

Medicare Advantage Plans: Options for Colorado Consumers



**State Health Insurance Assistance Program
Colorado Division of Insurance**

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The **SHIP (State Health Insurance Assistance Program)** is a counseling program for Medicare beneficiaries and their families who wish assistance in understanding Medicare benefits, coverage gaps, billings concerns, Medigap, Medicare Health Plan, long-term care insurance and other health insurance options.

Services are provided through a statewide network of organizations that recruit counselors, publicize services, and operate the local programs. Many counselors donate their time and expertise.

SHIP provides free, unbiased information and education. Counselors will not recommend or endorse specific insurance policies but will assist consumers with information to make informed choices. SHIP counselors are true consumer advocates and SHIP never sells or endorses any insurance company or product.

All services are provided without charge.

Colorado State Health Insurance Assistance Program (SHIP) volunteers can help you:

- Organize, understand, and process medical bills
- Assist with private health insurance claims
- Identify gaps in Medicare coverage and options to fill them
- Evaluate Medicare supplement insurance options
- File Medicare appeals
- Understand your hospital and Medicare rights
- Provide you with references information and referral sources
- Provide free educational presentations to the public on Medicare topics
- Screen and assist consumers in applying for financial assistance programs for Medicare
- Evaluate Long Term Care policies
- Assist with evaluating options during the Medicare Annual Open Enrollment Period

Medicare Health Plans: Options for Colorado Consumers

Medicare is the nation's health care program for people aged 65 and over and people who are under 65 who are disabled. Medicare is insurance and, as such, does not pay for all health care services. Medicare is hospital insurance (Part A), outpatient medical insurance (Part B) and insurance to help pay outpatient prescription drug costs (Part D). People with Medicare have several choices of how they receive their health care:

- Original Medicare (Parts A and B)
- Original Medicare + Medicare Supplement Insurance (Medigap)
- Original Medicare and some other type of health insurance, for example, health care through a current or former employer, the Department of Veterans Affairs, and other options
- Medicare Advantage or Other Medicare Plans (referred to in this publication as Medicare Health Plans), with or without drug coverage.

Medicare Advantage Plans are provided through private insurance companies and there are different types of plans to choose from. The types of Medicare Health Plans available in Colorado include:

- Health Maintenance Organizations (HMO)
- Preferred Provider Organizations (PPO)
- Private Fee for Service Plans (PFFS)
- Special Needs Plans (SNP)
- Program of All Inclusive Care for the Elderly (PACE)
- Medical Savings Accounts (MSA) **none are currently available in Colorado**

Medicare Advantage Plans generally offer services in addition to what Original Medicare may cover including some limited dental and vision, and wellness programs. Plans may also offer a wide range of other health related services that are not benefits of Original Medicare. These other health related services will vary for each plan.

CONSUMER BEWARE!

Medicare Advantage Plans **ARE NOT**:

- The same as Original Medicare
- Medicare Supplement Insurance
- Medicare Select policies

They **MAY** include prescription drug coverage but are **NOT** prescription drug plans (Part D).

All Medicare Advantage Plans follow some of the same rules, including:

- Medicare Advantage Plans cap the amount a consumer must pay (called a Maximum Out-of-Pocket limit) through copayments, coinsurance and deductibles each year; however, those caps may not apply to all health care costs.
- With Medicare Advantage Plans Medicare pays the plan a set monthly fee to provide your care and Medicare no longer can be billed for any of your health care costs.
- A consumer must continue to pay Medicare Part B premium while enrolled in Medicare Advantage Plans.
 - Consumers with low or limited income may qualify for financial assistance for their Part B premium and should consult with a SHIP counselor to discuss the eligibility criteria and for assistance in applying.
- Medicare beneficiaries are generally only able to enroll in Medicare Advantage Plans during certain Enrollment Periods.
 - However, there are several enrollment periods that a beneficiary may be able to use, depending on their situation and should consult with a SHIP counselor to better understand their specific enrollment options.
- Once someone enrolls in a Medicare Advantage Plans they are generally 'locked' into that plan for the calendar year.
- A consumer cannot enroll in a Medicare Advantage Plan and a Medigap plan at the same time.
- All Advantage Plans must cover a consumer in a medical emergency, even if they are out of the network area of the plan.

Other facts that a consumer should be aware of regarding Medicare Advantage Plans:

- Medicare Advantage Plans can vary from county to county, in each state and a consumer can only enroll in a Medicare Advantage Plan that is sold in the county the permanently reside in.
- If a consumer moves out of the county they live in, to another county or another state, they cannot take their Medicare Advantage Plan with them, the plan stays behind and the consumer must enroll in a new plan in the county that they make a permanent move to.
 - There may be additional insurance options available to the consumer in this situation and they should consult with a SHIP counselor to better understand their options.

Medicare Advantage Plans have evolved and expanded over the last several years and will likely continue to do so as time goes on. While this can provide more options and benefits for consumers, it can also create confusion.

Consumers should always be willing to ask questions when working with an insurance company or agent/broker to be fully aware of all benefits available within each plan, how they can access those benefits, what limitations each plan may have and if a Medicare Advantage Plan includes drug coverage, that all of their specific prescriptions are covered by a plan.

Consumers are also encouraged to check with any of their existing medical providers to find out if their providers accept or participate in any of the Medicare Advantage Plans they are thinking about enrolling in BEFORE they enroll in a Medicare Advantage Plan.

Health Maintenance Organizations: HMOs

What are Health Maintenance Organizations?

Health Maintenance Organizations are a Medicare Advantage Plan offered by a private insurance company. Medicare pays a set amount of money every month to the private insurance company to provide health care to people with Medicare. Health Maintenance Organizations (HMO) generally focus on managed care and preventing disease and illness. HMOs are the most restrictive type of Medicare Health Plan. HMO's contract with providers (doctors, hospitals, laboratories, etc.) and suppliers to provide health care services and products, such as durable medical equipment and other supplies, for its members. These contracted providers form the provider network. HMO members, usually, must choose a primary care physician within the HMO network who directs and oversees the health care provided to the individual. The primary care doctor, in most instances, must refer a patient for specialized services or to see a specialist. Some services required approval (Prior Authorization) before the plan will pay for the services.

In Medicare Advantage HMO, members, generally, must get all services within the network, unless during an emergency, or the plan will not pay for those services. Any non-emergency medical services a member received outside of the plans network will not be covered the HMO plan or by Original Medicare. Medicare Advantage Plan are paid a set monthly rate to provide all health care for its members, without any additional payments from Medicare during the year.

Is Prescription Drug Coverage Included in HMOs?

HMOs usually include drug coverage, which is considered the members Part D benefit. People who qualify for Extra Help paying their prescription drug costs can enroll in an HMO with drug coverage and receive the benefits of the Extra Help through the plan's coverage. If a Medicare Advantage Plan HMO includes drug coverage, the member must get their pharmacy drugs through the plan. If the Medicare Advantage Plan HMO does not include drug coverage, the member cannot choose a stand-alone drug plan to cover their drugs. People who may have other prescription coverage options, such as VA pharmacy benefits, may choose a Medicare Advantage Plan HMO without drug coverage.

What are the Costs with an HMO?

A consumer who joins a Medicare Advantage HMO must continue to pay the Medicare Part B premium. In addition, the consumer must pay any monthly premium for the plan, if the plan does have a monthly premium. HMOs also include deductibles and will include copays and/or coinsurance amounts that can vary based on the service received. Generally, copay amounts in the plans with no monthly premium will be higher than in plan that have a monthly premium. People who also receive Medicaid benefits and Original Medicare may pay higher out of pocket costs if they enroll in an HMO than with Original Medicare plus Medicaid only.

What are the Advantages of an HMO?

- Total costs (premiums, deductibles, and copays and/or coinsurance) for HMOs may be lower than Original Medicare, with or without a Medigap.
- Member may be able to get services, such as limited dental, vision, hearing benefits; wellness programs and other health related services, that are not available through Original Medicare (and/or Medigap coverage).
- HMOs have a network of doctors and providers that are available to members without the hassle of searching for a doctor or provider that can provide services to patients with Medicare.
- Members generally do not have to file any paperwork.

What are the Disadvantages of an HMO?

- For members with preexisting health issues, HMO costs will probably be higher than Original Medicare with a Medigap plan, due to the copays the patient is required to pay for services.
- A member's current doctor(s) may not be in the HMO plans network, however HMOs plans must cover/pay for emergency services, even if they are received out of the plans network.
- Doctors in the HMOs network may leave the plan while the member is locked into the plan until the next Open Enrollment Period.
- Access to health care providers in a Medicare Advantage HMO may be more restrictive than with Original Medicare.
- A member may not use a Medigap plan to pay the health care costs (copays) that are not covered by the HMO.
- The HMO may require Prior Authorization for certain health care services and Referrals to see specialists before it will pay for those services.

Preferred Provider Organizations: PPOs

What are Preferred Provider Organizations?

A **Preferred Provider Organization (PPO)** is a Medicare Advantage Plan offered by a private insurance company. Medicare pays a set amount of money every month to the private insurance company to provide health care to people with Medicare. A Medicare PPO plan contracts with providers (doctors, hospitals, laboratories, etc.) and suppliers to provide health care services and products, such as durable medical equipment and other supplies, for its members. These contracted providers form the provider network for the PPO plan. A PPO plan member may use the providers in the PPO network. A PPO plan member may also go to any doctor, specialist, hospital, or provider not in the PPO plan network, if the provider is approved by Medicare and is willing to accept the PPO for payment of services provided to the member. **Members who do not use the PPO network providers will usually have higher costs than those who do use the PPO network providers.**

PPO members do not need a referral to see a specialist or any out-of-network provider, however they may still be required to get Prior Authorization for some services, regardless of whether they are using in-network or out-of-network providers. Emergency medical services are always covered in or out of network.

Is Prescription Drug Coverage Included in PPOs?

PPOs usually include drug coverage, which is considered the members Part D benefit. People who qualify for Extra Help paying their prescription drug costs can enroll in a PPO with drug coverage and receive the benefits of the Extra Help through the plan's coverage. If a Medicare Advantage Plan PPO includes drug coverage, the member must get their pharmacy drugs through the plan. If the Medicare Advantage Plan PPO does not include drug coverage, the member cannot choose a stand-alone drug plan to cover their drugs. People who may have other prescription coverage options, such as VA pharmacy benefits, may choose a Medicare Advantage Plan PPO without drug coverage.

What are the Costs in a PPO?

A consumer who joins a Medicare Advantage PPO must continue to pay the Medicare Part B premium. In addition, the consumer must pay any monthly premium for the plan, if the plan does have a monthly premium. PPOs can also include deductibles and will include copays and/or coinsurance amounts that can vary based on the service received. Generally, copay amounts in the plans with no monthly premium will be higher than in plans that have a monthly premium and will be higher for any services a member receives from out-of-network providers. People who also receive Medicaid benefits and Original Medicare may pay higher out of pocket costs if they enroll in an PPO than with Original Medicare plus Medicaid only.

What are the Advantage of a PPO?

- Total costs (premiums, deductibles, and copays and/or coinsurance) may cost less than with Original Medicare, with or without a Medigap.
- A PPO member may save money by using in-network providers
- A member is not required to have a referral to see a specialist. However, getting Prior Authorization approval before using an out-of-network provider may cost less than using an out-of-network provider without Prior Authorization.
- Member may be able to get services, such as limited dental, vision, hearing benefits, wellness programs and other health related services, that are not available through Original Medicare (and/or Medigap coverage).

What are the Disadvantages of a PPO?

- For members with preexisting health issues, PPO costs will probably be higher than Original Medicare with a Medigap plan, due to the copays the patient is required to pay for services.
- Doctors in the HMOs network may leave the plan while the member is locked into the plan until the next Open Enrollment Period.
- A member's current doctor(s) may not be in the PPO plans network. If a member continues to see a doctor that is out-of-network, they may be required to pay higher costs. However, PPOs plans must cover/pay for emergency services, even if they are received out of the plans network.
- A member may not use a Medigap plan to pay the health care costs (copays) that are not covered by the HMO.
- The PPO may require Prior Authorization for certain health care services before it will pay for those services, in or out of the PPO network.

Private Fee-for-Service Plans (PFFS)

What are Private Fee-for-Service Plans?

Private Fee-for-Service plans are a Medicare Advantage Plan offered by a private insurance company. Medicare pays private companies a set amount each month to provide health care for people on Medicare on a 'fee-for-service' basis. A consumer who joins a Medicare Advantage PFFS must continue to pay the Medicare Part B premium. In addition, the consumer must pay any monthly premium for the plan, if the plan does have a monthly premium.

Medicare Part A and Part B services, and sometimes prescription drug coverage, will be covered through the plan and not through Original Medicare. The insurance company marketing the PFFS plans determines what the consumer pays for services, how much will be paid to providers and how providers must bill the insurance company. PFFS plans, may sometimes require Prior Authorization for some services, however they generally do not provide a network of providers to their members, and they do not manage a members care or services.

Those who join a PFFS plan must use providers that are Medicare approved AND that accept the plan's terms and conditions. Health care providers are not required to accept a PFFS plan or patient. A plan member must present their PFFS member card each time they go for health care services so that the provider can determine whether they will work with the PFFS plan. Generally, PFFS plan are only required to contract with a single provider in any given service area (county of residence), otherwise, the PFFS plan does not contract a network of providers for services to a member. If a provider chooses not to bill a PFFS plan you will have to find another provider who will accept and bill the PFFS plan. Since all services must be billed through the PFFS plan, Original Medicare cannot be billed directly for any services.

Is Prescription Drug Coverage Included in PFFS Plans?

PFFS plans may or may not include prescription coverage (Part D) which is determined by the insurance company who offers the plan. If a PFFS plan does include a prescription benefit, it is considered the members Part D benefit. If a Medicare Advantage Plan PFFS includes drug coverage, the member must get their pharmacy drugs through the plan. If the Medicare Advantage Plan PFFS does not include drug coverage, the member CAN choose a stand-alone drug plan (Part D) to cover their drugs. People who qualify for Extra Help paying their prescription drug costs can enroll in a PFFS with drug coverage and receive the benefits of the Extra Help through the plan's coverage.

What Are the Costs in a PFFS Plan?

A consumer who joins a Medicare Advantage PFFS must continue to pay the Medicare Part B premium. In addition, the consumer may pay any monthly premium for the plan, if the plan does have a monthly premium. PFFS plans can also include deductibles and will include copays and/or coinsurance amounts that can vary based on the service received. Some providers that accept PFFS plans are allowed to 'balance bill'. This means that the provider may be allowed to add an additional 15% to the cost the member pays in copay and/or coinsurance. People who also receive Medicaid benefits and Original Medicare may pay higher out of pocket costs if they enroll in an PPO than with Original Medicare plus Medicaid only.

What are the Advantages of PFFS Plans?

- Total costs (premiums, deductibles, and copays and/or coinsurance) may cost less than with Original Medicare, with or without a Medigap.
- A member is not required to have a referral to see a specialist.
- PFFS generally do have networks, so the member may have more choice in which providers they may use and may use the PFFS anywhere in the country with any Medicare approved provider that will accept the PFFS plan.
- Member may be able to get services, such as limited dental, vision, hearing benefits, wellness programs and other health related services, that are not available through Original Medicare (and/or Medigap coverage).

What are the Disadvantages of PFFS Plans?

- For members with preexisting health issues, PFFS costs will probably be higher than Original Medicare with or without a Medigap plan, due to the copays the patient is required to pay for services.
- A member may not use a Medigap plan to pay the health care costs (copays) that are not covered by the PFFS.
- The PFFS may require Prior Authorization for certain health care services before it will pay for those services.
- Providers choose when or if they will accept a patients PFFS plan, on a visit-by-visit basis. This means a provider may provide health care services to a PFFS member one week and refuse to accept the PFFS plan the following week.

CONSUMER ALERT:

- PFFS plans **ARE NOT:**
 - Medicare Supplement Insurance (Medigap) plans
 - Original Medicare
- PFFS generally **DO NOT** use networks of contracted providers.
- PFFS generally **DO NOT** require members to get a referral to see a specialist.
- PFFS Plan **MAY** require members get Prior Authorization for some services.

Consumers should always check with their chosen providers to make sure the providers will accept the PFFS plan **BEFORE** enrolling in the PFFS plan.

Special Needs Plans (SNP's)

A **Special Needs Plan (SNP)** is a Medicare Advantage Plan with a special emphasis on managed care, like an HMO. SNPs are available for specific populations only:

- Those with both Medicare and Medicaid (commonly referred to as 'dual-eligible').
- Those who are institutionalized, e.g., lives in a nursing home or receives nursing care at home
- Those who have multiple chronic and/or disabling health conditions

SNPs are health plans approved by Medicare and run by private companies. A person who joins a SNP get all health care services through the plan. The SNP helps the member manage different services and providers. SNPs contract with providers (doctors, hospitals, laboratories, etc.) and suppliers to provide health care services and products, such as durable medical equipment and other supplies, for its members. These contracted providers form the provider network. SNP member must see providers in the plan network and generally must get a referral to see a specialist. Prior Authorization for some services is also usually required. Emergency medical services are covered for consumer in or out of the plans network.

Some SNPs use a care coordinator to help members manage their health care needs. For example, care coordinators can assist with medication management, socialization, scheduling preventive services, accessing community resources and coordinating their different Medicare and Medicaid services.

Is prescription drug coverage included in the SNP?

Yes, Medicare requires that all SNPs include drug coverage (Medicare Part D). People who qualify for Extra Help paying their prescription drug costs can enroll in an SNP and received the benefits of Extra Help through the plan's coverage.

What are the costs of an SNP?

An individual who has both Medicare and Medicaid will pay very little for his/her health care received through an SNP. Those who do not have Medicare and Medicaid and who join an SNP must continue to pay Part B premiums, any premium for the SNP plan and any additional monthly premiums charged by the plan for extra benefits and the deductible, copays or coinsurance charged by the plans for services received. It is a good idea to call the plan to make sure you qualify for the SNP enrollment and if you qualify ask what the costs will be before enrolling in the plan.

What are the advantages of an SNP?

- Those with Medicare and Medicaid may receive health care services through an SNP at little or no cost, however those without Medicaid may still pay less for services than with Original Medicare and Medigap.
- SNP members may be able to get extra benefits offered by the plan that are not offered through Original Medicare and that are tailored to the needs of the members.
- SNPs provide coordination of services not provided through Original Medicare.
- SNPs have a network of doctors that provide services to members who have Medicare and Medicaid, so members do not have to search for providers.

What are the disadvantages of an SNP?

- Those who are not on Medicare and Medicaid may pay more in the long term than with Original Medicare and a Medigap.
- SNP members may not use a Medigap to pay costs not covered by the SNP plan (deductibles and copays).
- SNP members are usually required to have a referral to see a specialist.
- SNP members that do not have Medicaid benefits are locked into the plan for the calendar year, however, doctors and coordinators of care can leave the plan's network at any time.

Medicare Medical Savings Accounts (MSA's) **

What are Medicare Medical Savings Accounts (MSA)?

Medicare MSA Medicare Advantage plans are offered by private insurance companies that are contracted by Medicare. MSAs are one of the newest Medicare Advantage plan options. Medicare MSA plan are similar to Health Savings Account plans offered to people without Medicare. There are two parts to Medicare MSA plans: a high deductible health plan and a savings account.

Basic Steps to a Medicare Medical Savings Account (MSA) Plan:

- You choose a join the high deductible Medicare Advantage Plan.'
- You set up a special Medical Savings Account with the bank the MSA plan selects.
- Medicare gives the plan an amount of money each year for your healthcare.
- The plan deposits some money into your account. The money in your account and any interest on that money isn't subject to taxes as long as the money is used for health care costs. You may or may not be allowed to move the money to another bank account, depending on the plan.
- You can use the money in your account to pay your health care costs, including health care cost that are not covered by Medicare, however, only Medicare covered service costs are applied to the plan high deductible.
- If you use all of the money in your account and you r additional health care costs, you will have to pay out-of-pockets until you reach your plan's deductible (for Medicare covered services).
- During the time you are paying out-of-pocket for services before the deductible is met, doctors/providers cannot charge you more than the Medicare-approved amount.
- After you reach your deductible, your plan will cover any additional Medicare covered health care needs at 100% until the end of the calendar year.
- Money left in your account at the end of the year stays in the account and may be used for future health care needs.
- If you use any of the money in your account, you must include a special form with information on how you used that money when you file taxes.

Is Prescription Drug Coverage Covered by a Medicare MSA?

No, Medicare MSAs do not provide prescription drug coverage (Medicare Part D). MSA members may join a stand-alone Medicare Part D prescription plan in order to have a drug benefit.

What are the Medicare MSA plan costs?

Medicare MSA members continue to pay Part B premiums and may be required to pay a monthly premium for the Medicare MSA. Additionally, the member must pay the high deductible amount before the plan will pay for Medicare approved services. However, Medicare MSAs generally do include a maximum out-of-pocket limit.

What are the advantages of a Medicare MSA?

- Medicare MSAs may cover services, such as dental, vision, and long-term care, that are not benefits or Original Medicare.
- If the member does not use all of the money in their account, the funds will roll over to the next year. People who have little health care costs may accumulate funds to be used in later if health care costs increase.
- Medicare MSAs may include an out-of-pocket limit, which protects members from catastrophic costs.

What are the disadvantages of a Medicare MSA?

- Services covered by the Medicare MSA that are not covered by Original Medicare generally cost the consumer more in terms of premiums.
- Medicare MSAs include an annual high-deductible health plan. If the members financial status in adversely changed during the year, the member my not be able to afford to pay health care costs.
- Medicare MSA member cannot use a Medigap plan to pay for health care costs not covered by the plan.
- If an MSA member runs out of money in their account, the member is required to pay out-of-pocket for medical services.

**** NOTE:** Currently, there are no insurance companies offering Medicare Medical Savings Account Advantage Plans for enrollment in Colorado. However, that is subject to change at any year in the future and you can contact your local SHIP office at any time for the most current updates.

Program of All Inclusive Care of the Elderly (PACE)

What is the Program of All Inclusive Care for the Elderly (PACE)?

PACE is a multi-disciplinary approach to a consumer's social and health needs. **PACE is specifically designed for individuals aged 55 and older who are impaired, frail and nursing home eligible.** A team of professionals assesses the needs of the member, develops care plans and delivers all services (including acute care and nursing facility services, when necessary) to assist the member to continue to live in the community. To join PACE, the consumer may have Medicare and/or Medicaid, be aged 55 or older, live in the plan's service area (county), be certified by the State of Colorado as eligible for a nursing home level of care and be able to live safely in the community with the help of the PACE program. County Departments of Human Services determine eligibility for the PACE program. Members can choose to leave/disenroll from the PACE program at any time.

PACE provides all the care and services covered by Medicare and Medicaid, as authorized by the members care team, as well as any medically necessary care or services not covered by Medicare or Medicaid.

Does PACE provide prescription drug coverage?

Yes, PACE is required to provide prescription drug coverage (Medicare Part D), and members are required to get their prescriptions through the PACE plan.

What are the costs in a PACE plan?

For those who qualify for Medicare, all Medicare covered services are paid for by Original Medicare. If the member also qualifies for Medicaid, they may have a small monthly premium payment or may pay nothing, for the long-term care portion of their coverage. Those who do not qualify for Medicaid will be charged a monthly premium to pay for the long-term care portion of their PACE coverage, as well as a premium for the prescription drug coverage (Medicare Part D). Otherwise, members are never required to pay any deductibles or copays for drugs, services or care that has been approved by the PACE care team.

Additional Information

Medicare Advantage Plans have evolved and expanded over the last several years and will likely continue to do so as time goes on. While this can provide more options and benefits for consumers, it can also create confusion.

Medicare continues to allow the insurance companies that offer Medicare Advantage Plans more flexibility to offer benefits and services not available under Original Medicare to better support beneficiaries' health needs and situations. Medicare Advantage Plans are currently allowed to offer many more medical and non-medical benefits in addition to all benefits covered by Original Medicare. These 'extra' benefits are referred to as 'supplemental benefits' for Medicare Advantage Plans. Some examples of 'supplement benefits' a Medicare Advantage Plan may offer at no additional cost are:

- Transportation to medical appointments
- A Medicare Part B premium 'buy-back', (the Medicare Advantage Plan can arrange for all or part of a consumers Part B premium to be reimbursed to them by Social Security)
- Health and Wellness programs and gym memberships
- Over the Counter drug or other pharmacy items subsidy

Some supplemental benefits may only be available and offered to consumers with specific or chronic health conditions and Medicare Advantage Plans may tailor benefits to those needs.

Some Medicare Advantage Plans may also offer more comprehensive benefits 'packages' for some services, at an additional monthly premium such as comprehensive dental coverage or vision coverage.

Although Medicare Advantage Plans are allowed to offer more of these types of benefits, be aware that not all plans do and that there may be different benefits and plans types offered to consumers in each county of the state. Consumers should always ask very specific questions about what benefits each Medicare Advantage Plan in their county of residence offers and how they can access those services through the plan.

Consumers are always encouraged to contact their local SHIP office for assistance, information, or education on all of the Medicare options and for one-on-one, personalized consultations at no cost.

To find your local SHIP office, call the Colorado SHIP toll free number:

1-888-696-7213