Medicare

2022
Summary of Benefits

Molina Medicare Complete Care (HMO D-SNP)

Arizona H8845-001

Serving the following counties: Gila, Maricopa and Pinal

Effective January 1 through December 31, 2022

MOLINA® HEALTHCARE

Introduction to the Summary of Benefits

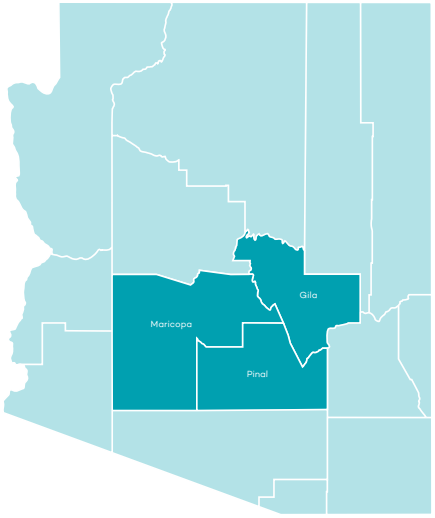
Molina Medicare Complete Care

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 www.MCCofAZ.com. You can also call Member Services at 1-800-424-4509, (TTY 711) from 8 a.m. to 8 p.m., Monday through Friday (from October 1-March 31, 7 days a week) and we will mail you a copy.

To join our plan, you must

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



Our plan 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 Services team at 1-800-424-4509, (TTY 711) from 8 a.m. to 8 p.m., Monday through Friday (from October 1-March 31, 7 days a week).

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 hospital, 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:

- **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.
- **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 Arizona, the Arizona Health Care Cost Containment System (AHCCCS) (Medicaid) can be reached at 1-855-HEA-PLUS (1-855-432-7587) from Monday through Friday 8 a.m. – 5 p.m. Or you can call the AZ Relay Service for the hearing impaired at 1-800-367-8939. You may also visit their website at azahcccs.gov.

Summary of Premium & Benefits

Molina Medicare Complete Care	
Monthly plan premium	**$0** You must keep paying your Medicare Part B premium.
Medical deductible	**$0** We do not have annual deductibles.
Maximum out-of-pocket responsibility	**$7,550 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.

What are my Molina benefits and services?

The chart below includes a list of Medicare benefits and what is covered by our plan. For AHCCCS (Medicaid) covered services, see pages 15-19.

Molina Medicare Complete Care

Inpatient hospital

$0 per stay

Our plan covers 90 days for an inpatient 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, 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 for non-emergency admissions.

Outpatient hospital

$0

- Surgical services
- Nonsurgical services
  - Observation
  - Mental health
  - Rehabilitation
  - Substance abuse

Prior authorization may be required.

Ambulatory surgery center

$0

Prior authorization may be required.

Doctor visits

$0

- Primary care providers
- Specialists
- Includes laboratory and radiology

Prior authorization may be required for specialist care.

Preventive care

$0

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.

Molina Medicare Complete Care

Emergency care 	**$0** Coverage is limited to emergency care received in the U.S. and its territories.
Urgently needed services 	**$0** Coverage is limited to emergency care received in the U.S. and its territories.
Diagnostic services/labs/imaging  • Diagnostic tests and procedures • Lab services • Diagnostic radiology services (such as MRI, CT scan) • Outpatient x-rays • Therapeutic radiology	**$0** *Prior authorization may be required.*
Hearing services  • Medicare-covered diagnostic hearing and balance exams • Routine hearing exam • Fitting for hearing aid/evaluation • Hearing aids	**$0** Hearing aid allowance of $1,250 both ears combined every year *Prior authorization may be required for hearing aids.*
Dental services 	In general, preventive dental services (such as cleaning, routine dental exams and dental x-rays) are not covered by Original Medicare or by our plan.

Molina Medicare Complete Care

Vision services

$0

Medicare covers:

- One routine eye exam each year
- One pair of contact lenses or eyeglasses (lenses and frames)

Up to $200 every year

- Eye exams to diagnose and treat diseases and conditions of the eye
- One glaucoma screening each calendar year if you are at high risk of glaucoma
- One diabetic retinopathy screening each calendar year if you have diabetes
- One pair of eyeglasses or contact lenses after each cataract surgery that includes insertion of an intraocular lens

Medicare-covered eyewear following cataract surgery is a limited benefit and only includes basic frames, lenses, or contact lenses.

- One pair of corrective lenses/frames and replacement(s) needed after a cataract removal without a lens implant

Mental health services

$0

- **Inpatient visits**

  - Our plan covers up to 190 days in a lifetime for inpatient mental health care in a psychiatric hospital. The inpatient hospital care limit does not apply to inpatient mental services provided in a general hospital.
  - Our plan covers 90 days for an inpatient hospital stay.
  - 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.

This does not include emergencies.

- **Outpatient individual/group therapy visits**
  - Covered when services are provided by Medicare-qualified mental health care professionals

Summary of Premium & Benefits (continued)

Molina Medicare Complete Care

Skilled Nursing Facility (SNF)

$0

Our plan covers up to 100 days in a skilled nursing facility.

No prior hospitalization is required.

Prior authorization may be required.

Physical therapy

$0

- Physical therapy and speech therapy
- Cardiac and pulmonary rehabilitation
- Occupational therapy

Prior authorization may be required.

Ambulance

$0

Prior authorization may be required for non-emergency ambulance only.

Medicare Part B Drugs

Chemotherapy/radiation and other Part B drugs

$0

Part B step therapy may be required when receiving Part B prescription drugs.

Summary of Premium & Benefits (continued)

Medicare Part D Drug Coverage Stages	Member cost
Deductible Stage Since you have Medicaid, you are already enrolled in "Extra Help," also called the Low-Income Subsidy (LIS). Extra Help pays your prescription drug premiums, annual deductibles and copayments. Copays vary based on the level of "Extra Help" you receive.	**$0** Because you receive "Extra Help", this payment stage does not apply to you.

Initial Coverage Stage

Since you have no deductible, the plan pays its share of the cost of your drugs, and you pay your share of the cost. These copayments may change when you enter another stage of the Part D benefit.

Category	Generic drugs & preferred multi-source drugs	All other drugs
Standard retail cost-sharing • In-network • Up to a 30-day supply	**$0/$1.35/$3.95 per prescription**	**$0/$4.00/$9.85 per prescription**
Mail-order cost-sharing • In-network • Up to a 90-day supply	**$0/$1.35/$3.95 per prescription**	**$0/$4.00/$9.85 per prescription**
Long-term care (LTC) cost-sharing • Up to a 30-day supply	**$0/$1.35/$3.95 per prescription**	**$0/$4.00/$9.85 per prescription**
Standard retail cost-sharing • Up to a 5-day supply • Coverage is limited to certain situations; see Chapter 5 of the 2022 Evidence of Coverage for details.	**$0/$1.35/$3.95 per prescription**	**$0/$4.00/$9.85 per prescription**

Coverage Gap Stage	Because you receive "Extra Help," this payment stage does not apply to you.
Catastrophic Stage When you reach the out-of-pocket limit of $7,050 for your prescription drugs, the Catastrophic Coverage Stage begins. You will stay in the Catastrophic Coverage Stage until the end of the calendar year. During this stage, the plan will pay most of the costs of your drugs for the rest of the calendar year (through December 31, 2022).	**$0**

Summary of Other Benefits

Molina Medicare Complete Care

Diabetes programs and supplies

$0

- Supplies to monitor blood glucose
- Diabetes self-management training is covered under certain conditions.
- For people with diabetes who have severe diabetic foot disease, shoes and inserts are covered under certain conditions
- If you qualify, benefits include:
  - o Diabetes self-management training
  - o Diabetic therapeutic shoes or inserts

We have a preferred manufacturer for diabetic test strips. We have an exception request coverage review process for non-preferred brands.

Prior authorization may be required for shoes and inserts.

Dialysis services

$0

Authorization required only if using dialysis services out-of-network.

Durable medical equipment

$0

- Medical equipment (wheelchairs, oxygen, etc.)

Prior authorization may be required.

Home health services

$0

- Includes medically necessary intermittent skilled nursing care, home health aide services, rehabilitation services, etc.
- Medical and social services
- Medical equipment and supplies

Prior authorization may be required.

Home infusion therapy

$0

Covered services include, but are not limited to:

- Professional services, including nursing services, furnished in accordance with the plan of care
- Patient training and education not otherwise covered under the durable medical equipment benefit
- Remote monitoring

Monitoring services for the provision of home infusion therapy and home infusion drugs furnished by a qualified home infusion therapy supplier

Summary of Other Benefits (continued)

Molina Medicare Complete Care

Immunizations

$0

Covered Medicare Part B services include:

- Pneumonia vaccine
- Flu shots, once each flu season in the fall and winter, with additional flu shots if medically necessary
- Hepatitis B vaccine if you are at high or intermediate risk of getting Hepatitis B
- COVID-19 vaccine
- Other vaccines if you are at risk and they meet Medicare Part B coverage rules

We also cover some vaccines under our Part D prescription drug benefit.

Opioid treatment program services

$0

Prior authorization may be required.

Members of our plan with opioid use disorder (OUD) can receive coverage of services to treat OUD through an Opioid Treatment Program (OTP).

- FDA-approved opioid agonist and antagonist medication-assisted treatment (MAT) medications
- Dispensing and administration of MAT medications (if applicable)
- Substance use counseling
- Individual and group therapy
- Toxicology testing
- Intake activities
- Periodic assessments

Other health care professional services

$0

Prior authorization may be required.

- Mental health specialty services
- Psychiatric services
- Additional telehealth services

Outpatient diagnostic radiological services

$0

No authorization is required for outpatient x-ray services.

Outpatient hospital services:

$0

Observation

Prior authorization is not required.

Summary of Other Benefits (continued)

Molina Medicare Complete Care	
Outpatient substance abuse care Individual and group therapy	**$0** *Prior authorization is not required.*
Over-the-counter (OTC) items	Up to $45 every 3 months for OTC benefits Allowance does not carry over to the next quarter.
Prosthetics Includes braces, artificial limbs and eyes, etc.	**$0** *Prior authorization may be required.*
Pulmonary rehabilitation services	**$0** *Prior authorization may be required*
Remote access technology Nursing hotline	**$0**
Services to treat kidney disease • Kidney disease education services • Outpatient dialysis treatments • Inpatient dialysis treatments • Self-dialysis training • Home dialysis equipment and supplies	**$0** Authorization is required only if using dialysis services out-of-network.
Smoking and tobacco use cessation (counseling to stop smoking or tobacco use) Eight (8) visits are offered in addition to Medicare's visits.	**$0** Prior authorization is not required for these additional sessions
Supervised Exercise Therapy (SET) For members who have symptomatic peripheral artery disease (PAD) and a referral for PAD from the physician responsible for PAD treatment	**$0** Up to 36 sessions over a 12-week period are covered under certain conditions

Summary of Other Benefits (continued)

Molina Medicare Complete Care

Special supplemental benefits for the chronically ill Coverage provided for those who have a chronic and disabling mental health condition, including but not limited to those listed in the *Evidence of Coverage (EOC).* Those that qualify may access one or more of the following: • Mental health & wellness applications • Service animal supplies	**$0** Upon approval, your MyChoice Debit card will be loaded with a $150 allowance every quarter (3 months). Allowance expires at the end of each quarter and does not roll over to the next quarter. Allowance expires at the end of the calendar year. *Participation in a care management program may be required. Members must also have physician sign off for testing based on lack of historical medical information.*
Telehealth services • Primary care physician services • Physician specialist services • Individual sessions for mental health specialty services • Individual sessions for psychiatric services • Kidney disease education services • Diabetes self-management training	*Prior authorization may be required*

Summary of Medicaid-covered Benefits

What AHCCCS (Medicaid) covers

Molina Medicare Complete Care coordinates with Arizona Health Care Cost Containment System (AHCCCS) (Medicaid) on your Medicare and Medicaid benefits. To help you better understand your health care options, the following chart notes your charges for certain services under AHCCCS Medicaid as an individual who has both Medicare and Medicaid. For full details on your Medicaid benefits, limitations, restrictions and exclusions, please see your AHCCCS Medicaid member handbook or other Arizona Medicaid documents.

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

Summary of Medicaid-covered Benefits

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)		
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.
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.

Summary of Medicaid-covered Benefits

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)		
Durable Medical Equipment	$0	$0
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.

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)		
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.*
Routine Eye Exam, Eyeglasses, Contact Lenses, Lenses and Frames	$0 for ages 20 and under. *Not covered for ages 21and 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)		
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), Regional Behavioral Health Authorities (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, copayment and benefits related information.

(3) Medicare Part D copayment 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 your Part A and Part B benefits and often offers extra benefits, like dental and vision care.

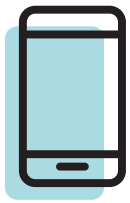
Original Medicare
Medicare Part A (hospital insurance) and Part B (medical insurance). Most people get it when they turn 65. The federal government manages Original Medicare.

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 **1-800-424-4505, (TTY 711)** to enroll over the phone. Our team of Molina Medicare Trusted Advisors is 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 www.MCCofAZ.com to apply online.

This is not a complete description of benefits. Call 1-800-424-4509, (TTY 711) for more information.

This information is available in other formats, such as braille, large print, and audio.

Product offered by Molina Healthcare of Arizona, Inc., a wholly owned subsidiary of Molina Healthcare, Inc.

Molina Medicare Complete Care (HMO D-SNP) is a managed care plan with a Medicare Advantage contract and a contract with the State of Arizona Medicaid program. Enrollment in our plan depends on contract renewal.

Out-of-network/non-contracted providers are under no obligation to treat Molina members, except in emergency situations. Please call our Member Services number or see your *2022 Evidence of Coverage* for more information, including the cost-sharing that applies to out-of-network services.

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, or geographic location.

Contact us

Ready to enroll or have questions?
Call **1-800-424-4505, TTY/TDD 711**
Current members call: **1-800-424-4509, TTY/TDD 711**
8 a.m. to 8 p.m., local time
Monday through Friday
(from October 1–March 31, 7 days a week)

MOLINA® HEALTHCARE

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