



# 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



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.

The information in this booklet describes the Medicare Program at the time this booklet was printed. Changes may occur after printing. Visit [Medicare.gov](https://www.Medicare.gov), or call 1-800-MEDICARE (1-800-633-4227) to get the most current information. TTY users can 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 can call 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.**

# 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 (like you 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.

Words in red  
are defined on  
pages 21–23.



# Section 1: Outpatient mental health care & professional services

## What **Original Medicare** covers

Medicare Part B (Medical Insurance) helps cover mental health visits you would get from a doctor and services you generally get outside of a hospital, like:

- Psychiatrist or other doctor
- Clinical psychologist
- Clinical social worker
- Clinical nurse specialist
- Nurse practitioner
- Physician assistant
- Lab tests ordered by your doctor

An assignment is 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. Doctors and psychiatrists who participate in Part B must accept assignment. Ask your doctor or psychiatrist if they accept assignment before you schedule an appointment. Some health professionals, like clinical social workers and clinical nurse specialists, must always accept assignment. **Deductibles** and **coinsurance** may apply.

Part B may also pay for partial hospitalization services if you need intensive coordinated outpatient care.

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 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. Visit [Medicare.gov/coverage/depression-screenings](https://www.medicare.gov/coverage/depression-screenings) for more information.

Words in **red** are defined on pages 21–23.

- 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.
- 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.) Visit [Medicare.gov/coverage/welcome-to-medicare-preventive-visit](https://www.Medicare.gov/coverage/welcome-to-medicare-preventive-visit) for more information.
- 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. Visit [Medicare.gov/coverage/yearly-wellness-visits](https://www.Medicare.gov/coverage/yearly-wellness-visits) for more information.

### **Opioid use disorder treatment services**

Medicare covers opioid use disorder treatment services provided by opioid treatment programs. The services include medication, counseling, drug testing, and individual and group therapy. Counseling and therapy services are covered in person and by virtual delivery (using 2-way audio/video communication technology). Talk to your doctor or other health care provider to find out where you can go for these services. For more information, visit [Medicare.gov/coverage/opioid-use-disorder-treatment-services](https://www.Medicare.gov/coverage/opioid-use-disorder-treatment-services).



## Alcohol misuse screening & counseling

Medicare covers one alcohol misuse screening per year for adults with Medicare (including pregnant women) who use alcohol, but don't meet the medical criteria for alcohol dependency. If your health care provider determines you're misusing alcohol, you can get up to 4 brief face-to-face counseling sessions per year (if you're competent and alert during counseling). You must get counseling in a primary care setting (like a doctor's office).

If you have a substance use disorder or a co-occurring mental health disorder, you can get telehealth services from home.

These outpatient services are usually provided outside a hospital (like in a clinic, doctor's office, or therapist's office) or in a hospital's outpatient department. Partial hospitalization services can be provided in a hospital outpatient department or community mental health center. For more information, visit [Medicare.gov/coverage/alcohol-misuse-screenings-counseling](https://www.Medicare.gov/coverage/alcohol-misuse-screenings-counseling).

## 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.

Under Original Medicare, you pay nothing for opioid use disorder treatment services if you get them from an opioid treatment program who's enrolled in Medicare.

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.

For alcohol misuse screening and counseling, you pay nothing if the doctor or other qualified health care provider accepts assignment.

**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.

For more information on outpatient mental health care services, visit [Medicare.gov/coverage/mental-health-care-outpatient](https://www.Medicare.gov/coverage/mental-health-care-outpatient).

## 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.

Along with your partial hospitalization services, Medicare may also cover:

- Occupational therapy that's part of your mental health treatment
- Individual patient training and education about your condition
- Individual or group therapy
- Family counseling (when the main purpose is treatment of your condition)
- Activity therapy
- Diagnostic services
- Certain drugs

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.

For more information on partial hospitalization services, visit [Medicare.gov/coverage/mental-health-care-partial-hospitalization](https://www.Medicare.gov/coverage/mental-health-care-partial-hospitalization).

## What you pay

You pay a percentage of the **Medicare-approved amount** for each service you get 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, and the Part B deductible applies.

## What **Original Medicare** doesn't cover

- Meals.
- Transportation to or from mental health care services.
- Activity therapy that's for recreation or to divert attention from other issues.
- 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 cover 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 inpatient mental health services.

Part A covers your:

- Room
- Meals
- Nursing care
- Therapy or other treatment for your condition
- Lab tests
- Medications
- Other related services and supplies

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.

For more information, visit [Medicare.gov/coverage/mental-health-care-inpatient](https://www.Medicare.gov/coverage/mental-health-care-inpatient).

### 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.

Words in **red** are defined on pages 21–23.

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.

As a hospital inpatient, you pay these amounts in 2020:

- \$1,408 **deductible** for each benefit period
- Days 1–60: \$0 **coinsurance** per day of each benefit period
- Days 61–90: \$352 coinsurance per day of each benefit period
- Days 91 and beyond: \$704 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/your-medicare-costs](https://www.Medicare.gov/your-medicare-costs).

Part B covers certain doctors' services, outpatient care, medical supplies, and preventive services. This includes 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.

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.** You can write down the names of your current prescriptions and doses on page 16.

Visit [Medicare.gov/plan-compare](https://www.Medicare.gov/plan-compare) 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. For example, changes may include immediately removing a drug from the plan's formulary if the Food and Drug Administration (FDA) deems the drug unsafe, or the drug's manufacturer removes the drug from the market. Plans can also, in certain cases, immediately remove a brand name drug from their formularies if the plan adds a new generic in place of the brand drug, or plans can change the cost or coverage rules for a brand name drug when adding the new generic drug. If you're currently taking one of these drugs, you'll get information about the specific changes. For other changes involving a drug you're currently taking that will affect you during the year, your plan must do one of these:

- Give you notice at least 30 days before the date the change becomes effective; or
- At the time you request a refill, provide notice of the change and a month's supply of the drug under the same plan rules as before the change.

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

If you're in a Medicare drug plan, you have the right to ask for 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.

For more information on your appeal rights, see page 19 of this booklet.

## Learn more about Medicare prescription drug coverage

To find out more about **Medicare prescription drug coverage**:

- Visit [Medicare.gov/part-d](https://www.Medicare.gov/part-d).
- Visit [Medicare.gov/publications](https://www.Medicare.gov/publications) to view or print “Your Guide to Medicare’s Prescription Drug Coverage.”
- Visit [Medicare.gov/plan-compare](https://www.Medicare.gov/plan-compare) 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 can call 1-877-486-2048.



- Call your State Health Insurance Assistance Program (SHIP) to get personalized help. Visit [shiptacenter.org](https://www.shiptacenter.org), or call 1-800-MEDICARE to get the phone number.





## Section 4: Income, rights & resources

### 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](https://socialsecurity.gov/i1020) to apply for Extra Help online.

For more information:

- Visit [Medicare.gov/your-medicare-costs/get-help-paying-costs](https://www.medicare.gov/your-medicare-costs/get-help-paying-costs).
- Call Social Security at 1-800-772-1213. TTY users can 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](https://www.medicare.gov/contacts), or call 1-800-MEDICARE (1-800-633-4227) to get the phone number. TTY users can call 1-877-486-2048.

**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](https://www.Medicare.gov/pharmaceutical-assistance-program/state-programs.aspx).
- Call your State Health Insurance Assistance Program (SHIP). Visit [shiptacenter.org](https://www.shiptacenter.org), or call 1-800-MEDICARE (1-800-633-4227) to get the phone number. TTY users can 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/your-medicare-costs/get-help-paying-costs](https://www.Medicare.gov/your-medicare-costs/get-help-paying-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](https://www.Medicare.gov/contacts), or call 1-800-MEDICARE.
- Visit [Medicare.gov/publications](https://www.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](https://www.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/your-medicare-costs/get-help-paying-costs/medicaid](https://www.medicare.gov/your-medicare-costs/get-help-paying-costs/medicaid).
- To see if you qualify, call your State Medical Assistance (Medicaid) office. Visit [Medicare.gov/contacts](https://www.medicare.gov/contacts), or call 1-800-MEDICARE (1-800-633-4227) to get the phone number. TTY users can call 1-877-486-2048.
- To learn about the Medicaid program, visit [Medicare.gov/publications](https://www.medicare.gov/publications) to view or print the brochure “Medicaid: Getting Started.”

## 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 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](https://www.medicare.gov/appeals).
- Visit [Medicare.gov/publications](https://www.medicare.gov/publications) to view or print the booklet “Medicare Appeals.”
- Call 1-800-MEDICARE.

All people with Medicare have certain rights and protections. For more information, visit [Medicare.gov/claims-appeals/your-medicare-rights](https://www.medicare.gov/claims-appeals/your-medicare-rights).

## 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 can call 1-800-799-4889.

### For more information about Medicare mental health benefits and coverage:

- Visit [Medicare.gov](https://www.medicare.gov), or call 1-800-MEDICARE (1-800-633-4227). TTY users can call 1-877-486-2048.
- Call your State Health Insurance Assistance Program (SHIP). Visit [shiptacenter.org](https://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](https://www.mentalhealth.gov), or one of these resources:

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

- Visit [nimh.nih.gov](https://www.nimh.nih.gov).
- Call 1-866-615-6464. TTY users can call 1-866-415-8051.
- Email [nimhinfo@nih.gov](mailto:nimhinfo@nih.gov).

### Substance Abuse and Mental Health Services Administration (SAMHSA)

- Visit [samhsa.gov](https://www.samhsa.gov). To find treatment facilities in your area, visit [findtreatment.samhsa.gov](https://www.findtreatment.samhsa.gov).
- Call 1-877-SAMHSA-7 (1-877-726-4727). TTY users can call 1-800-487-4889.

### Mental Health America

- Visit [mentalhealthamerica.net](https://www.mentalhealthamerica.net).
- Call 1-800-969-6642. TTY users can call 1-800-433-5959.

### National Alliance on Mental Illness (NAMI)

- Visit [nami.org](https://www.nami.org).
- Call the Information Helpline at 1-800-950-NAMI (1-800-950-6264).

### National Council for Behavioral Health

- Visit [thenationalcouncil.org](https://www.thenationalcouncil.org).
- Call 1-202-684-7457.
- Email [Communications@thenationalcouncil.org](mailto:Communications@thenationalcouncil.org).

## Section 5: Definitions

**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.

**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. PACE plans 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 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.







## **CMS Accessible Communications**

To help ensure people with disabilities have an equal opportunity to participate in our services, activities, programs, and other benefits, we provide communications in accessible formats. The Centers for Medicare & Medicaid Services (CMS) provides free auxiliary aids and services, including information in accessible formats like Braille, large print, data/audio files, relay services and TTY communications. If you request information in an accessible format from CMS, you won't be disadvantaged by any additional time necessary to provide it. This means you'll get extra time to take any action if there's a delay in fulfilling your request.

To request Medicare or Marketplace information in an accessible format you can:

**1. Call us:**

For Medicare: 1-800-MEDICARE (1-800-633-4227)

TTY: 1-877-486-2048

**2. Email us:** [altformatrequest@cms.hhs.gov](mailto:altformatrequest@cms.hhs.gov)

**3. Send us a fax:** 1-844-530-3676

**4. Send us a letter:**

Centers for Medicare & Medicaid Services Offices of Hearings  
and Inquiries (OHI)

7500 Security Boulevard, Mail Stop S1-13-25

Baltimore, MD 21244-1850

Attn: Customer Accessibility Resource Staff

Your request should include your name, phone number, type of information you need (if known), and the mailing address where we should send the materials. We may contact you for additional information.

Note: If you're enrolled in a Medicare Advantage Plan or Medicare Prescription Drug Plan, contact your plan to request its information in an accessible format. For Medicaid, contact your State or local Medicaid office.

## **Nondiscrimination Notice**

The Centers for Medicare & Medicaid Services (CMS) doesn't exclude, deny benefits to, or otherwise discriminate against any person on the basis of race, color, national origin, disability, sex, or age in admission to, participation in, or receipt of the services and benefits under any of its programs and activities, whether carried out by CMS directly or through a contractor or any other entity with which CMS arranges to carry out its programs and activities.

You can contact CMS in any of the ways included in this notice if you have any concerns about getting information in a format that you can use.

You may also file a complaint if you think you've been subjected to discrimination in a CMS program or activity, including experiencing issues with getting information in an accessible format from any Medicare Advantage Plan, Medicare Prescription Drug Plan, State or local Medicaid office, or Marketplace Qualified Health Plans. There are three ways to file a complaint with the U.S. Department of Health and Human Services, Office for Civil Rights:

**1. Online:**

[hhs.gov/civil-rights/filing-a-complaint/complaint-process/index.html](https://hhs.gov/civil-rights/filing-a-complaint/complaint-process/index.html).

**2. By phone:**

Call 1-800-368-1019. TDD user can call 1-800-537-7697.

**3. In writing:** Send information about your complaint to:

Office for Civil Rights

U.S. Department of Health and Human Services

200 Independence Avenue, SW

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**Centers for Medicare & Medicaid Services**

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