2026
Summary of Benefits

Central Health Embrace Choice Plan (HMO C-SNP)

California H5649-026-004
Serving: San Francisco and San Mateo Counties
Effective January 1 through December 31, 2026

H5649_26_026_004_CA_SB_M
CA-H5649-26-4-SB-EN-26-S

CENTRAL HEALTH MEDICARE PLAN

2026 Summary of Benefits

Central Health Embrace Choice Plan (HMO C-SNP) H5649-026-004

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.

To join **Central Health Embrace Choice Plan (HMO C-SNP)** you must be entitled to Medicare Part A, be enrolled in Medicare Part B, and live in our service area, and must have Diabetes, Chronic Heart Failure (CHF), or Cardiovascular disorders (limited to cardiac arrhythmias, coronary artery disease, peripheral vascular disease and chronic venous thromboembolic disorder). Our service area includes the following counties in California: San Francisco and San Mateo 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 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.

Premium & Benefits	Central Health Embrace Choice Plan (HMO C-SNP) (26-4)	Your Cost w/ Medicare+full Medi-Cal
Monthly Plan Premium You must keep paying your Medicare Part B premium.	**$0**	**$0**
Deductible	**No deductible**	**No deductible**
Maximum Out-of-Pocket Responsibility (does not include prescription drugs)	**No more than $9,250 annually**	**$0**
Inpatient Hospital*	**$1,676 deductible** **$0 copay** per day for days 1–60 **$419 copay** per day for days 61–90 **$838 copay** per day for each lifetime reserve day These are 2025 cost-sharing amounts and may change for 2026. We will provide updated rates at www.centralhealthplan.com as soon as they are released.	**$0 copay**
Outpatient Hospital*‡	**$0 - 20% coinsurance**	**$0 copay**
Ambulatory Surgery Center*	**$0 copay**	**$0 copay**
Doctor Visits • Primary care providers • Specialists*	 **$0 copay** **$0 - 30% coinsurance**	 **$0 copay** **$0 copay**
Preventive Care Other preventive services are available. • Flu vaccine, diabetic screenings, etc.*	**$0 copay**	**$0 copay**

* Services may require authorization.
‡ Please reference Evidence of Coverage (EOC) for details on specific services.

Premium & Benefits	Central Health Embrace Choice Plan (HMO C-SNP) (26-4)	Your Cost w/ Medicare+full Medi-Cal
Emergency Care Copayment waived if admitted to the hospital or readmitted to the ER within 72 hours	**$115 copay**	**$0 copay**
Urgent Care	**$0 copay**	**$0 copay**
Diagnostic Services/Labs/ Imaging* • Diagnostic tests and procedures • Lab services • Diagnostic radiology (e.g. MRIs, CAT scans) • X-rays	 **$0 - 20% coinsurance** **$0 copay** **$0 - 20% coinsurance** **$0 copay**	 **$0 copay** **$0 copay** **$0 copay** **$0 copay**
Hearing Services* • Medicare-covered hearing exam • Routine hearing exam One per year • Hearing aid fittings and evaluations One per year • Hearing aid	 **$0 copay** **$0 copay** **$0 copay** **$49 copay per hearing aid for the entry model** **$149 copay per hearing aid for the basic model** **$449 copay per hearing aid for the prime model** **$849 copay per hearing aid for the preferred model** **$1,049 copay per hearing aid for the advanced model** **$1,549 copay per hearing aid for the premium model** **You receive 2 hearing aids every 3 years**	 **$0 copay** **Refer to Medi-Cal handbook for details about your Medi-Cal benefits.**

* Services may require authorization.

Premium & Benefits	Central Health Embrace Choice Plan (HMO C-SNP) (26-4)	Your Cost w/ Medicare+full Medi-Cal
Dental Services†*		
• Medicare-covered dental services	**$0 copay**	**$0 copay**
• Preventive dental		**Refer to Medi-Cal handbook for details about your Medi-Cal benefits.**
◦ Oral exams	**$0 copay**	
◦ X-rays	**$0 copay**	
◦ Cleanings	**$0 copay**	
◦ Fluoride treatment	**$0 copay**	
Comprehensive Dental*		**Refer to Medi-Cal handbook for details about your Medi-Cal benefits.**
• Restorative Services	**$0 copay**	
• Endodontics	**$0 copay**	
• Periodontics	**$0 copay**	
• Prosthodontics removable	**$0 copay**	
• Prosthetics	**$0 copay**	
• Implant Services	**$0 copay**	
• Prosthodontics fixed	**$0 copay**	
• Oral and Maxillofacial Surgery	**$0 copay**	
• Orthodontics	**$0 copay**	
• Adjunctive General Services	**$0 copay**	
Annual Dental Maximum	$1,600 for preventive and comprehensive dental services each year	**Refer to Medi-Cal handbook for details about your Medi-Cal benefits.**
Vision Services*†		
• Medicare-covered eye exams	**$0 copay**	**$0 copay**
• Medicare-covered eyewear	**$0 copay**	**$0 copay**
• Routine eye exam One per year	**$0 copay**	**Refer to Medi-Cal handbook for details about your Medi-Cal benefits.**
• Eyewear allowance	**Up to $300 per year**	
Mental Health Services*		
• Outpatient individual therapy	**$0 copay**	**$0 copay**
• Outpatient group therapy	**$0 copay**	**$0 copay**

† Limitations may apply. See your EOC for details.
* Services may require authorization.

Premium & Benefits	Central Health Embrace Choice Plan (HMO C-SNP) (26-4)	Your Cost w/ Medicare+full Medi-Cal
Skilled Nursing Facility (SNF)*	**$0 copay** per day for days 1–20 **$209.50 copay** per day for days 21–100 **These are 2025 cost-sharing amounts and may change for 2026. We will provide updated rates at www.centralhealthplan.com as soon as they are released.**	**$0 copay**
Physical Therapy*	**$0 copay**	**$0 copay**
Ambulance (Ground)*	**20% coinsurance per ride**	**$0 copay**
Ambulance (Air)*	**20% coinsurance**	**$0 copay**
Transportation*	**$0 for 12 one-way trips to plan approved locations (up to 50 mile limit)**	**Refer to Medi-Cal handbook for details about your Medi-Cal benefits.**
Medicare Part B Drugs*		
• Chemotherapy drugs	**20% coinsurance unless capped by Inflation Reduction Act (IRA) rules**	**$0 copay**
• Other Part B drugs	**20% coinsurance unless capped by Inflation Reduction Act (IRA) rules**	**$0 copay**
• Part B insulin drugs	**You pay a 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.**	**$0 copay**

* Services may require authorization.

Outpatient Prescription Drugs	Central Health Embrace Choice Plan (HMO C-SNP) (26-4)	
Part D Deductible **(Tiers 2-5)**	**$615**	
	Retail Rx 31-day supply	**Mail Order 100-day supply**
Part D Insulins **Tier 3 – Preferred Brand**	**$35 copay**	**$105 copay**
Initial Coverage You are in the Initial Coverage Phase until your year-to-date "out-of-pocket costs" (your payments) reach a total of $2,100 **Tier 1 – Preferred Generic** **Tier 2 – Generic** **Tier 3 – Preferred Brand** **Tier 4 – Non-Preferred Brand** **Tier 5 – Specialty Tier** **Tier 6 – Select Care**	**$0 copay** **15% of the cost** **15% of the cost** **30% of the cost** **25% of the cost** **$0 copay**	**$0 copay** **15% of the cost** **15% of the cost** **30% of the cost** **Not available** **$0 copay**
Catastrophic Coverage You are in this stage after your year-to-date "out-of-pocket costs" (your payments) reach a total of $2,100.	During this stage, the plan will pay for the full cost of your covered Part D drugs. 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).	
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 Embrace Choice Plan (HMO C-SNP) (26-4)
24/7 Telehealth	$0 - $30 copay or $0 - 30% coinsurance depending on the type of service you receive
Acupuncture* • Medicare-covered acupuncture • Routine acupuncture	 $0 copay $0 copay Up to 30 visits every year combined with Routine Chiropractic services.
Chiropractic Services* • Medicare-covered chiropractic care • Routine chiropractic care	 $0 copay $0 copay Up to 30 visits every year combined with Routine Acupuncture services.
Durable Medical Equipment (DME)*	20% coinsurance
Pre-funded Debit Card You will have one card to use at retail locations for all of your individual benefits listed below: • **Over-The-Counter (OTC) Items, including OTC Hearing Aids**	 Up to $130 every 3 months Unused allowance does not carry over to the next quater.
Gym Membership*	$0 copay
Healthy Foods Allowance‡* 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 $40 each month for healthy foods for members with a qualifying chronic condition
Herbal Catalog	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.

* Services may require authorization.
‡ Please reference Evidence of Coverage (EOC) for details on specific services.

Extra Benefits	Central Health Embrace Choice Plan (HMO C-SNP) (26-4)
Meals for members with a qualifying chronic condition*‡	You pay $0 for 14 meals each month for 1 year (168 total meals). 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.
In-Home Meal Program (for members post-discharge or homebound)*‡	You pay a $0 copay per meal through the in-home meal program. 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. This benefit is available up to 2 times per calendar year (56 total meals).
Opioid Treatment*	$0 copay
Outpatient Substance Abuse*	20% coinsurance for group therapy visits 20% coinsurance for individual therapy visits
Personal Emergency Response System (PERS)*	$0 copay
Worldwide Emergency Care • Urgent Care • Emergency Room • Emergency Transportation	$110 copay Coverage up to $50,000

* Services may require authorization.
‡ Please reference Evidence of Coverage (EOC) for details on specific services.

Non-Discrimination Notice – Section 1557
Central Health Plan

CENTRAL HEALTH MEDICARE 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 **Civil.Rights@MolinaHealthcare.com**. You can also visit Central Health Plan's website at **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**.
- **Electronically:** Send an email to **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**.
- **Electronically:** Visit the Office for Civil Rights Complaint Portal at **OCRportal.hhs.gov/ocr/portal/lobby.jsf**.

CENTRAL HEALTH MEDICARE PLAN

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

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 يمكنهم الاتصال على 711). تتوفر أيضًا المساعدات والخدمات للأشخاص ذوي الإعاقة، مثل المستندات المكتوبة بطريقة بريل والخط الكبير، اتصل بـ 1-866-314-2427 (وبالنسبة لمستخدمي الهاتف النصي TTY: يمكنهم الاتصال على 711). هذه الخدمات مجانية.

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

ខ្មែរ (Cambodian)
ចំណាំ៖ បើអ្នកត្រូវការជំនួយជាភាសារបស់អ្នក សូមទូរសព្ទទៅលេខ 1-866-314-2427(TTY: 711)។ ជំនួយ និងសេវាកម្មសម្រាប់ជនពិការ ដូចជាឯកសារសរសេរជាអក្សរផុសសម្រាប់ជនពិការភ្នែក 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 (TTY: 711) 1-866-314-2427تماس بگیرید. کمکها و خدمات مخصوص افراد دارای معلولیت، مانند نسخه‌هایی به خط بریل و چاپ درشت، نیز موجود است. با (TTY: 711) 1-866-314-2427 تماس بگیرید. این خدمات رایگان ارائه می‌شوند.

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 बडे 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: ເອກະສານທີ່ເປັນອັກສອນນູນແລະມີໂຕພິມໃຫຍ່ ໃຫ້ໂທຫາເບີ 1-866-314-2427(TTY: 711). ການບໍລິການເຫົ່ານີ້ແມ່ນຟຣີ.

Mien
LONGC HNYOUV JANGX LONGX OC: Beiv taux meih qiemx 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। ਅਪਾਹਜ 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।

CENTRAL HEALTH MEDICARE PLAN

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 serbisyong 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.

CENTRAL HEALTH MEDICARE PLAN