INTRODUCTION

Introduction

The Colorado Gerontological Society (CGS) is a non-profit organization founded in 1980 dedicated to Colorado older adults.

CGS administers grant assistance for dental work, eyeglasses, and hearing aids for the Denver metro area to seniors 60 years old or older.

We provide person-and family-centered older adult counseling, advocacy and referral programs. Benefits counseling includes education of benefits, assistance with applications, and referrals. Every year during Medicare open enrollment we assist older adults to make educated and informed decision on their Medicare benefits for the following year with a series of educational presentations called Medicare Mondays throughout the Metro Denver area. Medicare Mondays are followed by one-on-one counseling sessions.

Our Health Insurance Literacy program focuses on providing education to older adults regarding their health insurance. The goal is to provide them with the information they need to better use their health insurance effectively. Educational trainings as well as one-on-one sessions are provided to older adults and their families. We have developed a toolkit, printed in English, Spanish, and Mandarin, to provide older adults and their families with the tools they need.

CGS provides assistance to older adults and their families to complete their Advance Care Planning. We provide educational trainings as well as one-on-one counseling sessions in English and Spanish. We provide assistance with completion of Advance Directives.

Every Holiday season we provide 200 low-income and isolated older adults with Holiday Baskets. Numerous companies and individuals provide food donations and their time to make the baskets possible.

INTRODUCTION

CGS is a professional membership organization of aging professionals. CGS works to promote ongoing and relevant education to our members and professionals throughout Colorado to reflect current best practice in the field of aging. Those professionals in turn bring their new information and skills to the agencies and clients they serve. The professional trainings CGS conducts include training in Assisted Living Administrator, Elder Abuse Reporting, Leadership in Diversity – Latino Elders, Quality Management Plan, Advance Care Planning, and how to successfully complete Colorado First applications for financial assistance programs available to Colorado older adults.

In addition, CGS provides Senior Issues Briefing, Network North, and CGS Benefit Cohort, three monthly professional educational networking groups, for professionals in the aging field. Community partners have the opportunity to instruct professionals regarding the most current issues in aging as well as networking with other professionals in the aging field.

We provide several publications for the aging community. Our quarterly newsletter, STAWell News, is distributed to older adults. The newsletter contains articles on upcoming events, state and federal happenings, and benefits that readers may be eligible to receive. The Colorado Senior Resource Guidebook is published annually. Consumers use The Guidebook to learn more about health insurance including Medicare and Medicaid. The Guidebook is a comparison of housing and home care options using pricing data, services, and other amenities. Lastly, The Guidebook features preprinted copies of advance directive forms that can be used for end-of-life planning. 20,000 copies of The Guidebook are distributed free at libraries throughout the State, as well as through senior fairs and direct mail. Visit our website www.senioranswers.org for more details on publications.

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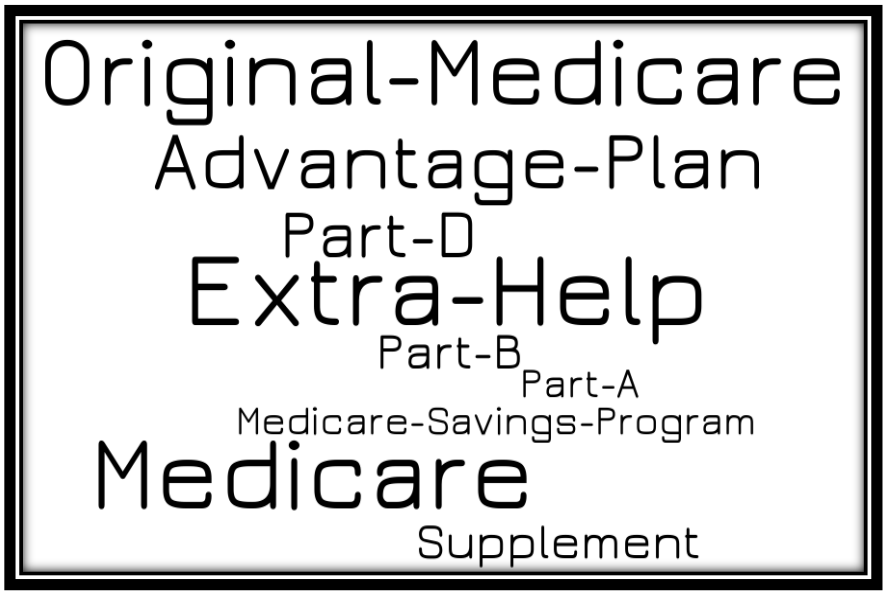
1330 Leyden Street, Denver CO 80220

MEDICARE

Medicare



ELIGIBILITY

For most people, you need to be 65 years old and apply through Social Security Administration (SSA).

INITIAL ENROLLMENT PERIOD

For most people, the first time you can enroll for Medicare is during the three months prior to the month you turn 65, the month you turn 65, and three months after you turn 65. If you are younger than 65, disabled, and receive Social Security Disability Insurance (SSDI) benefits, Medicare starts on the 25th month after you start receiving SSDI benefits.

MEDICARE

MAKING CHANGES

Every year during the Annual Enrollment Period, you have the opportunity to make a change in the Medicare Part C and D plan(s) you have. The change can be made without penalty during the "Open Enrollment" Period, from October 15th through December 7th. Under certain situations, changes can be made in addition to the "Open Enrollment" period.

MEDICARE PART A

This is also known as "Hospital" Insurance. This pays for inpatient hospital stays, skilled nursing facility (SNF) stays, skilled home health care, and hospice.

For most people, if you are 65 years old and have worked 40 quarters and contributed taxes toward Medicare, Medicare Part A is free and you don't have to pay a monthly premium.

If you have not worked 40 quarters, you will have to pay a monthly premium. The monthly premium is dependent on the number of quarters you worked.

There are exceptions to the age and work requirements, most frequently for those who may be disabled, are still employed, have a retiree health insurance plan, or may have worked for federal, state or local governments.

MEDICARE PART B

This is also known as "Medical" Insurance. While coverage is optional, there is a 10% penalty for every year that you are eligible that you do not sign up. In addition to doctor visits, Part B helps pay for other services including:

- preventative care
- durable medical equipment (DME)

- oxygen, diabetic supplies
- ostomy supplies
- care provided in outpatient clinics (medical, therapists, and mental health)
- immunizations (such as flu, pneumonia, and Hepatitis B)
- ambulance when medically necessary

A one-time annual deductible for Part B services must be paid by the beneficiary (or the Medicare Supplement/MediGap plan) before eligible services are paid by Medicare. After the deductible is paid, then Medicare pays 80% of the Medicare approved charge. This means if the provider does not accept "Medicare Assignment," the provider will bill you for the 20% and for the difference between the provider's charge and the charge that Medicare has approved.

If you have a Medicare Advantage Plan, co-pays will vary depending on the health insurance company and plan you chose.

ORIGINAL MEDICARE (OR FEE FOR SERVICE MEDICARE)

When you have combined Medicare Part A and Medicare Part B and you do not have an Advantage HMO (health maintenance organization) or PPO (preferred provider organization) Plan administering your health insurance benefits.

MEDICARE PART C

Medicare Part C is better known as a "Medicare Advantage Plan." Medicare Part C is a combination of Medicare Parts A, B, and D. Private insurance companies offer this insurance and actively participate in the delivery of care through networks of approved providers. The majority of plans require a monthly

premium, may require copays for many procedures, and may charge coinsurance for some services. You choose to have either a Medicare Advantage Plan or a Medicare Supplement/MediGap Plan; you cannot have both plans.

MEDICARE PART D

Medicare Part D or prescription drug coverage is provided through "Stand Alone Prescription Drug Plans" by private insurance companies. If you have Original Medicare, prescription drug coverage is optional, with its own monthly premium (cost). However, there is a 1% per month penalty for every month that you are eligible for Part D that you do not sign up, unless you have creditable coverage.

In addition to the monthly premium, there will be the yearly deductible, and then depending on the plan you choose, there will be either a copayment or coinsurance for each prescription medication. When you choose a prescription drug plan, it is important to look at the medications you take, to make sure the medications are covered by the drug plan.

The shingles shot is covered under Medicare Part D. Talk with your health insurance plan about the cost to get your shingles shot.

For some people who have a high out-of-pocket cost because of their medication(s), they may reach the "donut hole," which is a gap in prescription drug coverage. That means the drug plan will not pay as much money after they have paid a certain amount of money for your prescription medications. If that happens, you will have to pay a higher share of the cost. Then, once the "donut hole" has been crossed, the drug plan begins to pay a higher percentage of the cost.

If you are receiving Low Income Subsidy (LIS) or Extra Help which pays for Medicare Part D costs, you will not have to worry about the donut hole.

MEDICARE

When you decide to get your health insurance through either a HMO (health maintenance organization) or PPO (preferred provider organization), those plans will include a prescription drug coverage benefit. The amount of coverage will depend on two things: (1) if you use the health insurance plan's in-network pharmacy and (2) if your medication is on the health insurance plan's drug formulary. A formulary is the list of medications that are covered by the prescription drug plan.

MEDICARE SUPPLEMENT OR MEDIGAP PLAN

You can buy this plan if you have Original Medicare (Medicare Part A and Part B). This is an optional plan through a private health insurance company, with its own monthly premium (cost). The plan helps pay some of the costs like the copayments, coinsurance, and annual deductibles when Medicare Part A and Medicare Part B does not fully cover a service, treatment, or item. You may use any provider in the United States that accepts Medicare without a referral. Care does not have to be prior authorized.

MEDICARE SAVINGS PROGRAM (MSP)

A program for low-income people. Depending on your monthly income and assets, you are eligible for one of three levels of financial help to pay for Medicare Part B premiums. Low-income individuals can receive assistance with Part A and B deductibles as well as copays and coinsurance. The three programs are:

1. Qualifying Medicare Beneficiary (QMB)
2. Specified Low-Income Medicare Beneficiary (SLIMB)
3. Qualifying Individual (QI)

MEDICARE

You apply for the MSP program through the county Department of Human Services (or the Medicaid agency).

LOW INCOME SUBSIDY (LIS) OR EXTRA HELP

A program for low-income people to help pay for prescription medication monthly premiums, annual deductibles, copayments and coinsurance.

You receive LIS or Extra Help automatically If you:

1. Receive Medicare and Medicaid
2. Receive Supplemental Security Income and Medicare
3. Receive financial assistance from one of the three Medicare Savings Programs

If you are on Medicare, your income is significantly low, and you meet the asset requirements and you have not yet applied for MSP, then apply for Extra Help first through the Social Security Administration, www.ssa.gov.

Then one week later, apply for MSP through the county Department of Human Services.

MEDICARE ASSIGNMENT

When a doctor, provider, or durable medical equipment (DME) supplier agrees to accept the amount of money Medicare approves for a service and only bills you for 20% coinsurance.

SPECIAL ENROLLMENT PERIOD

You may qualify for a special enrollment period if you delay coverage in Medicare Part B and D due to employment; you are low income; or you move to a skilled

nursing facility. If you need to change your Medicare coverage, check with 1-800-Medicare to see if qualify for a Special Enrollment Period.

NOTE: Every year the income eligibility requirements and monthly premiums change. The information in this toolkit is based on 2018 numbers.

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FINANCIAL ASSISTANCE PROGRAMS

Financial Assistance Programs

Many types of assistance are available, depending on:

- Age
- Income
- Financial Resources (Including savings; owning more than one car; whole life insurance; and burial insurance, if it can be "cashed in" or is "revocable")
- The home you live in is not included in your financial resources.

Some programs also require you to pass eligibility screens:

When you need help with activities of daily living (ADLs), also called "Functional Needs." ADLs can include shopping for food, preparing meals, walking, transfers, dressing, taking a shower, using the bathroom, scheduling

medical appointments, transportation to medical appointments, and banking.

Services can be provided in your home or in an assisted living or a nursing home.

You apply in the county you live. Please refer to "Resources" section in this booklet for agency names and telephone numbers (page 49-57).

NOTE: Every year the income eligibility requirements and resource limits change. The information in this toolkit is based on 2018 numbers.

HOW DO YOU QUALIFY FOR MEDICAID?

1. Supplemental Security Income (SSI):
   a. If you receive SSI, you automatically qualify for Medicaid (Federal).
2. Health First Colorado Buy-In Program (formerly known as the "Medicaid Buy-In" Program). To qualify for the program, you must have the following four requirements:
   a. Be between 16 and 64 years old
   b. Be working
   c. Have a disability listed with the Social Security Administration (SSA)
   d. Make less than 450% of the Federal Poverty Level. In 2018, a person can make about $4,523 a month.
3. Home and Community Based Services. Programs for long term care in your home, an assisted living, or a nursing home.

If you are eligible, you will get Health First Colorado benefits.

Applications can be done at your local county Department of Human Services or with a local advocacy group.

FINANCIAL ASSISTANCE PROGRAMS

CONNECT FOR HEALTH COLORADO

This program is the "health insurance marketplace," formerly known as the "health insurance exchange." The Affordable Care Act created this for people who did not qualify for Health First Colorado (or Medicaid).

You can apply by:

- Filling out the application at www.ConnenctForHealth.com
- Complete the application with a person who is a certified agent/broker or certified application counselor
- Fax the paper application to 1-855-346-5175
- Telephone 1-855-752-6749, Monday through Friday, 7 a.m. to 6 p.m.

The programs that provide financial assistance with health-related expenses include:

Medicare Savings Program (MSP)

This is a Medicare program that helps people with limited income and resources pay for Medicare costs.

You apply for MSP through the county Department of Human Services.

There are three levels of financial assistance. Depending on the level you qualify for depends on your monthly income and assets:

1. Qualified Medicare Beneficiary (QMB) will pay the Medicare B monthly premium, annual deductibles, coinsurance, and copayments
2. Specified Low-Income Medicare Beneficiary (SLMB) will pay Medicare B monthly premiums only
3. Qualifying Individual (QI) will pay Medicare B monthly premiums only

FINANCIAL ASSISTANCE PROGRAMS

Low Income Subsidy or Extra Help

When you qualify for any of the three MSP programs, you will also receive a low-income subsidy (LIS) benefit (sometimes referred to as Extra Help) for your stand-alone prescription drug plan or your Medicare Advantage Plan.

You automatically qualify for Low Income Subsidy (LIS) also known as "Extra Help" if you have Medicare and:

1. You are enrolled in one of the MSP plans
2. You receive Medicaid
3. You receive Supplemental Security Income (SSI) benefits

The LIS program provides financial help with your Medicare Part D drug plan monthly premiums, yearly deductibles, copayments and coinsurance.

Some people who are not eligible for full LIS or Extra Help are eligible for partial Extra Help benefits. The partial benefits help with your monthly premium, yearly deductible, copayments and coinsurance.

Old Age Pension (OAP) Health and Medical Fund

Old Age Pension Health and Medical Fund provides health coverage for those who receive OAP-A or OAP-B if they do not qualify for Medicare or Medicaid. OAP-A (for persons age 65+) and OAP-B (for persons age 60-64) provides a cash benefit to individuals 60 and over who meet the income and resource requirements. The cash benefit is $788 (January 2018) per month from all sources. For example, if an individual receives Social Security of $500 a month, they may receive $288 a month from OAP. You apply for OAP at your county Department of Human Services.

Individuals who are eligible for Medicare, usually do not receive OAP Health and Medical insurance.

FINANCIAL ASSISTANCE PROGRAMS

The portion of the OAP program that helps with dental and health care is called "OAP Health and Medical Care Program." This program is only for people who do not qualify for Health First Colorado (Colorado's Medicaid program).

Home and Community Based Services (HCBS)
Elderly, Blind, and Disabled (EBD)

A waiver program that helps you to pay for personal care, medications, and medical care so that you can stay as independent as possible.

This program requires both a financial and functional eligibility determination.

Through the HCBS-EBD waiver you can receive:

- **In-home services**. A Medicaid licensed home care agency provides services include shopping, light housekeeping, and a medical alert device. Services in a day program and transportation to medical appointments can also be provided.
- **Consumer Directed Attendant Support Services (CDASS)**. Medicaid funds are used to pay family members or health workers to provide personal care in the home that is directed by the client (or their representative), rather than by a home care agency.
- **In-home Support Services (IHSS)**. Medicaid funds are used to pay family members or health workers to provide personal care in the home that is directed by the client (or their representative); however, the care is directed, scheduled and supervised by a home care agency.
- **Care provided in another location,** when living at home no longer meets a person's care needs, due to safety concerns. The program helps to pay for alternative care facility (ACF), also called an assisted living. Your portion of the payment is based on your income and Medicaid pays for the remaining amount.

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Frequently Asked Questions

1. I HAVE MEDICARE AND MEDICAID. WHICH INSURANCE PAYS FIRST?

Medicare is the first insurance used to pay your healthcare related bills. Medicaid will be the second insurance and will pay for the deductibles and copayments.

2. WHAT IS DUAL ELIGIBLE?

Dual Eligible adults are people who qualify for:

- Medicare and QMB (Qualified Medicare Beneficiary)
- Medicare and OAP (Old Age Pension)
- Medicare and SSI (Supplemental Security Income)

FREQUENTLY ASKED QUESTIONS

3. WHERE DO I APPLY FOR QMB?

Apply for QMB through the county Department of Human Services. Refer to Financial Assistance Programs section.

4. WHERE DO I APPLY FOR OLD AGE PENSION?

Apply for OAP through the county Department of Human Services. Refer to Financial Assistance Programs section.

5. WHERE DO I APPLY FOR SUPPLEMENTAL SECURITY INCOME?

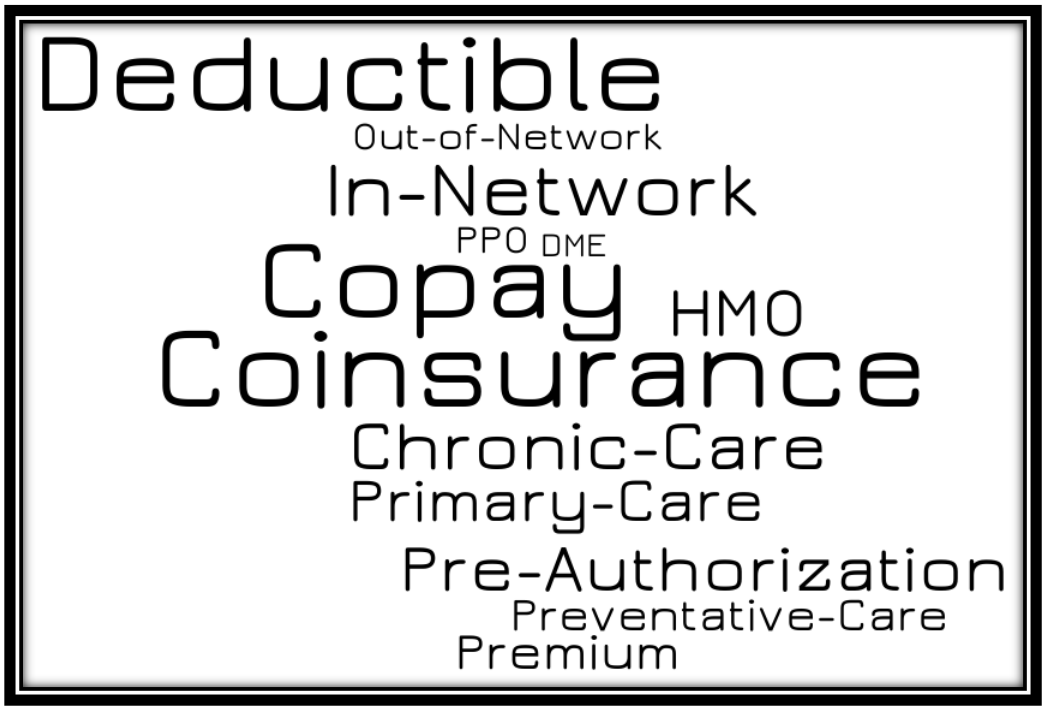
Apply for SSI benefits through Social Security Administration (SSA).

SSI monthly benefits are for people with limited income and resources, who are disabled, blind, or 65 years or older.

Social Security Administration: 1-800-772-1213.

NEED-TO-KNOW WORDS

Need-To-Know Words



PREMIUM

A monthly charge, whether or not you use the insurance. For Medicare, most people have a monthly premium for Part B and Part D. People who have a Medicare Supplement/Medigap plan, or a Medicare Advantage Health Plans will most likely have a monthly premium as well.

COPAYMENT/COPAY (OUT-OF-POCKET)

The fixed amount of money you pay, before a service, test, piece of durable medical equipment (DME) is provided, or for each prescription medication. This is a fixed amount of money for each type of care or service and does not vary, as the coinsurance does. However, the copay can be different depending on the

type of service provided. For example, the copay for a primary care doctor visit might be $20; for a specialist visit might be $40; for an urgent care clinic visit might be $75; and for a hospital emergency department visit might be $500.

COINSURANCE (OUT-OF-POCKET)

The percentage you pay for a service. The amount will vary, based on the percentage of the approved reimbursement rate. The percentage that you need to pay will be different, according to the insurance company, the plan you choose, and if you receive the service "in-network" or "out-of-network." The coinsurance is in addition to the deductible.

DEDUCTIBLE

The amount a person is required to pay out-of-pocket, before the health insurance coverage begins. The deductible begins each year, is a specified amount, and varies according to the plan you have and according to the type of service provided. For example, for an inpatient hospital stay, outpatient care, and durable medical equipment (DME), there may be separate deductibles you pay for each level of care, services, and items, before the health insurance coverage will begin to pay.

IN-NETWORK

Your insurance company has a contract with doctors and other service providers. The provider agrees to receive less money for the service they provide, than if they provided the same service to another person who doesn't have the insurance. This means that you will pay less money when you receive care and

services from an "in-network" provider, than if you use an "out-of-network" provider.

OUT-OF-NETWORK

These are doctors and other service providers who have not agreed with your insurance company to receive less money for the service they provide. You can call your insurance plan and they will tell you how much money they would pay if you go to an out-of-network provider. That means that you will have to pay the service provider a larger amount of money, than if you had received services from an "in-network" provider. There are exceptions. If your insurance company has given you special permission to go to an out-of-network provider, also called "pre-authorization," you will pay the "in-network" approved amount.

> For example: When you go to an "in-network" provider with approval from your doctor or insurance company, if the insurance pays 80% of the approved amount for a service, then you pay 20% and the provider will not bill you more money than the insurance agreed to pay for the service.
>
> When you go to an "out-of-network" provider without approval from your doctor or insurance company usually the insurance company does not pay at all or pays a lower amount. For example, the insurance may pay 60% of the approved amount, leaving you responsible for 40% of the approved amount **and** the difference between what the insurance agreed to pay for the service and what the provider bills for the service.

HMO (HEALTH MAINTENANCE ORGANIZATION)

A HMO is a type health insurance plan that offers health care services with either no or a smaller amount of money you have to pay. If you have Medicare Part A

and Part B, you can choose to enroll in a "Medicare Advantage Plan." For you to get the financial benefit, you have to go to a doctor or other service provider in the HMO network.

The HMO will only pay an "out-of-network" provider if the service you need is not "in-network." For this to happen, your primary care physician must request and receive a pre-authorization from the HMO, before you receive the service.

HMOs tend to focus on preventive care (such as annual physicals, screenings, and immunizations like shingles, flu, and pneumonia), care coordination, and keeping you healthy.

PPO (PREFERRED PROVIDER ORGANIZATION)

A PPO is a type of health insurance plan that has both "in-network" and "out-of-network" providers. If you have Medicare Part A and Part B, you can choose to enroll in a "Medicare Advantage Plan." The plan will have two levels of what you have to pay, depending if you decide to receive care and services from an "in-network" or "out-of-network" provider.

PPOs tend to focus on preventive care (such as annual physicals, screenings, and immunizations like shingles, flu, and pneumonia), care coordination, and keeping you healthy.

APPROPRIATE UTILIZATION OR MEDICALLY NECESSARY OR MEDICAL NECESSITY

These words mean the health care services or supplies that are needed to prevent, diagnose, or treat an illness, injury, disease, or the symptoms that meet accepted standards of care. All these words mean the same thing.

NEED-TO-KNOW WORDS

PRE-AUTHORIZATION OR PRIOR APPROVAL OR PRECERTIFICATION

This is when your insurance company approves a service, treatment, medication, or durable medical equipment (DME) before you receive it. The service or item must be "medically necessary." All these words mean the same thing.

PRIMARY CARE PROVIDER (PCP)

Many times, "PCP" is a short cut when talking about your primary care physician, nurse practitioner, and physician assistant. All these professionals help you to get the health care services that are "medically necessary."

- A physician can be a medical doctor (MD) or a doctor of osteopathic medicine (DO).
- A nurse can be an advanced practice registered nurse (APRN), a nurse practitioner (NP), an adult geriatric nurse practitioner (AGNP), a family nurse practitioner (FNP), or a clinical nurse specialist (CNS). Sometimes they will have a specialty in geriatrics or working with older adults.
- A physician assistant (PA).

REFERRAL

When your primary care provider (PCP) writes an order for you to see a specialist or get a specific service or item. When you belong to a health maintenance organization (HMO), a referral is usually required from your PCP, before you receive additional care and services, so your insurance will pay for the service.

NEED-TO-KNOW WORDS

DURABLE MEDICAL EQUIPMENT (DME)

This is the equipment or supplies your doctor orders for you, so you can be safe in your home. This includes oxygen, diabetic supplies, ostomy supplies, walkers, and wheelchairs. Medicare Part B covers these services.

Depending on the type of health insurance you have, you may have a coinsurance and the Part B annual deductible for DME.

Not all durable medical equipment suppliers have a contract with Medicare.

PHARMACEUTICALS

A word that is related to medications, including how they are made, used, or sold.

PREVENTATIVE CARE

What you do to prevent illness; including what you eat, how much you exercise, seeing your doctor at least once a year, and health care to prevent illness when treatment is most likely to work best (like shots). Medicare Part B covers preventive care services such as immunizations, wellness visits, colonoscopies, mammograms, diabetic counseling, and more.

CHRONIC CARE

Care that is provided to people who have chronic illnesses (including asthma, coronary heart disease, diabetes, arthritis) to maintain and manage current health conditions. Managing chronic illness includes making life style behaviors such as: eating, sleeping, exercising, and taking medications following the instructions provided by your doctor. It also includes making follow-up visits to your doctor to monitor changes, improvements and progression of your chronic

illness. At each doctor visit, you talk with your health care team (primary care provider and specialists) to see if the prescribed treatments and equipment are helping you or if there need to be a change.

EXPLANATION OF BENEFITS (EOB)

After you receive services, the Explanation of Benefits is the statement that your insurance company sends you, to tell you how an insurance claim was paid. The EOB will have "This is not a bill" on the top of the paper. The insurance company does not send you a bill; only the provider will send you a bill. The EOB will include what you have paid for the copay and the deductible as well as what you owe the provider. Typically, you will receive the EOB from your insurance company before the provider sends the bill. The information written on the EOB for what you owe ("patient pays") should be the same as the "amount owed" on the provider's bill.

MEDICARE SUMMARY NOTICE (MSN)

The notice shows all the services you received and supplies that were billed during a three-month period. The MSN shows what Medicare paid and the maximum amount you may owe the provider.

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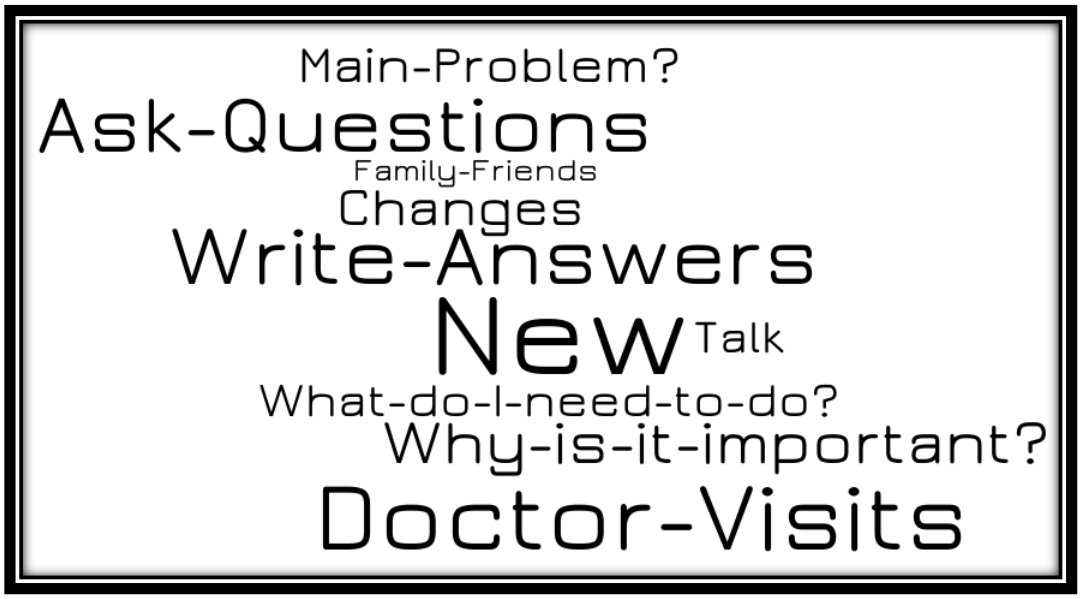
Doctor Visits



The following tips are ways to use the time with your doctor, so that you and your doctor get the most benefit from each visit.

TIP 1

It is a very good idea to ask a family member or close friend to go with you when you see your doctor.

That person can help you by listening to what the doctor tells you. They can help you ask important questions. They can write information (new diagnosis, new treatment, and new medication) for you, so you can look at it when you are at home.

DOCTOR VISITS

TIP 2

It is also very important to tell your doctor if you:

- Stopped taking a medication (including cost, side effects, inconvenient time, too many times a day)
- Changed the way you take a medication (including time of day, the number of times a day, instructions were too confusing, with or without food)
- Began taking over-the-counter (OTC) medications (including for pain, stomach, constipation, diarrhea)
- Began taking supplements (vitamins, minerals, herbs)

TIP 3

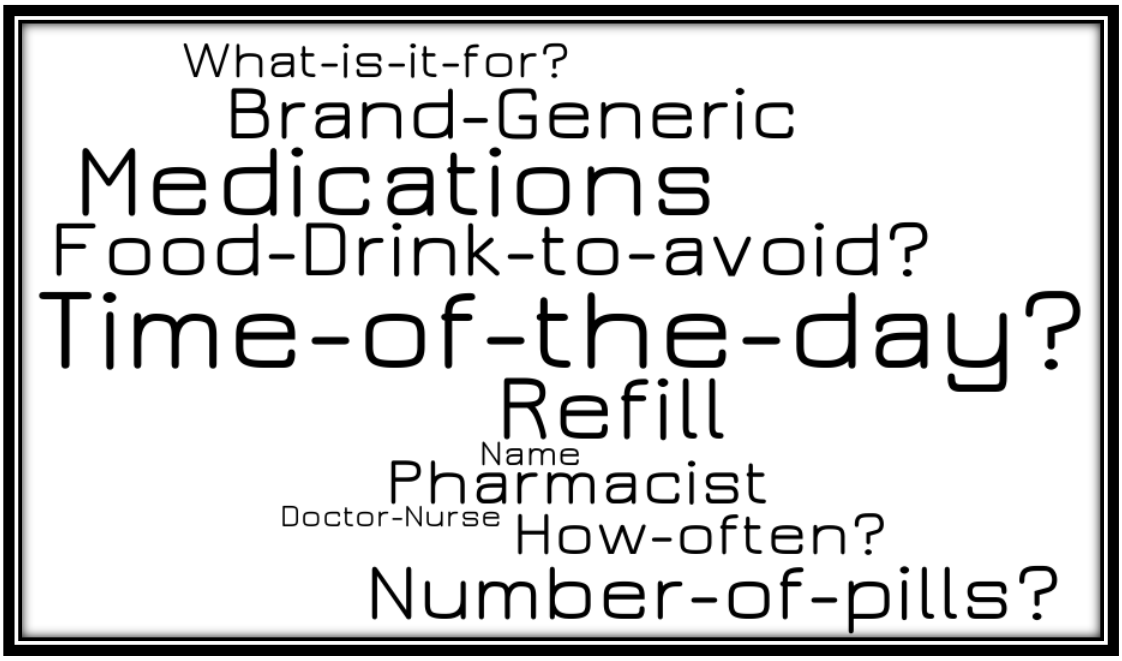
After you update your doctor on how you are using your medications and new symptoms you may be having since the last visit, you and your family/friend should ask these three questions:

- What is my main problem?
- What do I need to do about it?
- Why is it important for me to do this?

Write the answers so you and your family can look at it later.

MEDICATIONS

Medications



DOCTOR

When your doctor prescribes a new medication for you, it is very important to ask these questions. It is a good idea to write the answers, so you can look at the information when you are at home.

- What is the name?
- What is it for? How will it help me?
- How do I take it? (The number of pills, the time(s) each day, how many days, with or without food)
- Are there better times in the day to take it – morning, noon, afternoon, or bedtime?
- Will there be side effects? What should I do if there are side effects?

MEDICATIONS

- Are there certain foods I should not eat? Can I drink alcohol (beer, wine, hard liquor)?
- Can I take this with the other medications, vitamins, and supplements that I'm already taking?
- When will the medication begin to "work?" How will I know it is "working?"
- How should it be stored (room temperature, in the refrigerator)?
- Will I need to refill it when I use the supply?
- Is there anything else I should know?

You can ask your doctor or nurse for a list of your medications with the time(s) and how you should take them.

PHARMACIST

If you have questions about your medication(s) after you have left the doctor's office, the pharmacist is another person to ask if you have questions.

The pharmacist wants to help you, to make sure you understand the purpose of the medication and how to take it correctly.

You can ask the pharmacist the same questions that you asked the doctor.

Just like with your doctor, it is a good idea to write the answers, so you can look at the information when you are at home.

You can ask your pharmacist for a list of your medications with the time(s) and how you should take them.

MEDICATIONS

OPTIONS FOR REDUCING THE COST OF MEDICATIONS

1. Ask your doctor to write for a generic, instead of a brand name, on the prescription.
2. Ask your doctor if he has samples.
3. Use the pharmacy that is approved by the insurance company. If you have insurance through a HMO (health maintenance organization) or PPO (preferred provider organization); TRICARE West Veteran Prescription Benefits; PACE (program of all-inclusive care for the elderly) such as InnovAge; or a pension that includes a pharmacy benefit, use the approved pharmacy(ies).
4. Make sure the pharmacy knows the health insurance plan(s) you have, so that the prescription medication benefit can be used. Insurance plans can include:
    a. Medicare Part D using a private insurance company
    b. Medicaid
    c. Medicare Advantage Plan
    d. TRICARE West (includes Colorado). In 2018, the prescription medication benefit for Colorado residents is TRICARE West, administered through HNFS (Health Net Federal Services). The website is www.myhealth.va.gov. West Region: 1-844-866-9378
    e. Veterans Prescription Drug Benefits often use mail order for maintenance medications.
    f. PACE (Program of All-inclusive Care for the Elderly):
    g. Pension or Retiree coverage
    h. Mail Order – 90 days supply. This is a good option when you have a medication that you will be taking for a while and you don't think your doctor will change the medication. Many health insurance

companies, including Medicaid and TRICARE West (military retirees), encourage the use of mail order. Many offer discounts for using mail order programs.

i. Ask what the cash price would be, if the insurance was not used.
j. Ask your pharmacist for ideas to save money.
k. The Partnership for Patient Assistance (PPA) is a free service that helps you find a program to get your medications at a lower or at no cost. The website is www.pparx.org. You type in the name of the medication and information is provided regarding the drug manufacturer's patient assistance program. Complete the application and mail it to the manufacturer. Medications can be sent to you directly, to your pharmacy or to your physician, depending on the company.

PRESCRIPTION SAVINGS PROGRAMS OPTIONS TO FIND LOWER COST MEDICATIONS

Pharmacy Discounts and Coupons can be used if you do not get your medications from Kaiser, the VA, or you have a similar medication benefit that requires you to get your medications from a specific pharmacy.

For people who can use this medication discount program, you can use it for all medications approved by the Food and Drug Administration (FDA). To begin the process, select the program you want to use from the list below. For most of the programs, you can print, text, or e-mail the "prescription discount card" or "prescription savings card." Many of the programs have an application you can download to your cell phone and some of the programs will mail you a card.

MEDICATIONS

When you bring the card to the pharmacy, ask the pharmacist to compare the cost of each medication using (1) your drug insurance benefit, (2) the discount program or coupon (see below), or (3) if you pay for the co-payment out-of-pocket to determine the lowest price that you have to pay. Then choose that option.

Most of the pharmacy discounts and coupons can be used at pharmacies including: Walmart, Sam's Club, Kmart, CVS Pharmacy (free-standing pharmacies and in Target stores), Walgreens, Rite Aid, Kroger (known as King Soopers or City Market), and Safeway. Check the websites for participating pharmacies that are close to your home.

For Colorado residents, the state's Prescription Assistance Program (PAP) at www.coloradodrugcard.com. For additional programs that offer reduced medication prices visit the following websites:

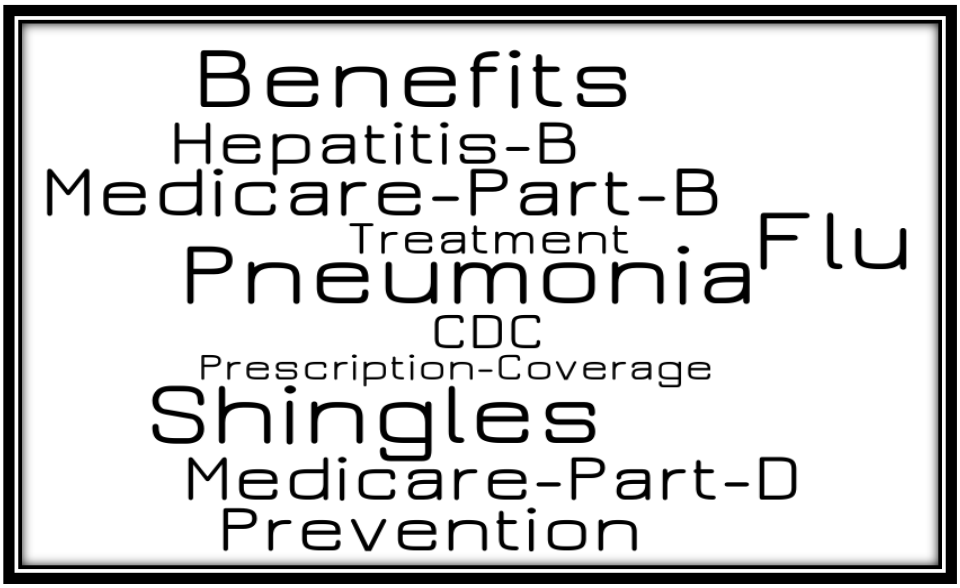
- www.discountdrugnetwork.com
- www.drugs.com
- www.familywize.org
- www.freedrugcard.us
- www.goodrx.com
- www.myrxsaver.com
- www.rxpharmacycoupons.com

NOTE: Listed in alphabetical order; this is not an all-inclusive list.

[redacted]

IMMUNIZATIONS

Immunizations



INFLUENZA

Influenza, also known as the "flu." This is a respiratory illness caused by influenza viruses that infects the nose, throat, and lungs. It is spread from person-to-person, when people with the flu cough, sneeze, or talk within six feet from other people. The virus enters through the mouth or nose.

The Center for Disease Control and Prevention (CDC) recommends that people get a flu shot every year. It is the best way to protect yourself from the flu.

Prevention

Ways to prevent getting sick and to keep from getting others sick during the flu season:

1. Cover your mouth and nose with a tissue when coughing or sneezing and throw the tissue away after using it

2. Cough or sneeze into your elbow
3. Wash your hands often with soap and warm water, especially after coughing or sneezing
4. Don't touch your eyes, nose, and mouth
5. Stay home for 24 hours after your fever is gone without taking medication to reduce your fever

You should get a flu shot if

1. You are 65 years and older
2. You have a chronic illness, such as lung disease, heart disease, or diabetes
3. You live in a community-setting, such as senior housing, assisted living or nursing home
4. You provide care to young children and adults

Treatment

It is a good idea to call your doctor when you have symptoms of the flu. There is a medication that will lessen the symptoms. The medication works best within the first two days that your symptoms began.

Over-the-counter medication can help lessen the symptoms. Be sure to talk with your doctor before you take over-the-counter medication, to make sure it doesn't interact in a bad way with the medications your doctor has prescribed.

What is the Difference Between the "Flu" and a "Cold"?

A cold is also a respiratory illness, but it is caused by a different virus than influenza. Colds generally do not result in serious health problems. The common cold may cause pneumonia which can lead to being in the hospital.

IMMUNIZATIONS

Typical Symptoms of the flu compared to symptoms of a cold:

Flu	Cold
• Sudden on-set of symptoms • Fever • Body aches • Fatigue • Weakness • Cough • Chills	• Gradual on-set of symptoms • Stuffy nose • Sore throat • Fatigue • Weakness • Cough

Health Insurance Coverage

Medicare: The flu shot is covered once a year, under Medicare Part B. It is important you understand what is covered under Medicare Part B, including out-of-pocket expenses.

For more information about covered benefits and out-of-pocket expenses, you can go to www.Medicare.gov.

If you have health insurance through a health plan that is not "straight Medicare," please contact the company using their customer service number or website, to ask about the flu shot.

PNEUMONIA

Pneumonia is an infection in the lungs. It is spread from person-to-person by direct contact with respiratory secretions, like saliva or mucus. Pneumonia may develop from a virus, a bacteria, or a combination of the two. Symptoms include

a cough, fever, and trouble breathing. Antibiotics are commonly used to treat pneumonia.

Prevention

Pneumonia can often be prevented with a shot. Most people need a pneumonia shot one time.

Ways you can help prevent getting a respiratory infection:

1. Wash your hands
2. Clean surfaces that many people touch (including hand rails, chair backs and side arms, elevator buttons, door handles, telephones, computer keyboards and mouse, condiment containers on tables)
3. Cough and sneeze into a tissue or into your elbow
4. Minimize your contact with cigarette smoke
5. Take care of your chronic health conditions

Ways you can take care of your chronic health conditions

Follow your doctor's suggestions for what to eat, exercise, and get enough sleep. Take the medication(s) the way you and your doctor have talked about.

People who are at greater risk to get pneumonia and who should get the pneumonia shot

- 65 years or older
- Have a chronic illness, such as lung disease, heart disease, or diabetes
- Have a weakened immune system from cancer or other chronic disease
- You smoke cigarettes or you have contact with cigarette smoke

Health Insurance Coverage

The pneumonia shot is covered under Medicare Part B. It is important you understand what is covered under Medicare Part B, including out-of-pocket

expenses. For more information about covered benefits and out-of-pocket expenses, you can go to www.Medicare.gov.

If you have health insurance through a health plan that is not "straight Medicare," please contact the company using their customer service number or website, to ask about the pneumonia shot.

SHINGLES

Chickenpox and shingles are caused by the same virus. Studies have shown that 99% of Americans ages 40 and older have had chickenpox.

After you have had chickenpox, the virus stays inactive in your body. The virus can reactivate many years later and causes shingles.

Approximately one-third of the people who had chickenpox will get shingles as adults.

Symptoms of shingles are typically a painful rash on one side of your face or body which blisters and then scabs. You may also experience headaches; fever; chills; and upset stomach. Severe pain can last for months or years after the rash goes away.

Even if you did not have chickenpox when you were younger, if you are around young children who can get chickenpox, you should talk with your doctor about getting the shingles shot.

The CDC recommends that healthy people who are 50 years of age or older should get the shingles shot.

Even if you have had shingles or got the shot in the past, there is a new shot that is more effective to prevent shingles. Talk with your doctor to see if getting the new shot will be good for you.

IMMUNIZATIONS

Benefits

Some of the benefits of getting a shingles shot are:

1. It helps protect you against shingles, if you are 50 years or older.
2. If you get the shot and still get shingles, the symptoms will be less compared to not getting the shot.

Health Insurance Coverage

The shingles shot is covered under Medicare Part D. It is important you understand what is covered under Medicare Part D, including out-of-pocket expenses. There is a standard benefit, but not all companies offer the standard benefit. The companies can charge less than the standard benefit if Medicare approves.

For more information about covered benefits and out-of-pocket expenses, you can go to www.Medicare.gov.

If you have prescription coverage through a plan that is not Medicare Part D, please contact the company using their customer service number or website, since the out-of-pocket cost will vary person-to-person, depending on the health insurance plan you have for prescription drug coverage.

It is important to compare prescription drug coverage plans every year to ensure you understand your out-of-pocket expenses.

HEPATITIS

"Hepatitis" means inflammation of the liver. There are three common types of hepatitis viruses: Hepatitis A, Hepatitis B, and Hepatitis C. How you got hepatitis will determine the type you have.

IMMUNIZATIONS

Hepatitis A

Hepatitis A is common in areas where there are poor sanitary conditions or poor personal hygiene. It is caused when the Hepatitis A virus is ingested from food or drinks contaminated by small amounts of feces from a person who is infected with Hepatitis A.

Prevention

1. There is a shot to prevent Hepatitis A
2. Wash your hands after using the bathroom and changing diapers
3. Wash your hands before preparing food
4. Wash your hands before eating food

The shot is most effective when it is administered in a series. The number of shots and the time between shots will depend on the type used. Talk with your doctor about the best shot for you, since there are different types of shots.

Hepatitis B

The Hepatitis B virus is spread by blood or sexual contact with a person who is infected with Hepatitis B.

Prevention

There is a shot to prevent Hepatitis B; it is a set of three shots. If an injected medication such as insulin is used, use a needle only one time. Don't use the same needle more than once or share the needle with someone else. Talk to your doctor about the best shot for you, since there are different types of shots.

Hepatitis C

The Hepatitis C virus is spread by blood with a person who is infected with Hepatitis C. As of now, there is no shot to prevent Hepatitis C.

IMMUNIZATIONS

Prevention

Ways to reduce the risk of being infected with Hepatitis C:

1. Don't share needles or syringes in any situation
2. Don't share personal items (such as razors, nail clippers, toothbrushes, or glucose monitors) that might have small amounts of blood from a person infected with Hepatitis C

Talk to your doctor about the best medication to treat this virus since there are different types of shots.

Health Insurance Coverage

The Hepatitis B shot is covered under Medicare Part B. It is important you understand what is covered under Medicare Part B, including out-of-pocket expenses. For more information about covered benefits and out-of-pocket expenses, you can go to www.Medicare.gov.

If you have health insurance through a health plan that is not "straight Medicare," please contact the company using their customer service number or website, to ask about the Hepatitis B shot.

ACCESS TO MEDICAL CARE

Access to Medical Care

Appropriate utilization of your healthcare services means you use your health insurance benefits and save money. Different out-of-pocket costs are associated with each level of care, depending on the health insurance plan and whether it is in-network or out-of-network.

PRIMARY CARE PHYSICIAN

Your doctor (physician) provides education and preventative health services, including annual physicals and screenings. Your doctor also provides care if you suddenly become ill or are in pain, as well as helping you to manage chronic medical conditions, including diabetes and asthma. Your doctor is the person who knows your medical history the best and coordinates services you need.

ACCESS TO MEDICAL CARE

SPECIALIST PHYSICIAN

A doctor (physician) who has in-depth knowledge in an area of medicine. Examples of a "specialist" physician include cardiologists (heart), pulmonologists (lungs), and endocrinologists (diabetes). The specialist often manages your chronic illness and your primary care physician (PCP) manages your preventative care. The specialist and PCP will share information so they both know about your health and can coordinate the care you need.

HOME VISITS

Home visits are made by doctors, physician assistants, nurses or nurse practitioners. You can search for the professionals who provide this service on the internet by entering "house calls Denver" on a search engine such as Google at www.google.com.

WALK-IN CLINICS

These are also known as "Retail Clinics" and "Convenience Care Clinics" because they are located inside larger stores, including Walmart, Target, King Soopers, Walgreens, and CVS Pharmacy. The clinics provide care similar to the care provided in your physician's office, for non-life threatening illness. You use this level of care when you need to see your doctor for an unexpected health need and they can't see you that day or when your doctor's office is closed. Services include minor injuries, burns, illnesses like the flu and cold, strep throat, "pink" eye, earaches, urinary tract infection, skin rash, shots, and physicals.

ACCESS TO MEDICAL CARE

URGENT CARE

Provides care for non-life threatening illness. You use this level of care when you need to see your doctor for an unexpected health need and they can't see you that day or when your doctor's office is closed. It is like a walk-in clinic with enhanced services. This level of care is appropriate when you need care, your physician office is not able to see you and emergency department services are not required. The urgent care will have a laboratory and x-ray equipment. Services include minor injuries, treatment of illnesses like the flu and cold, fevers, vomiting, diarrhea, stomach pain, strep throat, "pink" eye, urinary tract infection, skin rash, shots, and physicals. They can also provide services to treat injuries that can't be treated in a walk-in clinic, including broken bones, deep lacerations, and burns.

EMERGENCY DEPARTMENT

An emergency department that is attached to a hospital. The emergency room is open 24 hours a day, 7 days a week, and is meant to treat life-threatening illnesses. If you are seriously ill and have severe chest pain, extensive bleeding that won't stop, unconsciousness, serious weaknesses and can't walk or lift your arms, heart attack, a stroke, broken bones, difficulty breathing, or a head injury, then go directly to an emergency department attached to a hospital. You may want to call "911" for an emergency transport.

FREE-STANDING EMERGENCY DEPARTMENT

An emergency department that is not attached to a hospital and provides the same services as an emergency department. If you have a life threatening illness that requires being admitted to the hospital, you will be transported to a hospital

after your health concern has been stabilized. State law requires the free-standing emergency departments provide a statement of available insurance coverage, prices, and facility fees, by telling you the information and providing it in writing. Before you receive care, make sure you understand all the prices and if your health insurance can be used at that location.

LEVELS OF CARE AFTER A HOSPITAL STAY

Levels of Care After a Hospital Stay

Appropriate utilization of healthcare services after discharge from a **qualifying** hospitalization, care may be provided at the following levels if medically necessary.

For each of the following levels of care, the person must be making progress towards goals in order for the insurance to continue, within the coverage provided in their health insurance plan.

Different out-of-pocket costs are associated with each level of care, depending on the health insurance plan, whether it is in-network or out-of-network, and the length of time the service is provided.

REHABILITATION STAY

Intensive daily physical therapy, occupational therapy, speech therapy, and/or skilled nursing services are provided in an in-patient setting, for a short period. If

you have Original Medicare, you need to be admitted to the hospital and stay for three overnights. Other health insurance plans may have different criteria to qualify for the rehabilitation benefit.

SKILLED NURSING FACILITY (SNF)

Less intensive daily therapy and/or skilled nursing services are provided in an in-patient setting, typically in a nursing home, for a limited number of days. If you have Original Medicare, you need to be admitted to the hospital and stay for three overnights. Other health insurance plans may have different criteria to qualify for the rehabilitation benefit.

HOMECARE

Therapy and/or skilled nursing services are provided to a person in their home on an intermittent basis. The person must be homebound and not be able to travel to an outpatient clinic or physician office for care.

OUTPATIENT REHABILITATIONCLINIC

The person is able to travel to a clinic to receive intermittent skilled nursing or therapy services.

Advance Care Planning

The term "Advance Directives" refers to the following tools which permit you to express your wishes in writing, for use if you can no longer direct your care and/or finances in the future due to a physical and/or cognitive impairment. Two of the advance directives, the Medical Durable Power of Attorney and Financial Power of Attorney, can be effective as soon as the documents are finalized or can become effective only when you are determined to be incapacitated, or no longer able to make decisions for yourself. It is up to you to decide when you want the two documents to become effective.

All Advance Directives become null and void upon the death of the person. The person's Last Will and Testament is the legal document that tells others how you want your financial resources and belongings to be distributed, as well as how you want the disposition of your remains to be handled.

MEDICAL DURABLE POWER OF ATTORNEY (MDPOA)

The Medical Durable Power of Attorney is a document that lets you tell other people how you want to be cared for, when you are not able to direct your own

care. This legal document includes the word "durable," so that is effective when you are not able to speak to the doctors and health care providers yourself. The first section of the MDPOA is where you designate whom you want to talk for you, also known as your "agent." It is a good idea to designate alternate agents, in the event your main agent is not available, for whatever reason. The MDPOA also has the authority to help put services in place to keep you safe and healthy, whether you need in-home services, adult day program, hospital care, or more supportive housing.

FINANCIAL DURABLE POWER OF ATTORNEY (FDPOA):

The financial power of attorney is a legal document to give authority to someone to handle your finances, such as paying your bills and working with your bank when you are unable to make financial decisions. Making the financial power of attorney durable, makes it effective when you are not able to make decisions. The first section of the FPOA is where you designate whom you want to pay your bills and work with your bank, also known as your "representative." It is a good idea to designate alternate representatives, in the event your primary (first) agent is not available, for whatever reason. The FPOA also has the authority to work with your long-term finances and sell your property, should you need that.

CPR DIRECTIVE

A CPR Directive is a doctor's order that tells emergency medical services (EMS) staff what type of care you want when you are not able to talk to EMS or the emergency department doctors and nurses because you have stopped breathing, your heart has stopped, you are unable to speak, or you are unconscious. Before the form is completed with your wishes, you and your doctor and other family members should discuss the different medical interventions and the possible

outcomes of each option. After the discussion and all your questions have been answered, then fill out the form with what you have decided. Most people tape the form to the wall by their bed, on the back of their front door, or on their refrigerator door. That way, the EMS staff know where to look for the CPR Directive.

A Cardio-Pulmonary Resuscitation (CPR) Directive is effective only after you and your doctor (or health care provider) have signed it. A CPR Directive may also be signed by your doctor (or health care provider) and your MDPOA.

LIVING WILL (LW)

The living will is a legal document that is used when you are not able to talk with your doctor, you have been in a persistent, vegetative state, and two doctors have said your health will not improve due to a terminal illness. The Living Will lets the doctors know when to stop feedings and other life-supportive measures.

COLORADO MOST (MEDICAL ORDERS FOR SCOPE OF TREATMENT) FORM:

This is a written physician order so doctors know what type of care you want for:

- CPR (cardio pulmonary resuscitation) in case your heart stops
- the level of medical care
- use of antibiotics
- if you want supplemental food and water

This is valid only after you and your doctor (Physician Assistant or advanced practice nurse) have discussed your wishes; the doctor or other provider has written them on the form; and you and your doctor have signed the form.

ADVANCE CARE PLANNING

It is recommended for people who are chronically or seriously ill and who go to the hospital frequently OR for people who live in nursing homes. It is a good idea to review your choices with your doctor when you have a change in your health.

This form is not met to be used by people who do not have chronic illnesses and do not frequently go to the hospital.

ADDITIONAL LEGAL TOOLS

Health Care Proxy/Medical Proxy

If you have not implemented the MDPOA and are determined to be incapacitated, then a Health Care Proxy or Medical Proxy, can be drawn up. Your primary care physician coordinates this legal tool and contacts your family and friends who are involved with you. If all the people agree to appoint the same person as the decision-maker, then a Health Care Proxy is signed by all the people on the physician's letterhead and is a valid tool to appoint a representative to speak on your behalf.

Guardian

When a MDPOA is not in place, you are determined to be incapacitated, AND there is disagreement between the people involved in your life so a Health Care Proxy is not an option, then a guardian will need to be appointed by the court. The guardian is responsible for making decisions on your day-to-day needs, medical decisions, and housing. A guardianship takes time and money, so it is best to develop your MDPOA when you are able to make decisions about the care you want and who you want to be your agent.

A Guardian's report must be written and filed with the court once a year. Based on satisfactory performance, the guardian is reappointed for another year. This process is repeated every year.

Conservator

When a FDPOA is not in place and you are determined to be incapacitated and are unable to manage your finances, then a conservator will need to be appointed by the court. A conservatorship takes time and money, so it is best to develop your FDPOA when you are able to make decisions about your finances who you want to be your agent.

A report must be written and filed with the court once a year. Based on satisfactory performance, the conservator is reappointed for another year. This process is repeated every year.

Most of the time, the same person can't be both the guardian and conservator for someone. When someone has low income, the guardian will also pay the person's bills and manage their money.

Videos

CGS has created videos on topics that include information about Medicare, Medicaid, how to talk to your doctor and pharmacist, immunizations, medications, and different levels of care. The videos are in English and Spanish and are approximately two minutes long.

They are available on CGS's YouTube channel at: https://www.youtube.com/cogerontology.

You can watch them as often as you would like. Your family members and friends can also watch the videos. That way, the people who help you make important decisions about your health care can also have information.

[redacted]

Resources

MEDICARE

Medicare		
Name	Phone	Website
Medicare	1-800-633-4227	www.medicare.gov

MEDICAID

Health First Colorado (Medicaid)		
Resource	Phone	Website
Health First Colorado (Medicaid)	1-800-221-3943	https://www.colorado.gov/pacific/hcpf/contact-hcpf * Benefits administered by Department of Health Care Policy and Financing (HCPF)
Local county office or Application assistance site		www.colorado.gov/cdhs/contact-your-county *Listing of each county's Department of Human Services (DHS)

Local application assistance site	https://www.colorado.gov/pacific/hcpf/application-assistance-sites

Financial Assistance Programs		
Colorado Peak	1-800-221-3943	https://coloradopeak.secure.force.com/

As of Spring 2018, you can choose to apply for benefits electronically at www.coloradopeak.secure.force.com for

- Food Assistance (SNAP) formerly known as Food Stamps.
- OAP (Old Age Pension) financial benefits

The online site is not yet set-up for applying for medical assistance programs, including HCBS (Home and Community Based Services). To apply for HCBS services, please contact your county Department of Human Services office.

If you meet the financial and functional eligibility criteria, HCBS:

- Pays for care in the home
- Pays for assisted living
- Pays for nursing home
- Is used as part of application for the PACE benefit program

County Assistance		
County	Phone	Website
Adams	720-523-2000 (main) 303-227-2348 (Health First Colorado)	www.adcogov.org/humanservices

	303-227-2348 (financial eligibility screen) 1-877-710-9993 (functional eligibility screen)	
Alamosa	719-589-2581 (main)	www.colorado.gov/pacific/alamosacounty/assistance-adults
Arapahoe	303-636-1130 (main)	http://www.co.arapahoe.co.us/388/Human-Services
Broomfield	720-887-2200 (main)	www.broomfield.org
Denver	720-944-3666 (main)	https://www.denvergov.org/content/denvergov/en/denver-human-services.html Address: Castro Building-1200 Federal Blvd, Denver East Satellite Office-3815 Steele St., Denver Montbello Satellite Office-4685 Peoria St., Denver
Delta	970-874-2030 (Long-Term Care options)	www.deltacounty.com/7/Human-Services
Douglas	303-688-4825 (main)	https://www.douglas.co.us/government/commissioners/board-priorities/partnering-to-make-sure-no-one-falls-through-the-cracks/
Elbert	303-621-3149 (main)	www.elbertcounty-co.gov/health_and_human_services.php
Jefferson	303-271-1388 (main)	www.jeffco.us/human-services

Montrose	970-252-5000 (main)	www.co.montrose.co.us/824/Medical-Financial-Assistance
Weld	970-352-1551 (main)	www.weldgov.com/departments/human_services
Colorado Access Medical Application Assistance Site	1-855-221-4138 (main)	The Medicaid single entry point (SEP) case management organization for Adams, Arapahoe, Denver, Douglas, and Elbert counties. The agency will assist with application for medical enrollment services.
Colorado Department of Human Services (CDHS)		www.colorado.gov/cdhs/contact-your-county * Not all counties are listed. For a comprehensive list of each county go to website.

PRIVATE HEALTH INSURANCE COMPANIES

Health insurance company alternatives to Original Medicare:

- A HMO (health maintenance organization) or PPO (preferred provider organization) administers Medicare Parts A, B, and D
- Affordable Care Act for health care when you are not eligible for Medicare, Medicaid, or another health insurance plan
- PACE

PACE		
Name	**Area(s)**	**Phone**
InnovAge Greater Colorado PACE:	Adams, Arapahoe, Broomfield, Denver, Jefferson, Larimer, Weld	1-888-992-4464

TRU Community Care/TRU PACE	Boulder, Weld (southwest)	303-665-0115
InnovAge Greater Colorado PACE	Pueblo	719-553-0400
Rocky Mountain PACE	El Paso	719-314-2327
Senior CommUnity Care/Volunteers of America PACE	Delta	970-835-8500
Senior CommUnity Care/Volunteers of America PACE	Montrose	970-252-0522

Selected health insurance companies providing coverage in Affordable Care Act Exchange, Medicare Supplement, and Medicare Advantage plans:

Selected Health Insurance Company	Affordable Care Act/ Exchange	Medicare Supplement	Medicare Advantage	Website
Aetna		X	X	www.aetna.com
Anthem Blue Cross Blue Shield	X	X	X	www.anthem.com
Humana Market POINTE		X	X	www.humana.com
Kaiser Permanente	X		X	www.KP.org
United Health Care		X	X	www.uhc.com

RESOURCES

Colorado Division of Veterans Affairs

Veterans

Veterans and family members in Colorado who served in the military for less than 20 years and who meet eligibility requirements can receive health insurance benefits from the Veterans Administration medical facilities or a contracted facility. Primary care clinics, nursing homes, regional benefit offices, acute care facilities, and cemeteries are located throughout Colorado. Call your local provider of veterans' benefits or contact the Colorado Department of Veterans Affairs at https://www.colorado.gov/pacific/dmva/contact-us-47 or call 303-284-6077 or 303-914-5832 for eligibility requirements and more details.

Veterans Service Officer

Each county has a Veterans Service Officer who is responsible for assisting veterans to apply for pensions, health care coverage, housing, financial assistance through the aid and attendance benefit, financial assistance for burial, and more. You must have the Veterans DD214 to access service.

The Colorado Division of Veterans Affairs (CDVA) can answer your questions and help you apply for benefits, if you or a family member is eligible.

Military Retirees

You are retired from the military having served for 20 years or more (or a spouse served in the military for more than 20 years). You and your dependents are listed with Defense Enrollment Eligibility Reporting System (DEERS). You may qualify for benefits by calling 1-800-538-9552 or https://tricare.mil/deers. You may qualify to receive TRICARE for Life health benefits. These benefits are administered by TRICARE West.

Contact Options

RESOURCES

https://www.colorado.gov/pacific/vets/county-veterans-service-officers	Website has listed Veterans Service Officer contact information
303-284-6077	Main Phone
303-284-3163	Fax

RESOURCES

PRIVATE HEALTH INSURANCE COMPANIES OFFERING PRESCRIPTION DRUG COVERAGE THROUGH MEDICARE PART D PLANS

In 2018, there are 11 companies who offer Medicare Part D coverage, through 24 plans.

Insurance Name	Phone	Website
Aetna Medicare	1-855-338-7030	www.AetnaMedicare.com
Anthem Blue Cross and Blue Shield	1-800-261-8667	www.Anthem.com/Medicare
Cigna Health Springs RX	1-800-735-1459	www.cignahealthsprings.com
EnvisionRX Plus	1-866-250-2005	www.EnvisionRXPlus.com
Express Scripts Medicare	1-866-477-5704	www.Express-ScriptsMedicare.com
First Health Part D	1-855-389-9688	www.FirstHealthPartD.com
Humana Insurance Company	1-800-833-2364	www.Humana.com/Medicare
Magellan Rx	1-800-424-5759	www.MagellanRx.com
SilverScript	1-866-552-6106	www.Silverscript.com
United Healthcare	1-888-867-5564	www.AARPMedicareRx.com
Symphonix Value Prescription Plan	1-855-355-2280	https://q1medicare.com/
WellCare	1-888-293-5151	www.Wellcarepdp.com

RESOURCES

LIS OR EXTRA HELP

If you are eligible for Medicare Extra Help, six of the 11 companies have one plan each that provides the lowest premiums and deductibles. The six companies, listed in alphabetical order, are:

Insurance Name	Phone	Website
Aetna Medicare Rx Saver	1-855-338-7030	www.AetnaMedicare.com
EnvisionRxPlus	1-866-250-2005	www.EnvisionRXPlus.com
Humana Preferred Rx	1-800-833-2364	www.Humana.com/Medicare
SilverScript Choice	1-866-552-6106	www.Silverscript.com
Symphonix Value Rx	1-855-355-2280	https://q1medicare.com/
Wellcare Classic	1-888-293-5151	www.Wellcarepdp.com

The above companies are Medicare Part D plans that offer assistance to qualified low income individuals who need help paying prescriptions. The LIS or Extra Help medication benefit is available to qualified individuals who are enrolled in Medicare Advantage Plans, or Medicare Part C. Apply for LIS or Extra Help by calling 1-800-772-1213 or access the online application at www.ssa.gov.

STATE HEALTH INSURANCE ASSISTANCE PROGRAM (SHIP)

The SHIP provides information about Medicare, including Medicare Supplement (Medigap) plans and Medicare Advantage benefits.

- English: 1-888-696-7213 or 720-321-8850 (local)
- Spanish: 1-866-665-9668

RESOURCES

AFFORDABLE CARE ACT (ACA)

The ACA provides people with better health coverage and is comprised of two pieces of legislation:

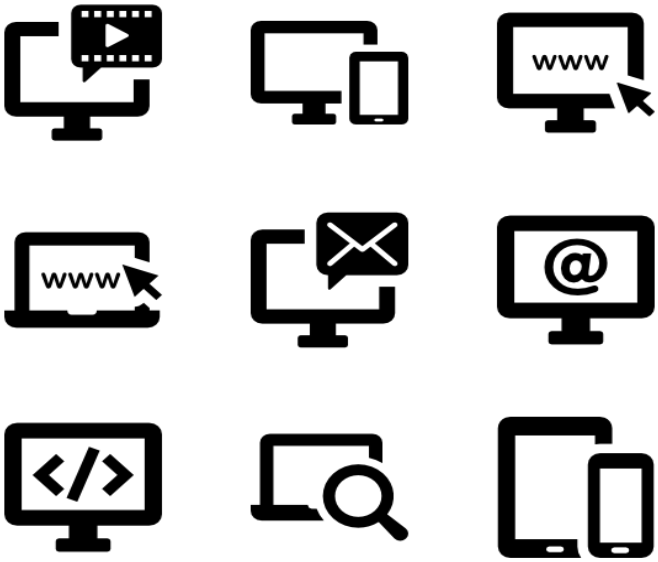
- The Patient Protection and Affordable Care Act
- The Health Care and Education Reconciliation Act of 2010

The intention of ACA is to:

- Expand health coverage
- Enhance the quality of care
- Guarantee more choice
- Lower health care costs
- Hold insurance companies accountable for the services provided and the costs

In Colorado, health insurance coverage options can be accessed through the Colorado Health Insurance Marketplace, "Connect for Health Colorado;" www.connectforhealthco.com. ACA includes dental and vision plans, in addition to health coverage.

Technology



You can use health insurance applications on smart telephones and computers to access each plan's information. Features of applications "apps" include:

- View your health plan details
- Digital ID card on your smart phone
- Find an "in-network" doctor, clinic, Urgent Care, Emergency Department, and Hospital
- Compare costs
- Provider reviews
- Pharmacies and order medication refills
- Track your deductibles
- Talk with the nurse on the 24-Hour Nurse lines on "Live Chat"
- Talk with service representatives on "Live Chat"

Download the application at no cost on Apple iTunes App Store and the Android App on Android/Google Play App Store on your smart phone or tablet.

TECHNOLOGY

There are many health insurance companies. The most common health insurance companies in the Colorado Marketplace are listed in alphabetical order:

Insurance Provider	App Name	24 Hour Nurse Line
Aetna	Aetna Mobile	1-800-556-1555
Anthem Blue Cross Blue Shield	Anthem Anywhere	1-800-224-0336
Cigna	myCigna Mobile app	Provided when you enroll in a Cigna HealthCare medical plan
Health First Colorado (Medicaid)	PEAKHealth	1-800-283-3221
Humana	MyHumana	1-800-622-9529
PACE (InnovAge)	www.myinnovage.org	www.myinnovage.org
Kaiser Permanente	KP	303-338-4545 or 1-800-218-1059
Medicare	Medicare's Blue Button Download on www.MyMedicare.gov	
TRICARE West		1-800-874-2273, option 1 www.MHSNurseAdviceLine.com
United Health Care	Health4Me	1-800-846-4678

References

Medicare

Centers for Medicare & Medicaid Services. www.CMS.gov

Medicare Rights Center. www.medicarerights.org

The Official U.S. Government Site for Medicare. www.Medicare.gov

Financial Assistance Programs

The Official U.S. Government Site for Medicare. www.Medicare.gov

Social Security Administration. www.ssa.gov

Connect For Health. www.connectforhealth.com

Colorado Department of Human Services, Department of Health Care Policy & Financing. www.colorado.gov/hcpf

Colorado Department of Human Services. www.colorado.gov/cdhs

Frequently Asked Questions

Centers for Medicare & Medicaid Services. www.CMS.gov

Social Security Administration. www.ssa.gov

Need-To- Know Words

Centers for Medicare & Medicaid Services. www.CMS.gov

Verywell Health. www.verywell.com

Colorado Department of Regulatory Agencies. www.colorado.gov/dora

Doctor Visits

Agency for Healthcare Research and Quality. www.ahrq.gov

Institute for Health Care Improvement. Ask Me 3: Good Questions for Your Good Health. http://www.npsf.org/?page=askme3

Indian Health Services. www.ihs.gov

Medications

Agency for Healthcare Research and Quality. www.ahrq.gov

REFERENCES

Institute for Health Care Improvement. Ask Me 3: Good Questions for Your Good Health. http://www.npsf.org/?page=askme3

Immunizations

Centers for Disease Control and Prevention. www.cdc.gov

U.S. Department of Health and Human Services. www.HHS.gov

Access to Medical Care

Scripps Research Institute. www.scripps.org

Icahn School of Medicine at Mount Sinai. www.mountsinai.org

Where for Care. www.whereforcare.org

Levels of Care After a Hospital Stay

The Official U.S. Government Site for Medicare. www.Medicare.gov

National Center on Caregiving. www.caregiver.org

Advance Directives

Bell, S. (2017 Ed). Colorado Elder Law Book. Continuing Legal Education in Colorado, Inc.

Colorado Gerontological Society. (2017). *Colorado Senior Resource Guidebook: A Directory for Older Adults, Families, and Aging Service Professionals*. (24 Ed.)

Videos

Centers for Disease Control and Prevention. www.cdc.gov

The Official U.S. Government Site for Medicare. www.Medicare.gov

Colorado Gerontological Society YouTube Channel. https://www.youtube.com/channel/UCH-OUGEB543ZcW__dd6fLYw

Resources

References as listed in the Resources section.

Technology

Health Insurance company websites as listed in Technology section.