Medicare

2024
Summary of Benefits

Molina Medicare Complete Care HMO D-SNP

Arizona H8845-001

Serving Gila, Maricopa and Pinal

Effective January 1 through December 31, 2024

MOLINA® HEALTHCARE

Introduction to the Summary of Benefits

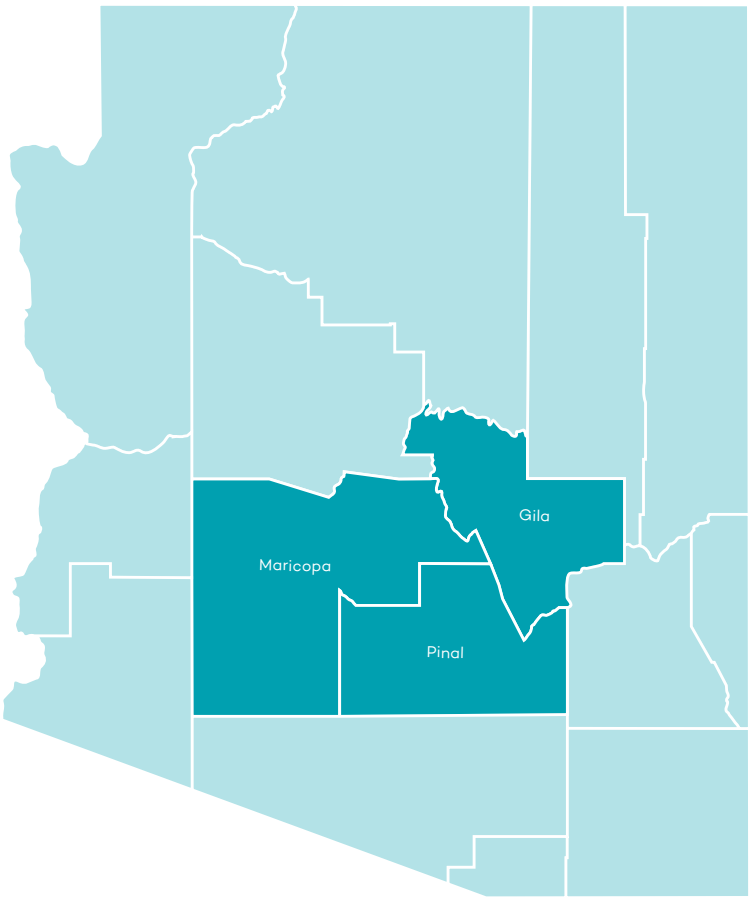
Molina Medicare Complete Care

Thank you for considering Molina Healthcare! Everyone deserves quality care. Since 1980, our members have been able to lean on Molina. Because today, as always, we put your needs first.

This document does not include every benefit and service that we cover or every limitation or exclusion. To get a complete list of services, please refer to the Evidence of Coverage (EOC). A copy of the EOC is located on our website at MolinaHealthcare.com/Medicare. You can also call Member Services at (800) 424-4509, TTY/TDD 711 and we will mail you a copy.

To join our plan, you must:

- Have or be eligible for Medicare Parts A and B
- Be enrolled in Arizona Health Care Cost Containment System (Medicaid)
- Live in our service area. Our service area includes the following counties in Arizona: Gila, Maricopa and Pinal.



Molina has a network of doctors, hospitals, pharmacies, and other providers. Except in emergency situations, if you use providers that are not in our network, we may not pay for those services.

If you want to compare our plan with other Medicare health plans, ask the other plans for their Summary of Benefits or use the Medicare Plan Finder at medicare.gov.

For coverage and costs of Original Medicare, look in your current "Medicare & You" handbook. View it online at medicare.gov or get a copy by calling **1-800-MEDICARE (1-800-633-4227).** TTY users should call 1-877-486-2048. If you have any questions, please call our Member Service team at **(800) 424-4509, TTY/TDD 711,** 7 days a week, 8 a.m. to 8 p.m., local time.

About Medicare

Medicare is health insurance for people who are 65 years old or older, or who are under 65 years old with certain disabilities.

Original Medicare is a Federal Insurance Program. It pays a fee for your care directly to the doctors and hospitals you visit. Original Medicare does not cover most preventive care and has unpredictable out-of-pocket expenses.

Medicare Part A (Hospital Insurance) covers inpatient care in hospitals, skilled nursing facilities, hospice care, and some home health care services.

Medicare Part B (Medical Insurance) covers certain doctors' services, outpatient care, medical supplies and preventive services.

Medicare Part C (Medicare Advantage) is an all-in-one alternative to Original Medicare. Medicare Advantage plans include Parts A, B and usually Part D. Some Medicare Advantage plans may have lower out-of-pocket costs than Original Medicare and may cover extra benefits that Original Medicare doesn't – like dental, vision or hearing. Medicare pays a fixed fee to the plan for your care, and then the plan directly pays the doctors and hospitals. Medicare Advantage has predictable out-of-pocket expenses and offers preventive care and care coordination.

Medicare Part D (Prescription Drug Coverage) helps you pay for drugs you get from a pharmacy.

Medicaid Dual Eligibility Coverage Categories

Depending on your level of Medicaid eligibility, you may not have any cost-sharing responsibility for Medicare-covered services. Molina offers coverage for these levels of beneficiaries:

- **Qualified Medicare Beneficiary Plus (QMB+):** Medicaid pays your Medicare Part A and Part B premiums, deductibles, coinsurance, and copayment amounts. You receive Medicaid coverage of Medicare cost-share and are eligible for full Medicaid benefits.
- **Specified Low-Income Medicare Beneficiary Plus (SLMB+):** Medicaid pays your Medicare Part B premium and provides full Medicaid benefits.
- **Full-Benefit Dual Eligible (FBDE):** At times, individuals may qualify for both limited coverage of Medicare cost-sharing as well as full Medicaid benefits.

If you are a QMB+ Beneficiary: You have a $0 cost share, except for Part D prescription drug copays, as long as you remain a QMB+ Member.

If you are a SLMB+ or FBDE Beneficiary: You are eligible for full Medicaid benefits and, at times, limited Medicare cost-share. As such, your cost share is $0. Typically, your cost share is $0 when the service is covered by both Medicare and Medicaid.

Additionally, preventive wellness exams and most supplemental benefits provided by our plan are also at a $0 cost share.

Eligibility Changes:
It is important to read and respond to all mail that comes from Social Security and your state Medicaid office and to maintain your Medicaid eligibility status.

Periodically, as required by CMS, we will check the status of your Medicaid eligibility as well as your dual eligible category. If your eligibility status changes, your cost share may also change. If you lose Medicaid coverage entirely, you will be given a grace period so that you can reapply for Medicaid and become reinstated if you still qualify.

If you no longer qualify for Medicaid, you may be involuntarily disenrolled from the Plan. Your state Medicaid agency will send you notification of your loss of Medicaid or change in Medicaid category. We may also contact you to remind you to reapply for Medicaid. For this reason, it is important to let us know whenever your mailing address and/or phone number changes.

If you are currently entitled to receive full or partial Medicaid benefits, please see your Medicaid member handbook or other state Medicaid documents for full details on your Medicaid benefits, limitations, restrictions, and exclusions. In your state, the Medicaid program can be reached through the Arizona Health Care Cost Containment System (AHCCCS).

Summary of Premiums & Benefits

Molina Medicare Complete Care	
Monthly Premium	$0 per month
Medical Deductible	This plan does not have a deductible.
Maximum Out-of-Pocket Responsibility	$8,850 each year for services you receive from in-network providers. (does not include prescription drugs) You are not responsible for paying any out-of-pocket costs toward the maximum out-of-pocket amount for covered Part A and Part B services.

Questions? Call our team of Medicare Trusted Advisors at (866) 403-8293, TTY: 711.

Molina Medicare Complete Care	
Inpatient Hospital 	You pay $0 for days 1 - 90 of a hospital stay per benefit period. Our plan also covers 60 "lifetime reserve days." These are "extra" days that we cover. If your hospital stay is longer than 90 days per benefit period, you can use these extra days. But once you have used up these extra 60 days, your inpatient hospital coverage will be limited to 90 days per benefit period. *Prior authorization may be required.*
Outpatient Hospital 	$0 copay per visit *Prior authorization may be required.*
Ambulatory Surgical Center 	$0 copay per visit *Prior authorization may be required.*
Doctor Visits 	**Primary Care** $0 copay per visit **Specialists** $0 copay per visit
Preventive Care 	$0 copay Look for the rows with the apple in the Chapter 4 Medical benefits chart in the Evidence of Coverage. Any additional preventive services approved by Medicare during the plan year will be covered.

Summary of Premiums & Benefits (Continued)

Molina Medicare Complete Care	
Emergency Care	$0 copay
Urgently Needed Services	$0 copay
Diagnostic Services/Labs/ Imaging	**Diagnostic tests and procedures** $0 copay **Lab services** $0 copay **Diagnostic radiology services** (such as MRI, CT scan) $0 copay **Outpatient X-rays** $0 copay **Therapeutic radiology** $0 copay *Prior authorization may be required for some services.* *No authorization is required for outpatient lab services and outpatient x-ray services. Genetic lab testing requires prior authorization.*

Molina Medicare Complete Care	
Hearing Services 	**Medicare-covered diagnostic hearing and balance exams** $0 copay **Routine hearing exam** $0 copay, 1 every year **Fitting for hearing aid/evaluation** $0 copay, 1 every year **Hearing aids** $0 copay Our plan covers an annual maximum allowance of $3,500 for both ears combined.
Dental Services 	**Medicare-covered dental services** $0 copay **We have partnered with a Dental Vendor to give you more options for your routine dental needs.** If you use a Provider within our Dental Vendor, you will get Preventive Dental Services of Oral Exams, Cleanings, Fluoride Treatments, and X-Rays at no cost to you. In addition, you will have $550 on your MyChoice card for any additional services at this provider. If you chose to utilize a dental provider outside of the Vendor network, any and all services rendered (including any preventive or comprehensive dental services) will only be covered when you use your MyChoice card and only up to the benefit allowance of $550. The MyChoice card is a debit card (not a credit card) and is for the use by the member for your dental needs only. This dental benefit allowance will be loaded to your MyChoice card at the start of your benefit period (annually). At the end of each benefit year, any unused benefit allowance will expire and does not carry over to the following period or plan year. See EOC for additional coverage details.

Summary of Premiums & Benefits (Continued)

Molina Medicare Complete Care

Vision Services

Medicare-covered vision services

- Vision exam to diagnose/treat diseases of the eye (including yearly glaucoma screening): $0 copay
- Eyeglasses or contact lenses after cataract surgery: $0 copay

We have partnered with a Vision Vendor to give you more value for your routine vision needs!

Supplemental Vision services covered include, but not limited to:

Coverage includes:

- One routine eye exam every calendar year
- An eyewear allowance

You can use your $500 eyewear allowance to purchase:

- Contact lenses*
- Eyeglasses (lenses and frames)
- Eyeglass lenses and / or frames
- Upgrades (such as, tinted, U-V, polarized or photochromatic lenses).

*If you choose contact lenses, your eyewear allowance can also be used to pay down all or a portion of your contact lens fitting fee.

You are responsible for paying for any corrective eyewear over the limit of the plan's eyewear allowance.

$0 copay for up to one routine eye exam (and refraction) for eyeglasses every calendar year.

Molina Medicare Complete Care	
Mental Health Services 	**Inpatient visit** You pay $0 for days 1 - 90 of an inpatient hospital stay. There is a 190 day lifetime limit for inpatient psychiatric hospital care. The inpatient hospital care limit does not apply to inpatient mental services provided in a general hospital. Our plan also covers 60 "lifetime reserve days." These are "extra" days that we cover. If your hospital stay is longer than 90 days, you can use these extra days. But once you have used up these extra 60 days, your inpatient hospital coverage will be limited to 90 days. *Prior authorization may be required.* **Outpatient individual/group therapy visit** $0 copay
Skilled Nursing Facility 	You pay $0 for days 1-100 of a skilled nursing facility stay. No prior hospitalization is required. *Prior authorization may be required.*
Physical Therapy 	**Physical therapy and speech therapy** $0 copay *Prior authorization may be required.* **Cardiac and pulmonary rehabilitation** $0 copay *Prior authorization may be required.* **Occupational therapy services** $0 copay *Prior authorization may be required.*
Ambulance 	$0 copay *Prior authorization required for non-emergent ambulance only.*
Transportation 	Not Covered

Summary of Premiums & Benefits (Continued)

Medicare Part B Drugs	
Chemotherapy/ Radiation Drugs and other Part B Drugs	$0 copay *Prior authorization may be required.*

Summary of Drug Coverage

Standard Retail Pharmacy and Mail-Order Pharmacy

Depending on your income and institutional status, you pay the following:

For generic drugs (including brand drugs treated as generic):

- $0 copay

For all other drugs:

- $0 copay

Summary of Drug Coverage (Continued)

Coverage Stages	
Stage 1: Deductible	Because there is no drug deductible for this plan, this stage does not apply to you.
Stage 2: Initial Coverage	You begin this stage when you fill your first prescription of the year. During this stage, the plan pays its share of the cost of your drugs, and you pay your share of the cost. You stay in this stage until your year-to-date "total drug costs" (your payments plus any Part D plan payments) total $5,030. If you reside in a long-term care facility, you pay the same as at a retail pharmacy. You may get drugs from an out-of-network pharmacy at the same cost as an in-network pharmacy.
Stage 3: Gap Coverage	During this stage, you pay 25% of the price for brand name drugs (plus a portion of the dispensing fee) and 25% of the price for generic drugs. You stay in this stage until your year-to-date “out-of-pocket costs” (your payments) reach a total of $8,000. This amount and rules for counting costs toward this amount have been set by Medicare.
Stage 4: Catastrophic Coverage	After your yearly out-of-pocket drug costs (including drugs purchased through your retail pharmacy and through mail order) reach $8,000 the plan will pay all of the costs of your drugs.

Summary of Other Benefits

Molina Medicare Complete Care	
Acupuncture 	**Medicare-Covered Acupuncture** $0 copay Up to 12 visits in 90 days are covered for chronic lower back pain. Up to eight additional sessions are covered in the same year for those patients demonstrating an improvement.
Additional Smoking and Tobacco Use Cessation 	$0 copay 8 counseling visits offered in addition to Medicare.
Additional Telehealth Services 	$0 copay Includes Primary Care Physician Services, Physician Specialist Services, and Opioid Treatment Program Services.
Chiropractic Care 	**Medicare-Covered Chiropractic Services** $0 copay Manipulation of the spine to correct a subluxation (when one or more of the bones of your spine move out of position). **Routine Chiropractic Services** $0 copay Up to 12 visits every year for routine services
Dialysis 	$0 copay
Foot Care (Podiatry) 	**Medicare-Covered Foot Exam and Treatment** $0 copay Foot exams and treatment if you have diabetes-related nerve damage and/or meet certain conditions. *Prior authorization may be required.*

Summary of Other Benefits (Continued)

Molina Medicare Complete Care	
Home Health Care 	$0 copay *Prior authorization may be required.*
Medical Equipment and Supplies 	**Durable Medical Equipment** (such as wheelchairs, oxygen) $0 copay **Prosthetics/Medical Supplies** $0 copay **Diabetic Supplies and Services** $0 copay *Prior authorization may be required for Durable Medical Equipment, Prosthetics/Medical supplies, and Diabetic supplies.* *Prior authorization required for diabetic shoes and inserts.* *Prior authorization not required for preferred manufacturer.*
24-Hour Nurse Advice Line 	$0 copay Available 24 hours a day, 7 days a week.
Opioid Treatment Program Services 	$0 copay *Prior authorization may be required.*
Outpatient Blood Services 	$0 copay
Outpatient Substance Abuse 	$0 copay Individual or group therapy visits *Prior authorization may be required.*

Molina Medicare Complete Care	
Over-the-Counter Items 	$0 copay $150 allowance every quarter for OTC items. Unused allowance does not carry over to the next quarter. You must use your MyChoice card to get the benefit and services.
Worldwide Emergency and Urgent Care 	$0 copay You are covered for worldwide emergency and urgent care services up to $10,000.
MyChoice Card 	$0 copay You receive a prepaid debit card that may be used toward select supplemental plan benefits such as: • Dental • Food and produce* • Over-the-counter items • Special Supplemental Benefits for Chronic Illnesses* Funds are loaded onto the card each benefit period. A benefit period can be monthly, quarterly, or annually depending on the benefits. At the end of each benefit period, any unused allocated money will not carry over to the following period or plan year. *Eligibility requirements applicable

Summary of Other Benefits (Continued)

Molina Medicare Complete Care	
Special Supplemental Benefits for Chronic Illnesses 	$0 copay $150 allowance every quarter for the following benefits: • Mental health and wellness applications • Service Animal supplies • Pest control • Non-Medicare covered genetic test kits Unused allowance does not carry over to the next quarter. $110 allowance every month for food and produce. Unused allowance does not carry over to the next month. *Prior authorization may be required.* You must use your MyChoice card to get the benefit and services. See MyChoice card section for more information. Members must complete a Health Risk Assessment and meet the criteria outlined in Chapter 4 of the Evidence of Coverage.

Summary of Medicaid-Covered Benefits

Arizona Health Care Cost Containment System
Medicare Advantage Special Needs Plans for Dual Eligible Members 2024 Benefits
In order for you to better understand your health care options, the following chart notes your charges for certain services under the Arizona Health Care Cost Containment System (Medicaid) as an individual who has both Medicare and Medicaid.

Your Medicare cost sharing responsibility is based on your level of Medicaid eligibility.

- Qualified Medicare Beneficiary (QMB) – $0. Your Medicare cost sharing amounts will be paid by your Medicaid Health Plan unless otherwise noted below.
- Non-QMB with Medicare Parts A and B – Your Medicare cost sharing amounts will be paid by your Medicaid Health Plan only when the benefit is also covered by Medicaid.

Benefit	As an Arizona Health Care Cost Containment System (AHCCCS) – QMB Dual Eligible – You Pay:	As an Arizona Health Care Cost Containment System (AHCCCS) – Non-QMB Dual Eligible – You Pay:
ACUTE AND LONG TERM CARE MEDICAID PROGRAMS (1)		
Inpatient Hospital Stay	$0	$0
Inpatient Behavioral Health Care Stay	$0	$0
Nursing Facility Services	$0	$0
Home Health Care Visit	$0	$0
Primary Care Physician (PCP) Visit	$0	$0 for well visits, and $0 to $4 for other visits depending on eligibility (2) for ages 21 and over (2). $0 for ages 20 and under.
Specialist Physician Visit	$0	$0 for well visits, and $0 to $4 for other visits depending on eligibility (2) for ages 21 and over. $0 for ages 20 and under.

Summary of Medicaid-Covered Benefits (Continued)

Benefit	As an Arizona Health Care Cost Containment System (AHCCCS) – QMB Dual Eligible – You Pay:	As an Arizona Health Care Cost Containment System (AHCCCS) – Non-QMB Dual Eligible – You Pay:
ACUTE AND LONG TERM CARE MEDICAID PROGRAMS (1) (CONTINUED)		
Medicare-Covered Services, including Chiropractic Care Visit, Chronic/Complex Case Management, etc,	$0	$0 for ages 20 and under. *Not covered for ages 21 and over.*
Podiatry Services Visit	$0	$0
Outpatient Behavioral Health Care Visit	$0	$0
Outpatient Substance Abuse Care Visit	$0	$0
Ambulatory Surgical Center or Outpatient Hospital Facility Visit	$0	$0 to $3 depending on eligibility (2) for ages 21 and over. $0 for ages 20 and under.
Ambulance Services	$0	$0
Emergency Services	$0	$0
Urgently Needed Care Visit	$0	$0 to $4 depending on eligibility (2) for ages 21 and over. $0 for ages 20 and under.
Outpatient Occupational/ Physical/Speech Therapy Visit	$0	$0 to $3 depending on eligibility (2) for ages 21 and over. $0 for ages 20 and under.
Durable Medical Equipment	$0	$0

Benefit	As an Arizona Health Care Cost Containment System (AHCCCS) – QMB Dual Eligible – You Pay:	As an Arizona Health Care Cost Containment System (AHCCCS) – Non-QMB Dual Eligible – You Pay:
ACUTE AND LONG TERM CARE MEDICAID PROGRAMS (1) (CONTINUED)		
Prosthetic Devices	$0	$0. *Lower limb microprocessor controlled limb or joint not covered for ages 21 and over.*
Diabetes Self-Monitoring Training & Supplies (when provided as part of a PCP visit)	$0	$0
Diagnostic Tests, X-rays, and Laboratory Services (including COVID-19 diagnostic & testing services)	$0	$0
Colorectal Screening	$0	$0
Flu and Pneumonia Vaccines	$0	$0
Screening Mammogram	$0	$0
Pap Smear and Pelvic Exam	$0	$0
Prostate Cancer Screening	$0	$0
Renal Dialysis or Nutritional Therapy for End-Stage Renal Disease	$0	$0
Prescription Medications (3)	$0	$0 to $2.30 depending on eligibility (2) for ages 21 and over. $0 for ages 20 and under.

Summary of Medicaid-Covered Benefits (Continued)

Benefit	As an Arizona Health Care Cost Containment System (AHCCCS) – QMB Dual Eligible – You Pay:	As an Arizona Health Care Cost Containment System (AHCCCS) – Non-QMB Dual Eligible – You Pay:
ACUTE AND LONG TERM CARE MEDICAID PROGRAMS (1) (CONTINUED)		
Hearing Exams, Routine Hearing Tests, and Fitting Evaluations for a Hearing Aid	$0 for ages 20 and under. *Not covered for ages 21 and over.*	$0 for ages 20 and under. *Not covered for ages 21 and over.*
Hearing Aids	$0 for ages 20 and under. *Not covered for ages 21 and over.*	$0 for ages 20 and under. *Not covered for ages 21 and over.*
Routine Eye Exam, Eyeglasses, Contact Lenses, Lenses and Frames	$0 for ages 20 and under. *Not covered for ages 21 and over unless following cataract surgery.*	$0 for ages 20 and under. *Not covered for ages 21 and over.*
Adult Emergency Dental Services	$0 for ages 21 and over. *Services subject to a $1,000 limit per each 12 month period beginning October 1st of each year.*	$0 for ages 21 and over. *Services subject to a $1,000 limit per each 12 month period beginning October 1st of each year.*
Non-Emergency Medically Necessary Transportation	$0	$0
LONG TERM CARE MEDICAID PROGRAMS ONLY (1)		
Nursing Facility Services	Cost sharing determined by AHCCCS	Cost sharing determined by AHCCCS
Respite Services	$0. *Subject to a 600 hour limit per each 12 month period beginning October 1st of each year.*	$0. *Subject to a 600 hour limit per each 12 month period beginning October 1st of each year.*

Benefit	As an Arizona Health Care Cost Containment System (AHCCCS) – QMB Dual Eligible – You Pay:	As an Arizona Health Care Cost Containment System (AHCCCS) – Non-QMB Dual Eligible – You Pay:
LONG TERM CARE MEDICAID PROGRAMS ONLY (1) (CONTINUED)		
Home and Community Based Services	Member contribution determined by AHCCCS	Member contribution determined by AHCCCS
Adult Preventive Dental Services (4)	$0 for ages 21 and over. *Services subject to a $1,000 limit per each 12 month period beginning October 1st of each year.*	$0 for ages 21 and over. *Services subject to a $1,000 limit per each 12 month period beginning October 1st of each year.*

(1) Acute Medicaid Programs include AHCCCS Complete Care (ACC), ACC Regional Behavioral Health Agreements (ACC-RBHAs), and the Mercy Care Department of Child Safety Comprehensive Health Plan (Mercy Care DCS CHP). Long Term Care Medicaid Programs include Elderly and Physically Disabled (E-PD) and Division of Developmental Disabilities (DDD).

(2) See the AHCCCS Website for additional beneficiary cost sharing, co-payment and benefits related information.

(3) Medicare Part D co-payment amounts are the sole responsibility of the beneficiary. AHCCCS health plans cannot assist with the payment of these amounts, except for behavioral health medications for those beneficiaries determined to be Seriously Mentally Ill (SMI) utilizing allowable Non-Title XIX funding.

(4) In addition to Adult Emergency Dental Services described above.

Glossary of Terms

Coinsurance
The percentage you pay as your share of the cost for medical services or prescription drugs. For example, if you have 20 percent coinsurance, you pay 20 percent of the cost of your medical bill.

Copay
The fixed amount you pay as your share of the cost of a medical service or supply. For example, you might have a $20 copay every time you see your primary care doctor.

Deductible
The amount you pay for health care services or prescriptions before your insurance begins to pay.

Extra Help
A Medicare program to help people with limited income and resources pay prescription drug program costs, like premiums, deductibles, and coinsurance.

Long-term care
Services and support for people who can't perform basic activities of daily living, like dressing and bathing. Medicare and most health insurance plans do not pay for long-term care.

Medicaid
A state and federal program that provides health coverage to low-income people.

Medicare Advantage
Also known as Part C. A type of Medicare plan offered by a private company approved by Medicare. A Medicare Advantage plan is an alternative to Original Medicare. It provides all of your Part A and Part B benefits and often offers extra benefits, like dental and vision care.

Original Medicare
Medicare Part A (hospital insurance) and Part B (medical insurance). Most people get it when they turn 65. The federal government manages Original Medicare.

Out-of-pocket maximum
The most you have to pay for covered services in one year. Once you reach this amount, your insurance covers 100 percent of your medically necessary care for the rest of the year.

Premium
The money you pay monthly to Medicare or a health care plan for coverage.

Preventive services
Health care to prevent or detect illness at an early stage. Most health plans must cover some important preventive services, like flu shots and blood pressure screening, at no cost to you.

How can you enroll?

Apply by Phone
Call **(866) 403-8293, TTY/TDD 711**, to enroll over the phone. Our team of Molina Medicare Trusted Advisors are happy to answer your questions and help you enroll.

Apply in Person
If you prefer to meet face-to-face with one of our Molina Medicare Trusted Advisors, please call us to schedule an appointment.

Apply by Mail
Simply complete the enrollment application and return it using the postage-paid envelope. If you do not already have an enrollment application, call us and we will be happy to mail one to you.

Apply Online
Visit MolinaHealthcare.com/Medicare to apply online.

Molina Healthcare is a DSNP and HMO plan with a Medicare contract. DSNP plans have a contract with the state Medicaid program. Enrollment depends on contract renewal. Molina Healthcare complies with applicable Federal civil rights laws and does not discriminate on the basis of race, ethnicity, national origin, religion, gender, sex, age, mental or physical disability, health status, receipt of healthcare, claims experience, medical history, genetic information, evidence of insurability, geographic location. We have free interpreter services to answer any questions you may have about our health or drug plan. To get an interpreter, just call us at (800) 424-4509, TTY: 711. Someone who speaks English can help you. This is a free service.Spanish: Tenemos servicios de intérprete sin costo alguno para responder cualquier pregunta que pueda tener sobre nuestro plan de salud o medicamentos. Para hablar con un intérprete, por favor llame al (800) 424-4509, TTY: 711. Alguien que hable español le podrá ayudar. Este es un servicio gratuito. The benefits mentioned are a part of special supplemental program for the chronically ill. Not all members qualify.

Contact us

Ready to enroll or have questions?
Call **(866) 403-8293, TTY: 711**
Current Members Call: **(800) 424-4509, TTY: 711**
7 days a week, 8 a.m. - 8 p.m. local time

MOLINA® HEALTHCARE

H8845_24_001_AZSB_M

AZM01SBEN0924

AZS884501SBEN24