CENTERS for MEDICARE & MEDICAID SERVICES

Medicare & Your Mental Health Benefits

This official government booklet has information about mental health benefits for people with Original Medicare, including:

- **Who's eligible**
- **Outpatient & inpatient benefits**
- **Prescription drug coverage**
- **Help for people with limited income & resources**
- **Where to get the help you need**

DEPARTMENT OF HEALTH & HUMAN SERVICES · USA

The information in this booklet describes the Medicare program at the time this booklet was printed. Changes may occur after printing. Visit Medicare.gov, or call 1-800-MEDICARE (1-800-633-4227) to get the most current information. TTY users should call 1-877-486-2048.

"Medicare & Your Mental Health Benefits" isn't a legal document. Official Medicare Program legal guidance is contained in the relevant statutes, regulations, and rulings.

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If you or someone you know is in crisis and would like to talk to a crisis counselor, call the free and confidential National Suicide Prevention Lifeline at 1-800-273-TALK (1-800-273-8255). TTY users should call 1-800-799-4TTY (1-800-799-4889). You can talk to a counselor 24 hours a day, 7 days a week. Call the Lifeline:

- To talk to someone who cares
- If you feel you might be in danger of hurting yourself
- If you're concerned about a family member or friend
- To find referrals to mental health treatments and services in your area

Call 911 if you're in an immediate medical crisis.

Introduction

Mental health care & Medicare

Mental health conditions, like depression or anxiety, can happen to anyone at any time. If you think you may have problems that affect your mental health, you can get help. Talk to your doctor or other health care provider if you have:

- Thoughts of ending your life (like a fixation on death or suicidal thoughts or attempts)
- Sad, empty, or hopeless feelings
- Loss of self-worth (like worries about being a burden, feelings of worthlessness, or self-loathing)
- Social withdrawal and isolation (don't want to be with friends, engage in activities, or leave home)
- Little interest in things you used to enjoy
- A lack of energy
- Trouble concentrating
- Trouble sleeping (like difficulty falling asleep or staying asleep, oversleeping, or daytime sleepiness)
- Weight loss or loss of appetite
- Increased use of alcohol or other drugs

Mental health care includes services and programs to help diagnose and treat mental health conditions. These services and programs may be provided in outpatient and inpatient settings. Medicare helps cover outpatient and inpatient mental health care, as well as prescription drugs you may need to treat a mental health condition.

This booklet gives you information about mental health benefits in Original Medicare. If you get your Medicare benefits through a Medicare Advantage Plan (like an HMO or PPO) or other Medicare health plan, check your plan's membership materials, and call the plan for details about how to get your Medicare-covered mental health benefits.

Words in red are defined on pages 21–25.

Medicare helps cover mental health services

Medicare Part A (Hospital Insurance) helps cover mental health care if you're a hospital inpatient. Part A covers your room, meals, nursing care, therapy or other treatment for your condition, lab tests, medications, and other related services and supplies.

Medicare Part B (Medical Insurance) helps cover mental health services that you would get from a doctor and services that you generally get outside of a hospital, like visits with a psychiatrist or other doctor, visits with a clinical psychologist or clinical social worker, and lab tests ordered by your doctor. Part B may also pay for partial hospitalization services if you need intensive coordinated outpatient care. See page 10 for more information about partial hospitalization services.

Medicare prescription drug coverage (Part D) helps cover drugs you may need to treat a mental health condition.

Section 1: Outpatient mental health care & professional services

What Original Medicare covers

Medicare Part B (Medical Insurance) helps cover mental health services and visits with these types of health professionals (deductibles and coinsurance may apply):

- Psychiatrist or other doctor
- Clinical psychologist
- Clinical social worker
- Clinical nurse specialist
- Nurse practitioner
- Physician assistant

Psychiatrists and other doctors must accept assignment if they participate in Medicare. Ask your doctor or psychiatrist if they accept assignment before you schedule an appointment. The other health professionals listed above must always accept assignment.

Words in red are defined on pages 21–25.

Part B covers outpatient mental health services, including services that are usually provided outside a hospital (like in a clinic, doctor's office, or therapist's office) and services provided in a hospital's outpatient department. Part B also covers outpatient mental health services for treatment of inappropriate alcohol and drug use. Part B helps pay for these covered outpatient services (deductibles and coinsurance may apply):

- One depression screening per year. The screening must be done in a primary care doctor's office or primary care clinic that can provide follow-up treatment and referrals. You pay nothing for your yearly depression screening if your doctor or health care provider accepts assignment.
- Individual and group psychotherapy with doctors or certain other licensed professionals allowed by the state where you get the services.
- Family counseling, if the main purpose is to help with your treatment.
- Testing to find out if you're getting the services you need and if your current treatment is helping you.
- Psychiatric evaluation.
- Medication management.
- Certain prescription drugs that aren't usually "self administered" (drugs you would normally take on your own), like some injections.
- Diagnostic tests.
- Partial hospitalization, as discussed on page 10.
- A one-time "Welcome to Medicare" preventive visit. This visit includes a review of your potential risk factors for depression. You pay nothing for this visit if your doctor or other health care provider accepts assignment. (**Note:** This visit is only covered if you get it within the first 12 months you have Part B.)
- A yearly "Wellness" visit. Medicare covers a yearly "Wellness" visit once every 12 months (if you've had Part B for longer than 12 months). This is a good time to talk to your doctor or other health care provider about changes in your mental health so they can evaluate your changes year to year. You pay nothing for your yearly "Wellness" visit if your doctor or other health care provider accepts assignment.

What you pay

In general, after you pay your yearly Part B deductible for visits to a doctor or other health care provider to diagnose or treat your condition, you pay 20% of the Medicare-approved amount if your health care provider accepts assignment.

If you get your services in a hospital outpatient clinic or hospital outpatient department, you may have to pay an **additional** copayment or coinsurance amount to the hospital.

Note: If you have a Medicare Supplement Insurance (Medigap) policy or other health coverage, tell your doctor or other health care provider so your bills get paid correctly.

Medicare may cover partial hospitalization

Part B covers partial hospitalization in some cases. Partial hospitalization is a structured program of outpatient psychiatric services provided to patients as an alternative to inpatient psychiatric care. It's more intense than the care you get in a doctor's or therapist's office. This type of treatment is provided during the day and doesn't require an overnight stay. Medicare helps cover partial hospitalization services when they're provided through a hospital outpatient department or community mental health center. As part of your partial hospitalization program, Medicare may cover occupational therapy that's part of your mental health treatment and/or individual patient training and education about your condition.

For Medicare to cover a partial hospitalization program, you must meet certain requirements, and your doctor must certify that you would otherwise need inpatient treatment. Your doctor and the partial hospitalization program must accept Medicare payment.

You pay a percentage of the Medicare-approved amount for each service you get from a doctor or certain other qualified mental health professionals if your health care professional accepts assignment. You also pay coinsurance for each day of partial hospitalization services provided in a hospital outpatient setting or community mental health center.

What Original Medicare doesn't cover

- Meals.
- Transportation to or from mental health care services.
- Support groups that bring people together to talk and socialize. (**Note:** This is different from group psychotherapy, which is covered.)
- Testing or training for job skills that isn't part of your mental health treatment.

Section 2: Inpatient mental health care

What Original Medicare covers

Medicare Part A (Hospital Insurance) helps pay for mental health services you get in a hospital that require you to be admitted as an inpatient. You can get these services either in a general hospital or in a psychiatric hospital that only cares for people with mental health conditions. No matter which type of hospital you choose, Part A will help cover mental health services.

If you're in a psychiatric hospital (instead of a general hospital), Part A only pays for up to 190 days of inpatient psychiatric hospital services during your lifetime.

What you pay

Medicare measures your use of hospital services (including services you get in a psychiatric hospital) in benefit periods. A benefit period begins the day you're admitted as an inpatient in a general or psychiatric hospital. The benefit period ends after you haven't had any inpatient hospital care for 60 days in a row. If you go into a hospital again after 60 days, a new benefit period begins, and you must pay a new deductible for any inpatient hospital services you get.

There's no limit to the number of benefit periods you can have when you get mental health care in a general hospital. You can also have multiple benefit periods when you get care in a psychiatric hospital, but there's a lifetime limit of 190 days.

Words in red are defined on pages 21–25.

As a hospital inpatient, you pay these amounts in 2016:

- $1,288 deductible for each benefit period
- Days 1–60: $0 coinsurance per day of each benefit period
- Days 61–90: $322 coinsurance per day of each benefit period
- Days 91 and beyond: $644 coinsurance per each "lifetime reserve day" after day 90 for each benefit period (up to 60 days over your lifetime)
- Beyond lifetime reserve days: all costs

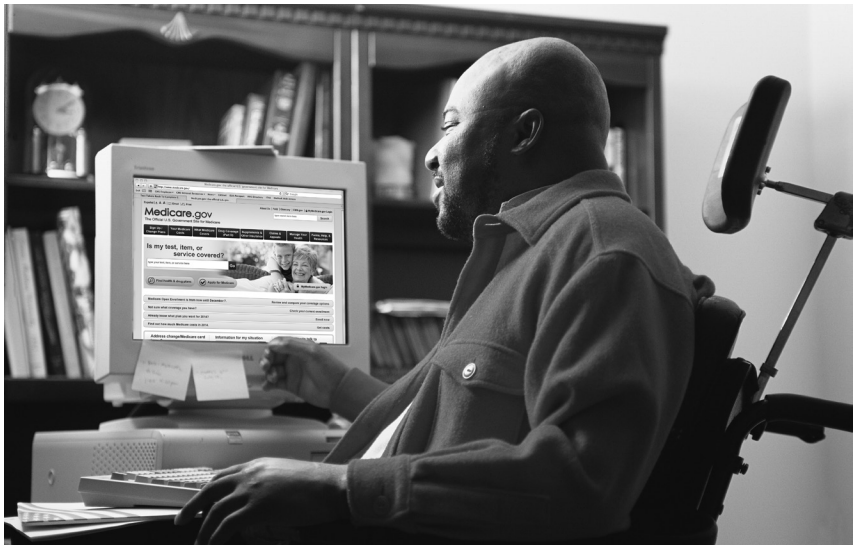
For the most up-to-date costs, visit Medicare.gov, and select "Costs at a glance" under "Your Medicare Costs."

Part B also helps cover mental health services provided by doctors and other health care professionals if you're admitted as a hospital inpatient. You pay 20% of the Medicare-approved amount for these mental health services while you're a hospital inpatient.

Note: If you have a Medicare Supplement Insurance (Medigap) policy or other health coverage, tell your doctor or other health care provider so your bills get paid correctly.

What Original Medicare doesn't cover

- Private duty nursing
- A phone or television in your room
- Personal items (like toothpaste, socks, or razors)
- A private room (unless medically necessary)



Section 3: Medicare prescription drug coverage (Part D)

To get Medicare prescription drug coverage, you must join a Medicare Prescription Drug Plan. Medicare drug plans are run by insurance companies and other private companies approved by Medicare. Each Medicare drug plan can vary in cost and in the specific drugs it covers. It's important to know your plan's coverage rules and your rights.

Medicare drug plans have special rules

Will my plan cover the drugs I need?

Most Medicare drug plans have a list of drugs that the plan covers, called a formulary. Medicare drug plans aren't required to cover all drugs, but they're required to cover all (with limited exceptions) antidepressant, anticonvulsant, and antipsychotic medications, which may be necessary to keep you mentally healthy. Medicare reviews each plan's formulary to make sure it contains a wide range of drugs and that it doesn't discriminate against certain groups (like people with disabilities or mental health conditions).

If you take prescription drugs for a mental health condition, it's important to find out whether a plan covers your drugs before you enroll. Visit Medicare.gov/find-a-plan to find out which plans cover your drugs.

Can my drug plan's formulary change?

A Medicare drug plan can make some changes to its formulary during the year within guidelines set by Medicare. If the change involves a drug you're currently taking, your plan must do one of these:

- Provide written notice to you at least 60 days prior to the date the change becomes effective.
- At the time you request a refill, provide written notice of the change and a 60-day supply of the drug under the same plan rules as before the change.

Words in red are defined on pages 21–25.

What if my prescriber thinks I need a certain drug that my plan doesn't cover?

If you belong to a Medicare drug plan, you have the right to request a coverage determination (including an exception). You can appoint a representative to help you. Your representative can be a family member, friend, advocate, attorney, doctor, or someone else you trust who will act on your behalf. You, your representative, or your doctor or other prescriber must contact your plan to ask for a coverage determination.

Request a coverage determination

You, your representative, or your doctor or other prescriber can request that your plan cover a drug you need. You can request a coverage determination in certain situations, like if your pharmacist or plan tells you:

- A drug you believe should be covered isn't covered
- A drug is covered at a higher cost sharing amount than you think you should have to pay
- You have to meet a plan coverage rule (like prior authorization) before you can get the drug you requested
- The plan won't cover a drug because the plan believes you don't need the drug

If you request a coverage determination, your doctor or other prescriber may need to give a supporting statement to your plan explaining why you need the drug you're requesting. You, your representative, or your doctor or other prescriber can request a coverage determination orally or in writing. Your plan may request additional written information from your prescriber.

Request an exception

You, your representative, or your doctor or other prescriber can request an exception (a type of coverage determination) if:

- You think your plan should cover a drug that's not on its formulary because the other treatment options on your plan's formulary won't work for you.
- Your doctor or other prescriber believes you can't meet one of your plan's coverage rules (like prior authorization, step therapy, or quantity or dosage limits).
- You think your plan should charge a lower amount for a drug you're taking on the plan's non-preferred drug tier because the other treatment options in your plan's preferred drug tier won't work for you.

If you request an exception, your doctor or other prescriber will need to give a supporting statement to your plan explaining why you need the drug you're requesting. You, your representative, or your doctor or other prescriber can request an exception orally or in writing. Your plan may request additional written information from your prescriber.

What if I disagree with my plan's coverage determination or exception decision?

Once your plan has gotten your request, in most cases, it has 72 hours (or 24 hours if you request that a fast decision be made) to notify you of its decision. If you disagree with your Medicare drug plan's coverage determination or exception decision, you have the right to appeal the decision. The plan's written decision will explain how to file an appeal. Read this decision carefully.

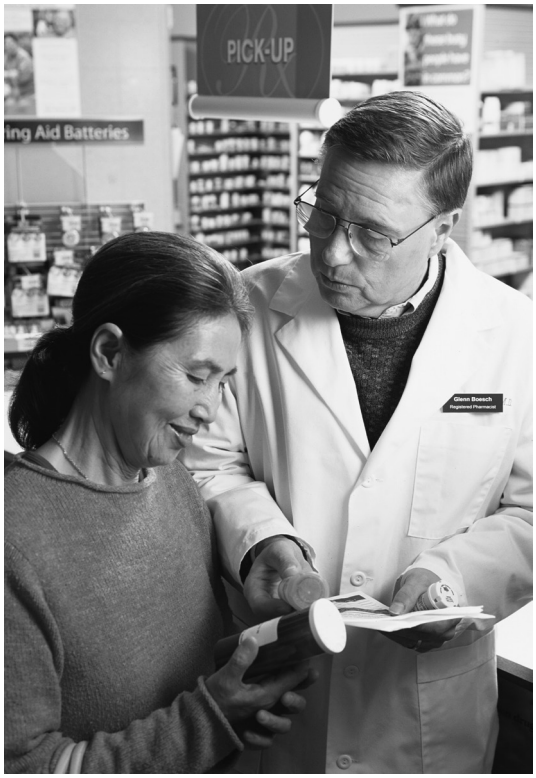
For more information on your appeal rights, how to file an appeal, and how to appoint a representative to help you:

- Visit Medicare.gov/appeals.
- Visit Medicare.gov/publications to view or print the booklet "Medicare Appeals."
- Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

Learn more about Medicare prescription drug coverage

To find out more about Medicare prescription drug coverage:

- Visit Medicare.gov/part-d.
- Visit Medicare.gov/publications to view or print "Your Guide to Medicare's Prescription Drug Coverage."
- Visit Medicare.gov/find-a-plan to find and compare plans in your area. Have your Medicare card, a list of your drugs and their dosages, and the name of the pharmacy you use available.
- Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.
- Call your State Health Insurance Assistance Program (SHIP) to get personalized help. Visit shiptacenter.org, or call 1-800-MEDICARE to get the phone number.



Section 4: Get the help you need

Help if you have limited income & resources

Extra Help paying your Medicare prescription drug costs

If you meet certain income and resource limits, you may qualify for Extra Help from Medicare to help pay the costs of Medicare prescription drug coverage. You should apply even if you aren't sure if you qualify.

Visit socialsecurity.gov/i1020 to apply for Extra Help online.

For more information:

- Visit Medicare.gov, and select "Get help paying costs" under "Your Medicare Costs."
- Visit socialsecurity.gov, and select "Medicare" under "Benefits."
- Call Social Security at 1-800-772-1213. TTY users should call 1-800-325-0778. You can apply for Extra Help by phone or ask for a paper application.
- Contact your State Medical Assistance (Medicaid) office. Visit Medicare.gov/contacts, or call 1-800-MEDICARE (1-800-633-4227) to get the phone number. TTY users should call 1-877-486-2048.

Words in red are defined on pages 21–25.

State Pharmacy Assistance Programs (SPAPs)

Many states have SPAPs that help certain people pay for prescription drugs. Each SPAP makes its own rules on how to help its members. To find out if there's an SPAP in your state and how it works:

- Visit Medicare.gov/pharmaceutical-assistance-program/state-programs.aspx.
- Call your State Health Insurance Assistance Program (SHIP). Visit shiptacenter.org, or call 1-800-MEDICARE (1-800-633-4227) to get the phone number. TTY users should call 1-877-486-2048.

Medicare Savings Programs

If you have limited income and resources, you may be able to get help from your state to pay your Medicare costs (like premiums, deductibles, and coinsurance) if you meet certain conditions.

For more information:

- Visit Medicare.gov, and select "Get help paying costs" under "Your Medicare Costs."
- Contact your State Medical Assistance (Medicaid) office, and ask for information on Medicare Savings Programs. Call even if you aren't sure if you qualify. To get the phone number for your state, visit Medicare.gov/contacts, or call 1-800-MEDICARE.
- Visit Medicare.gov/publications to view or print the brochure "Get Help With Your Medicare Costs: Getting Started."
- Call your State Health Insurance Assistance Program (SHIP). Visit shiptacenter.org, or call 1-800-MEDICARE to get the phone number.

Medicaid

Medicaid is a joint federal and state program that helps with medical costs for some people with limited income and resources. Medicaid also offers some benefits not normally covered by Medicare, like custodial nursing home care and personal care services. Each state has different rules about eligibility and applying for Medicaid.

For more information:

- Visit Medicare.gov, and select "Get help paying costs" under "Your Medicare Costs."
- To see if you qualify, call your State Medical Assistance (Medicaid) office. Visit Medicare.gov/contacts, or call 1-800-MEDICARE (1-800-633-4227) to get the phone number. TTY users should call 1-877-486-2048.
- To learn about the Medicaid program, visit Medicare.gov/publications to view or print the brochure "Medicaid: Getting Started."

Your Medicare rights

No matter how you get Medicare, you generally have certain rights and protections. All people with Medicare have the right to:

- Be treated with dignity and respect at all times.
- Be protected from discrimination.
- Have their personal and health information kept private.
- Get a decision about health care payment, coverage of services, or prescription drug coverage.

To learn more about your Medicare rights:

- Visit Medicare.gov, and select "Your Medicare rights" under "Claims & Appeals."
- Visit Medicare.gov/publications to view or print the booklet "Medicare Rights & Protections."

Your Medicare appeal rights

An appeal is an action you can take if you disagree with a coverage or payment decision by Medicare, your Medicare health plan, or your Medicare Prescription Drug Plan. If you decide to file an appeal, ask your doctor, health care provider, or supplier for any information that may help your case. Keep a copy of everything you send to Medicare or your plan as part of the appeal.

For more information:

- Visit Medicare.gov/appeals.
- Visit Medicare.gov/publications to view or print the booklet "Medicare Appeals."
- Call 1-800-MEDICARE.

Mental health resources

If you or someone you know is in crisis:

- Call the National Suicide Prevention Lifeline at 1-800-273-TALK (1-800-273-8255). You can talk to a crisis counselor 24 hours a day, 7 days a week. TTY users should call 1-800-799-4TTY (1-800-799-4889).

For more information about Medicare mental health benefits and coverage:

- Visit Medicare.gov, or call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.
- Call your State Health Insurance Assistance Program (SHIP). Visit shiptacenter.org, or call 1-800-MEDICARE to get the phone number.

If you're in an immediate medical crisis, call 911.

Talk to your doctor or other health care provider if you have questions or concerns about your mental health, to find out more about mental health, or to find mental health treatment. You can also visit mentalhealth.gov, or one of these resources:

National Institute of Mental Health (NIMH), National Institutes of Health (NIH)

- Visit nimh.nih.gov.
- Call 1-866-615-6464. TTY users should call 1-866-415-8051.
- Email nimhinfo@nih.gov.

Substance Abuse and Mental Health Services Administration (SAMHSA)

- Visit samhsa.gov. SAMHSA has a treatment facility locator and a mental health services locator on its website.
- Call 1-877-SAMHSA-7 (1-877-726-4727). TTY users should call 1-800-487-4889.
- Email SAMHSAInfo@samhsa.hhs.gov.

Mental Health America

- Visit mentalhealthamerica.net.
- Call 1-800-969-6642. TTY users should call 1-800-433-5959.
- Email info@mentalhealthamerica.net.

National Alliance on Mental Illness (NAMI)

- Visit nami.org.
- Call the Information Helpline at 1-800-950-NAMI (1-800-950-6264).
- Email info@nami.org.

National Council for Behavioral Health

- Visit www.thenationalcouncil.org.
- Call 1-202-684-7457.
- Email Communications@thenationalcouncil.org.

Section 5: Definitions

Appeal—An appeal is the action you can take if you disagree with a coverage or payment decision made by Medicare, your Medicare health plan, or your Medicare Prescription Drug Plan. You can appeal if Medicare or your plan denies one of these:

- Your request for a health care service, supply, item, or prescription drug that you think you should be able to get
- Your request for payment of a health care service, supply, item, or prescription drug you already got
- Your request to change the amount you must pay for a health care service, supply, item, or prescription drug

You can also appeal if Medicare or your plan stops providing or paying for all or part of a health care service, supply, item, or prescription drug you think you still need.

Assignment—An agreement by your doctor, provider, or other supplier to be paid directly by Medicare, to accept the payment amount Medicare approves for the service, and not to bill you for any more than the Medicare deductible and coinsurance.

Benefit period—The way that Original Medicare measures your use of hospital and skilled nursing facility (SNF) services. A benefit period begins the day you're admitted as an inpatient in a hospital or SNF. The benefit period ends when you haven't received any inpatient hospital care (or skilled care in a SNF) for 60 days in a row. If you go into a hospital or a SNF after one benefit period has ended, a new benefit period begins. You must pay the inpatient hospital deductible for each benefit period. There's no limit to the number of benefit periods.

Coinsurance—An amount you may be required to pay as your share of the cost for services after you pay any deductibles. Coinsurance is usually a percentage (for example, 20%).

Copayment—An amount you may be required to pay as your share of the cost for a medical service or supply, like a doctor's visit, hospital outpatient visit, or prescription drug. A copayment is usually a set amount, rather than a percentage. For example, you might pay $10 or $20 for a doctor's visit or prescription drug.

Coverage determination (Part D)—The first decision made by your Medicare drug plan (not the pharmacy) about your drug benefits, including:

- Whether a particular drug is covered
- Whether you've met all the requirements for getting a requested drug
- How much you're required to pay for a drug
- Whether to make an exception to a plan rule when you request it

The drug plan must give you a prompt decision (72 hours for standard requests, 24 hours for expedited requests). If you disagree with the plan's coverage determination, the next step is an appeal.

Deductible—The amount you must pay for health care or prescriptions before Original Medicare, your prescription drug plan, or your other insurance begins to pay.

Exception—A type of Medicare prescription drug coverage determination. A formulary exception is a drug plan's decision to cover a drug that's not on its drug list or to waive a coverage rule. A tiering exception is a drug plan's decision to charge a lower amount for a drug that's on its non-preferred drug tier. You or your prescriber must request an exception, and your doctor or other prescriber must provide a supporting statement explaining the medical reason for the exception.

Formulary—A list of prescription drugs covered by a prescription drug plan or another insurance plan offering prescription drug benefits. Also called a drug list.

Lifetime reserve days—In Original Medicare, these are additional days that Medicare will pay for when you're in a hospital for more than 90 days. You have a total of 60 reserve days that can be used during your lifetime. For each lifetime reserve day, Medicare pays all covered costs except for a daily coinsurance.

Medically necessary—Health care services or supplies needed to diagnose or treat an illness, injury, condition, disease, or its symptoms and that meet accepted standards of medicine.

Medicare Advantage Plan (Part C)—A type of Medicare health plan offered by a private company that contracts with Medicare to provide you with all your Part A and Part B benefits. Medicare Advantage Plans include Health Maintenance Organizations, Preferred Provider Organizations, Private Fee-for-Service Plans, Special Needs Plans, and Medicare Medical Savings Account Plans. If you're enrolled in a Medicare Advantage Plan, Medicare services are covered through the plan and aren't paid for under Original Medicare. Most Medicare Advantage Plans offer prescription drug coverage.

Medicare-approved amount—In Original Medicare, this is the amount a doctor or supplier that accepts assignment can be paid. It may be less than the actual amount a doctor or supplier charges. Medicare pays part of this amount and you're responsible for the difference.

Medicare health plan—Generally, a plan offered by a private company that contracts with Medicare to provide Part A and Part B benefits to people with Medicare who enroll in the plan. Medicare health plans include all Medicare Advantage Plans, Medicare Cost Plans, and Demonstration/Pilot Programs. Programs of All-inclusive Care for the Elderly (PACE) organizations are special types of Medicare health plans that can be offered by public or private entities and provide Part D and other benefits in addition to Part A and Part B benefits.

Medicare Part A (Hospital Insurance)—Part A covers inpatient hospital stays, care in a skilled nursing facility, hospice care, and some home health care.

Medicare Part B (Medical Insurance)—Part B covers certain doctors' services, outpatient care, medical supplies, and preventive services.

Medicare prescription drug coverage (Part D)—Optional benefits for prescription drugs available to all people with Medicare for an additional charge. This coverage is offered by insurance companies and other private companies approved by Medicare.

Medicare Prescription Drug Plan (Part D)—Part D adds prescription drug coverage to Original Medicare, some Medicare Cost Plans, some Medicare Private-Fee-for-Service Plans, and Medicare Medical Savings Account Plans. These plans are offered by insurance companies and other private companies approved by Medicare. Medicare Advantage Plans may also offer prescription drug coverage that follows the same rules as Medicare Prescription Drug Plans.

Medigap policy—Medicare Supplement Insurance sold by private insurance companies to fill "gaps" in Original Medicare coverage.

Original Medicare—Original Medicare is a fee-for-service health plan that has 2 parts: Part A (Hospital Insurance) and Part B (Medical Insurance). After you pay a deductible, Medicare pays its share of the Medicare-approved amount, and you pay your share (coinsurance and deductibles).

Premium—The periodic payment to Medicare, an insurance company, or a health care plan for health or prescription drug coverage.

Prior authorization—Approval that you must get from a Medicare drug plan before you fill your prescription in order for the prescription to be covered by your plan. Your Medicare drug plan may require prior authorization for certain drugs.

State Health Insurance Assistance Program (SHIP)—A state program that gets money from the federal government to give free local health insurance counseling to people with Medicare.

State Medical Assistance (Medicaid) office—A state or local agency that can give information about, and assist with applications for, Medicaid programs that help pay medical bills for people with limited income and resources.

Step therapy—A coverage rule used by some Medicare Prescription Drug Plans that requires you to try one or more similar, lower cost drugs to treat your condition before the plan will cover the prescribed drug.

Tiers—Groups of drugs that have a different cost for each group. Generally, a drug in a lower tier will cost you less than a drug in a higher tier.

Notes

U.S. DEPARTMENT OF
HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services
7500 Security Blvd.
Baltimore, MD 21244-1850

Official Business
Penalty for Private Use, $300

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