on the plans you choose, how many dependents you cover, and for medical coverage, how much you earn. Your healthcare costs are deducted from your pay on a pre-tax basis — before federal, state, and social security taxes are calculated — so you pay less in taxes.

	CHOICE PPO MEDICAL PLAN		ESSENTIAL HDHP MEDICAL PLAN		PREMIER HDHP MEDICAL PLAN	
	Paycheck Premium	Annual Premium	Paycheck Premium	Annual Premium	Paycheck Premium	Annual Premium
Employee Only	$88.00	$2,288.00	$42.00	$1,092.00	$57.00	$1,482.00
Employee + Spouse	$240.00	$6,240.00	$137.00	$3,562.00	$178.00	$4,628.00
Employee + Children	$161.00	$4,186.00	$74.00	$1,924.00	$106.00	$2,756.00
Employee + Family	$367.00	$9,542.00	$205.00	$5,330.00	$271.00	$7,046.00

	PPO (HIGH) DENTAL PLAN		PPO (LOW) DENTAL PLAN	
	Paycheck Premium	Annual Premium	Paycheck Premium	Annual Premium
Employee Only	$14.00	$364..00	$6.00	$156.00
Employee + Spouse	$30.00	$780.00	$11.00	$286.00
Employee + Children	$30.00	$780.00	$13.00	$338.00
Employee + Family	$45.00	$1,170.00	$18.00	$468.00

VISION PLAN	Paycheck Premium	Annual Premium
Employee Only	$3.00	$78.00
Employee + Spouse	$6.00	$156.00
Employee + Children	$6.00	$156.00
Employee + Family	$6.00	$156.00

EMPLOYEE **CONTRIBUTIONS, CON'T**

Employee Contribution for AFLAC Voluntary Plans

Rates vary depending on your medical plan election. If you enroll in the Premier Medical (HDHP) or Essential Medical (HDHP), you can enroll in employee only coverage at no cost to you or enroll in family coverage at a discount. For those who select the Choice Medical (PPO) or no medical insurance at all, you can purchase Accident Insurance for yourself and your family.

AFLAC ACCIDENT PLAN	EMPLOYEES ENROLLED IN THE ESSENTIAL HDHP or PREMIER HDHP MEDICAL PLAN		EMPLOYEES NOT ENROLLED IN THE ESSENTIAL HDHP or PREMIER HDHP MEDICAL PLAN	
	Paycheck Premium	Annual Premium	Paycheck Premium	Annual Premium
Employee Only	$0.00	$0.00	$1.83	$47.58
Employee + Spouse	$1.15	$29.90	$3.37	$87.62
Employee + Children	$2.39	$62.14	$5.03	$130.78
Employee + Family	$3.54	$92.04	$6.57	$170.82

AFLAC CRITICAL ILLNESS PLAN	Employee $10,000 Benefit		Spouse/ Domestic Partner $5,000 Benefit	
Covered Person's Age	Paycheck Premium	Annual Premium	Paycheck Premium	Annual Premium
18 - 25	$2.01	$52.26	$1.36	$35.36
26 - 30	$2.38	$61.88	$1.62	$42.12
31 - 35	$2.62	$68.12	$1.80	$46.80
36 – 40	$3.11	$80.86	$2.04	$53.04
41 - 45	$3.54	$92.04	$2.26	$58.76
46 - 50	$4.03	$104.78	$2.51	$65.26
51 - 55	$5.71	$148.46	$3.34	$86.84
56 – 60	$5.65	$146.90	$3.31	$86.06
61 – 65	$10.42	$270.92	$5.70	$148.20
66+	$17.45	$453.70	$9.21	$239.46

AFLAC HOSPITAL INDEMNITY PLAN	Paycheck Premium	Annual Premium
Employee Only	$7.26	$188.76
Employee + Spouse	$14.75	$383.50
Employee + Children	$11.48	$298.48
Employee + Family	$18.97	$493.22

EMPLOYEE **CONTRIBUTIONS, CON'T**

Voluntary Life Insurance

Your cost for employee coverage will depend on your age and how much coverage you buy. The cost increases for a higher age and higher benefit amount. The cost of spouse coverage is based on the employee's age and the amount of spouse coverage elected. The cost of child coverage is based on the policy amount selected and covers all children. These rates will be calculated for you and your cost will be displayed when you enroll online.

VOLUNTARY LIFE INSURANCE MONTHLY RATE PER $1,000 OF COVERAGE		
Age Band	**Employee**	**Spouse**
Age 24 and under	$0.088	$0.088
Age 25 - 29	$0.090	$0.096
Age 30 - 34	$0.094	$0.123
Age 35 - 39	$0.123	$0.200
Age 40 - 44	$0.205	$0.357
Age 45 - 49	$0.355	$0.547
Age 50 - 54	$0.546	$0.917
Age 55 - 59	$0.919	$1.113
Age 60 - 64	$1.070	$2.061
Age 65 - 69	$2.141	$3.834
Age 70 - 74	$4.348	$6.377
Age 75 - 79	$5.678	$10.450
Age 80+	$10.450	$26.397
Child(ren)	Rate per $1,000 of Coverage	
		$0.050

IDENTITY THEFT PROTECTION	Paycheck Premium	Annual Premium
Employee Only	$4.59	$119.34
Employee + Family	$8.28	$215.28

LEGAL INSURANCE	Paycheck Premium	Annual Premium
Employee Only	$6.35	$165.10

LONG-TERM DISABILITY BUY-UP	Rate Per $100 of Your Monthly Salary
Employee Only	$0.456

GLOSSARY

-A-

AD&D Insurance
An insurance plan that pays a benefit to you or your beneficiary if you suffer from loss of a limb, speech, sight, or hearing, or if you have a fatal accident.

Allowed Amount
The maximum amount your plan will pay for a covered healthcare service.

Ambulatory Surgery Center (ASC)
A healthcare facility that specializes in same-day surgical procedures such as cataracts, colonoscopies, upper GI endoscopy, orthopedic surgery, and more.

Annual Limit
A cap on the benefits your plan will pay in a year. Limits may be placed on particular services such as prescriptions or hospitalizations. Annual limits may be placed on the dollar amount of covered services or on the number of visits that will be covered for a particular service.
After an annual limit is reached, you must pay all associated health care costs for the rest of the plan year.

-B-

Balance Billing
In-network providers are not allowed to bill you for more than the plan's allowable charge, but out-of-network providers are. This is called balance billing. For example, if the provider's fee is $100 but the plan's allowable charge is only $70, an out-of-network provider may bill YOU for the $30 difference (the balance).

Beneficiary
The person (or persons) that you name to be paid a benefit should you die. Beneficiaries are requested for life, AD&D, and retirement plans. You must name your beneficiary in advance.

Brand Name Drug
A drug sold under its trademarked name. For example, Lipitor is the brand name of a common cholesterol medicine.

-C-

COBRA
A federal law that may allow you to temporarily continue healthcare coverage after your employment ends, based on certain qualifying events. If you elect COBRA (Consolidated Omnibus Budget Reconciliation Act) coverage, you pay 100% of the premiums, including any share your employer used to pay, plus a small administrative fee.

Claim
A request for payment that you or your health care provider submits to your healthcare plan after you receive services that may be covered.

Coinsurance
Your share of the cost of a healthcare visit or service. Coinsurance is expressed as a percentage and always adds up to 100%. For example, if the plan pays 70%, your coinsurance responsibility is 30% of the cost. If your plan has a deductible, you pay 100% of the cost until you meet your deductible amount.

Copayment
A flat fee you pay for some healthcare services, for example, a doctor's office visit. You pay the copayment (sometimes called a copay) at the time you receive care. In most cases, copays do not count toward the deductible.

-D-

Deductible
The amount of healthcare expenses you have to pay for with your own money before your health plan will pay. The deductible does not apply to preventive care and certain other services.

Family coverage may have an ***aggregate*** or ***embedded*** deductible. Aggregate means your family must meet the entire family deductible before any individual expenses are covered. Embedded means the plan begins to make payments for an individual member as soon as they reach their individual deductible.

Dental Basic Services
Services such as fillings, routine extractions and some oral surgery procedures.

Dental Diagnostic & Preventive Generally includes routine cleanings, oral exams, x-rays, and fluoride treatments.
Most plans limit preventive exams and cleanings to two times a year.

Dental Major Services
Complex or restorative dental work such as crowns, bridges, dentures, inlays and onlays.

Dependent Care Flexible Spending Account (FSA)
An arrangement through your employer that lets you pay for eligible child and elder care expenses with tax-free dollars. Eligible expenses include day care, before and after-school programs, preschool, and summer day camp for children underage 13. Also included is care for a spouse or other dependent who lives with you and is physically incapable of self-care.

-E-

Eligible Expense
A service or product that is covered by your plan. Your plan will not cover any of the cost if the expense is not eligible.

Excluded Service
A service that your health plan doesn't pay for or cover.

-F-

Formulary
A list of prescription drugs covered by your medical plan or prescription drug plan. Also called a drug list.

-G-

Generic Drug
A drug that has the same active ingredients as a brand name drug but is sold under a different name. For example, Atorvastatin is the generic name for medicines with the same formula as Lipitor.

Grandfathered
A medical plan that is exempt from certain provisions of the Affordable Care Act (ACA).

-H-

Health Reimbursement Account (HRA) An account funded by an employer that reimburses employees, tax-free, for qualified medical expenses up to a maximum amount per year. Sometimes called Health Reimbursement Arrangements.

Healthcare Flexible Spending Account (FSA)
A health account through your employer that lets you pay for many out-of-pocket medical expenses with tax-free dollars. Eligible expenses include insurance copayments and deductibles, qualified prescription drugs, insulin, and medical devices, and some over-the-counter items.

High Deductible Health Plan (HDHP) A medical plan with a higher deductible than a traditional insurance plan. The monthly premium is usually lower, but you pay more health care costs (the deductible) before the insurance company starts to pay its share. A high deductible plan (HDHP) may make you eligible for a health savings account (HSA) that allows you to pay for certain medical expenses with money free from federal taxes.

GLOSSARY, **CON'T**

-I-

In-Network
In-network providers and services contract with your healthcare plan and will usually be the lowest cost option. Check your plan's website to find doctors, hospitals, labs, and pharmacies. Out-of-network services will cost more or may not be covered.

-L-

Life Insurance
An insurance plan that pays your beneficiary a lump sum if you die.

Long Term Disability Insurance
Insurance that replaces a portion of your income if you are unable to work due to a debilitating illness, serious injury, or mental disorder. Long term disability generally starts after a 90-day waiting period.

-M-

Mail Order
A feature of a medical or prescription drug plan where medicines you take routinely can be delivered by mail in a 90-day supply.

-O-

Open Enrollment
The time of year when you can change the benefit plans you are enrolled in and the dependents you cover. Open enrollment is held one time each year. Outside of open enrollment, you can only make changes if you have certain events in your life, like getting married or adding a new baby or child in the family.

Out-of-Network
Out-of-network providers (doctors, hospitals, labs, etc.) cost you more because they are not contracted with your plan and are not obligated to limit their maximum fees. Some plans, such as HMOs and EPOs, do not cover out-of- network services at all.

Out-of-Pocket Cost
A healthcare expense you are responsible for paying with your own money, whether from your bank account, credit card, or from a health account such as an HSA, FSA or HRA.

Out-of-Pocket Maximum
Protects you from big medical bills. Once costs "out of your own pocket" reach this amount, the plan pays 100% of most remaining eligible expenses for the rest of the plan year.

Family coverage may have an *aggregate* or *embedded* maximum. Aggregate means your family must meet the entire family out-of-pocket maximum before the plan pays 100% for any member. Embedded means the plan will cover 100% for an individual member as soon as they reach their individual maximum.

Outpatient Care
Care from a hospital that doesn't require you to stay overnight.

-P-

Participating Pharmacy
A pharmacy that contracts with your medical or drug plan and will usually result in the lowest cost for prescription medications.

Plan Year
A 12-month period of benefits coverage. The 12-month period may or may not be the same as the calendar year.

Preferred Drug
Each health plan has a preferred drug list that includes prescription medicines based on an evaluation of effectiveness and cost. Another name for this list is a "formulary." The plan may charge more for non-preferred drugs or for brand name drugs that have generic versions. Drugs that are not on the preferred drug list may not be covered.

Preventive Care Services
Routine healthcare visits that may include screenings, tests, check-ups, immunizations, and patient counseling to prevent illnesses, disease, or other health problems. Many preventive care services are fully covered. Check with your health plan in advance if you have questions about whether a preventive service is covered.

Primary Care Provider (PCP)
The main doctor you consult for healthcare issues. Some medical plans require members to name a specific doctor as their PCP and require care and referrals to be directed or approved by that provider.

-S-

Short Term Disability Insurance
Insurance that replaces a portion of your income if you are temporarily unable to work due to surgery and recovery time, a prolonged illness or injury, or pregnancy issues and childbirth recovery.

-T-

Telehealth / Telemedicine / Teledoc
A virtual visit to a doctor using video chat on a computer, tablet or smartphone. Telehealth visits can be used for many common, non-serious illnesses and injuries and are available 24/7. Many health plans and medical groups provide telehealth services at no cost or for much less than an office visit.

-U-

UCR (Usual, Customary, and Reasonable)
The amount paid for a medical service in a geographic area based on what providers in the area usually charge for the same or similar medical service. The UCR amount sometimes is used to determine the allowed amount.

Urgent Care
Care for an illness, injury or condition serious enough that care is needed right away, but not so severe it requires emergency room care. Treatment at an urgent care center generally costs much less than an emergency room visit.

-V-

Vaccinations
Treatment to prevent common illnesses such as flu, pneumonia, measles, polio, meningitis, shingles, and other diseases. Also called immunizations.

Voluntary Benefit
An optional benefit plan offered by your employer for which you pay the entire premium, usually through payroll deduction.

HEALTH PLAN NOTICES

These notices must be provided to plan participants on an annual basis and are available in the Annual Notices document, located at the end of this guide.

- **Medicare Part D Notice:** Describes options to access prescription drug coverage for Medicare eligible individuals
- **Women's Health and Cancer Rights Act:** Describes benefits available to those that will or have undergone a mastectomy
- **Newborns' and Mothers' Health Protection Act:** Describes the rights of mother and newborn to stay in the hospital 48-96 hours after delivery
- **HIPAA Notice of Special Enrollment Rights:** Describes when you can enroll yourself and/or dependents in health coverage outside of open enrollment
- **HIPAA Notice of Privacy Practices:** Describes how health information about you may be used and disclosed
- **Premium Assistance Under Medicaid and the Children's Health Insurance Program (CHIP):** Describes availability of premium assistance for Medicaid eligible dependents.
- **Notice Regarding Wellness Program:** Describes voluntary nature of wellness program that includes biometrics and/or a Health Risk Assessment (HRA)

COBRA CONTINUATION COVERAGE

You and/or your dependents may have the right to continue coverage after you lose eligibility under the terms of our health plan. Upon enrollment, you and your dependents receive a COBRA Initial Notice that outlines the circumstances under which continued coverage is available and your obligations to notify the plan when you or your dependents experience a qualifying event. Please review this notice carefully to make sure you understand your rights and obligations.

PLAN **DOCUMENT**

Important documents for our health plan and retirement plan are available at the end of this guide. Paper copies of these documents and notices are available if requested. If you would like a paper copy, please contact the Plan Administrator.

SUMMARY PLAN DESCRIPTIONS (SPD)

The legal document for describing benefits provided under the plan as well as plan rights and obligations to participants and beneficiaries.

- Molina Healthcare, Inc Health and Welfare Plan

SUMMARY OF BENEFITS AND COVERAGE (SBC)

A document required by the Affordable Care Act (ACA) that presents benefit plan features in a standardized format. SBC documents are available on Alight.

- Choice PPO
- Premier HDHP
- Essential HDHP

STATEMENT OF MATERIAL MODIFICATIONS

This enrollment guide constitutes a Summary of Material Modifications (SMM) to the Molina Healthcare, Inc. Health and Welfare Plan. It is meant to supplement and/or replace certain information in the SPD, so retain it for future reference along with your SPD. Please share these materials with your covered family members.

LOOK-BACK MEASUREMENT METHOD

The information below explains how your eligibility for healthcare coverage is determined, in accordance with the rules of the Affordable Care Act (ACA).

Under the ACA, employers are required to report specific benefits information to IRS on “full-time” employees as defined by the ACA. A “full-time” employee is generally an employee whose works on average 130 hours per month. ACA full-time status can affect or determine major medical benefits eligibility but is not a guarantee of benefits eligibility. Molina uses the look-back measurement method to determine group health plan eligibility.

NEW EMPLOYEES HIRED TO WORK FULL-TIME: If you are hired as a new full-time employee (work on average 130 or more hours a month), you and your dependents are generally eligible for group health plan coverage as of the month following 30 days of continuous employment.

NEW EMPLOYEES HIRED TO WORK A PART-TIME, VARIABLE HOUR OR SEASONAL SCHEDULE: If you are hired into a part-time position, a position where your hours vary and Molina is unable to determine — as of your date of hire — whether you will be a full-time employee, or you are hired as a seasonal employee who will work for six (6) consecutive months or less (regardless of monthly hours worked), you will be placed in an initial measurement period (IMP) of 12 months. Your IMP will begin on 1st of the month following Date of Hire. If, during your IMP, you average 130 or more hours a month, you will become full-time and, if otherwise eligible for benefits, you will be offered coverage January 1. Your full-time status will remain in effect during an associated stability period that will last 12 Months. If your employment is terminated during that stability period, and you were enrolled in benefits, you will be offered coverage under COBRA.

ONGOING EMPLOYEES: An ongoing employee is an individual who has been employed for an entire standard measurement period. A standard measurement period is the 12-month period during which Molina counts employee hours to determine which employees work full-time. Those employees who average 130 or more hours a month over the standard measurement period will be deemed full time and, if otherwise eligible for benefits, offered coverage as of the first day of the stability period associated with the standard measurement period. Full-time status will be in effect during an associated stability period for 12 months. If your employment is terminated during a stability period, and you were enrolled in benefits, you will be offered continued coverage under COBRA.

Molina uses the standard measurement period and associated stability period annual cycle set forth below:

MEASUREMENT PERIOD: STARTS: October 3 DURATION: 12 months

Time to determine if you work 130+ hours per month on average – used to establish if you are "full-time" or "part-time" for medical eligibility.

STABILITY PERIOD: STARTS: January 1 DURATION: 12 Months

Time during which you will be considered "full-time" or "part-time" for medical plan eligibility - based on hours worked during preceding Measurement Period.

Important Notice from Molina Healthcare, Inc. About Your Prescription Drug Coverage and Medicare

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with Molina Healthcare, Inc. 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. Molina Healthcare, Inc. has determined that the prescription drug coverage offered by the Molina Healthcare, Inc. Group Health 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 Molina Healthcare, Inc. coverage will not be affected. See below for more information about what happens to your current coverage if you join a Medicare drug plan.

Since the existing prescription drug coverage under Anthem Blue Cross is creditable (e.g., as good as Medicare coverage), you can retain your existing prescription drug coverage and choose not to enroll in a Part D plan; or you can enroll in a Part D plan as a supplement to, or in lieu of, your existing prescription drug coverage.

If you do decide to join a Medicare drug plan and drop your Molina Healthcare, Inc. prescription drug coverage, be aware that you and your dependents can only get this coverage back at open enrollment or if you experience an event that gives rise to a HIPAA Special Enrollment Right.

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.

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 Molina Healthcare, Inc. and don't join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.

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

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

Contact the person listed below for further information or call Molina Healthcare, Inc.'s Administrator Anthem Blue Cross at 1-833-626-4308. 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 Molina Healthcare, Inc. 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 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 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:	January 1, 2023
Name of Entity/Sender:	Molina Healthcare, Inc.
Plan Administrator:	Anthem Blue Cross
Address:	P.O. Box 60007, Los Angeles, California 90060
Phone Number:	1-833-626-4308

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.

Women's Health and Cancer Rights Act

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 at.

Newborns' and Mothers' Health Protection 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). If you would like more information on maternity benefits, call your plan administrator.

HIPAA Notice of Special Enrollment Rights

If you decline enrollment in Molina Healthcare's health plan for you or your dependents (including your spouse) because of other health insurance or group health plan coverage, you or your dependents may be able to enroll in Molina's health plan without waiting for the next open enrollment period if you:

- Lose other health insurance or group health plan coverage. You must request enrollment within 31 days after the loss of other coverage.
- Gain a new dependent as a result of marriage, birth, adoption, or placement for adoption. You must request health plan enrollment within 30 days after the marriage, birth, adoption, or placement for adoption.
- Lose Medicaid or Children's Health Insurance Program (CHIP) coverage because you are no longer eligible. You must request medical plan enrollment within 60 days after the loss of such coverage.

If you request a change due to a special enrollment event within the 30-day timeframe, coverage will be effective the date of birth, adoption or placement for adoption. For all other events, coverage will be effective the first of the month following your request for enrollment. In addition, you may enroll in Molina's health plan if you become eligible for a state premium assistance program under Medicaid or CHIP. You must request enrollment within 60 days after you gain eligibility for medical plan coverage. If you request this change, coverage will be effective the first of the month following your request for enrollment. Specific restrictions may apply, depending on federal and state law.

Note: If your dependent becomes eligible for a special enrollment right, you may add the dependent to your current coverage or change to another health plan.

Availability of Privacy Practices Notice

We maintain the HIPAA Notice of Privacy Practices for Molina Healthcare, Inc. Health and Welfare Plan describing how health information about you may be used and disclosed. You may obtain a copy of the Notice of Privacy Practices by contacting the plan administrator. A copy of our notices are also available on the Employee Benefit Center.

NOTICE REGARDING **WELLNESS PROGRAM**

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

However, employees who choose to participate in the wellness program will receive an incentive as described in our wellness program materials. Although you are not required to complete an HRA or participate in any biometric screenings, only employees who do so will receive the incentive.

The information from your HRA and/or the results from your biometric screening will be used to provide you with information to help you understand your current health and potential risks and may also be used to offer you services through the wellness program, such as health coaching. You also are encouraged to share your results or concerns with your own doctor.

PROTECTIONS FROM DISCLOSURE OF MEDICAL INFORMATION

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

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

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

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

If you have questions or concerns regarding this notice, or about protections against discrimination and retaliation, please contact the plan administrator.

PREMIUM ASSISTANCE UNDER MEDICAID and the CHILDRENS'S HEALTH INSURANCE PROGRAM (CHIP)

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

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

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

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

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of January 31, 2022. Contact your State for more information on eligibility –

ALABAMA – Medicaid
Website: http://myalhipp.com/ Phone: 1-855-692-5447
ALASKA – Medicaid
The AK Health Insurance Premium Payment Program | Website: http://myakhipp.com/ Phone: 1-866-251-4861 Email: CustomerService@MyAKHIPP.com Medicaid Eligibility: http://dhss.alaska.gov/dpa/Pages/medicaid/default.aspx
ARKANSAS – Medicaid
Website: http://myarhipp.com/ | Phone: 1-855-MyARHIPP (855-692-7447)
CALIFORNIA – Medicaid
Website: Health Insurance Premium Payment (HIPP) Program http://dhcs.ca.gov/hipp Phone: 916-445-8322 | Fax: 916-440-5676 Email: hipp@dhcs.ca.gov
COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)
Health First Colorado Website: https://www.healthfirstcolorado.com/ Health First Colorado Member Contact Center: 1-800-221-3943 | State Relay 711 CHP+: https://www.colorado.gov/pacific/hcpf/child-health-plan-plus CHP+ Customer Service: 1-800-359-1991 | State Relay 711 Health Insurance Buy-In Program (HIBI): https://www.colorado.gov/pacific/hcpf/health-insurance-buy-program HIBI Customer Service: 1-855-692-6442
FLORIDA – Medicaid
Website: https://www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html Phone: 1-877-357-3268

PREMIUM ASSISTANCE UNDER MEDICAID and the CHILDRENS'S HEALTH INSURANCE PROGRAM (CHIP). CON'T

GEORGIA – Medicaid
A HIPP Website: https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp Phone: 678-564-1162, press 1 GA CHIPRA Website: https://medicaid.georgia.gov/programs/third-party-liability/childrens-health-insurance-program-reauthorization-act-2009-chipra Phone: 678-564-1162, press 2
INDIANA – Medicaid
Healthy Indiana Plan for low-income adults 19-64 | Website: http://www.in.gov/fssa/hip/ Phone: 1-877-438-4479 All other Medicaid | Website: https://www.in.gov/medicaid/ Phone 1-800-457-4584
IOWA – Medicaid and CHIP (Hawki)
Medicaid Website: https://dhs.iowa.gov/ime/members | Medicaid Phone: 1-800-338-8366 Hawki Website: http://dhs.iowa.gov/Hawki | Hawki Phone: 1-800-257-8563 HIPP Website: https://dhs.iowa.gov/ime/members/medicaid-a-to-z/hipp | HIPP Phone: 1-888-346-9562
KANSAS – Medicaid
Website: https://www.kancare.ks.gov/ | Phone: 1-800-792-4884
KENTUCKY – Medicaid
Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP) Website: https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx | Phone: 1-855-459-6328 Email: KIHIPP.PROGRAM@ky.gov KCHIP Website: https://kidshealth.ky.gov/Pages/index.aspx | Phone: 1-877-524-4718 Kentucky Medicaid Website: https://chfs.ky.gov
LOUISIANA – Medicaid
Website: www.medicaid.la.gov or www.ldh.la.gov/lahipp Phone: 1-888-342-6207 (Medicaid hotline) or 1-855-618-5488 (LaHIPP)
MAINE – Medicaid
Enrollment Website: https://www.maine.gov/dhhs/ofi/applications-forms Phone: 1-800-442-6003 | TTY: Maine relay 711 Private Health Insurance Premium Webpage: https://www.maine.gov/dhhs/ofi/applications-forms Phone: 800-977-6740 | TTY: Maine relay 711
MASSACHUSETTS – Medicaid and CHIP
Website: https://www.mass.gov/masshealth/pa | Phone: 1-800-862-4840
MINNESOTA – Medicaid
Website: https://mn.gov/dhs/people-we-serve/children-and-families/health-care/health-care-programs/programs-and-services/other-insurance.jsp Phone: 1-800-657-3739
MISSOURI – Medicaid
Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm | Phone: 573-751-2005
MONTANA – Medicaid
Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP | Phone: 1-800-694-3084
NEBRASKA – Medicaid
Website: http://www.ACCESSNebraska.ne.gov Phone: 1-855-632-7633 | Lincoln: 402-473-7000 | Omaha: 402-595-1178
NEVADA – Medicaid
Medicaid Website: http://dhcfp.nv.gov | Medicaid Phone: 1-800-992-0900
NEW HAMPSHIRE – Medicaid
Website: https://www.dhhs.nh.gov/oii/hipp.htm | Phone: 603-271-5218 Toll free number for the HIPP program: 1-800-852-3345, ext. 5218
NEW JERSEY – Medicaid and CHIP
Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ Medicaid Phone: 609-631-2392 CHIP Website: http://www.njfamilycare.org/index.html | CHIP Phone: 1-800-701-0710

PREMIUM ASSISTANCE UNDER MEDICAID and the CHILDRENS'S HEALTH INSURANCE PROGRAM (CHIP). CON'T

NEW YORK – Medicaid
Website: https://www.health.ny.gov/health_care/medicaid/ | Phone: 1-800-541-2831
NORTH CAROLINA – Medicaid
Website: https://medicaid.ncdhhs.gov/ | Phone: 919-855-4100
NORTH DAKOTA – Medicaid
Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/ | Phone: 1-844-854-4825
OKLAHOMA – Medicaid and CHIP
Website: http://www.insureoklahoma.org | Phone: 1-888-365-3742
OREGON – Medicaid
Website: http://healthcare.oregon.gov/Pages/index.aspx or http://www.oregonhealthcare.gov/index-es.html Phone: 1-800-699-9075
PENNSYLVANIA – Medicaid
Website: https://www.dhs.pa.gov/Services/Assistance/Pages/HIPP-Program.aspx | Phone: 1-800-692-7462
RHODE ISLAND – Medicaid and CHIP
Website: http://www.eohhs.ri.gov/ | Phone: 1-855-697-4347 or 401-462-0311 (Direct RIte Share Line)
SOUTH CAROLINA – Medicaid
Website: https://www.scdhhs.gov | Phone: 1-888-549-0820
SOUTH DAKOTA – Medicaid
Website: http://dss.sd.gov | Phone: 1-888-828-0059
TEXAS – Medicaid
Website: http://gethipptexas.com/ | Phone: 1-800-440-0493
UTAH – Medicaid and CHIP
Medicaid Website: https://medicaid.utah.gov/ | CHIP Website: http://health.utah.gov/chip Phone: 1-877-543-7669
VERMONT – Medicaid
Website: http://www.greenmountaincare.org/ | Phone: 1-800-250-8427
VIRGINIA – Medicaid and CHIP
Websi Website: https://www.coverva.org/en/famis-select or https://www.coverva.org/en/hipp Medicaid Phone: 1-800-432-5924 | CHIP Phone: 1-800-432-5924
WASHINGTON – Medicaid
Website: https://www.hca.wa.gov/ | Phone: 1-800-562-3022
WEST VIRGINIA – Medicaid and CHIP
Website: https://dhhr.wv.gov/bms/ or http://mywvhipp.com/ Medicaid Phone: 304-558-1700 | CHIP Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)
WISCONSIN – Medicaid and CHIP
Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm | Phone: 1-800-362-3002
WYOMING – Medicaid
Website: https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/ | Phone: 1-800-251-1269

To see if any other states have added a premium assistance program since January 31, 2022, or for more information on special enrollment rights, contact either:

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

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

PREMIUM ASSISTANCE **UNDER MEDICAID and the CHILDRENS'S HEALTH INSURANCE PROGRAM (CHIP). CON'T**

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 1/31/2023)

ACA **DISCLAIMER**

This offer of coverage may disqualify you from receiving government subsidies for an Exchange plan even if you choose not to enroll. To be subsidy eligible you would have to establish that this offer is unaffordable for you, meaning that the required contribution for employee only coverage under our base plan exceeds 9.61% in 2022 of your modified adjusted household income.

PROVIDER CONTACT INFORMATION

If you need to reach our plan providers, here is their contact information:

Plan Type	Provider	Phone Number	Website	Policy No.
Medical Plans	Anthem Blue Cross	1-833-626-4308	anthem.com/ca Virtual Visits: Livehealthonline.com	Refer to ID card
Prescription Drugs	CarelonRx	1-833-626-4738, Option 1	anthem.com/ca	174232
Dental Plans	Delta Dental	1-800-765-6003	deltadentalins.com	5202
Vision	Vision Service Plan	1-800-877-7195	vsp.com/	12067408
Health Savings Account (HSA)	Smart-Choice	1-833-665-4620	digital.alight.com/molinahealthcare	Molina HealthCare
Flexible Spending Accounts (FSA)	Smart-Choice	1-833-665-4620	digital.alight.com/molinahealthcare	Molina Healthcare
Life Insurance	Mutual of Omaha	1-800-775-8505	submitgrlife@mutualofomaha.com	GC000C734
Short-Term and Long-Term Disability	Mutual of Omaha	1-800-877-5176	Newdisabilityclaim@mutualofomaha.com	GC000C734
Accident, Critical Illness and Hospital Indemnity	AFLAC	1-800-433-3036	aflacgroupinsurance.com	23849
Employee Assistance Program (EAP)	Mutual of Omaha	1-800-316-2796	Mutualofomaha.com/eap	GC0000C734
Employee Advocacy	Health Advocate	1-866-695-8622	healthadvocate.com/members	N/A
Medicare Assistance	Alliant Medicare Solutions	1-833-888-1495	N/A	Molina
401(k) Retirement	Fidelity	1-800-835-5097	401k.com	N/A
Stock Purchase Plan	Employee Stock Purchase Plan (ESPP)	1-800-838-0908	etrade.com	N/A
Auto/Home	Farmers	1-888-327-6335	farmers.com	N/A
Backup Care	LifeCare	1-833-322-7282	member.lifecare.com	Molina
Commuter Benefits	Smart-Choice	1-833-665-4620	digital.alight.com/molinahealthcare	Molina HealthCare
Elevate Wellness	Limeade	1-844-794-3647	ERC@molinahealthcare.com	Molina
Rewards Program	LifeBalance	N/A	MolinaHealthcare.LifeBalanceProgram.com	
Identity Theft	Allstate (InfoArmor)	1-800-789-2720	myaip.com customercare@aip.com	N/A
Legal	ARAG	1-800-247-4184	ARAGLegalCenter.com; Access Code: 18312mhc	N/A
Pet Insurance	Nationwide	1-800-540-2016	petinsurance.com	N/A

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HEALTHCARE