

2026

# Summary of Benefits

## Central Health Classic Care Plan I (HMO)

California H5649-027-000

Serving: Kern, Los Angeles, Orange, Riverside, San Bernardino, and San Diego Counties

Effective January 1 through December 31, 2026



# 2026 Summary of Benefits

## Central Health Classic Care Plan I (HMO) H5649-027

January 1, 2026 - December 31, 2026.

Central Health Medicare Plan is an HMO/HMO SNP plan with a Medicare contract. Enrollment depends on contract renewal.

The benefit information provided does not list every service that we cover or list every limitation or exclusion. To get a complete list of services we cover, please access the “Evidence of Coverage” at [www.centralhealthplan.com](http://www.centralhealthplan.com).

To join **Central Health Classic Care Plan I (HMO)** you must be entitled to Medicare Part A, be enrolled in Medicare Part B, and live in our service area. Our service area includes the following counties in California: Kern, Los Angeles, Orange, Riverside, San Bernardino, and San Diego Counties.

Except in emergency or urgent situations, if you use providers that are not in our network, we may not pay for these services.

For coverage and costs of Original Medicare, look in your current “**Medicare & You**” handbook. View it online at [Medicare.gov](http://Medicare.gov) or get a copy by calling 1-800-MEDICARE (1-800-633-4227) available 24 hours, 7 days a week including some federal holidays. TTY/TDD users should call 1-877-486-2048.

**Have questions?** Please call Central Health Medicare Plan Member Services Department at (866) 314-2427, TTY: 711, Hours are October 1 – March 31, 8 a.m. to 8 p.m. local time, 7 days a week. From April 1 – September 30, Monday – Friday, 8 a.m. to 8 p.m. local time. or visit our website at [www.centralhealthplan.com](http://www.centralhealthplan.com).

Premium & Benefits	Central Health Classic Care Plan I (HMO) 27
<b>Monthly Plan Premium</b> You must keep paying your Medicare Part B premium.	\$0
<b>Deductible</b>	No deductible
<b>Maximum Out-of-Pocket Responsibility</b> (does not include prescription drugs)	No more than \$799 annually
<b>Inpatient Hospital*</b>	\$0 per stay
<b>Outpatient Hospital*‡</b>	\$0 - \$65 copay
<b>Ambulatory Surgery Center*</b>	\$0 copay
<b>Doctor Visits</b> <ul style="list-style-type: none"> <li>• Primary care providers</li> <li>• Specialists*</li> </ul>	\$0 copay \$0 copay
<b>Preventive Care</b> Other preventive services are available. <ul style="list-style-type: none"> <li>• Flu vaccine, diabetic screenings, etc.*</li> </ul>	\$0 copay
<b>Emergency Care</b> Copayment waived if admitted to the hospital or readmitted to the ER within 72 hours	\$100 copay
<b>Urgent Care</b>	\$0 copay
<b>Diagnostic Services/Labs/Imaging*</b> <ul style="list-style-type: none"> <li>• Diagnostic tests and procedures</li> <li>• Lab services</li> <li>• Diagnostic radiology (e.g. MRIs, CAT scans)</li> <li>• X-rays</li> </ul>	\$0 copay \$0 copay \$0 copay \$0 copay

\* Services may require authorization.

‡ Please reference Evidence of Coverage (EOC) for details on specific services.

Premium & Benefits	Central Health Classic Care Plan I (HMO) 27
<p><b>Hearing Services*</b></p> <ul style="list-style-type: none"> <li>• Medicare-covered hearing exam</li> <li>• Routine hearing exam One per year</li> <li>• Hearing aid fittings and evaluations One per year</li> <li>• Hearing aid</li> </ul>	<p>\$0 copay</p> <p>\$0 copay</p> <p>\$0 copay</p> <p>\$575 copay per hearing aid for the entry model \$699 copay per hearing aid for the basic model \$999 copay per hearing aid for the prime model \$1,399 copay per hearing aid for the preferred model \$1,599 copay per hearing aid for the advanced model \$2,099 copay per hearing aid for the premium model</p> <p>You receive 2 hearing aids every year</p>
<p><b>Dental Services†*</b></p> <ul style="list-style-type: none"> <li>• Medicare-covered dental services</li> <li>• Preventive dental <ul style="list-style-type: none"> <li>◦ Oral exams</li> <li>◦ X-rays</li> <li>◦ Cleanings</li> <li>◦ Fluoride treatment</li> </ul> </li> </ul> <p><b>Comprehensive Dental*</b></p> <ul style="list-style-type: none"> <li>• Restorative Services</li> <li>• Endodontics</li> <li>• Periodontics</li> <li>• Prosthodontics removable</li> <li>• Prosthetics</li> <li>• Implant Services</li> <li>• Prosthodontics fixed</li> <li>• Oral and Maxillofacial Surgery</li> <li>• Orthodontics</li> <li>• Adjunctive General Services</li> </ul>	<p>\$0 copay</p> <p>\$0 copay</p> <p>\$0 copay</p> <p>\$0 copay</p> <p>\$0 copay</p> <p>\$25 - \$400 copay</p> <p>\$25 - \$720 copay</p> <p>\$0 - \$780 copay</p> <p>\$0 - \$600 copay</p> <p>Not Covered</p> <p>\$45 - \$2,160 copay</p> <p>\$0 - \$840 copay</p> <p>\$0 - \$380 copay</p> <p>Not Covered</p> <p>\$0 - \$300 copay</p>

\* Services may require authorization.

† Limitations may apply. See your EOC for details.

Premium & Benefits	Central Health Classic Care Plan I (HMO) 27
<b>Vision Services*†</b> <ul style="list-style-type: none"> <li>• Medicare-covered eye exams</li> <li>• Medicare-covered eyewear</li> <li>• Routine eye exam One per year</li> <li>• Eyewear allowance</li> </ul>	\$0 copay \$0 copay \$0 copay  Up to \$300 per year
<b>Mental Health Services*</b> <ul style="list-style-type: none"> <li>• Outpatient individual therapy</li> <li>• Outpatient group therapy</li> </ul>	\$0 copay \$0 copay
<b>Skilled Nursing Facility (SNF)*</b>	\$0 copay per day for days 1–20 \$217 copay per day for days 21–100
<b>Physical Therapy*</b>	\$0 copay
<b>Ambulance (Ground)*</b>	\$0 - \$150 copay per ride
<b>Ambulance (Air)*</b>	20% coinsurance per ride
<b>Transportation*</b>	\$0 for 24 one-way trips to plan approved locations (up to 50 mile limit)
<b>Medicare Part B Drugs*</b> <ul style="list-style-type: none"> <li>• Chemotherapy drugs</li> <li>• Other Part B drugs</li> <li>• Part B insulin drugs</li> </ul>	20% coinsurance unless capped by Inflation Reduction Act (IRA) rules 20% coinsurance unless capped by Inflation Reduction Act (IRA) rules 20% coinsurance unless capped by Inflation Reduction Act Rules.  Your Part B insulin cost share will not exceed \$35 for a one-month supply of any insulin on our formulary.

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† Limitations may apply. See your EOC for details.

## Outpatient Prescription Drugs

### Central Health Classic Care Plan I (HMO) 27

<b>Part D Deductible</b> (Tiers 2-5)	<b>\$99</b>	
	<b>Retail Rx 31-day supply</b>	<b>Mail Order 100-day supply</b>
<b>Part D Insulins</b> <b>Tier 3 – Preferred Brand</b>	<b>\$35 copay</b>	<b>\$70 copay</b>
<b>Initial Coverage</b> You are in the Initial Coverage Phase until your year-to-date “out-of-pocket costs” (your payments) reach a total of \$2,100		
<b>Tier 1 – Preferred Generic</b>	<b>\$0 copay</b>	<b>\$0 copay</b>
<b>Tier 2 – Generic</b>	<b>\$2 copay</b>	<b>\$4 copay</b>
<b>Tier 3 – Preferred Brand</b>	<b>\$35 copay</b>	<b>\$70 copay</b>
<b>Tier 4 – Non-Preferred Brand</b>	<b>\$100 copay</b>	<b>\$200 copay</b>
<b>Tier 5 – Specialty Tier</b>	<b>30% of the cost</b>	<b>Not available</b>
<b>Tier 6 – Select Care</b>	<b>\$0 copay</b>	<b>\$0 copay</b>
<b>Catastrophic Coverage</b> You are in this stage after your year-to-date “out-of-pocket costs” (your payments) reach a total of \$2,100.	<p>During this stage, the plan will pay for the full cost of your covered Part D drugs.</p> <p>Once you are in the Catastrophic Coverage Stage, you will stay in this payment stage until the end of the calendar year (through December 31, 2026).</p>	

Cost-Sharing may change depending on the pharmacy you choose and when you enter a new phase of the Part D benefit.

Extra Benefits	Central Health Classic Care Plan I (HMO) 27
<b>24/7 Telehealth</b>	\$0 copay or 20% coinsurance depending on the type of service you receive
<b>Acupuncture*</b> <ul style="list-style-type: none"> <li>• Medicare-covered acupuncture</li> <li>• Routine acupuncture</li> </ul>	\$0 copay \$0 copay Up to 30 visits every year combined with Routine Chiropractic services.
<b>Chiropractic Services*</b> <ul style="list-style-type: none"> <li>• Medicare-covered chiropractic care</li> <li>• Routine chiropractic care</li> </ul>	\$0 copay \$0 copay Up to 30 visits every year combined with Routine Acupuncture services.
<b>Durable Medical Equipment (DME)*</b>	\$0 - 20% coinsurance
<b>Pre-funded Debit Card</b> You will have one card to use at retail locations for all of your individual benefits listed below: <ul style="list-style-type: none"> <li>• <b>Over-The-Counter (OTC) Items, including OTC Hearing Aids</b></li> <li>• <b>Fitness Allowance</b></li> </ul>	Up to \$150 every 3 months Unused allowance does not carry over to the next quarter. Up to \$60 every month Unused allowance does not roll over to the next month.
<b>Gym Membership*</b>	\$0 copay
<b>Healthy Foods Allowance‡*</b> This is a special supplemental benefit for the chronically ill (SSBCI). In order to access this benefit, you must be diagnosed with a qualifying chronic condition and meet criteria outlined in Chapter 4 of the Evidence of Coverage.	Up to \$48 each month for healthy foods for members with a qualifying chronic condition

\* Services may require authorization.

‡ Please reference Evidence of Coverage (EOC) for details on specific services.

Extra Benefits	Central Health Classic Care Plan I (HMO) 27
<b>Herbal Catalog</b>	Products in the catalog are covered through your over-the-counter (OTC) allowance. You can only order these items through a plan approved vendor, but not at a retail location. For more information, please call Member Services.
<b>Meals for members with a qualifying chronic condition*‡</b>	<p>You pay \$0 for 15 meals each week for 6 weeks (90 total meals), once per year. Member is eligible to receive up to 30 additional meals per year for a \$5 copay per meal. Meal delivery is included 1 time per week.</p> <p>This benefit is available only to members diagnosed with a qualifying chronic condition. Please see your Evidence of Coverage (EOC) for more details on the qualifying chronic conditions and how to access this benefit.</p>
<b>In-Home Meal Program (for members post-discharge or homebound)*‡</b>	<p>You pay a \$0 copay per meal through the in-home meal program.</p> <p>You get 2 meals a day for 14 days immediately following surgery or inpatient hospitalization, or if you are ordered to isolate at home for 14 days by a healthcare provider due to a COVID-19 diagnosis or exposure.</p> <p>This benefit is available up to 2 times per calendar year (56 total meals).</p>
<b>Opioid Treatment*</b>	\$0 copay
<b>Outpatient Substance Abuse*</b>	<p>20% coinsurance for group therapy visits</p> <p>20% coinsurance for individual therapy visits</p>
<b>Personal Emergency Response System (PERS)*</b>	\$0 copay
<b>Worldwide Emergency Care</b> <ul style="list-style-type: none"> <li>• Urgent Care</li> <li>• Emergency Room</li> <li>• Emergency Transportation</li> </ul>	<p>\$140 copay</p> <p>Coverage up to \$50,000</p>

\* Services may require authorization.

‡ Please reference Evidence of Coverage (EOC) for details on specific services.

# Non-Discrimination Notice – Section 1557

## Central Health Plan



Discrimination is against the law. Central Health Plan follows State and Federal civil rights laws. Central Health Plan does not unlawfully discriminate, exclude people, or treat them differently because of sex, race, color, religion, ancestry, national origin, ethnic group identification, age, mental disability, physical disability, medical condition, genetic information, marital status, gender, gender identity, or sexual orientation.

Central Health Plan provides:

- Free aids and services in a timely manner to people with disabilities to help them communicate better, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Free language services in a timely manner to people whose primary language is not English, such as:
  - Qualified interpreters
  - Written information in other languages

If you need these services, contact Central Health Plan between 8:00 a.m. to 8:00 p.m. by calling 1-866-314-2427. If you cannot hear or speak well, please call 711. Upon request, this document can be made available to you in braille, large print, audiocassette, or electronic form. To obtain a copy in one of these alternative formats, please call or write to:

Central Health Plan  
Civil Rights Coordinator  
200 Oceangate, Suite 100  
Long Beach, CA 90802

**By phone:** 1-866-606-3889. If you cannot hear or speak well, please call 711.

### HOW TO FILE A GRIEVANCE

If you believe that Central Health Plan has failed to provide these services or unlawfully discriminated in another way on the basis of sex, race, color, religion, ancestry, national origin, ethnic group identification, age, mental disability, physical disability, medical condition, genetic information, marital status, gender, gender identity, or sexual orientation, you can file a grievance with Central Health Plan's Civil Rights Coordinator. You can file a grievance by phone, in writing, in person, or electronically:

- **By phone:** Contact Central Health Plan's Civil Rights Coordinator between 8:30 a.m. to 5:30 p.m. by calling 1-866-606-3889. Or, if you cannot hear or speak well, please call 711.
- **In writing:** Fill out a complaint form or write a letter and send it to:  
Central Health Plan  
Civil Rights Coordinator  
200 Oceangate, Suite 100  
Long Beach, CA 90802

- In person: Visit your doctor's office or Central Health Plan and say you want to file a grievance.
- Electronically: Send an email to [CivilRights@MolinaHealthcare.com](mailto:CivilRights@MolinaHealthcare.com). You can also visit Central Health Plan's website at [MolinaHealthcare.Alertline.com](http://MolinaHealthcare.Alertline.com).

## OFFICE OF CIVIL RIGHTS – CALIFORNIA DEPARTMENT OF HEALTH CARE SERVICES

You can also file a civil rights complaint with the California Department of Health Care Services, Office of Civil Rights by phone, in writing, or electronically:

- **By phone:** Call 916-440-7370. If you cannot speak or hear well, please call 711 (Telecommunications Relay Service).
- **In writing:** Fill out a complaint form or send a letter to:  
Deputy Director, Office of Civil Rights  
Department of Health Care Services  
Office of Civil Rights  
P.O. Box 997413  
Sacramento, CA 95899-7413

Complaint forms are available at [DHCS.ca.gov/Pages/Language\\_Access.aspx](http://DHCS.ca.gov/Pages/Language_Access.aspx).

- **Electronically:** Send an email to [CivilRights@dhcs.ca.gov](mailto:CivilRights@dhcs.ca.gov).

## OFFICE OF CIVIL RIGHTS – U.S DEPARTMENT OF HEALTH AND HUMAN SERVICES

If you believe you have been discriminated against on the basis of race, color, national origin, age, disability, or sex, you can file a civil rights complaint (grievance) with the U.S. Department of Health and Human Services, Office for Civil Rights, by phone, in writing, or electronically:

- **By phone:** Call 1-800-368-1019. If you cannot speak or hear well, please call TTY/TDD: 1-800-537-7697.
- **In writing:** Fill out a complaint form or send a letter to:  
U.S. Department of Health and Human Services  
200 Independence Avenue, SW  
Room 509F, HHH Building  
Washington, D.C. 20201

Complaint forms are available at [HHS.gov/ocr/office/file/index.html](http://HHS.gov/ocr/office/file/index.html).

- **Electronically:** Visit the Office for Civil Rights Complaint Portal at [OCRportal.hhs.gov/ocr/portal/lobby.jsf](http://OCRportal.hhs.gov/ocr/portal/lobby.jsf).

## **Notice of Availability of Language Assistance Services and Auxiliary Aids and Services**

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### **English**

ATTENTION: If you need help in your language call 1-866-314-2427(TTY: 711). Aids and services for people with disabilities, like documents in braille and large print, are also available. Call 1-866-314-2427(TTY: 711). These services are free of charge.

### **العربية (Arabic)**

يرجى الانتباه: إذا احتجت إلى المساعدة بلغتك، فاتصل بـ 1-866-314-2427، (وبالنسبة لمستخدمي الهاتف النصي TTY: يمكنك الاتصال على 711). تتوفر أيضًا المساعدات والخدمات للأشخاص ذوي الإعاقة، مثل المستندات المكتوبة بطريقة بريـل والخط الكبير، اتصل بـ 1-866-314-2427 (وبالنسبة لمستخدمي الهاتف النصي TTY: يمكنك الاتصال على 711). هذه الخدمات مجانية.

### **Հայերեն (Armenian)**

ՈՒՇԱԴՐՈՒԹՅՈՒՆ. Եթե ձեզ հարկավոր է աջակցություն ձեր լեզվով, սպազանգահարեք 1-866-314-2427 (TTY՝ 711) հեռախոսահամարով: Հաշմանդամություն ունեցող անձանց համար գործում են նաև օժանդակ միջոցներ ու ծառայություններ, օրինակ՝ Բրայլի գրաստիպով ու խոշորատառ տպատառով տրամադրվող նյութեր: Տվյալ դեպքում զանգահարեք 1-866-314-2427 (TTY՝ 711) հեռախոսահամարով: Ծառայությունները գործում են անվճար:

### **ខ្មែរ (Cambodian)**

ចំណាំ: បើអ្នកត្រូវការជំនួយជាភាសាសរបស់អ្នក សូមទូរសព្ទទៅលេខ 1-866-314-2427(TTY: 711)។ ជំនួយ និងសេវាកម្មសម្រាប់ជនពិការ ដូចជាឯកសារសរសេរជាអក្សរដុសសម្រាប់ជនពិការភ្នែក ឬឯកសារសរសេរជាអក្សរពុម្ពធំ ក៏អាចរកបានផងដែរ។ ទូរសព្ទមកលេខ 1-866-314-2427(TTY: 711)។ សេវាកម្មទាំងនេះមិនគិតថ្លៃឡើយ។

### **简体中文 (Chinese)**

请注意：如果您需要以您的语言提供帮助，请致电 1-866-314-2427(TTY: 711)。另外还提供针对残疾人士的辅助工具和服务，例如盲文文件和大字体文件。请致电 1-866-314-2427(TTY: 711)。这些服务均免费提供。

### **فارسی (Farsi)**

توجه: اگر می‌خواهید به زبان خود راهنمایی دریافت کنید، با 1-866-314-2427 (TTY: 711) تماس بگیرید. کمکها و خدمات مخصوص افراد دارای معلولیت، مانند نسخه‌هایی به خط بریل و چاپ درشت، نیز موجود است. با 1-866-314-2427 (TTY: 711) تماس بگیرید. این خدمات رایگان ارائه می‌شوند.

## Notice of Availability/Taglines – Section 1557 Central Health Plan

### **हिंदी (Hindi)**

ध्यान दें: अगर आपको अपनी भाषा में सहायता की आवश्यकता है तो 1-866-314-2427(TTY: 711) पर कॉल करें। अशक्तता वाले लोगों के लिए सहायता और सेवाएं, जैसे ब्रेल और बड़े प्रिंट में भी दस्तावेज़ उपलब्ध हैं। 1-866-314-2427(TTY: 711) पर कॉल करें। ये सेवाएं निशुल्क हैं।

### **Hmoob (Hmong)**

CEEB TOOM: Yog koj xav tau kev pab txhais koj hom lus hu rau 1-866-314-2427 (TTY: 711). Tsis tas li ntawd, kuj tseem muaj cov kev pab txhawb thiab kev pab cuam rau cov neeg xiam oob qhab, xws li cov ntawv su thiab luam tawm ua tus ntawv loj. Hu rau 1-866-314-2427(TTY: 711). Cov kev pab cuam no yog pab dawb xwb.

### **日本語 (Japanese)**

注記：日本語での対応が必要な場合は 1-866-314-2427(TTY: 711) までお電話ください。点字の資料や文字の拡大表示など、障がいをお持ちの方のためのサービスもご用意しております。1-866-314-2427(TTY: 711)までお電話ください。これらのサービスは無料です。

### **한국어 (Korean)**

알림: 귀하의 언어로 도움을 받고 싶으시면 1-866-314-2427(TTY: 711)번으로 전화하십시오. 점자나 큰 활자로 된 문서와 같이 장애가 있는 분들을 위한 지원 및 서비스도 이용하실 수 있습니다. 1-866-314-2427(TTY: 711)번으로 전화하십시오. 이러한 서비스는 무료로 제공됩니다.

### **ພາສາລາວ (Laotian)**

ປະກາດ: ຖ້າທ່ານຕ້ອງການຄວາມຊ່ວຍເຫຼືອເປັນພາສາຂອງທ່ານໃຫ້ໂທຫາເບີ 1-866-314-2427(TTY: 711). ນອກນີ້ຍັງມີຄວາມຊ່ວຍເຫຼືອ ແລະ ການບໍລິການສໍາລັບຄົນພິການ ເຊັ່ນ: ເອກະສານທີ່ເປັນອັກສອນນູນແລະມິໂຕໂຟມໃຫຍ່ ໃຫ້ໂທຫາເບີ 1-866-314-2427(TTY: 711). ການບໍລິການເຫຼົ່ານີ້ແມ່ນພຣີ.

### **Mien**

LONGC HNYOUV JANGX LONGX OC: Beiv taux meih qiex longc mienh tengx faan benx meih nyei waac nor douc waac daaih lorx taux 1-866-314-2427(TTY: 711). Liouh lorx jauv-louc tengx aengx caux nzie gong bun taux ninh mbuo wuaaic fangx mienh, beiv taux longc benx nzangc-pokc bun hluo mbiutc aengx caux aamz mborqv benx domh sou se mbenc nzoih bun longc. Douc waac daaih lorx 1-866-314-2427(TTY: 711). Naaiv deix nzie weih gong-bou jauv-louc se benx wang-henh tengx mv zuqc cuotv nyaanh oc.

### **ਪੰਜਾਬੀ (Punjabi)**

ਧਿਆਨ ਦਿਓ: ਜੇ ਤੁਹਾਨੂੰ ਆਪਣੀ ਭਾਸ਼ਾ ਵਿੱਚ ਮਦਦ ਦੀ ਲੋੜ ਹੈ ਤਾਂ 1-866-314-2427(TTY: 711) 'ਤੇ ਕਾਲ ਕਰੋ। ਅਪਾਰਜ ਲੋਕਾਂ ਲਈ ਸਹਾਇਤਾ ਅਤੇ ਸੇਵਾਵਾਂ, ਜਿਵੇਂ ਕਿ ਬ੍ਰੇਲ ਅਤੇ ਮੋਟੀ ਛਪਾਈ ਵਿੱਚ ਦਸਤਾਵੇਜ਼, ਵੀ ਉਪਲਬਧ ਹਨ। 1-866-314-2427(TTY: 711)'ਤੇ ਕਾਲ ਕਰੋ। ਇਹ ਸੇਵਾਵਾਂ ਮੁਫਤ ਹਨ।

## Notice of Availability/Taglines – Section 1557 Central Health Plan

### **Русский (Russian)**

ВНИМАНИЕ! Если вам нужна помощь на вашем родном языке, звоните по номеру 1-866-314-2427 (TTY: 711). Также предоставляются средства и услуги для людей с ограниченными возможностями, например документы крупным шрифтом или шрифтом Брайля. Звоните по номеру 1-866-314-2427 (TTY: 711). Такие услуги = бесплатны.

### **Español (Spanish)**

ATENCIÓN: si necesita ayuda en su idioma, llame al 1-866-314-2427 (TTY: 711). También ofrecemos asistencia y servicios para personas con discapacidades, como documentos en braille y con letras grandes. Llame al 1-866-314-2427 (TTY: 711). Estos servicios son gratuitos.

### **Tagalog (Filipino)**

ATENSIYON: Kung kailangan mo ng tulong sa iyong wika, tumawag sa 1-866-314-2427 (TTY: 711). Mayroon ding mga tulong at serbisyo para sa mga taong may kapansanan, tulad ng mga dokumento sa braille at malaking print. Tumawag sa 1-866-314-2427 (TTY: 711). Libre ang mga serbisyo ng ito.

### **ภาษาไทย (Thai)**

โปรดทราบ: หากคุณต้องการความช่วยเหลือเป็นภาษาของคุณ กรุณาโทรศัพท์ไปที่หมายเลข 1-866-314-2427 (TTY: 711) นอกจากนี้ ยังพร้อมให้ความช่วยเหลือและบริการต่าง ๆ สำหรับบุคคลที่มีความพิการ เช่น เอกสารต่าง ๆ ที่เป็นอักษรเบรลล์และเอกสารที่พิมพ์ด้วยตัวอักษรขนาดใหญ่ กรุณาโทรศัพท์ไปที่หมายเลข 1-866-314-2427 (TTY: 711) ไม่มีค่าใช้จ่ายสำหรับบริการเหล่านี้

### **Українська (Ukrainian)**

УВАГА! Якщо вам потрібна допомога вашою рідною мовою, телефонуйте на номер 1-866-314-2427 (TTY: 711). Люди з обмеженими можливостями також можуть скористатися допоміжними засобами й послугами, наприклад отримати документи, надруковані шрифтом Брайля та великим шрифтом. Телефонуйте на номер 1-866-314-2427 (TTY: 711). Ці послуги безкоштовні.

### **Tiếng Việt (Vietnamese)**

CHÚ Ý: Nếu quý vị cần trợ giúp bằng ngôn ngữ của mình, vui lòng gọi số 1-866-314-2427 (TTY: 711). Chúng tôi cũng hỗ trợ và cung cấp các dịch vụ dành cho người khuyết tật, như tài liệu bằng chữ nổi Braille và chữ khổ lớn (chữ hoa). Vui lòng gọi số 1-866-314-2427 (TTY: 711). Các dịch vụ này đều miễn phí.



# Ready to enroll or have questions?

**Call (844) 216-9941, TTY: 711**

**Current Members Call:  
(866) 314-2427, TTY: 711**

Hours are October 1 – March 31, 8 a.m. to 8 p.m. local time, 7 days a week. From April 1 – September 30, Monday – Friday, 8 a.m. to 8 p.m. local time.