Welcome to Your Molina Healthcare Benefits

At Molina Healthcare, we know that our success depends on our people and we consider each employee a member of our extended family. In recognition of your contributions, Molina Healthcare offers comprehensive, high-quality benefits at a reasonable cost, which are intended to provide you with the resources you need to help you succeed in both your professional and personal life.

Using This Guide

This interactive guide is designed to give you clear, easy-to-read, and convenient benefits information. You can:

- Use the links on the left to learn about the topic areas you're interested in.
- Search the guide using the search tool below.
- Easily print a page — or the entire guide — if you prefer a printed version.

The information provided summarizes the basic features of the benefit plans offered by Molina Healthcare. All plan provisions are governed by the legal documents in effect for each plan. Molina Healthcare reserves the right to amend, change, or terminate these plans at any time.

Benefits Eligibility

All regular employees who work 30 or more hours per week are eligible for Molina Healthcare benefits. Most benefits are effective on the first of the month after 30 days of employment if you enroll.

We offer a variety of choices so you can elect the benefits that are best for you and your family. Some of these benefits are provided automatically to you at no cost as a Molina Healthcare employee. You may change benefit elections after your initial enrollment only if you experience a **qualified status change** such as marriage, divorce, or the birth or adoption of a child. Otherwise, you'll have to wait until the next Open Enrollment period.

We know that taking care of your family is important, too. You may enroll your eligible dependents for medical, dental, vision and dependent life insurance coverage. Your eligible dependents generally include:

- Legal spouse or domestic partner (with **Domestic Partner Affidavit**).
- Your children, up to age 26, including stepchildren, children of your domestic partner, or children in your legal guardianship.
- Adult children, stepchildren, children of your domestic partner, or children in your legal guardianship of any age who are disabled and cannot support themselves.

Keep in mind, if you and your spouse, domestic partner, and/or child work for Molina Healthcare, or your spouse, domestic partner, 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.

Please note: If your legal spouse or domestic partner has access to health and welfare insurance coverage through their own employer, they are no longer eligible to be covered on the Molina Healthcare Plans. If your legal spouse or domestic partner does not work or is not eligible for health insurance coverage through their own employer, they can remain on the Molina Healthcare Plans.
Please be aware that the Plan will be audited.

Domestic Partner Coverage

Your domestic partner is eligible if both you and your partner meet the following requirements:

- Are each other's sole domestic partner and intend to be so indefinitely
- Share the same residence and have been for the at least six months and intend to do so indefinitely
- Are engaged in a committed relationship of mutual caring and support and are jointly responsible for your common welfare and living expenses
- Are unmarried or not in another domestic partnership at present and within the last 6 months
- Are not related to each other in a way that would prohibit marriage in the state in which you legally reside
- Are 18 years or older and are mentally competent to consent to contract
- Are not in the domestic partner relationship solely to obtain benefits coverage.

Be sure to complete a **Domestic Partner Affidavit** to enroll your Domestic Partner.

Making Changes to Your Benefits

You may make changes to your benefits once a year during Molina Healthcare's **Open Enrollment** period.

Because most of our benefits are available on a pre-tax basis, the IRS requires that all benefits you select remain in effect for an entire calendar year. The only time you may change your benefit elections during the year is if you have a qualified status change, such as:

- Marriage, legal separation or divorce,
- Birth, adoption, or placement for an adoption,
- Disability,
- Death of a spouse/domestic partner or dependent child,
- Dependent ceases to meet dependent eligibility requirements,
- Beginning or ending of a spouse/domestic partner's employment, or
- A change in employment (yours or your spouse/domestic partner's) from part-time to full-time or from full-time to part-time.

If you wish to make changes to your benefits due to a qualified status change, you must do so through HR Connect within 30 days of the event and you must provide supporting documentation to **MHIBenefitsHelpMailbox@Molinahealthcare.com**. To submit your qualified event through HR Connect:

- Click the Benefits icon,
- Create your contacts if not already created, on ***Manage People I Plan to Cover***
- Create a life event on ***Record Life Events***, click the appropriate life event to submit the qualified event.

Your life event will be suspended until you provide supporting documentation and it is approved by the Benefits Administrator. The change you request must be consistent with the status change. For example, if you have a baby, you may add the child to your medical coverage but you cannot change plans or remove any dependents that are already covered.

Benefits at a Glance

As an eligible Molina Healthcare employee, you have the following benefits:

Type of Benefit	Benefit Plans Available	Carrier Name	Enrollment Required
Medical (Includes prescription drug coverage)	Exclusive Network Plan (an in-network-only plan) Select Plan (a PPO plan) Premier Plan (a PPO plan) High Deductible Health Plan (a HDHP plan)	Administered by Delta Health Systems	Yes, when first eligible or during Open Enrollment
Well-Being Program	Health Assessment to improve your health and lower your medical contributions	Anthem	Yes – must be enrolled in a Molina Healthcare medical plan
Dental	Low Dental PPO Plan High Dental PPO Plan	Delta Dental	Yes, when first eligible or during Open Enrollment
Vision	Vision Plan	Vision Service Plan (VSP)	Yes, when first eligible or during Open Enrollment
EAP	Employee Assistance Program	Life Works	No
Health Savings Account (HSA)	Health Savings Account (HSA) for employees enrolled in the HDHP only	HSA Bank	Yes, when first eligible and during Open Enrollment
Flexible Spending Accounts (FSAs)	Health Care FSA Dependent Care FSA Limited Purpose FSA (Dental & Vision Only, if enrolled in the HDHP)	Delta Health Systems	Yes, when first eligible and during Open Enrollment
Life and AD&D Insurance	Basic Life and AD&D Insurance	The Standard	No – 100% company paid
Voluntary Life Insurance	Employee Life Insurance Spouse/Domestic Partner Life Insurance Child Life Insurance	The Standard	Yes, when first eligible or at any time with EOI (must complete paper form)
Disability	Short-Term Disability (STD) Insurance	The Standard	No – 100% company paid
	Long-Term Disability (LTD) Insurance	The Standard	No – 100% company paid
Retirement	401(k) Plan	Fidelity	Automatically enrolled at 4%; Molina matches 100% of the first 4% you contribute. Contributions can be changed throughout the year
Employee Stock Purchase Plan	Opportunity to purchase discounted stock in Molina Healthcare	E*Trade	Yes, on January 1 or July 1
Educational Reimbursement	Up to $5,250 a year reimbursement for work-related education	N/A	No

Open Enrollment

Open Enrollment is your once-a-year opportunity to choose the benefits that are right for you. If you do not make changes during the open enrollment period, your current benefit will roll over to 2017, with the exception of the Health Care Flexible Spending Account and the Dependent Care Flexible Spending Account. **You must enroll for 2017and indicate the amount you want for the year.** The Flexible Spending Accounts do not roll over to the new year.

- Medical
- Dental
- Vision
- Health Savings Account (HSA) *(New for 2017!)*
- Health Care Flexible Spending Account (FSA)
- Limited Purpose Flexible Spending Account (FSA) *(New for 2017!)*
- Dependent Care Flexible Spending Account (FSA)

Molina Healthcare's benefit plan year is January 1, 2017 through December 31, 2017.

Once the Open Enrollment period ends, you cannot make changes to your benefit choices unless you experience a qualified life event (see **Making Changes to Your Benefits**).

Open Enrollment for 2017 benefits is from November 9 through November 22, 2016.

Go to Employee Self Service in Molina HR Connect to learn about your options, plan your elections, and enroll.

If you have questions, contact the Benefits Service Center:

- **Phone: 562-435-3666, Ext. 111030 or 866-472-9485 (M – F: 7:00 a.m. PST – 5:30 p.m. PST)**
- **Email: MHIBenefitsHelpMailbox@Molinahealthcare.com**
- **Mobile App: www.benefitsonthego.com/molina**

What's New for 2017

New Medical Plan Option for 2017

We're excited to offer you a new medical plan option in 2017: The **High Deductible Health Plan (HDHP)**. This is a different kind of medical plan, offered in addition to your current coverage options, and giving you more choice and flexibility when selecting the best medical plan for you and your family.

The HDHP gives you more control over your health care spending and includes a tax-advantaged savings account, called a Health Savings Account (HSA), which allows you — and Molina Healthcare — to save for your current or future health care expenses. Click **Your Benefits** at the left to learn more about your new medical plan options and the HSA.

Changes to the Premier Plan Effective January 1, 2017

- **Hospitalization, outpatient surgery, complex imaging, lab and X-ray** — After you have met the annual deductible, the plan will pay 90% and you pay 10% of eligible expenses.

Changes to the Exclusive Network Plan Effective January 1, 2017

- **Annual deductible** — The annual deductible is $750/individual or $2,250/family.
- **Office visit copay** — The copay for a primary care physician is $30.

See the **Benefits at a Glance** chart for an overview of your benefits.

What You Need to Do

Learn

Read this *Benefits Guide* to find out **What's New for 2017**, what you need to do to enroll or make benefit changes, and what coverage costs. Click the links at the left to go to each section.

Decide

Review the list of benefits in the **Benefits at a Glance** chart. For more details about each benefit option, click the links at the left to navigate through this *Benefits Guide*.

Enroll

Log on to Molina HR Connect to enroll by November 22, 2016 for benefits effective January 1, 2017. See the **Enrollment** section in this guide for more details about how to enroll.

Your Benefits

Medical Plans

All eligible employees and their eligible dependents may enroll in comprehensive medical coverage offered by Molina. You have a choice of four medical plans:

- ***NEW* High Deductible Health Plan (HDHP)**, which has the lowest payroll contribution of all of the medical plan options, allows you to receive care from any provider or facility you wish. However, the plan pays higher benefits when you use providers in the Anthem/Blue Cross Blue Shield network. You must first meet a deductible for **medical services and prescription drugs**, which is the highest of all of the plans, before the plan will begin to pay benefits. The HDHP includes a tax-advantaged savings account, called a Health Savings Account (HSA), which allows you to save for your current or future health care expenses. Molina Healthcare will make a contribution to your HSA as well!
- **Exclusive Network Plan**, which has the next lowest payroll contribution of the medical plan options, requires you to receive care from physicians and facilities in the Anthem/Blue Cross Blue Shield provider network.
- **Select PPO Plan**, allows you to receive care from any provider or facility you wish. However, you will pay less if you use providers in the Anthem/Blue Cross Blue Shield network. For most out-of-network care, you pay 50% after you meet the deductible.
- **Premier PPO Plan**, which has the highest payroll contributions of the medical plan options, also allows you to receive care from any provider or facility you wish. However, it also provides the highest level of benefits of all of the medical plan options for in-network and out-of-network care.

All Medical Plans

All four medical plan options provide:

- 100% coverage for in-network preventive care
- Access to **Well-Being Resources** that help you stay healthy, manage conditions, and have immediate access to health care information and advice.

Exclusive Network Plan

The Exclusive Network Plan offers affordable health care for you and your family through a network of doctors, hospitals, and other health care facilities that provide medical services at reasonable negotiated rates. With the Exclusive Network plan, you must receive **all** of your care from physicians and facilities in the Anthem/Blue Cross Blue Shield network; otherwise the plan will not pay benefits (except in an emergency).

Select and Premier PPO Plans

While both the Select and Premier PPO plans have the same Anthem/Blue Cross Blue Shield PPO provider network, each plan offers a different deductible amount and out-of-pocket limit, and different benefit levels.

Although you can receive care from any licensed physician or health care facility, each of the PPO plans gives you access to the Anthem/Blue Cross Blue Shield network of providers who agree to charge members negotiated rates. You can receive care from an in-network provider anywhere in the U.S., the provider will file claims for you and your claims will be paid at the highest level, which saves you money.

If you go to a non-PPO (out-of-network) provider, there is no negotiated rate and your costs will be higher. The plan will only cover eligible expenses from an out-of-network provider up to the allowed amount. Therefore, you would be responsible for your coinsurance, deductible, and any amount over the allowed amount.

High Deductible Health Plan (HDHP)

The HDHP is a PPO medical plan that includes a tax-advantaged savings account feature, called a Health Savings Account (HSA). Together, these two components give you comprehensive medical coverage and complete control over what health services you buy and how you spend your money on health care.

The HDHP and the HSA: How They Work Together

Your Health Savings Account (HSA)

Together, your and Molina Healthcare's contributions can cover a portion of the deductible and coinsurance.

Free In-Network Preventive Care	Deductible	Coinsurance	Out-of-Pocket Maximum
To emphasize the importance of wellness, preventive care is covered at 100% from in-network providers.	You pay for your initial **medical and prescription** drug costs until you meet the annual deductible. This deductible is higher compared to the other medical plans, but offset by HSA contributions you and Molina Healthcare make.	Once the deductible is met, you and the HDHP share any future health care costs until you meet the out-of-pocket maximum.	The plan limits the total amount you'll pay each year. Once you meet the out-of-pocket maximum, the plan pays 100% of your eligible, in-network expenses for the remainder of the year.

2017 HSA Contribution Limits

Coverage Level	Annual HSA Maximum	Molina Healthcare contributes…	So you can contribute up to…
Employee Only Employee + Dependents	$3,400 $6,750	$300/year $600/year	$3,100/year $6,150/year
Age 55 or older? You can contribute an additional $1,000 per year.			

More about the HSA >>

Advantages of an HSA

- **Molina Healthcare will help build your savings:** When you enroll in the HDHP, Molina Healthcare will make a contribution to your HSA to help you pay your health care expenses: $300 if you enroll in employee only coverage or $600 if you enroll in employee + dependent(s) coverage.
- **You can also contribute to your HSA:** You can contribute funds to your HSA through HSA Bank.
- **You own the account:** Your HSA funds — including any contributions Molina Healthcare makes to your HSA — belong to you. That means you can take your HSA funds with you, even if you change medical plans, leave Molina Healthcare, or retire.
- **You control how you use it:** You can use your HSA funds to cover eligible expenses or you can pay out of your own pocket and save your HSA funds for a later date.
- **You can invest your savings:** You can invest your savings in a variety of mutual funds.

Using Your HSA

Once your HSA is set up, you will receive a debit card to access the funds in your account. Just present your card at the doctor's office, pharmacy or other merchant or service provider to pay for qualified health care expenses. Molina Healthcare's HSA will be administered by HSA Bank.

Not everyone can open an HSA.

All benefit-eligible employees can enroll in the HDHP. However, you ***aren't eligible to open an HSA if you're:***

- Enrolled in another medical plan (such as a spouse's/domestic partner's plan), unless it's a qualified high deductible health plan
- Enrolled in Medicare
- Eligible to be claimed as a dependent on another individual's tax return
- Not a U.S. resident
- An active military member enrolled in TRICARE.

A Note About FSA and HSA Funding

If you have FSA funds in your account as of January 1, 2017, and you elect the new HDHP plan, you will not be able to contribute to a Health Savings Account (HSA) until April 1, 2017. You also will not receive Molina's contribution to your HSA until April 1, 2017.

Save on Medical Costs and Learn About Your Health

You and your spouse/domestic partner can get a snapshot of your health and save on your medical plan contributions – all you have to do is take Anthem's free, confidential online health assessment once your coverage becomes effective AND you have a medical ID. It's quick and easy:

1. **Register:** Go to **Anthem.com/ca** and click Register Now. You'll need your Anthem ID to complete the process. It may take up to 24 hours for your registration to be processed.
2. **Gather Your Health Information:** Before you take the Health Assessment, you'll need:
   a. Lab results from the last time you had preventive care services
   b. Your waist size and Body Mass Index (BMI)
   c. Blood pressure
   d. Height and weight
3. **Take the Health Assessment:** After you are registered, return to **Anthem.com/ca**, click on Health and Wellness, and select Take My HA Now. It takes less than 15 minutes to complete. Be sure to print and save the confirmation statement that will appear once the health assessment is completed.
4. **Start Reaping the Benefits:** Anthem will report to Molina when you have completed the Health Assessment and you will then be charged the discounted "Well-Being" contribution amount. Please note that due to timing of reports and when you complete the Health Assessment, it may take more than three to five pay dates for you to receive the discounted rate. The discount is not retroactive and no refunds will be provided.

Well-Being Resources

All Molina Healthcare medical plan participants can access these well-being resources at no additional cost.

- **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,
  - Gaining access to other necessary medical management programs,
  - Depression screening with referral to behavioral health services, if needed, and
  - Coordination of care between many providers and services.

  To speak with a nurse, call 1-800-522-5560.

- **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 1-800-522-5560.

- **Future Moms**, a program offering information and the assistance of a nurse to help future moms have healthy pregnancies, includes:
  - A toll-free number to talk with a nurse coach about pregnancy at any time, any day,
  - A book that shows the changes the future mom can expect over the next nine months,
  - Screening to check for depression or early delivery,
  - Suggestions for healthy choices throughout pregnancy,
  - Free phone calls with pharmacists, nutritionists, and other specialists as needed.

  To get started, call 1-866-664-5404.

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- **24/7 Nurse Line.** You can talk with a registered nurse 24 hours a day; 7 days a week about your health concerns, no matter where you are. Whether your question is about yourself, your spouse, or your child, a nurse is always available to answer them and help you through the issue.

  To speak with a nurse, call 1-800-700-9184.

- **Live Health Online.** Is a convenient way for you to interact with a doctor through live, two-way video from your computer or mobile phone. You can access an in-network doctor's expertise 24/7 from anywhere you have an internet connection – and it only costs the same as an office visit copay. Live Health doctors can even ePrescribe if applicable.

  To access a doctor, go to **www.livehealthonline.com**.

Medical Plans at a Glance

	Exclusive Network Plan	Select Plan		Premier Plan		HDHP	
	In-Network ONLY[1]	In-Network[1]	Out-of-Network[2]	In-Network[1]	Out-of-Network[2]	In-Network[1]	Out-of-Network[2]
Calendar Year Deductible • Individual • Family	$750 $2,250	$500 $1,500	$1,500 $4,500	$500 $1,500	$1,500 $3,000	$2,600 $5,200 (includes prescription drugs)	$4,800 $9,600 (includes prescription drugs)
Calendar Year Out-of-Pocket Maximum (includes deductible) • Individual • Family	$4,000 $8,000	$4,000 $8,000	$8,000 $16,000	$2,500 $5,000	$5,000 $10,000	$3,000 $6,000 (includes prescription drugs)	$9,600 $19,200 (includes prescription drugs)
Health Savings Account (HSA) Funding	N/A	N/A		N/A		Molina Healthcare pays: $300/employee only $600/employee + dependents	
Lifetime Maximum Benefit	Unlimited	Unlimited		Unlimited		Unlimited	

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Molina Healthcare Benefits

	Exclusive Network Plan	Select Plan		Premier Plan		HDHP	
	In-Network ONLY[1]	In-Network[1]	Out-of-Network[2]	In-Network[1]	Out-of-Network[2]	In-Network[1]	Out-of-Network[2]
Medical Benefits							
Office Visit • Primary Care • Specialist	You pay $30 copay $40 copay	You pay $25 copay $40 copay	You pay 50% after deductible	You pay $25 copay $40 copay	You pay 40% after deductible	You pay 10% after deductible	You pay 50% after deductible
Well-baby Care (birth through age 6)	No charge	No charge	You pay 50% after deductible	No charge	You pay 40% after deductible	No charge	Not covered
Preventive Care	No charge	No charge	You pay 50% after deductible	No charge	You pay 40% after deductible	No charge	Not covered
X-ray and Laboratory Services	You pay 20% after deductible	No charge	You pay 50% after deductible	You pay 10% after deductible	You pay 40% after deductible	You pay 10% after deductible	You pay 50% after deductible
Complex Imaging	You pay 20% after deductible	$40 copay	You pay 50% after deductible	You pay 10% after deductible	You pay 40% after deductible	You pay 10% after deductible	You pay 50% after deductible
Chiropractic	$40 copay; up to 20 visits/year	$40 copay; up to 20 visits/year	You pay 50% after deductible; up to 20 visits/year	$40 copay; up to 20 visits/year	You pay 40% after deductible; up to 20 visits/year	You pay 10% after deductible	You pay 50% after deductible
Hospital Benefits							
Inpatient Hospitalization	You pay 20% after deductible	You pay 10% after deductible	You pay 50% after deductible	You pay 10% after deductible	You pay 40% after deductible	You pay 10% after deductible	You pay 50% after deductible
Outpatient Surgery	You pay 20% after deductible	You pay 10% after deductible	You pay 50% after deductible	You pay 10% after deductible	You pay 40% after deductible	You pay 10% after deductible	You pay 50% after deductible
Emergency Room	$155 copay	$155 copay	$155 copay	$155 copay	$155 copay; then you pay 10%	You pay 10% after deductible	You pay 50% after deductible
Urgent Care	$40 copay	$40 copay	$40 copay	$40 copay	$40 copay	You pay 10% after deductible	You pay 50% after deductible

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	Exclusive Network Plan	Select Plan		Premier Plan		HDHP	
	In-Network ONLY[1]	In-Network[1]	Out-of-Network[2]	In-Network[1]	Out-of-Network[2]	In-Network[1]	Out-of-Network[2]
Mental Health Benefits							
Outpatient	$40 copay	$40 copay	You pay 50% after deductible	$40 copay	You pay 40% after deductible	You pay 10% after deductible	You pay 50% after deductible
Inpatient	You pay 20% after deductible	You pay 10% after deductible	You pay 50% after deductible	You pay 10% after deductible	You pay 40% after deductible	You pay 10% after deductible	You pay 50% after deductible
Substance Abuse Benefits							
Outpatient	$40 copay	$40 copay	You pay 50% after deductible	$40 copay	You pay 40% after deductible	You pay 10% after deductible	You pay 50% after deductible
Inpatient	You pay 20% after deductible	You pay 10% after deductible	You pay 50% after deductible	You pay 10% after deductible	You pay 40% after deductible	You pay 10% after deductible	You pay 50% after deductible

Continued >>

	Exclusive Network Plan	Select Plan		Premier Plan		HDHP	
	In-Network ONLY[1]	In-Network[1]	Out-of-Network[2]	In-Network[1]	Out-of-Network[2]	In-Network[1]	Out-of-Network[2]
Prescription Drug Benefits — Express Scripts[3, 4, 5, 6]							
Retail Pharmacy (30-day supply) • Generic • Brand Formulary • Non-formulary • Injectable	 $15 copay 20% ($35 min; $60 max) 20% ($50 min-$75 max) $75 copay	 $15 copay 20% ($35 min; $60 max) 20% ($50 min-$75 max) $75 copay	You pay the in-network cost plus the difference	 $10 copay 20% ($30 min; $50 max) 20% ($45 min-$65 max) $75 copay	You pay the in-network cost plus the difference	You pay 10% after deductible (certain preventive care drugs are covered at 100% with no deductible)	You pay the in-network cost plus the difference
Mail Order (90-day supply) • Generic • Brand Formulary • Non-formulary	 $30 copay 20% ($70 min-$120 max) 20% ($100 min-$150 max)	 $30 copay 20% ($70 min-$120 max) 20% ($100 min-$150 max)	No coverage	 $20 copay 20% ($60 min-$100 max) 20% ($90 min-$130 max)	No coverage	You pay 10% after deductible	No coverage

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

[2] Subject to deductible; paid at usual, customary and reasonable (UCR) rates.

[3] Generic contraceptives will be paid at $0 copay if filled at an in-network pharmacy or mail order. Brand contraceptives will be paid at the brand copay or coinsurance shown above.

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

[5] All plans include Limited Step Therapy, so you may be asked to take a Step 1 drug before the drug you are taking.

[6] If you are taking a maintenance drug, you should use mail order. After two refills at retail, the third refill will be denied until you contact Express Scripts.

Dental Plans

You can choose from two Delta Dental PPO plans, both of which allow you to receive care from any dentist you wish. However, Delta's in-network dentists have agreed to charge only negotiated rates and the plan provides a higher level of coverage – so you pay less. Out-of-network providers may charge whatever they wish and the plan will pay benefits up to the reasonable and customary (R&C) amount typically charged for the service; you must pay the full cost of any amount over R&C.

The Low PPO Dental Plan has a lower payroll contribution and reimburses less; the High PPO Dental Plan costs more each paycheck, but provides a higher level of benefits.

Here is an overview of dental benefits:

	Low PPO Dental Plan		High PPO Dental Plan	
Plan Features	**In-Network** (Delta Dental PPO Network)	**Out-of-Network** (Includes Delta's Premier Network)	**In-Network** (Delta Dental PPO Network)	**Out-of-Network** (Includes Delta's Premier Network)
Annual Deductible	$50/person $150/family	$75/person $225/family	$50/person $150/family	
Annual Benefit Maximum (excluding orthodontia and preventive/diagnostic care)	$1,000		$1,500	
Preventive Services (oral exams, x-rays, cleanings)	100% (no deductible)	80% of R&C	Covered at 100%	Covered at 100%
Basic Services (periodontics, restorative, endodontics	80% after deductible	60% of R&C after deductible	80% after deductible	80% of R&C after deductible
Major (crowns, bridges, dentures)	50% after deductible	50% of R&C after deductible	50% after deductible	50% of R&C after deductible
Orthodontia (up to age 19)	Not covered		50% after deductible	50% of R&C after deductible
Orthodontia Lifetime Maximum Benefit	Not applicable		$1,500 (in-network and out-of-network combined)	

Find a Network Dentist
You can find a Delta network dentist near you at **www.deltadentalins.com** or by calling 1-800-765-6003.

Vision Plan

The Vision Plan, provided by Vision Service Plan (VSP), provides a benefit for exams and materials on a yearly basis. You have the freedom to see any vision provider you choose, but the plan generally pays better benefits when you receive care from doctors who participate in the VSP network. If you decide to go to an out-of-network provider, you'll be reimbursed for exams and eyewear according to a schedule of benefits. VSP has a national Assignment of Benefits (AOB) arrangement with Walmart and Sam's Club locations. No ID card is necessary for services.

Plan Features:

Here is an overview of vision benefits:

Vision Service Plan	VSP Providers	Out-of-Network Providers
Examination (once every 12 months)	$25 copay	$25 copay, then covered up to $50
Contact Lens Examination (once every 12 months)	15% discount on exam. Copay maximum is $60	
Eyeglass Lenses (once every 12 months) • Single vision • Lined bifocal • Lined trifocal	 100% covered 100% covered 100% covered	 Covered up to $50 Covered up to $75 Covered up to $100
Frames (every 24 months)	Covered up to $130 plus 20% discount on amounts over $130	Covered up to $70 (retail)
Contact Lenses (every 12 months in lieu of eyeglass frames and lenses) • Medically necessary • Elective	 100% covered Covered up to $105	 Covered up to $210 Covered up to $105
Lasik Vision Correction Procedures	At contracted centers, up to 15% discount off regular price or 5% off promotional price	Not covered

For more information, call VSP at 800-877-7195, or go to **www.vsp.com**.

Employee Assistance Program (EAP)

As a Molina Healthcare employee, you automatically have access to EAP — a confidential resource available to help you with life's everyday issues. When you contact the EAP offered through Life Works, you can speak with a licensed behavioral health professional who can offer advice and assistance in resolving issues that may arise in your professional or personal life, such as:

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

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

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

Call the EAP at 888-267-8126 at any time.

For more information, visit **www.lifeworks.com**, (User ID: molina / Password: healthcare) or scan the QR code on this page.

Flexible Spending Accounts

With Flexible Spending Accounts (FSAs), you can set aside before-tax dollars through convenient payroll deductions to pay for eligible health care and dependent care expenses. Here's how they work:

- You elect to make contributions from your pay on a before-tax basis. Your contributions aren't subject to federal income tax, Social Security tax, and, in most cases, state income tax. This reduces your taxable income, which means you pay less in taxes.
- The tax savings help offset the cost of eligible health care and dependent care expenses.
- You're not taxed on reimbursements from your FSAs.
- If you want to participate in an FSA, you must enroll each year and elect the amount you would like to contribute for the plan year.

Molina Healthcare offers two FSAs for the calendar year (January 1 – December 31, 2017):

- **Health Care FSA** — Contribute between $100 and $2,600 for the calendar year (January 1 – December 31, 2017)
- **Dependent Care FSA** — Contribute between $100 and $5,000 for the calendar year (January 1 – December 31, 2017), or between $100 and $2,500 if you're married and file taxes separately.

The "Use It or Lose It" Rule: Estimate Your Contributions Carefully

When deciding how much to contribute to an FSA, keep in mind that once you enroll and elect a contribution amount, your election generally remains in effect for the entire year. The FSA year ends on December 31, 2017. You can avoid forfeiting funds by carefully estimating your eligible FSA expenses before you enroll and then electing to contribute only the amount you think you will use during the plan year. Any funds left in your FSA(s) after the plan year ends are forfeited. This is called the "use it or lose it" rule.

For 2016 funds, Molina Healthcare's Health Care FSA allows a grace period for healthcare claims, so you have 14.5 months to incur expenses that can be reimbursed. The dollars you have set aside for the 2016 plan year can be used to reimburse for eligible expenses incurred up until March 15, 2017. You will then have until March 31, 2017 to submit these claims. This only applies to the Health Care FSA, not the Dependent Care FSA.

A Note About FSA and HSA Funding

If you have FSA funds in your account as of January 1, 2017, and you elect the new HDHP plan, you will not be able to contribute to a Health Savings Account (HSA) until April 1, 2017. You also will not receive Molina's contribution to your HSA until April 1, 2017.

For 2017 funds, there will no longer be a grace period. Instead, you will be able to roll over up to $500 of unused funds to 2018.

Health Care FSA

If you enroll in a Health Care FSA, you can use the funds to pay for eligible expenses like deductibles, copays, and coinsurance for you and your eligible dependents. You can contribute up to $2,600 for the year. You don't have to have medical, dental, or vision coverage through Molina Healthcare to enroll in a Health Care FSA. Be sure to plan your payroll contributions to coincide with expenses you will have during the year.

Eligible/Ineligible expenses

Here are a few common examples of expenses you can reimburse from your Health Care FSA, and others that are ineligible:

Eligible expenses		Ineligible expenses
• Ambulance services • Artificial teeth • Chiropractor • Contact lenses • Copays • Crutches • Deductibles and coinsurance	• Hearing aids • Insulin • Laser eye surgery • Long-term care • Prescription drugs • Smoking cessation programs	• Cosmetic surgery (if not medically necessary) • Teeth bleaching • Health care premiums • Over-the-counter medications, unless prescribed

For a full list of eligible and ineligible expenses, go to **www.deltahealthsystems.com**.

Reimbursements

The Health Care FSA issues a Benny Card with a Visa logo to use for qualified healthcare expenses. For paper reimbursements, you will access Delta Health Systems website **www.deltahealthsystems.com** to obtain the form and instructions for submitting for reimbursement.

Limited Purpose FSA

If you participate in an HSA, you cannot contribute to a Health Care FSA. You can, however, participate in a Limited Purpose FSA. You can contribute up to $2,600 for eligible expenses. This FSA offers limited purpose reimbursements for eligible non-medical expenses, such as dental and vision plan deductibles, copays and coinsurance. Additionally, once you've met your medical plan's deductible, you can use the Limited Purpose FSA to cover medical expenses and prescription drug costs.

Dependent Care FSA

If you enroll, you may use the Dependent Care FSA to pay for expenses for care of dependent children under the age of 13, or for the care of any disabled dependent who lives with you, and for whom you need care so that you and your spouse can work. You can contribute up to $5,000 for the year (January 1, 2017 – December 31, 2017), or up to $2,500 if you're married and file taxes separately. The limit applies to all contributions made by you and your spouse to any dependent care spending accounts through Molina Healthcare and any other employer.

Eligible Expenses

You can use your Dependent Care FSA for expenses you pay that allow you (or you and your spouse, if you're married) to work, such as:

- Child and elder day care
- Before- or after-school care
- Pre-school and nursery schools
- Summer day camp.

Here are some examples of **Ineligible Expenses**:

- Tuition
- Child or elder day care provided by someone living in your home
- Overnight camp.

Reimbursements

For reimbursements, you will access Delta Health Systems website **www.deltahealthsystems.com** to obtain the form and instructions for submitting for reimbursement.

Eligible Dependents

An eligible dependent is a person who shares the same primary place of residence with you for more than six months each year and is:

- Your child under age 13 whom you can claim as a dependent on your federal income tax return;
- Your spouse who is mentally or physically disabled; or
- Your dependent who is mentally or physically disabled and whom you can claim on your federal income tax return.

In most cases, your domestic partner and children of your domestic partner are not considered eligible dependents for purposes of your Dependent Care FSA.

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

Basic Life and AD&D Coverage

Molina Healthcare provides all eligible employees with **basic life insurance** and **accidental death & dismemberment insurance (AD&D)**. Each of these benefits is equal to two times your annual base salary up to a maximum benefit of $300,000. (Maximum life insurance coverage for the Executive Class is $750,000.) Life insurance pays a benefit in the event of your death regardless of the cause, while AD&D insurance provides an additional benefit if an accident causes your death or loss of limbs or senses.

Basic Life and AD&D coverage is provided through The Standard, and is 100% paid for by Molina Healthcare. Coverage begins automatically on the first of the month after you complete 30 days of employment in which you're scheduled to work at least 30 hours per week.

Voluntary Life Insurance Coverage (Paper enrollment form required*)
You can purchase Voluntary Life Insurance coverage through The Standard equal to:

Employee Coverage	Increments of $10,000, not to exceed coverage of 6 times salary or $300,000 whichever is less; coverage greater than $50,000 requires proof of good health and is subject to approval by The Standard[1]
Spouse/Domestic Partner Coverage	Increments of $10,000, not to exceed coverage of $300,000 or 100% of your coverage amount, whichever is less; coverage greater than $10,000 requires proof of good health and is subject to approval by The Standard[1]
Child Coverage (from birth to age 21; age 25 if full-time student)	Select coverage of $2,000, $5,000, or $10,000 per child[1]

[1] If you and/or your spouse/domestic partner/children apply for Voluntary Life Insurance (or increase your coverage amount) after you are first eligible, any amount of coverage requires proof of good health and is subject to approval by The Standard.

You pay the full cost of this coverage. See **Employee Contributions for Voluntary Life Insurance** for details.

*Scan/email completed form to **MHIBenefitsHelpMailbox@molinahealthcare.com**.

Disability Coverage

Disability coverage provides a percentage of your earnings if you are disabled and unable to work for a period of time due to non-occupational injury or illness.

- **Short-term disability (STD)** – pays a benefit of 66-2/3% of your weekly pre-disability salary up to a maximum benefit of $2,500 per week. Benefits begin on the 8th day of disability due to illness or pregnancy or the 1st day of disability due to injury; benefits last for up to 90 days of disability.
- **Long-term disability (LTD)** – **provided through The Standard** — pays 60% of your monthly pre-disability salary if your disability lasts longer than 90 days. The maximum monthly benefit depends on your insurance class. Benefits begin after 90 days of continuous disability, once approved by The Standard, and continue until the earlier of the date you are able to return to work or your Social Security Normal Retirement Age, as long as you remain disabled.

Your Molina Healthcare disability benefits will be coordinated with any other disability income received due to the same or related disabling condition, including available state disability benefits, Social Security disability benefits, or Workers' Compensation. Please refer to your certificate of insurance for additional information regarding other income.

For more information regarding disability coverage, call The Standard at 866-326-1380.

Short-term and Long-term Disability coverage is provided through The Standard, and is 100% paid for by Molina Healthcare. Coverage begins automatically on the first of the month after you complete 30 days of employment in which you're scheduled to work at least 30 hours per week.

401(k) Retirement Plan

Molina Healthcare employees are eligible to participate in our 401(k) Salaried Savings plan, administered by Fidelity. As long as you are at least 21 years old, you may participate starting the first of the month after you complete 30 days of employment or the first of any following month.

When you join the 401(k) plan, you'll decide what percentage of your salary to set aside (up to certain IRS limits) and how you'd like your funds to be invested. You will be enrolled automatically at a contribution equal to 4% of your eligible compensation.

Important 401(k) Plan features include:

- You will 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 by logging in to the Fidelity website.
- Through automatic payroll deduction, you can contribute between 1% and 90% of your eligible compensation on a before-tax basis, up to the IRS limit. For 2017, the IRS's annual maximum contribution is $18,000. If you are age 50 or older, you may make an additional "catch-up contribution." For 2017, the annual maximum catch-up contribution amount is $6,000.
- Molina Healthcare matches the first 4% of your employee contribution to the 401(k) plan.
- You are always 100% vested in your and Molina Healthcare's contributions to your 401(k) plan account.
- You may invest your account balance in any of the investment funds offered by the plan.
- You may change your contribution amount or investment options at any time, and the plan will make the changes as soon as administratively possible.
- Your contribution percentage will increase automatically by 1% each year, up to a maximum contribution of 8% of your eligible compensation, unless you opt out of this feature.

For more information, call Fidelity Customer Service at 800-835-5095, or go to **www.401k.com**.

Other Benefits

Employee Stock Purchase Plan (ESPP)

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

Educational Reimbursement

You can receive up to $5,250 per year (after you have completed six months of service as a full-time employee) for course work that relates to your current, or a likely future, position.

Paid Time Off

Molina Healthcare offers paid time off benefits that enable you to enrich your life. Please refer to the HR intranet for specific policies, including limitations, regarding each of these benefits.

Paid Time Off (PTO)

All eligible full-time employees regularly scheduled to work at least 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.

Paid Holidays

Molina Healthcare provides the following eight paid holidays and one paid floating holiday in 2017:

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

Costs for Coverage

You and Molina Healthcare share the cost of coverage for many benefits including medical, dental, and vision coverage, and you pay the full cost of any Voluntary Life Insurance coverage you elect. Use the links to the left or below to determine your cost for coverage for each of the plans.

- **Employee Payroll Contributions for Medical Plans**
- **Employee Payroll Contributions for Dental Plans**
- **Employee Payroll Contributions for Vision Plan**
- **Employee Payroll Contributions for Voluntary Life Insurance**

Employee Payroll Contributions for Medical Plans

	Well-Being Participation		No Well-Being Participation		Annual Savings with Well-Being
	2017 Per Pay Period	2017 Annual	2017 Per Pay Period	2017 Annual	Annual Difference
Exclusive Network Plan					
Employee Only	$26.28	$683.28	$39.42	$1,024.80	$341.64
Employee + Spouse/Domestic Partner	$70.52	$1,833.60	$105.78	$2,750.40	$916.80
Employee + Child(ren)	$65.77	$1,710.00	$98.65	$2,565.00	$855.00
Employee + Family	$143.41	$3,728.64	$215.11	$5,592.84	$1,864.32
Select PPO Plan					
Employee Only	$40.37	$1,049.55	$60.25	$1,566.49	$516.94
Employee + Spouse/Domestic Partner	$106.52	$2,769.53	$158.99	$4,133.63	$1,364.10
Employee + Child(ren)	$98.26	$2,554.72	$146.65	$3,813.01	$1,258.29
Employee + Family	$197.43	$5,133.19	$271.61	$7,061.78	$1,928.59
Premier PPO Plan					
Employee Only	$219.79	$5,714.52	$274.74	$7,143.15	$1,428.63
Employee + Spouse/Domestic Partner	$461.57	$12,000.84	$535.75	$13,929.43	$1,928.59
Employee + Child(ren)	$417.61	$10,857.84	$491.79	$12,786.43	$1,928.59
Employee + Family	$703.34	$18,286.80	$777.52	$20,215.39	$1,928.59
HDHP Plan					
Employee Only	$6.18	$160.72	$12.36	$321.43	$160.71
Employee + Spouse/Domestic Partner	$12.98	$337.51	$25.96	$675.01	$337.50
Employee + Child(ren)	$11.75	$305.36	$23.49	$610.73	$305.37
Employee + Family	$19.78	$514.29	$39.56	$1,028.59	$514.30

Well-Being Participation

If you enroll in one of the Anthem medical plans, you can lower your medical plan contributions by completing a confidential online health assessment. You will be able to take the assessment AFTER your benefits become effective and you receive your medical ID number from Anthem. Please do not try to complete the online assessment before your benefits effective date or you receive your medical ID number as it will not accurately reflect your participation.

Employee Contributions for Dental Plans

Delta Dental Low PPO Dental Plan	2017 Per Pay Period	2017 Annual
Employee Only	$4.62	$120.00
Employee + Spouse/Domestic Partner	$9.23	$240.00
Employee + Child(ren)	$11.08	$288.00
Employee + Family	$16.62	$432.00

Delta Dental High PPO Dental Plan	2017 Per Pay Period	2017 Annual
Employee Only	$12.69	$330.00
Employee + Spouse/Domestic Partner	$25.38	$659.88
Employee + Child(ren)	$25.38	$659.88
Employee + Family	$39.23	$1,020.00

Employee Contributions for Vision Plans

VSP	2017 Per Payroll	2017 Annual
Employee Only	$1.38	$35.88
Employee + Spouse/Domestic Partner	$2.65	$68.88
Employee + Child(ren)	$2.65	$68.88
Employee + Family	$2.65	$68.88

Employee Contributions for Voluntary Life Insurance

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

Children (From birth through age 21, or age 25 if a full-time student)	
Coverage Amount	**Monthly Cost of Coverage**
$2,000	$0.40
$5,000	$1.00
$10,000	$2.00

Enrollment

During Open Enrollment

Log on to HR Connect through Google Chrome, then:

1. Select ***Benefits***
2. Create a contact if you're adding a new family member or beneficiary, click ***Manage People I Plan to Cover***
3. Click ***Change Benefit Elections*** to proceed
4. A warning will pop up reminding you to designate dependents (contacts). If you already completed this, you can proceed with your enrollment.

At the end of your enrollment, a Benefit Confirmation page will summarize your elections. Please be sure to print your confirmation.

As a New Hire

Open HR Connect through Google Chrome, then:

1. Select ***Benefits***, once you do that it will open the Benefits window
2. If you plan to cover family members or add new family members or beneficiaries, click the ***Manage People I Plan to Cover***. The "Effective Start Date" needs to be your employment start date, complete the information and click ***Save***
3. To add more contacts you wish to cover, click ***Create Contact***
4. When ready to proceed, click ***Done***
5. Click ***Change Benefit Elections***
6. After confirming the people you wish to cover, click ***Continue***. *Result: when the Warning popup box appears, click **Continue Enrollment***
7. In the Authorization page, read the terms and click ***Accept***
8. Select your preferred Medical Plan and click ***Next***
9. Select your preferred Dental Plan and click ***Next***
10. Select your preferred Vision Plan and click ***Next***
11. Select your preferred Flexible Spending Account (FSA) and click ***Next***
12. The Company Paid Plans options are automatically selected for you as they are company-paid benefits. Click ***Next***.
13. Select your preferred Voluntary Life Plan and click ***Next***. *Result: This option does require you to complete a paper application which can be found on the Intranet > Departments > Human Resources > Employee Benefits > Life/AD&D/ Disability Benefits > Voluntary Life > Voluntary Life Enrollment Form_Medical History Statement*
14. Select and allocate to ***Designations*** accordingly and click ***Next***
15. Review your Benefits selection and, when ready, click ***Submit***. *Result: A Benefits Confirmation page will summarize your elections. Click **Print** to print your election. When ready, click **Done**.*

Contacts

For more details about any of the benefits or for enrollment information, contact the carriers below or the Benefits Service Center.

Benefit	Carrier	Phone	Website	Policy #
Medical Plans	Delta Health Systems (Third Party Administrator)	1-888-212-0276	www.deltahealthsystems.com	274
	Anthem Blue Cross Blue Shield Network	1-800-810-2583	In CA: www.anthem.com/ca Outside CA: www.bcbs.com	N/A
Health Savings Account (HSA)	HSA Bank	1-800-357-6246	www.hsabank.com	N/A
Prescription Drugs	Express Scripts	1-866-333-9716	www.express-scripts.com	003858
Well-Being	24/7 NurseLine	1-800-700-9184		
Dental Plans	Delta Dental	1-800-765-6003	www.deltadentalins.com	5202
Vision Plan	Vision Service Plan (VSP)	800-877-7195	www.vsp.com	12067408
Employee Assistance Program (EAP)	Life Works	1-888-267-8126	www.lifeworks.com	N/A
FSAs (Health Care and Dependent Care)	Delta Health Systems	1-888-212-0276	www.deltahealthsystems.com	274
Life/AD&D Insurance • Basic Life & AD&D • Voluntary Life	The Standard			639828 VT101972
Disability Coverage • Short-Term Disability (STD) • Long-Term Disability (LTD)	The Standard			639828
401(k) Retirement Plan	Fidelity	1-800-835-5097	www.401k.com	N/A
Stock Purchase Plan	Employee Stock Purchase Plan (ESPP)	1-800-838-0908	www.etrade.com/enroll	N/A
Assistance	Benefits Service Center	1-562-435-3666, Ext. 111030 or 1-866-472-9485	MHIBenefitsHelpMailbox.com	N/A
Molina's Mobile App			www.benefitsonthego.com/molina	N/A

Legal Notices

Federal law requires that Molina Healthcare provide you with certain notices about your rights regarding health care plan eligibility, enrollment, and coverage.

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 click **here** for more details.

Notice of Special Enrollment Rights for Medical Plan Coverage

Special enrollment events allow you and your eligible dependents to enroll for health coverage outside the Open Enrollment period under certain circumstances if you lose eligibility for other coverage, become eligible for state premium assistance under Medicaid or the Children's Health Insurance Program (CHIP), or acquire newly eligible dependents. This is required under the Health Insurance Portability and Accountability Act (HIPAA). If you decline enrollment in a Molina Healthcare medical plan for you or your dependents (including your spouse/domestic partner) because of other health insurance coverage, you or your dependents may be able to enroll in a Molina Healthcare medical plan without waiting for the next Open Enrollment period if you:

- Lose other health insurance. You must request enrollment within 30 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 enrollment within 30 days after the marriage, birth, adoption, or custody change of an eligible dependent.
- Lose Medicaid or Children's Health Insurance Program (CHIP) coverage because you are no longer eligible. You must request 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 marriage, birth, adoption or custody change of an eligible dependent. For all other events, coverage will be effective the first of the month following your request for enrollment. In addition, you may enroll in a Molina Healthcare medical 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 such 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. If you have questions, or to notify the plan, contact the Benefits Service Center. Note: If your dependent becomes eligible for a special enrollment rights, you may add the dependent to your current coverage.

Women's Health and Cancer Rights Act of 1998

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

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

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits available under your medical plan.

For information on WHCRA benefits or details about any state laws that may apply to your medical plan, please refer to the benefit plan material for the medical plan in which you are enrolled.

Newborns' and Mothers' Health Protection Act

Federal law protects the benefit rights of mothers and newborns related to any hospital stay in connection with childbirth. In general, group health plans and health insurance issuers may not:

- Restrict benefits for the length of hospital stay 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).
- Require that a provider obtain authorization from the plan or the insurance issuer for prescribing a length of stay of up to 48 hours (or 96 hours).

For details on any state maternity laws that may apply to your medical plan, please refer to the benefits material for the medical plan in which you are enrolled.

Health Insurance Portability and Accountability Act (HIPAA) Privacy Notice Reminder

As a reminder, Molina Healthcare has adopted a Health Insurance Portability and Accountability Act (HIPAA) Privacy Policy regarding the privacy of employees' personal health information. This notice describes how medical information about you may be used and disclosed and explains participants' rights and the Plan's legal duties with respect to protected health information.

Molina Healthcare will provide copies of the Privacy Notice to all employees. If you'd like to obtain an additional copy, contact the Benefits Service Center.

Consolidated Omnibus Budget Reconciliation Act (COBRA)

If you're an employee with medical, dental, vision, EAP or Health Care FSA coverage through Molina Healthcare, you have the right to choose continuation coverage if you lose your group health coverage due to reduction in your hours of employment or the termination of your employment for reasons other than gross misconduct. Your eligible dependents may also have the right to elect and pay for continuation of coverage for a temporary period in certain circumstances where coverage under the plan would otherwise end, such as divorce, or dependent children who no longer meet eligibility requirements.

Important note: This brief summary of the right you and your dependents have to continue insurance is not intended as the official notice of your rights required by federal and state law. We've included this brief summary to inform you that you have these rights. You'll receive a separate, detailed explanation of your right to continue health insurance coverage when applicable. Specific information is also available from your HR Representative.

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Important Notice from Molina Healthcare about Your Medicare Part D 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 and 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.

The purpose of this notice is to advise you that the prescription drug coverage listed below under the Molina Healthcare medical plan is expected to pay out, on average, at least as much as the standard Medicare prescription drug coverage will pay in 2017. This is known as "creditable coverage."

Why this is important: If you or your covered dependent(s) is enrolled in any prescription drug coverage listed in this notice during 2017 and is or will become covered by Medicare, you may decide to enroll in a Medicare prescription drug plan later and not be subject to a late enrollment penalty – as long as you had creditable coverage within 63 days of your Medicare prescription drug plan enrollment. You should keep this notice with your important records

If you or your family members aren't currently covered by Medicare and won't be covered by Medicare in the next 12 months, this notice doesn't apply to you. Medicare is generally available to people age 65 or older, people under age 65 with certain disabilities, and people of all ages with end-stage renal disease (permanent kidney failure requiring dialysis or a kidney transplant).

Notice of Creditable Coverage

Please read this notice carefully. It has information about prescription drug coverage with Molina Healthcare and prescription drug coverage available for people with Medicare. It also tells you where to find more information to help you make decisions about your prescription drug coverage.

You may have heard about Medicare's prescription drug coverage (called Part D), and wondered how it would affect you. Prescription drug coverage is available to everyone with Medicare through Medicare prescription drug plans. All Medicare prescription drug plans provide at least a standard level of coverage set by Medicare. Some plans also offer more coverage for a higher monthly premium.

Individuals can enroll in a Medicare prescription drug plan when they first become eligible, and each year from October 15 through December 7. Individuals leaving employer/union coverage may be eligible for a Medicare Special Enrollment Period.

If you are covered by the Molina Healthcare prescription drug plan listed below, you'll be interested to know that coverage is, on average, at least as good as standard Medicare prescription drug coverage for 2017:

- Exclusive Network Plan with prescription drug coverage through Express Scripts
- Select PPO Plan with prescription drug coverage through Express Scripts
- Premier PPO Plan with prescription drug coverage through Express Scripts
- High Deductible Health Plan with prescription drug coverage through Express Scripts

This is called creditable coverage. Coverage under one of these plans will help you avoid a late Part D enrollment penalty if you are or become eligible for Medicare and later decide to enroll in a Medicare prescription drug plan.

If you decide to enroll in a Medicare prescription drug plan and you are an active employee or family member of an active employee, you may also continue your employer coverage. In this case, the employer plan will continue to pay primary or secondary as it had before you enrolled in a Medicare prescription drug plan. If you waive or drop Molina Healthcare coverage, Medicare will be your only payer. You can re-enroll in the employer plan during Open Enrollment or if you have a special enrollment event for the Molina Healthcare plan, assuming you remain eligible.

You should know that if you waive or leave coverage with Molina Healthcare and you go 63 days or longer without creditable prescription drug coverage (once your applicable Medicare enrollment period ends), your monthly Part D premium will go up at least 1% per month for every month that you did not have creditable coverage. For example, if you go 19 months without coverage, your Medicare prescription drug plan premium will always be at least 19% higher than what most other people pay. You'll have to pay this higher premium as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to enroll in Part D.

Continued >>

You may receive this notice at other times in the future – such as before the next period you can enroll in Medicare prescription drug coverage, if this Molina Healthcare coverage changes, or upon your request.

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. Medicare participants will get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare prescription drug plans. Here's how to get more information about Medicare prescription drug plans:

Visit **www.medicare.gov** for personalized help.

Call your state Health Insurance Assistance Program (see a copy of the *Medicare & You* handbook for the telephone number).

Call 800-MEDICARE (800-633-4227). TTY users should call 877-486-2048.

For people with limited income and resources, extra help paying for a Medicare prescription drug plan is available. Information about this extra help is available from the Social Security Administration (SSA). For more information about this extra help, visit SSA online at **www.socialsecurity.gov** or call 800-772-1213 (TTY 800-325-0778).Remember: Keep this notice. If you enroll in a Medicare prescription drug plan after your applicable Medicare enrollment period ends, you may need to provide a copy of this notice when you join a Part D plan to show that you are not required to pay a higher Part D premium amount.

Date:	November 1, 2016
Name of Entity/Sender:	Molina Healthcare
Contact—Position/Office:	Benefits Service Center
Address:	200 Oceangate, Suite 100 Long Beach, CA 90802
Phone Number:	562-435-3666

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

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

If you or your dependents are already enrolled in Medicaid or CHIP and you live in a state listed below, you can 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, you can 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 permit 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, you can contact the Department of Labor at www.askebsa.dol.gov or call 1-866-444-EBSA (3272).

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If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of July 31, 2016. You should contact your state for further information on eligibility.

Alabama – Medicaid	Website: http://www.myalhipp.com Phone: 1-855-692-5447
Alaska – Medicaid	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 — CHIP	Website: http://myarhipp.com/ Phone: 1-855-MyARHIPP (1-855-692-7447)
Colorado – Medicaid	Website: http://www.colorado.gov/hcpf Phone: 1-800-221-3943
Florida – Medicaid	Website: http://flmedicaidtplrecovery.com/hipp/ Phone: 1-877-357-3268
Georgia – Medicaid	Website: http://dch.georgia.gov/medicaid (Click Health Insurance Premium Payment (HIPP)) Phone: 1-678-564-1162
Indiana – Medicaid	Website: http://www.hip.in.gov (Health Indiana Plan for low-income adults 19-64) Phone: 1-877-438-4479 Website: http://www.indianamedicaid.com (All other Medicaid) Phone: 1-800-403-0964
Iowa – Medicaid	Website: http://www.dhs.state.ia.us/hipp/ Phone: 1-888-346-9562
Kansas – Medicaid	Website: http://www.kdheks.gov/hcf/ Phone: 1-785-296-3512
Kentucky – Medicaid	Website: http://chfs.ky.gov/dms/default.htm Phone: 1-800-635-2570
Louisiana – Medicaid	Website: http://dhh.louisiana.gov/index.cfm/subhome/1/n/331 Phone: 1-888-342-6207
Maine – Medicaid	Website: http://www.maine.gov/dhhs/ofi/public-assistance/index.html Phone: 1-800-442-6003 TTY: Maine relay 711
Massachusetts – Medicaid and CHIP	Medicaid & CHIP Website: http://www.mass.gov/MassHealth Medicaid & CHIP Phone: 1-800-462-1120
Minnesota – Medicaid	Website: http://mn.gov/dhs/ma/ Phone (Outside Twin City area): 1-800-657-3739 Phone (Twin City area): 1-651-431-2670
Missouri – Medicaid	Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 1-573-751-2005

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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
Nevada – Medicaid	Website: http://dwss.nv.gov/ Phone: 1-800-992-0900
New Hampshire – Medicaid	Website: http://www.dhhs.nh.gov/oii/documents/hippapp.pdf Phone: 1-603-271-5218
New Jersey – Medicaid and CHIP	Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ Medicaid Phone: 1-800-356-1561 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710
New York – Medicaid	Website: http://www.nyhealth.gov/health_care/medicaid/ Phone: 1-800-541-2831
North Carolina – Medicaid	Website: http://www.ncdhhs.gov/dma/medicaid/hipp.htm Phone: 1-919-855-4100
North Dakota – Medicaid	Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/ Phone: 1-844-854-4825
Oklahoma – Medicaid	Website: http://www.insureoklahoma.org Phone: 1-888-365-3742
Oregon – Medicaid and CHIP	Medicaid & CHIP Website: http://healthcare.oregon.gov/Pages/index.aspx Medicaid & CHIP Phone: 1-800-699-9075
Pennsylvania – Medicaid	Website: http://www.dhs.pa.gov/hipp Phone: 1-800-692-7462
Rhode Island – Medicaid	Website: http://www.eohhs.ri.gov/ Phone: 1-401-462-5300
South Carolina – Medicaid	Website: http://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://www.gethipptexas.com/ Phone: 1-800-440-0493
Utah – Medicaid and CHIP	Medicaid Website: http://health.utah.gov/medicaid CHIP Website: http://health.utah.gov/chip Phone: 1-877-543-7669 (1-877-KIDSNOW)
Vermont– Medicaid	Website: http://www.greenmountaincare.org Phone: 1-800-250-8427
Virginia – Medicaid and CHIP	Medicaid & CHIP Website: http://www.coverva.org/programs_premium_assistance.cfm Medicaid & CHIP Phone: 1-855-242-8282
Washington – Medicaid	Website: http://www.hca.wa.gov/free-or-low-cost-health-care/program-administration/health-insurance-premium-program Phone: 1-800-562-3022, ext. 15473

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West Virginia – Medicaid	Website: http://www.dhhr.wv.gov/bms/Medicaid%20Expansion/Pages/default.aspx Phone: 1-877-598-5820, HMS Third Party Liability
Wisconsin – Medicaid	Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm Phone: 1-800-362-3002
Wyoming – Medicaid	Website: https://wyequalitycare.acs-inc.com/ Phone: 1-307-777-7531

To see if any more states have added a premium assistance program since July 31, 2016, or for more information on special enrollment rights, you can contact either:

U.S. Department of Labor
Employee Benefits Security Administration
www.dol.gov/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