2027

Summary of Benefits



ElderServe Star

(HMO I-SNP)

For more information, call us **1-800-580-7000** (TTY 711)
8 a.m. to 8 p.m. ET – 7 days a week.

www.ElderServeHealth.org

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ElderServe Star (HMO I-SNP)

Summary of Benefits

January 1, 2027 – December 31, 2027

This is a summary of drug and health services covered by **ElderServe Star (HMO I-SNP)** January 1, 2027 – December 31,2027.

ElderServe Star is an (HMO I-SNP) plan with a Medicare contract. Enrollment in ElderServe Star (HMO I-SNP) depends on contract renewal.

To join **ElderServe Star (HMO I-SNP)**, you must be entitled to Medicare Part A, be enrolled in Medicare Part B, live in our service area, and live in a nursing home or at home but require the same level of care as those who live in a nursing home.

Our service area includes the following counties in New York: Bronx, Kings, Nassau, New York, Queens, Richmond, and Westchester.

ElderServe Star (HMO I-SNP) has a network of doctors, hospitals, pharmacies, and other providers. If you use the providers that are not in our network, the plan may not pay for these services.

Out-of-network/non-contracted providers are under no obligation to treat ElderServe Star (HMO I-SNP) members, except in emergency situations. Please call our customer service number or see your Evidence of Coverage for more information, including the cost-sharing that applies to out-of-network services.

The benefit information provided is a summary of what we cover and what you pay. It does not list every single service that we cover or list every limitation or exclusion. To get a complete list of services we cover, you can visit our website www.ElderServeHealth.org and refer to the "Evidence of Coverage" or you can call us and request the "Evidence of Coverage."

This information is not a complete description of benefits. Call 1-800-580-7000 (TTY/TDD 711) for more information.

Monthly Premium, Deductible, and Limits on How Much You Pay for Covered Services	
How much is the monthly premium?	$22.00 per month for your Part D premium. In addition, you must keep paying your Medicare Part B premium.
How much is the deductible?	This plan has deductibles for some hospital and medical services, and Part D prescription drugs. $700 per year for Part D prescription Drugs. *$*283 per year for Part B Deductible for in-network services, except for insulin furnished through an item of durable medical equipment. *These amounts may change in 2027. New rates will be provided to you as they become available from Medicare.*
Is there any limit on how much I will pay for my covered services?	Yes. Like all Medicare health plans, our plan protects you by having yearly limits on your out-of-pocket costs for medical and hospital care. Your yearly limit(s) in this plan: • $9,850 for services you receive from in-network providers. If you reach the limit on out-of-pocket costs, you keep getting covered hospital and medical services and we will pay the full cost for the rest of the year. Please note that you will still need to pay your monthly premiums and cost-sharing for your Part D prescription drugs.
Premiums and Benefits	
Inpatient Hospital Coverage ***(continued on next page)***	A per admission deductible is applied once during the defined benefit period. In 2027 the amounts for each benefit period are: *These amounts may change in 2027. New rates will be provided to you as they become available from Medicare.* • $1788 deductible for each benefit period • Days 1-60: $0 copay • Days 61-90: $434 copay per day • Days 91 and beyond: $868 copay per day for each “lifetime reserve day” for each benefit period • Beyond lifetime reserve days, we will pay all costs

Inpatient Hospital Coverage (*continued from previous page)*	Authorization is required 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. The copays for hospital and skilled nursing facility (SNF) benefits are based on benefit periods. A benefit period begins the day you are admitted as an inpatient and ends when you have not received any inpatient care (or skilled care in a SNF) for 60 days in a row. If you go into a hospital or a SNF after one benefit period has ended, a new benefit period begins. You must pay the inpatient hospital deductible for each benefit period. There is no limit to the number of benefit periods.
Partial Hospitalization	20% of the cost – Authorization is required
Intensive Outpatient Program Services	20% of the cost – Authorization is **not** required
Outpatient Hospital Services	20% of the cost – Authorization is required
Ambulatory Surgical Center (ASC) services	20% of the cost – Authorization is required
Doctor's Office Visits	Primary care physician visit: 20% of the cost Specialist visit: 20% of the cost – Only the first 3 visits will not require a prior authorization. Authorization is required for all subsequent visits.
Preventative Care *(continued on next page)*	$0 copay Our plan covers many preventive services, including: • Abdominal aortic aneurysm screening • Alcohol misuse screening and counseling • Annual Wellness Visit • Bone mass measurement • Breast cancer screening (mammogram) • Cardiovascular disease risk reduction visit (therapy for cardiovascular disease) • Cardiovascular disease testing • Cervical and vaginal cancer screening

Preventive Care ***(continued from previous page)***	• Colorectal cancer screenings (Screening barium enemas, Colonoscopy, Fecal immunochemical test (FIT), Guaiac-based fecal occult blood test (gFOBT), Flexible sigmoidoscopy) • Depression screening • Diabetes screenings; Diabetes self-management training, diabetic services and supplies • Vision Care (Glaucoma screening, diabetic retinopathy screening, diagnosis and treatment of diseases and injuries of the eye, including treatment for age-related macular degeneration) Hepatitis C screening test • HIV screening • Immunizations (Flu shots, Pneumonia vaccine, Hepatitis B vaccines, COVID-19 vaccine) • Lung Cancer screening with low dose computed tomography (LDCT) • Medical Nutrition therapy services • Medicare Diabetes Prevention Program (MDPP) • Obesity screening and therapy to promote sustained weight loss • One-time "Welcome to Medicare" preventive visit • Prostate cancer screenings (PSA) • Sexually transmitted infections screening and counseling • Smoking and tobacco use cessation (counseling to stop smoking or tobacco use Any additional preventive services approved by Medicare during the contract year will be covered. Authorization is **not** required
Emergency Care	20% of the cost (up to $115) for each visit. If you are admitted to the hospital within 3 days, you do not have to pay your share of the cost for emergency care. See the "Inpatient Hospital Care" section of this booklet for other costs. Authorization is **not** required
Urgently Needed Services	20% of the cost (up to $40) for each visit. If you are admitted to the hospital within 3 days, you do not have to pay your share of the cost for emergency care. See the "Inpatient Hospital Care" section of this booklet for other costs. Authorization is required

Diagnostic Tests, Lab and Radiology Services, and X-Rays *(Costs for these services may be different in an outpatient surgery setting)*	Diagnostic radiology services (such as MRIs, CT scans): 20% of the cost Authorization is required for MRI and PET scans Diagnostic tests and procedures: 20% of the cost Authorization is required Lab services: 20% of the cost Authorization is required Outpatient x-rays: 20% of the cost Authorization is not required Therapeutic radiology services (such as radiation treatment for cancer): 20% of the cost Authorization is required Routine Lab Services do **not** require authorization. Some Lab Services might require an authorization.
Hearing Services	Exam to diagnose and treat hearing and balance issues: 20% of the cost Diagnostic hearing and balance evaluations are limited to one per year without prior authorization. All subsequent evaluations will require prior authorization.
Dental Services	Limited dental services (this does not include services in connection with care, treatment, filling, removal, or replacement of teeth): 20% of the cost Authorization is required
Vision Services	Exam to diagnose and treat diseases and conditions of the eye (including yearly glaucoma screening): 20% of the cost Diagnostic evaluation for the treatment of diseases and injuries of the eye are limited to one per year without prior authorization. Any subsequent evaluations will require a prior authorization. Eyeglasses or contact lenses after cataract surgery: 20% of the cost and Authorization is **not** required
Mental Health Care **(continued on next page)**	Inpatient Hospital Psychiatric Services: 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. The copays for hospital and skilled nursing facility (SNF) benefits are based on benefit periods. A benefit period begins the day you are admitted as an inpatient and ends when you have not received any inpatient care (or skilled care in a SNF) for 60 days in a row. If you go into a hospital or a SNF after one benefit period has ended, a new benefit period begins. You must pay the inpatient hospital deductible for each benefit period. There is no limit to the number of benefit periods.

	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. *These amounts may change in 2027. New rates will be provided to you as they become available from Medicare.* In 2027 the amounts for each benefit period are: • $1,736 deductible for each benefit period • Days 1-60: $0 copay • Days 61-90: $434 copay per day • Days 91 and beyond: $868 copay per day for each "lifetime reserve day" for each benefit period. • Beyond lifetime reserve days, we pay all costs <u>Outpatient Psychiatric Services:</u> Outpatient group therapy visit: 20% of the cost Outpatient individual therapy visit: 20% of the cost Authorization is required
Skilled Nursing Facility (SNF)	Our plan covers up to 100 days in a SNF. In 2027 the amounts for each benefit period are: • Days 1-20: $0 copay for each benefit period • Days 21-100: $217 copay per day • Days 101 and beyond: you pay all costs • A minimum of a 3-day inpatient hospital stay is required before admission to a Skilled Nursing Facility. Authorization is required

Outpatient Rehabilitation	Cardiac (heart) rehab services: 20% of the cost Intensive Cardiac Rehabilitation Services: 20% of the cost Pulmonary Rehabilitation Services: 20% of the cost Supervised Exercise Therapy (SET) for Symptomatic Peripheral Artery Disease (PAD) services: 20% of the cost Occupational therapy (OT) visit: 20% of the cost Physical Therapy (PT) and Speech and Language Therapy visit: 20% of the cost Authorization is required
Ambulance	20% of the cost Authorization is required for non-emergency services
Transportation	Not covered
Medicare Part B Drugs	For Part B drugs such as chemotherapy/radiation drugs: 20% of the cost Other Part B Drugs: 20% of the cost Authorization is required. You will not pay more than the co-insurance amount for Chemotherapy administration services including chemotherapy/radiation drugs or Other drugs covered under Part B of original Medicare.
What You Pay for Vaccines:	Our plan covers most Part D vaccines at no cost to you even if you haven't paid your deductible. Call Member Services for more information.
What You Pay for Insulin:	You won't pay more than $35 for a one-month supply of each insulin product covered by our plan, no matter what cost-sharing tier it's on, even if you haven't paid your deductible.
Foot Care *(Podiatry services)*	Foot exams and treatment if you have diabetes-related nerve damage and/or meet certain conditions: 20% of the cost Authorization is required If you have a diabetes diagnosis, an authorization will be required after six (6) visits to a podiatrist. If you do not have a diabetes diagnosis, authorization will be required after the fourth (4^{th}) visit to a podiatrist.

Durable Medical Equipment *(wheelchairs, oxygen, etc.)*	20% of the cost An authorization is required for DME equipment (non-disposable items that have a useful shelf life of over 1 year) with cost of $500 or more An authorization is required for DME supplies (disposable items that do not have a useful shelf life of over 1 year) with cost of $250 or more
Prosthetic Devices *(braces, artificial limbs, etc.)*	Prosthetic devices: 20% of the cost Related medical supplies: 20% of the cost Authorization is required
Diabetes Supplies and Services	Diabetes monitoring supplies: $0 We cover specific manufacturers for diabetic supplies and services: From Roche and LifeScan Authorization is required Diabetes self-management training: 20% of the cost Authorization is **not** required Therapeutic shoes or inserts: 20% of the cost Authorization is required
Wellness Programs *(fitness programs)*	Not covered

Optional Supplemental Benefits	
ElderServe Star (HMO I-SNP) plan offers supplemental benefits in addition to Part C benefits and Part D benefits. A summary of the supplemental benefits are listed below:	
Over-the-Counter (OTC) Supplies Benefit **(continued on next page)**	Our plan covers over-the-counter items up to $$185 per month. You have two ways to obtain eligible OTC items: • Using an OTC card provided by ElderServe at any participating location, or • Ordering OTC items by placing an order online through an online catalog Any unused portions will not roll over from month to month. The OTC balance does not roll over from year to year.

Over-the-Counter (OTC) Supplies Benefit **(continued from last page)**	The OTC items covered may be purchased for the member only. This benefit cannot be converted to cash. There is no cost to you for this benefit.
Over-the-Counter (OTC) Plus Grocery Benefit	For eligible members (with certain chronic conditions) the Special Supplemental Benefits for Chronically Ill (grocery benefit) combines with the OTC benefit to cover certain grocery items as part of the monthly OTC allowance, which may only be purchased at select pharmacies and/or retailers. You are allowed to spend $185of the OTC benefit amount towards food, produce and eligible OTC items. The benefits mentioned are a part of special supplemental program for the chronically ill. Some examples of conditions include Cardiovascular Disorder, Hypertension, Osteoarthritis, Endocrine Disorder and Gastrointestinal Disorder. Eligibility for this benefit cannot be guaranteed based solely on your condition. Eligible members will be notified and provided instructions on how to access this benefit

Prescription Drug Benefits	
Part D Annual out of Pocket (TrOOP or RxMOOP)	After you pay your yearly deductible, depending on your income and institutional status, you pay 25% coinsurance of the cost for all drugs covered by this plan until your total yearly drug costs reach $2400. Total yearly drug costs are the total drug costs paid by both you and our Part D plan. Tier 1: 25% coinsurance You may get your drugs at network retail pharmacies and mail order pharmacies. 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.
Catastrophic Coverage	Once you reach the annual out of pocket threshold of $2400 you enter the Catastrophic Coverage phase. This means you will have no cost-sharing for Medicare Part D Formulary drugs.

Tips for Comparing Your Medicare Choices

- If you want to compare our plan with other Medicare Health Plans, ask the other plans for their Summary of Benefits booklets. Or, use the Medicare Plan Finder on http://www.medicare.gov.
- If you want to know more about the coverage and costs of Original Medicare, look in your current **"Medicare & You"** handbook. View it online at http://www.medicare.gov or get a copy by calling 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

ElderServe Star (HMO I-SNP) Phone Numbers and Website

- Call toll-free 1-800-580-7000 or TTY users should call 711.
- You can find all plan materials, including the Provider and Pharmacy Directory at www.ElderServeHealth.org
- You can also see the complete list of covered drugs (Formulary) on our website listed above.
- Or, call us and we will send you a copy of our plan materials.

Hours of Operation

- From October 1 to March 31, you can call us 7 days a week from 8:00 a.m. to 8:00 p.m. ET.
- From April 1 to September 30, you can call us Monday through Friday from 8:00 a.m. to 8:00 p.m. ET.

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This information is not a complete description of benefits. Call 1-800-580-7000 or TTY/TDD 711 for more information.

This document is available in other formats such as Braille and large print. This document may be available in a non-English language. For additional information, call us at 1-800-580-7000.

Pre-Enrollment Checklist

Before making an enrollment decision, it is important that you fully understand our benefits and rules. If you have any questions, you can call and speak to a customer service representative at 1-800-580-7000 (TTY/TDD 711).

Understanding the Benefits

- ☐ The Evidence of Coverage (EOC), provides a complete list of all coverage and services. It is important to review plan coverage, costs, and benefits before you enroll. Visit www.ElderServeHealth.org or call 1-800-580-7000 (TTY/TDD 711) to view a copy of the EOC.
- ☐ Review the provider directory (or ask your doctor) to make sure the doctors you see now are in the network. If they are not listed, it means you will likely have to select a new doctor.
- ☐ Review the pharmacy directory to make sure the pharmacy you use for any prescription medicines is in the network. If the pharmacy is not listed, you will likely have to select a new pharmacy for your prescriptions.
- ☐ Review the formulary to make sure your drugs are covered.

Understanding Important Rules

- ☐ In addition to your monthly plan premium, you must continue to pay your Medicare Part B premium. This premium is normally taken out of your Social Security check each month.
- ☐ Benefits, premiums and/or copayments/co-insurance may change on January 1,2027.
- ☐ Except in emergency or urgent situations, we do not cover services by out-of-network providers (doctors who are not listed in the provider directory).
- ☐ This plan is an institutional special needs plan (I-SNP). Your ability to enroll will be based on verification that you, for 90 days or longer, have had or are expected to need the level of services provided in a skilled nursing facility, a nursing facility, an intermediate care facility for individuals with intellectual and developmental disabilities, a psychiatric hospital or unit, a rehabilitation hospital or unit, a long-term care hospital, a swing-bed hospital, or a facility approved by CMS that furnishes similar services.
- ☐ Effect on Current Coverage

ElderServe Health, Inc. Notice of Nondiscrimination

ElderServe Health, Inc. complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin (including limited English proficiency and primary language), age, disability, or sex (consistent with the scope of sex discrimination described at 45 CFR § 92.101(a)(2)). ElderServe Health, Inc. does not exclude people or treat them less favorable because of race, color, national origin, age, disability, or sex.

ElderServe Health, Inc.:

- Provides people with disabilities reasonable modifications and free appropriate auxiliary aids and services to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, which may include:
  - Qualified interpreters
  - Information written in other languages

If you need reasonable modifications, appropriate auxiliary aids and services, or language assistance services, contact Civil Rights Coordinator. If you believe that ElderServe Health, Inc. has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you may file a grievance with:

ElderServe Health, Inc.
ATTN Civil Rights Coordinator
80 West 225th Street
Bronx, NY, 10463

Phone: 1-800-771-0088, TTY 711
Fax: 1-888-341-5009

You may file a grievance in person or by mail, phone, or fax. If you need help filing a grievance, the Civil Rights Coordinator is available to help you.

You may also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW, Room 509F, HHH Building
Washington, D.C. 20201
1-800-368-1019, 1-800-537-7697 (TDD)

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html

ElderServe Star (HMO I-SNP): Summary of Benefits

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

English ATTENTION: If you speak another language, free language assistance services are available to you. Appropriate auxiliary aids and services to provide information in accessible formats are also available free of charge. Call **800-580-7000** (TTY: **711**; or speak to your provider.

Español (Spanish) ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. También están disponibles de forma gratuita ayuda y servicios auxiliares apropiados para proporcionar información en formatos accesibles. Llame al **800-580-7000** (TTY: **711**) o hable con su proveedor.

中文 **(Simplified Chinese)** 注意：如果您说[中文]，我们将免费为您提供语言协助服务。我们还免费提供适当的辅助工具和服务，以无障碍格式提供信息。致电 **800-580-7000**（文本电话： **711**）或咨询您的服务提供商。

РУССКИЙ (Russian) ВНИМАНИЕ: Если вы говорите на русском, вам доступны бесплатные услуги языковой поддержки. Соответствующие вспомогательные средства и услуги по предоставлению информации в доступных форматах также предоставляются бесплатно. Позвоните по телефону **800-580-7000** (TTY: **711**) или обратитесь к своему поставщику услуг.

Kreyòl Ayisyen (Haitian Creole) ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd aladispozisyon w gratis pou lang ou pale a. Èd ak sèvis siplemantè apwopriye pou bay enfòmasyon nan fòma aksesib yo disponib gratis tou. Rele nan **800-580-7000** (TTY: **711**) oswa pale avèk founisè w la.

한국어 (Korean) 주의: [한국어]를 사용하시는 경우 무료 언어 지원 서비스를 이용하실 수 있습니다. 이용 가능한 형식으로 정보를 제공하는 적절한 보조 기구 및 서비스도 무료로 제공됩니다. **800-580-7000** (TTY: **711**) 번으로 전화하거나 서비스 제공업체에 문의하십시오.

Italiano (Italian) ATTENZIONE: se parli Italiano, sono disponibili servizi di assistenza linguistica gratuiti. Sono inoltre disponibili gratuitamente ausili e servizi ausiliari adeguati per fornire informazioni in formati accessibili. Chiama l' **800-580-7000** (TTY: **711**) o parla con il tuo fornitore.

יידי ש (Yiddish) נאטיץ: אויב איר רעדט יידיש, שפראך הילף סערוויסעס זענען בארעכטיגט פאר דיר פריי .
צונעמען־אידס און בַאדינונגס אלַאר צרַאווייזינג אינאלָארמַאציע אין צוטריטלעך אלָארמַאטירונגען זענען אויך בנימצא פריי. רופן

. **711**אָדער רעדן מיט דיין טרעגער (TTY: **800-580-7000**)

(Bengali) ইংরেজিতে মনোযোগ: আপনি যদি অন্য ভাষা বলতে পারেন, তাহলে বিনামূল্যে ভাষা সহায়তা পরিষেবা আপনার জন্য উপলব্ধ। অ্যাক্সেসযোগ্য ফর্ম্যাটে তথ্য প্রদানের জন্য উপযুক্ত সহায়ক সহায়তা এবং পরিষেবাগুলিও বিনামূল্যে পাওয়া যায়। 800-580-7000 (TTY: 711; অথবা আপনার প্রদানকারীর সাথে কথা বলুন।

POLSKI (Polish) UWAGA: Osoby mówiące po polsku mogą skorzystać z bezpłatnej pomocy językowej. Dodatkowe pomoce i usługi zapewniające informacje w dostępnych formatach są również dostępne bezpłatnie. Zadzwoń pod numer **800-580-7000** (TTY: **711**) lub porozmawiaj ze swoim dostawcą.

العربية (Arabic)

تنبيه: إذا كنت تتحدث اللغة العربية، فستتوفر لك خدمات المساعدة اللغوية المجانية. كما تتوفر وسائل مساعدة وخدمات مناسبة لتوفير المعلومات بتنسيقات يمكن الوصول إليها مجانًا. اتصل على الرقم **800-580-7000**(**711**) أو تحدث إلى مقدم الخدمة .

Français (French) ATTENTION : Si vous parlez Français, des services d'assistance linguistique gratuits sont à votre disposition. Des aides et services auxiliaires appropriés pour
fournir des informations dans des formats accessibles sont également disponibles gratuitement. Appelez le **800-580-7000** (TTY: **711**) ou parlez à votre fournisseur.

اردو (Urdu)

توجہ دیں: اگر آپ اردو بولتے ہیں، تو آپ کے لیے زبان کی مفت مدد کی خدمات دستیاب ہیں۔ قابل رسائی فارمیٹس میں معلومات فراہم کرنے کے لیے مناسب معاون امداد اور خدمات بھی مفت دستیاب ہیں۔ (**711**) **800-580-7000**(TTY: پر کال کریں یا اپنے فراہم کنندہ سے بات کریں۔

Tagalog (Tagalog) PAALALA: Kung nagsasalita ka ng Tagalog, magagamit mo ang mga libreng serbisyong tulong sa wika. Magagamit din nang libre ang mga naaangkop na auxiliary na tulong at serbisyo upang magbigay ng impormasyon sa mga naa-access na format. Tumawag sa **800-580-7000** (TTY: **711**) o makipag-usap sa iyong provider.

Ελληνικά (Greek) ΠΡΟΣΟΧΗ: Εάν μιλάτε ελληνικά, υπάρχουν διαθέσιμες δωρεάν υπηρεσίες υποστήριξης στη συγκεκριμένη γλώσσα. Διατίθενται δωρεάν κατάλληλα βοηθήματα και υπηρεσίες για παροχή πληροφοριών σε προσβάσιμες μορφές. Καλέστε το **800-580-7000** (TTY: **711**) ή απευθυνθείτε στον πάροχό σας.

Hindi हिंदी ध्यान दें: यदि आप हिंदी बोलते हैं, तो आपके लिए निःशुल्क भाषा सहायता सेवाएं उपलब्ध होती हैं। सुलभ प्रारूपों में जानकारी प्रदान करने के लिए उपयुक्त सहायक साधन और सेवाएँ भी निःशुल्क उपलब्ध हैं। **800-580-7000 (TTY:** 711**)** पर कॉल करें या अपने प्रदाता से बात करें।.

ElderServe Health

1-800-580-7000 (TTY/TDD 711)

8 a.m. to 8 p.m. ET– 7 days a week.

www.ElderServeHealth.org