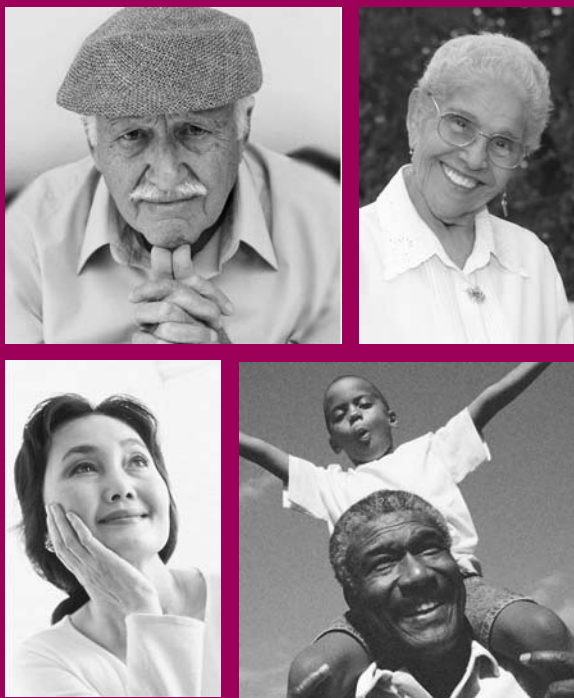




CENTERS FOR MEDICARE & MEDICAID SERVICES

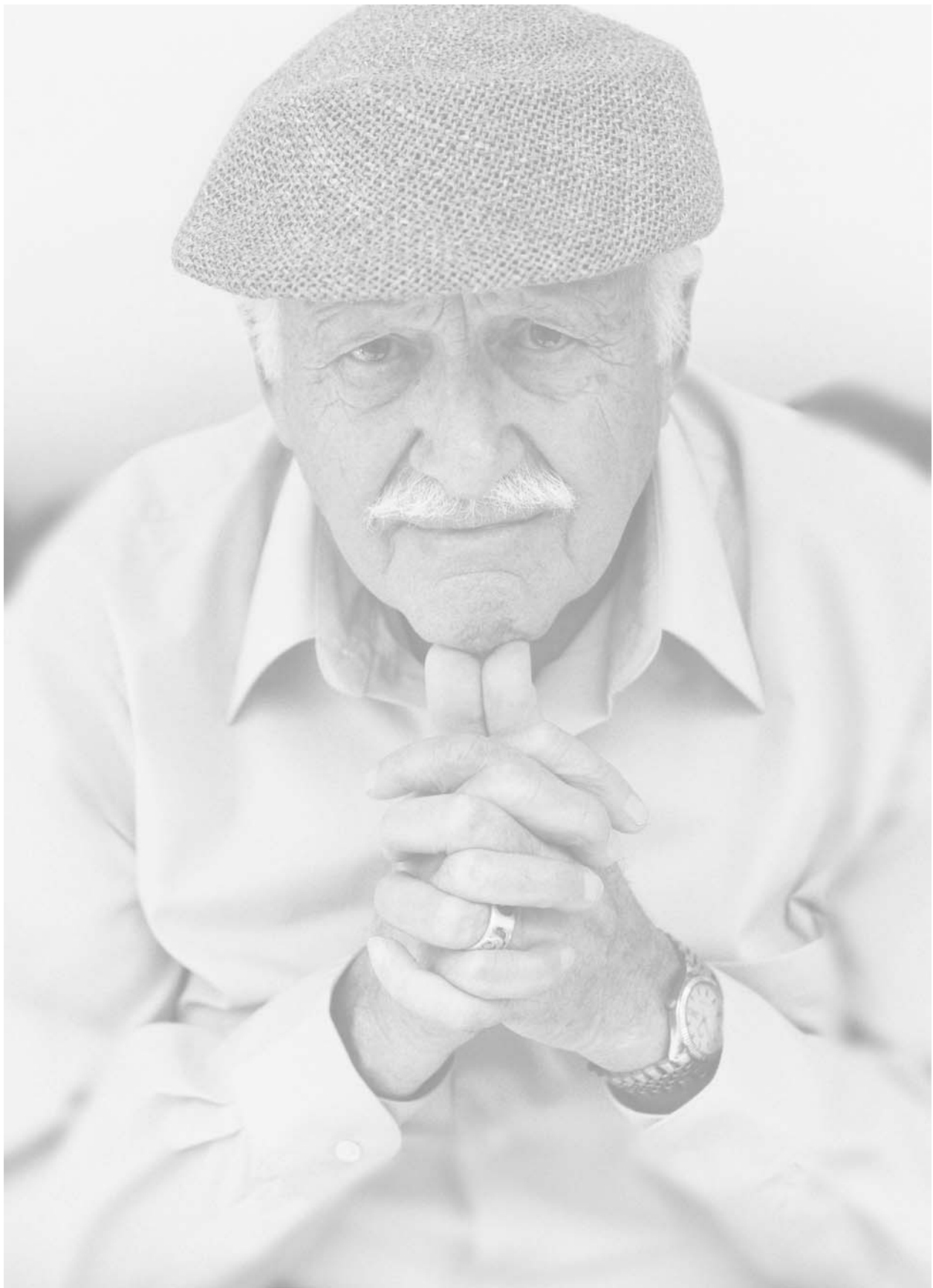


Medicare and Your Mental Health Benefits

This is the official government booklet about Medicare mental health benefits for people in the Original Medicare Plan. This booklet has important information including

- ★ who is eligible
- ★ outpatient benefits
- ★ inpatient benefits
- ★ prescription drug coverage
- ★ help for people with limited income and resources
- ★ where to get the help you need





“Medicare and Your Mental Health Benefits” isn’t a legal document. Official Medicare Program legal guidance is contained in relevant statutes, regulations, and rulings.

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The information, telephone numbers, and web addresses in this booklet were correct at the time of printing. Changes may occur after printing. To get the most up-to-date information and Medicare telephone numbers, visit www.medicare.gov on the web. Or, call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

Introduction

Mental health care and Medicare

Mental health conditions like depression or anxiety can come at any age and can happen to anyone. If you think you are having problems that are affecting your mental health, you can get help. Talk to your doctor if you have any of the following:

- Sad, empty, or hopeless feelings
- A lack of energy
- Trouble concentrating
- Difficulty sleeping
- Little interest in things you used to enjoy
- Thoughts of ending your life

Mental health care includes services and programs to help diagnose and treat mental health conditions. These services and programs may be given in outpatient and inpatient settings. Medicare helps cover outpatient and inpatient mental health care, as well as prescription drugs. This booklet gives you information about mental health benefits in the **Original Medicare Plan**.

If you get your Medicare benefits through a **Medicare Health Plan**, other than the Original Medicare Plan, check your plan's membership materials and call the plan for details about how the plan provides your Medicare-covered mental health benefits.

How mental health benefits are paid in the Original Medicare Plan

Words in **red** are defined on pages 18–20.

Medicare Part B (Medical Insurance) helps cover mental health services that you would generally get outside a hospital, including visits with a doctor, psychiatrist or other doctor, visits with a clinical psychologist, or clinical social worker, and lab tests ordered by your doctor. Medicare Part B may also pay for partial hospitalization services, if you need intensive coordinated outpatient care. See page 5 for more information about partial hospitalization services.

Medicare Part A (Hospital Insurance) helps cover mental health care if you are a hospital inpatient. Medicare Part A covers your room, meals, nursing, and other related services and supplies.

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

Section 1: Outpatient Mental Health Care and Professional Services

What the Original Medicare Plan covers

If you are in the **Original Medicare Plan** and have **Medicare Part B (Medical Insurance)**, Medicare helps cover visits with these types of health professionals:

- A psychiatrist or other doctor
- Clinical psychologist
- Clinical social worker
- Clinical nurse specialist
- Nurse practitioner
- Physician's assistant

It's important to know that Medicare only covers these visits when they are given by a health care professional who accepts Medicare payment. **To further reduce the amount you have to pay, you should also ask your health professional if they accept assignment before you schedule an appointment. See page 4.**

Medicare Part B helps cover outpatient mental health services. This includes services that are usually given outside a hospital (like in a clinic, or doctor's or therapist's office), and those that are given in a hospital's outpatient department. Medicare helps cover the following services*:

- Individual and group therapy with doctors or certain other licensed professionals allowed by the state to give these services
- Family counseling if the main purpose is to help with your treatment
- Testing to help find out if you are getting the right services and if your treatment is helping
- Psychiatric evaluation
- Medication management
- Occupational therapy that is part of your mental health treatment
- Certain prescription drugs that aren't usually self-administered, like some injections
- Individual patient training and education about your condition
- Diagnostic tests
- A screening for mental health conditions during the one-time "Welcome to Medicare" physical exam (**Note:** This physical exam is only covered if you have it within the first 6 months you have Medicare Part B.)
- Partial hospitalization may be covered. See page 5.

* **deductibles** and **coinsurance** apply

Section 1: Outpatient Mental Health Care and Professional Services

What you have to pay*

After you pay your yearly **Medicare Part B deductible** (\$135 in 2008), the amount of **coinsurance** you pay for mental health services will depend on the kind of service you get. For visits to a doctor to diagnose a mental health condition, or to monitor or change your drug prescription for mental health conditions, you will generally pay 20% of the Medicare-approved amount. For outpatient treatment of your mental health condition (such as therapy), you will have to pay about 50% of the Medicare-approved amount. Medicare will send you a notice showing what you owe. Talk to your doctor or other health care provider if you need help understanding your outpatient mental health benefits. See page 17 for additional help.

Words in **red** are defined on pages 18–20.

If you get your services in a hospital outpatient clinic, or in an outpatient department of a hospital, you will have to pay a separate **copayment** or coinsurance amount to the hospital. This amount will vary depending on the service provided, but won't exceed 40% of the Medicare-approved amount.

Getting treatment from a doctor or provider who is enrolled with Medicare and who accepts “assignment” can reduce your out-of-pocket costs. If a doctor or provider accepts assignment, they agree to the following conditions:

- To be paid by Medicare
- To accept only the amount Medicare approves for their services
- To only charge you, or other insurance you may have, the Medicare deductible or coinsurance amount

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Section 1: Outpatient Mental Health Care and Professional Services

Partial hospitalization may be covered

Partial hospitalization is a structured program of mental health care that is 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. These programs are given through hospital outpatient departments and local community mental health centers.

Your doctor or therapist may think that you could get help from a partial hospitalization program. Under certain conditions, Medicare helps cover this kind of care. For a partial hospitalization program to be covered, a doctor must say that you would otherwise need inpatient treatment. To be covered, your doctor and the program must accept Medicare payment.

What isn't covered by the Original Medicare Plan

Medicare doesn't cover the cost of the following:

- Meals
- Transportation to or from mental health care services
- Support groups that bring people together to talk and socialize (Unlike group therapy, which is covered. See page 3.)
- Testing or training for job skills that isn't part of your mental health treatment

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



Section 2: Inpatient Mental Health Care

What the Original Medicare Plan covers

If you are in the **Original Medicare Plan** and have **Medicare Part A (Hospital Insurance)**, Medicare helps pay for mental health services given in a hospital that require you to be admitted as an inpatient. These services can be given in a general hospital, or in a psychiatric hospital that only provides care for people with mental health conditions. Regardless of which type of hospital you choose, Medicare Part A will cover mental health services.

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

What you have to 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 go into a hospital or skilled nursing facility for either physical or mental health care. The benefit period ends after you haven't received hospital or skilled nursing care for 60 days in a row. If you go into a hospital after 60 days, a new benefit period begins and you must pay a new inpatient hospital **deductible** (\$1,024 in 2008).

There is 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 remember, there is a lifetime limit of 190 days.)

For each benefit period you pay (in 2008) the following:

- \$1,024 deductible and no **coinsurance** for days 1–60 each benefit period
- \$256 per day for days 61–90 each benefit period
- \$512 per “**lifetime reserve day**” after day 90 of each benefit period (up to 60 days over your lifetime)

Note: **Medicare Part B** helps cover doctor's and therapist's services if you are admitted as a hospital inpatient. You will have to pay a **copayment** or a coinsurance for these services while you are an inpatient in a hospital.

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Words in **red** are defined on pages 18–20.

Section 2: Inpatient Mental Health Care

What isn't covered by the Original Medicare Plan

Medicare doesn't cover the cost of private duty nursing, a telephone or television in your room, personal items (like toothpaste, socks, or razors) or a private room unless medically necessary.

Note: If you have Medigap or other health insurance coverage, be sure to tell your doctor or other health care provider so your bills can be paid correctly.

Section 3: Medicare Prescription Drug Coverage (Medicare Part D)

About Medicare prescription drug coverage

Medicare offers prescription drug coverage for everyone with Medicare. Medicare prescription drug coverage gives you access to drugs that you may need to stay physically and mentally healthy. To get Medicare prescription drug coverage, you must join a **Medicare 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 drugs covered.

Medicare drug plans have special rules

The Formulary

Words in **red** are defined on pages 18–20.

Almost all Medicare drug plans have a list of drugs that the plan covers. This list is called a **formulary**. In general, Medicare drug plans are not required to cover every drug, as long as they cover all drugs that are medically necessary. However, all Medicare drug plans are required to cover all or almost all anti-depressant, 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 medically-necessary drugs and that it doesn't discriminate against certain groups (like people with disabilities or mental health conditions).

There are certain drugs that Medicare drug plans aren't required to cover, such as benzodiazepines, barbiturates, or drugs for weight loss or gain. Some Medicare drug plans may choose to pay for these drugs as an added benefit. Also, some states may cover these drugs if you have Medicaid. See page 14 for more information about Medicaid. In addition, Medicare drug plans generally aren't allowed to cover over-the-counter drugs. Be sure to ask your doctor and your plan any questions you may have about the drugs you need.

The formulary can change

A Medicare drug plan can make some changes to its formulary during the year according to guidelines set by Medicare. If you are currently taking a drug and the plan's formulary changes, you will be notified before the change is made and the drug would usually be covered for you for the rest of the plan year. The cost of a drug can also change during the year, but established **copayments** should remain the same.

Section 3: Medicare Prescription Drug Coverage (Medicare Part D)

Medicare drug plans have special rules (continued)

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

Words in red are defined on pages 18–20.

If you belong to a **Medicare drug plan**, you have the right to:

- Get a written explanation (called a “**coverage determination**”) from your Medicare drug plan if your plan won't cover or pay for a certain prescription drug you need, or if you are asked to pay more than you think you should pay for a drug.
- Ask your Medicare drug plan for an **exception** which is a type of coverage determination. If you ask for an exception, your doctor must give your drug plan a supporting statement that says why you need the drug you are requesting. You can ask for an exception if:
 - You or your doctor believe you need a drug that isn't on your drug plan's list of covered drugs.
 - You or your doctor believe that a coverage rule (such as prior authorization) should be waived.
 - You believe you should get a drug you need at a lower copayment because you can't take any of the drugs on the drug plan's list of preferred drugs.

You or your doctor must contact your plan to ask for a coverage determination. If your network pharmacy can't fill a prescription as written, the pharmacist will give or show you a notice that explains how to contact your Medicare drug plan so you can make your request.

A standard request for a coverage determination (including an exception) must be made in writing (unless your plan accepts requests by phone). You or your doctor can also call or write your plan for an expedited (fast) request. **If you are requesting an exception, your prescribing doctor must provide a statement explaining the medical reason for the request (such as why similar drugs covered by your plan won't work or may be harmful to you).**

Once your Medicare drug plan gets your request for a coverage determination or your doctor's statement (if you are requesting an exception), the Medicare drug plan has 72 hours (for a standard request) or 24 hours (for an expedited request) to notify you of its decision.

Section 3: Medicare Prescription Drug Coverage (Medicare Part D)

Medicare drug plans have special rules (continued)

What if my doctor thinks I need a certain drug that my plan doesn't cover? (continued)

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. You should read this decision carefully.

For more information on Medicare appeal rights, look at your "Medicare & You" handbook or the "Your Medicare Rights and Protections" booklet. You can view or download these booklets by visiting www.medicare.gov on the web. Under "Search Tools," select "Find a Medicare Publication." Or, 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 look in your "Medicare & You" handbook or the "Your Guide to Medicare's Prescription Drug Coverage" booklet. You can view or download these booklets by visiting www.medicare.gov on the web. You can also learn more about Medicare prescription drug coverage and get personalized help comparing Medicare Prescription Drug Plans by:

- visiting www.medicare.gov on the web. Under "Search Tools," select "Compare **Medicare Prescription Drug Plans**."
- calling 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.
- calling your **State Health Insurance Assistance Program** (SHIP). To get their number call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048. Or, visit www.medicare.gov on the web. Under "Search Tools," select "Find Helpful Phone Numbers and Websites." Then, search by the word "organization" or "SHIP."

Have your Medicare card, a list of your drugs and their dosages, and the name of the pharmacy you use available.



Section 4: Getting the Help You Need

Medicare is here to help you get the information you need.

This section includes information about the following:

- Help for people with limited income and resources
- Your rights as a person with Medicare
- Your Medicare **appeal** rights
- Information about mental health
- Words to know

Help for people with limited income and resources

Extra Help Paying for Medicare Prescription Drug Coverage

You may qualify for “extra help” (low-income subsidy) from Medicare to pay prescription drug costs if you have a yearly income (in 2007) below \$15,315 (\$20,535 for a married person living with a spouse and no other dependents) and resources (in 2007) less than \$11,710 (\$23,410 for a married person living with a spouse). For more information, look at your “Medicare and You” handbook or call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

State Pharmacy Assistance Programs

Several states have **State Pharmacy Assistance Programs (SPAPs)** that help certain people pay for prescription drugs. Each SPAP makes its own rules about how to provide drug coverage to its members. Depending on your state, the SPAP will have different ways of helping you pay your prescription drug costs. To find out about the SPAPs in your state, call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

Words in **red** are defined on pages 18–20.

Section 4: Getting the Help You Need

Help for people with limited income and resources (continued)

Medicaid

Medicaid is a joint Federal and state program that helps pay medical costs for some people with limited income and resources. Some people qualify for both Medicare and Medicaid.

- Most of your health care costs are covered if you have Medicare and Medicaid.
- Medicaid programs vary from state to state. They may also be called by different names, like “Medical Assistance” or “Medi-Cal.”
- People with Medicaid may get coverage for services that aren’t fully covered by Medicare, such as nursing home and home health care.
- The income limits for Medicaid vary from state to state.

Call your State Medical Assistance (Medicaid) office to see if you qualify or for more information about Medicaid. Visit www.medicare.gov on the web or call 1-800-MEDICARE (1-800-633-4227) to get the telephone number for your State Medical Assistance office. TTY users should call 1-877-486-2048.

Section 4: Getting the Help You Need

Help for people with limited income and resources (continued)

Medicare Savings Programs (Help from Medicaid to pay Medicare premiums)

States have programs for people with limited income and resources that pay Medicare premiums and, in some cases, may also pay **Medicare Part A** and Part B **deductibles** and **coinsurance**. These programs help millions of people with Medicare save money each year.

To qualify for a **Medicare Savings Program**, you must meet the following conditions:

- Have Medicare Part A.
- Have resources of \$4,000 or less for an individual, or combined resources of \$6,000 or less for a married couple. Resources include money in a checking or savings account, stocks, and bonds. Resources don't include your home, car, burial plot, up to \$1,500 for burial expenses, furniture, or other household items.
- Have a monthly income of less than \$1,169 for an individual, or a combined monthly income of less than \$1,561 for a married couple.

Note: These rates are for 2007. Individual states may have higher income and/or resource limits, or they may have no resource limits. Income limits will increase slightly in 2008 or if you have other dependents in your household.

Words in **red** are defined on pages 18–20.

Call your State Medical Assistance (Medicaid) office or your **State Health Insurance Assistance Program (SHIP)**. Since the names of these programs may vary by state, ask for information on Medicare Savings Programs. It's very important to call if you think you qualify for any of these programs, even if you aren't sure. To get the number for your state, call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048. Or, visit www.medicare.gov on the web. Under "Search Tools," select "Find Helpful Phone Numbers and Websites."

Section 4: Getting the Help You Need

Your rights as a person with Medicare

As a person with Medicare, you have certain guaranteed rights. Your rights include the right to participate in treatment decisions, to know your treatment choices, and to have your personal and health information kept private. You also have the right to **appeal** decisions about your Medicare services (see below). These rights and protections are described in your “Medicare & You” handbook or the “Your Medicare Rights and Protections” booklet. You can view or download these booklets by visiting www.medicare.gov on the web. Under “Search Tools,” select “Find a Medicare Publication.” Or, call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

Your Medicare appeal rights

If you think Medicare should pay for something and Medicare doesn't pay, you can **appeal**. For more information about your Medicare appeal rights and how to ask for an appeal, you can

- look at the “Medicare & You” handbook or “Your Medicare Rights and Protections” booklet. Visit www.medicare.gov on the web. Under “Search Tools,” select “Find a Medicare Publication.”
- call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.
- visit www.medicare.gov on the web and select “Medicare Appeals.”
- look on the back of your Medicare Summary Notice that is mailed to you from the company that handles claims for the **Original Medicare Plan**.

Section 4: Getting the Help You Need

Information about mental health

If you have questions or concerns about your mental health talk to your doctor or other health care provider.

For more information about Medicare mental health benefits and coverage

- 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 the telephone number for the program in your area call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048. Have your zip code ready. Or, visit www.medicare.gov on the web. Under “Search Tools,” select “Find Helpful Phone Numbers and Websites.” Then, select “organization” and search for “SHIP.”

Words in **red** are defined on pages 18–20.

To find out more about mental health or to find mental health treatment in your community, talk to your doctor or other health care provider. You can also contact the following organizations:

- National Alliance on Mental Illness (NAMI)—Visit www.nami.org on the web. Or, you can call the HelpLine at 1-800-950-NAMI (1-800-950-6264), or email NAMI at info@nami.org on the web.
- Mental Health America—Visit www.mentalhealthamerica.net on the web, or call 1-800-969-6642. TTY users should call 1-800-433-5959.
- Substance Abuse & Mental Health Services Administration (SAMHSA)—Visit www.samhsa.gov on the web. SAMHSA has a treatment facility locator and a mental health services locator on its website.
- National Institute of Mental Health, National Institutes of Health—Visit www.nimh.nih.gov on the web.
- National Council on Community Behavioral Healthcare—Visit www.nccbh.org on the web.

If you need help, call **The National Suicide Prevention Lifeline at 1-800-273-TALK (8255)**.

Why should I call the Lifeline?

From an immediate suicidal crisis to information about mental health, crisis centers are equipped to take a wide range of calls. You can call 1-800-273-TALK:

- to speak with someone who cares.
- if you feel you might be in danger of hurting yourself.
- to find referrals to mental health services in your area.
- to speak to a crisis worker about someone you’re concerned about.

Section 4: Getting the Help You Need

Words to know

Appeal—A special kind of complaint you make 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 you request a health care service, supply, or prescription that you think you should be able to get, or if you request payment for health care you already got, and Medicare or your plan denies the request. You can also appeal if you are already getting coverage and Medicare or the plan stops paying.

Benefit Period—The way that the Original Medicare Plan measures your use of hospital and skilled nursing facility (SNF) services. A benefit period begins the day you go to a hospital or skilled nursing facility. 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 skilled nursing facility after one benefit period has ended, a new benefit period begins. You must pay the inpatient hospital deductible for each benefit period. There is no limit to the number of benefit periods, although inpatient mental health care in a psychiatric hospital is limited to 190 days in a lifetime.

Coinsurance—An amount you may be required to pay for services after you pay any plan deductibles. In the Original Medicare Plan, this is a percentage (like 20% or 50%) of the Medicare-approved amount. You have to pay this amount after you pay the Part A and/or Part B deductible. In a Medicare Prescription Drug Plan, the coinsurance will vary by plan and will depend on how much you have spent.

Copayment—An amount you pay in some Medicare health and prescription drug plans, for each medical service, like a doctor's visit, or prescription. A copayment is usually a set amount. For example, you could pay \$10 or \$20 for a doctor's visit or prescription. Copayments are lower for people with Medicaid and people who qualify for extra help. Copayments are also used for some hospital outpatient services in the Original Medicare Plan.

Section 4: Getting the Help You Need

Words to know (continued)

Coverage Determination (Part D)—The first decision made by a Medicare drug plan (not the pharmacy) about the drug benefits you may be entitled to get, including decisions about the following:

- Whether or not to provide or pay for a Part D drug
- An exception request you may have made
- The amount you have been asked to pay for a drug
- Whether you have satisfied a coverage rule for a requested drug

If the drug plan doesn't give you a prompt decision, and you can show that the delay would affect your health, the plan's failure to act is considered to be a coverage determination. If you disagree with the coverage determination, the next step is an appeal.

Deductible—The amount you must pay for health care or prescriptions, before the Original Medicare Plan, your prescription drug plan, or other insurance begins to pay. For example, in the Original Medicare Plan, you pay a new deductible for each benefit period for Part A and each year for Part B. These amounts can change every year. People who qualify for extra help either pay no deductible, or a small deductible for prescription drug coverage.

Exception—A type of coverage determination. A formulary exception is a decision to cover a drug that's not on the formulary or a decision to waive a coverage rule. A tiering exception is a decision to charge you a lower amount for a drug that is on the plan's non-preferred drug tier. Your doctor must send a supporting statement explaining the medical reason for the exception.

Formulary—A list of drugs covered by a Medicare Prescription Drug Plan.

Lifetime Reserve Days—In the Original Medicare Plan, these are additional days that Medicare will pay for when you are 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.

Section 4: Getting the Help You Need

Words to know (continued)

Medicare Health Plan — A Medicare Advantage Plan (such as an HMO, PPO, or Private Fee-for-Service Plan) or other plan such as a Medicare Cost Plan. Everyone who has Medicare Part A and Part B is eligible for a plan in their area, except those who have End-Stage Renal Disease (unless certain exceptions apply).

Medicare Part A (Hospital Insurance) — The part of Medicare that covers inpatient hospital stays, skilled nursing facility care, home health care, and hospice care.

Medicare Part B (Medical Insurance) — The part of Medicare that covers doctors' services and outpatient hospital care. It also covers other medical services that Part A doesn't cover, like physical and occupational therapy.

Medicare Prescription Drug Plan (Part D) — A stand-alone drug plan that adds prescription drug coverage to the Original Medicare Plan, 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 must follow the same rules as Medicare Prescription Drug Plans.

Medicare Savings Program — Medicaid program that helps people with limited income and resources pay some or all of their Medicare premiums and deductibles.

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

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

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 Pharmacy Assistance Program (SPAP) — A state program that provides help paying for drug coverage based on financial need, age, or medical condition.

**U.S. DEPARTMENT OF
HEALTH AND HUMAN SERVICES**

Centers for Medicare & Medicaid Services

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You can also get this booklet by visiting www.medicare.gov on the web. Under “Search Tools,” select “Find a Medicare Publication.” Search on the keywords “mental health.”

To get this booklet in Spanish, call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

*My Health.
My Medicare.*

¿Necesita usted una copia de esta guía en Español?
Llame GRATIS al 1-800-MEDICARE (1-800-633-4227).
Los usuarios de TTY deberán llamar al 1-877-486-2048.