SECTION 2

Find out if Medicare covers your test, service, or item

What services does Medicare cover?

Medicare Part A and Part B cover certain medical services and supplies in hospitals, doctors' offices, and other health care settings. Prescription drug coverage is provided through Medicare Part D.

If you have both Part A and Part B, you can get all of the Medicare-covered services listed in this section, whether you have Original Medicare or a Medicare health plan.

Important! To get Medicare-covered Part A and/or Part B services, you must be a U.S. citizen or be lawfully present in the U.S.

What does Part A cover?

Part A (Hospital Insurance) helps cover:

- Inpatient care in a hospital
- Inpatient care in a skilled nursing facility (not custodial or long-term care)
- Hospice care
- Home health care
- Inpatient care in a religious nonmedical health care institution

You can find out if you have Part A by looking at your red, white, and blue Medicare card. If you have it, it will be listed as "HOSPITAL" and will have an effective date. If you have Original Medicare, you'll use this card to get your Medicare-covered services. If you join a Medicare health plan, in most cases, you must use the card from the plan to get your Medicare-covered services.

Note: Definitions of blue words are on pages 113–116.

What do I pay for Part A-covered services?

Copayments, coinsurance, or deductibles may apply for each service listed on the following pages. Visit **Medicare.gov**, or call 1-800-MEDICARE (1-800-633-4227) to get specific cost information. TTY users can call 1-877-486-2048.

If you're in a Medicare Advantage Plan or have other insurance (like a Medicare Supplement Insurance (Medigap) policy, or employer or union coverage), your copayments, coinsurance, or deductibles may be different. Contact the plans you're interested in to find out about the costs, or visit the Medicare Plan Finder at **Medicare.gov/find-a-plan**.

Part A-covered services

Blood

If the hospital gets blood from a blood bank at no charge, you won't have to pay for it or replace it. If the hospital has to buy blood for you, you must either pay the hospital costs for the first 3 units of blood you get in a calendar year or have the blood donated by you or someone else.

Home health services

You can use your home health benefits under Part A and/or Part B. See page 41 for more information about home health benefits.

Hospice care

To qualify for hospice care, a hospice doctor and your doctor (if you have one) must certify that you're terminally ill, meaning you have a life expectancy of 6 months or less. You must accept palliative care (for comfort) instead of care to cure your illness. You also must sign a statement choosing hospice care instead of other Medicare-covered treatments for your terminal illness and related conditions. Coverage includes:

- All items and services needed for pain relief and symptom management
- Medical, nursing, and social services
- Drugs
- Certain durable medical equipment
- Aide and homemaker services
- Other covered services, as well as services Medicare usually doesn't cover, like spiritual and grief counseling

A Medicare-certified hospice usually gives hospice care in your home or other facility where you live, like a nursing home.

Hospice care doesn't pay for your stay in a facility (room and board) unless the hospice medical team determines that you need short-term inpatient stays for pain and symptom management that can't be addressed at home. These stays must be in a Medicare-approved facility, like a hospice facility, hospital, or skilled nursing facility that contracts with the hospice. Medicare also covers inpatient respite care, which is care you get in a Medicare-approved facility so that your usual caregiver (family member or friend) can rest. You can stay up to 5 days each time you get respite care. Medicare will pay for covered services for health problems that aren't related to your terminal illness or related conditions. After 6 months, you can continue to get hospice care as long as the hospice medical director or hospice doctor recertifies (at a face-to-face meeting) that you're terminally ill.

- You pay nothing for hospice care.
- You pay a copayment of up to $5 per prescription for outpatient prescription drugs for pain and symptom management. In the rare case your drug isn't covered by the hospice benefit, your hospice provider should contact your Medicare drug plan to see if it's covered under Part D.
- You pay 5% of the Medicare-approved amount for inpatient respite care.

Original Medicare will cover your hospice care, even if you're in a Medicare Advantage Plan.

Hospital care (inpatient care)

Medicare covers semi-private rooms, meals, general nursing, and drugs as part of your inpatient treatment, and other hospital services and supplies. This includes care you get in acute care hospitals, critical access hospitals, inpatient rehabilitation facilities, long-term care hospitals, inpatient care as part of a qualifying clinical research study, and inpatient mental health care given in a psychiatric hospital or other hospital. This doesn't include private-duty nursing, a television or phone in your room (if there's a separate charge for these items), or personal care items, like razors or slipper socks. It also doesn't include a private room, unless medically necessary. If you have Part B, it generally covers 80% of the Medicare-approved amount for doctor's services you get while you're in a hospital.

- You pay a deductible and no coinsurance for days 1–60 of each benefit period.
- You pay coinsurance per day for days 61–90 of each benefit period.
- You pay coinsurance per "lifetime reserve day" after day 90 of each benefit period (up to 60 days over your lifetime).
- You pay all costs for each day after you use all the lifetime reserve days.
- Inpatient psychiatric care in a freestanding psychiatric hospital is limited to 190 days in a lifetime.

Am I an inpatient or outpatient?

Staying overnight in a hospital doesn't always mean you're an inpatient. Your doctor must order your hospital admission and the hospital must formally admit you for you to be inpatient. Without the formal inpatient admission, you're still an outpatient, even if you stay overnight in a regular hospital bed, and/or you're getting emergency department services, observation services, outpatient surgery, lab tests, or X-rays. **You or a family member should always ask the hospital and/or your doctor if you're an inpatient or an outpatient each day during your stay, since it affects what you pay and can affect whether you'll qualify for Part A coverage in a skilled nursing facility.**

A "Medicare Outpatient Observation Notice" (MOON) is a document that lets you know you're an outpatient in a hospital or critical access hospital. You must receive this notice if you're getting observation services as an outpatient for more than 24 hours. The MOON will tell you why you're an outpatient receiving observation services, rather than an inpatient. It will also let you know how this may affect what you pay while in the hospital, and for care you get after leaving the hospital.

Religious non-medical health care institution (inpatient care)

In these facilities, religious beliefs prohibit conventional and unconventional medical care. If you qualify for hospital or skilled nursing facility care, Medicare will only cover the inpatient, non-religious, non-medical items and services. Examples are room and board, or any items and services that don't require a doctor's order or prescription, like unmedicated wound dressings or use of a simple walker.

Skilled nursing facility care

Medicare covers semi-private rooms, meals, skilled nursing and rehabilitative services, and other medically necessary services and supplies furnished in a skilled nursing facility after a 3-day minimum, medically necessary, inpatient hospital stay for a related illness or injury. An inpatient hospital stay begins the day the hospital formally admits you as an inpatient based on a doctor's order and doesn't include the day you're discharged. You may get coverage of skilled nursing care or skilled therapy care if it's necessary to help improve or maintain your current condition.

To qualify for skilled nursing facility care coverage, your doctor must certify that you need daily skilled care (like intravenous injections or physical therapy) which, as a practical matter, can only be provided in a skilled nursing facility if you're an inpatient.

You pay:

- Nothing for the first 20 days of each benefit period
- Coinsurance per day for days 21–100 of each benefit period
- All costs for each day after day 100 in a benefit period

Visit **Medicare.gov** later this fall to find out what you'll pay for inpatient hospital stays and skilled nursing facility care in 2019.

Note: Medicare doesn't cover long-term care or custodial care.

Medicare Advantage Plans can't charge more than Original Medicare for skilled nursing facility care services.

What does Part B cover?

Medicare Part B (Medical Insurance) helps cover medically necessary doctors' services, outpatient care, home health services, durable medical equipment, mental health services, and other medical services. Part B also covers many preventive services. You can find out if you have Part B by looking at your red, white, and blue Medicare card. If you have it, it will be listed as "MEDICAL" and will have an effective date. See pages 30–49 for a list of common Part B-covered services and general descriptions. Medicare may cover some services and tests more often than the timeframes listed if needed to diagnose or treat a condition. To find out if Medicare covers a service not on this list, visit **Medicare.gov/coverage**, or call 1-800-MEDICARE (1-800-633-4227). TTY users can call 1-877-486-2048. For more details about Medicare covered services, visit **Medicare.gov/publications** to view the booklet "Your Medicare Benefits." Call 1-800-MEDICARE to find out if a copy can be mailed to you.

What do I pay for Part B-covered services?

The alphabetical list on the following pages gives general information about what you pay if you have Original Medicare and see doctors or other health care providers who accept assignment. See page 53. You'll pay more if you see doctors or providers who don't accept assignment. **If you're in a Medicare health plan or have other insurance, your costs may be different. Contact your plan or benefits administrator directly to find out about the costs.**

Under Original Medicare, if the Part B deductible ($183 in 2018) applies, you must pay all costs (up to the Medicare-approved amount) until you meet the yearly Part B deductible. After your deductible is met, Medicare begins to pay its share and you typically pay 20% of the Medicare-approved amount of the service, if the doctor or other health care provider accepts assignment. There's no yearly limit for what you pay out-of-pocket. Visit **Medicare.gov**, or call 1-800-MEDICARE to get specific cost information.

You pay nothing for most covered preventive services if you get the services from a doctor or other qualified health care provider who accepts assignment. However, for some preventive services, you may have to pay a deductible, coinsurance, or both. These costs may also apply if you get a preventive service in the same visit as a non-preventive service.

See page 60 to find out what affects your Medicare Advantage Plan costs.

Medicare Advantage Plans have a yearly limit on your out-of-pocket costs for medical services. See page 57.

Part B-covered services

You'll see this apple next to the preventive services on pages 30–49.

Abdominal aortic aneurysm screening

Medicare covers a one-time abdominal aortic aneurysm screening ultrasound for people at risk. You must get a referral from your doctor or other qualified health care practitioner. You pay nothing for the screening if the doctor or other qualified health care practitioner accepts assignment.

Note: If you have a family history of abdominal aortic aneurysms, or you're a man 65–75 and you've smoked at least 100 cigarettes in your lifetime, you're considered at risk.

Advance care planning

Medicare covers voluntary advance care planning as part of the yearly "Wellness" visit. This is planning for care you would want to get if you become unable to speak for yourself. You can talk about an advance directive with your health care professional, and he or she can help you fill out the forms, if you want to. An advance directive is an important legal document that records your wishes about medical treatment at a future time, if you're not able to make decisions about your care. You pay nothing if it's provided as part of the yearly "Wellness" visit and the doctor or other qualified health care provider accepts assignment.

Note: Medicare may also cover this service as part of your medical treatment. When advance care planning isn't part of your yearly "Wellness" visit, the Part B deductible and coinsurance apply.

Alcohol misuse screening and 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). You pay nothing if the doctor or other qualified health care provider accepts assignment.

Ambulance services

Medicare covers ground ambulance transportation when you need to be transported to a hospital, critical access hospital, or skilled nursing facility for medically necessary services, and transportation in any other vehicle could endanger your health. Medicare may pay for emergency ambulance transportation in an airplane or helicopter to a hospital if you need immediate and rapid ambulance transportation that ground transportation can't provide.

In some cases, Medicare may pay for limited, medically necessary, non-emergency ambulance transportation if you have a written order from your doctor stating that ambulance transportation is medically necessary. An example may be a medically necessary ambulance transport to a dialysis facility for someone with End-Stage Renal Disease (ESRD).

Medicare will only cover ambulance services to the nearest appropriate medical facility that's able to give you the care you need.

You pay 20% of the Medicare-approved amount, and the Part B deductible applies.

Ambulatory surgical centers

Medicare covers the facility service fees related to approved surgical procedures provided in an ambulatory surgical center (facility where surgical procedures are performed, and the patient is expected to be released within 24 hours). Except for certain preventive services (for which you pay nothing if the doctor or other health care provider accepts assignment), you pay 20% of the Medicare-approved amount to both the ambulatory surgical center and the doctor who treats you, and the Part B deductible applies. You pay all of the facility service fees for procedures Medicare doesn't cover in ambulatory surgical centers.

Behavioral health integration services

If you have a behavioral health condition (like depression, anxiety, or another behavioral health condition), Medicare may pay for a health care provider's help to manage that condition if your provider offers the Psychiatric Collaborative Care Model. The Psychiatric Collaborative Care Model is a set of integrated behavioral health services that includes care management support if you have a behavioral health condition. This care management support may include care planning for behavioral health conditions, ongoing assessment of your condition, medication support, counseling, or other treatments that your provider recommends. Your health care provider will ask you to sign an agreement for you to get this set of services on a monthly basis. You pay a monthly fee, and the Part B deductible and coinsurance apply.

Blood

If the provider gets blood from a blood bank at no charge, you won't have to pay for it or replace it. However, you'll pay a copayment for the blood processing and handling services for each unit of blood you get, and the Part B deductible applies. If the provider has to buy blood for you, you must either pay the provider costs for the first 3 units of blood you get in a calendar year, or have the blood donated by you or someone else.

Bone mass measurement (bone density)

This test helps to see if you're at risk for broken bones. It's covered once every 24 months (more often if medically necessary) for people who have certain medical conditions or meet certain criteria. You pay nothing for this test if the doctor or other qualified health care provider accepts assignment.

Breast cancer screening (mammograms)

Medicare covers screening mammograms to check for breast cancer once every 12 months for all women with Medicare who are 40 and older. Medicare covers one baseline mammogram for women between 35–39. You pay nothing for the test if the doctor or other qualified health care provider accepts assignment.

Note: Part B also covers diagnostic mammograms more frequently than once a year when medically necessary. You pay 20% of the Medicare-approved amount for diagnostic mammograms, and the Part B deductible applies.

Cardiac rehabilitation

Medicare covers comprehensive programs that include exercise, education, and counseling for patients who meet at least one of these conditions:

- A heart attack in the last 12 months
- Coronary artery bypass surgery
- Current stable angina pectoris (chest pain)
- A heart valve repair or replacement
- A coronary angioplasty (a medical procedure used to open a blocked artery) or coronary stenting (a procedure used to keep an artery open)
- A heart or heart-lung transplant
- Stable, chronic heart failure

Medicare also covers intensive cardiac rehabilitation programs that are typically more rigorous or more intense than regular cardiac rehabilitation programs. Services are covered in a doctor's office or hospital outpatient setting. You pay 20% of the Medicare-approved amount if you get the services in a doctor's office. In a hospital outpatient setting, you also pay the hospital a copayment. The Part B deductible applies.

Cardiovascular disease (behavioral therapy)

Medicare will cover one visit per year with a primary care doctor in a primary care setting (like a doctor's office) to help lower your risk for cardiovascular disease. During this visit, the doctor may discuss aspirin use (if appropriate), check your blood pressure, and give you tips to make sure you eat well. You pay nothing if the doctor or other qualified health care provider accepts assignment.

Cardiovascular disease screenings

These screenings include blood tests that help detect conditions that may lead to a heart attack or stroke. Medicare covers these screening tests once every 5 years to test your cholesterol, lipid, lipoprotein, and triglyceride levels. You pay nothing for the tests if the doctor or other qualified health care provider accepts assignment.

Cervical and vaginal cancer screenings

Part B covers Pap tests and pelvic exams to check for cervical and vaginal cancers. As part of the pelvic exam, Medicare also covers a clinical breast exam to check for breast cancer. Medicare covers these screening tests once every 24 months. Medicare covers these screening tests once every 12 months if you're at high risk for cervical or vaginal cancer, or if you're of child-bearing age and had an abnormal Pap test in the past 36 months.

Part B also covers Human Papillomavirus (HPV) tests (when received with a Pap test) once every 5 years if you're age 30–65 without HPV symptoms.

You pay nothing for the lab Pap test or for the lab HPV with Pap test if your doctor or other qualified health care provider accepts assignment. You also pay nothing for the Pap test specimen collection and pelvic and breast exams if the doctor or other qualified health care provider accepts assignment.

Chemotherapy

Medicare covers chemotherapy in a doctor's office, freestanding clinic, or hospital outpatient setting for people with cancer. You pay a copayment for chemotherapy in a hospital outpatient setting.

For chemotherapy given in a doctor's office or freestanding clinic, you pay 20% of the Medicare-approved amount, and the Part B deductible applies.

For chemotherapy in a hospital inpatient setting covered under Part A, see Hospital care (inpatient care) on pages 27–28.

> Visit the Eldercare Locator at **eldercare.acl.gov** to get help with advance directives.

Chiropractic services (limited coverage)

Medicare covers manipulation of the spine if medically necessary to correct a subluxation (when one or more of the bones of your spine move out of position) when provided by a chiropractor or other qualified provider. You pay 20% of the Medicare-approved amount, and the Part B deductible applies.

Note: Medicare doesn't cover other services or tests ordered by a chiropractor, including X-rays, massage therapy, and acupuncture. If you think your chiropractor is billing Medicare for services that aren't covered, you can report suspected Medicare fraud by calling 1-800-MEDICARE (1-800-633-4227). TTY users can call 1-877-486-2048.

Chronic care management services

If you have 2 or more serious, chronic conditions (like arthritis, asthma, diabetes, hypertension, heart disease, osteoporosis, and other conditions) that are expected to last at least a year, Medicare may pay for a health care provider's help to manage those conditions. This includes a comprehensive care plan that lists your health problems and goals, other health care providers, medications, community services you have and need, and other information about your health. It also explains the care you need and how your care will be coordinated. Your health care provider will ask you to sign an agreement to provide this service. If you agree, he or she will prepare the care plan, help you with medication management, provide 24/7 access for urgent care needs, give you support when you go from one health care setting to another, review your medicines and how you take them, and help you with other chronic care needs. You pay a monthly fee, and the Part B deductible and coinsurance apply.

Clinical research studies

Clinical research studies test how well different types of medical care work and if they're safe. Medicare covers some costs, like office visits and tests, in qualifying clinical research studies. You may pay 20% of the Medicare-approved amount, and the Part B deductible may apply.

Note: If you're in a Medicare Advantage Plan (like an HMO or PPO), some costs may be covered by Original Medicare and some may be covered by your Medicare Advantage Plan.

Colorectal cancer screenings

Medicare covers these screenings to help find precancerous growths or find cancer early, when treatment is most effective. One or more of these tests may be covered:

- **Multi-target stool DNA test**: This lab test is generally covered once every 3 years if you meet all of these conditions:
  - Are between ages 50–85.
  - Show no signs or symptoms of colorectal disease including, but not limited to, lower gastrointestinal pain, blood in stool, positive guaiac fecal occult blood test or fecal immunochemical test.
  - At average risk for developing colorectal cancer, meaning:
    - Have no personal history of adenomatous polyps, colorectal cancer, inflammatory bowel disease, including Crohn's Disease and ulcerative colitis.
    - Have no family history of colorectal cancer or adenomatous polyps, familial adenomatous polyposis, or hereditary nonpolyposis colorectal cancer.

You pay nothing for the test if the doctor or other qualified health care provider accepts assignment.

- **Screening fecal occult blood test**: This test is covered once every 12 months if you're 50 or older. You pay nothing for the test if the doctor or other qualified health care provider accepts assignment.
- **Screening flexible sigmoidoscopy**: This test is generally covered once every 48 months if you're 50 or older, or 120 months after a previous screening colonoscopy for those not at high risk. You pay nothing for the test if the doctor or other qualified health care provider accepts assignment.
- **Screening colonoscopy**: This test is generally covered once every 120 months (high risk every 24 months) or 48 months after a previous flexible sigmoidoscopy. There's no minimum age. You pay nothing for the test if the doctor or other qualified health care provider accepts assignment.
  Note: If a polyp or other tissue is found and removed during the colonoscopy, you may have to pay 20% of the Medicare-approved amount for the doctor's services and a copayment in a hospital outpatient setting. The Part B deductible doesn't apply.
- **Screening barium enema**: This test is generally covered once every 48 months if you're 50 or older (high risk every 24 months) when used instead of a sigmoidoscopy or colonoscopy. You pay 20% of the Medicare-approved amount for the doctor services. In a hospital outpatient setting, you also pay the hospital a copayment. The Part B deductible doesn't apply.

Continuous Positive Airway Pressure (CPAP) therapy

Medicare covers a 3-month trial of CPAP therapy if you've been diagnosed with obstructive sleep apnea. Medicare may cover it longer if you meet with your doctor in person, and your doctor documents in your medical record that the CPAP therapy is helping you.

You pay 20% of the Medicare-approved amount for rental of the machine and purchase of related supplies (like masks and tubing), and the Part B deductible applies. Medicare pays the supplier to rent the machine for 13 months if you've been using it without interruption. After you've rented the machine for 13 months, you own it.

Note: If you had a CPAP machine before you got Medicare, Medicare may cover rental or a replacement CPAP machine and/or CPAP accessories if you meet certain requirements.

Defibrillator (implantable automatic)

Medicare covers these devices for some people diagnosed with heart failure. If the surgery takes place in an outpatient setting, you pay 20% of the Medicare-approved amount for the doctor's services. If you get the device as a hospital outpatient, you also pay the hospital a copayment. In most cases, the copayment amount can't be more than the Part A hospital stay deductible. The Part B deductible applies. Part A covers surgeries to implant defibrillators in a hospital inpatient setting. See Hospital care (inpatient care) on pages 27–28.

Depression screening

Medicare covers one depression screening per year. The screening must be done in a primary care setting (like a doctor's office) that can provide follow-up treatment and referrals. You pay nothing for this screening if the doctor or other qualified health care provider accepts assignment.

Diabetes screenings

Medicare covers these screenings if your doctor determines you're at risk for diabetes or diagnosed with prediabetes. You may be eligible for up to 2 diabetes screenings each year. You pay nothing for the test if your doctor or other qualified health care provider accepts assignment.

New!

Medicare Diabetes Prevention Program

Prediabetes is a serious health condition where blood sugar levels are higher than normal, but not high enough yet to be diagnosed as having type 2 diabetes. Fortunately, type 2 diabetes can sometimes be delayed or prevented with health behavior changes. If you have prediabetes, losing even a small amount of weight if you're overweight and getting regular exercise can lower your risk for developing type 2 diabetes.

If you have Medicare Part B, have prediabetes, and meet other criteria, Medicare covers a proven health behavior change program to help you prevent diabetes. The program begins with at least 16 core sessions offered in a group setting over a 6-month period. After the core sessions, you may be eligible for additional monthly sessions will help you maintain healthy habits.

The diabetes prevention program sessions will include:

- Training to make realistic, lasting lifestyle changes
- Tips on how to get more exercise
- Strategies for controlling your weight
- A lifestyle coach, specially trained to help keep you motivated
- Support from people with similar goals and challenges

If you think you're at risk, ask your doctor to be tested for prediabetes to find out if you have the condition. If you qualify for the program, you can join a program at no out-of-pocket cost without a referral from your doctor. If you're in a Medicare Advantage Plan, contact your plan for more information.

Diabetes self-management training

Medicare covers diabetes outpatient self-management training to teach you to cope with and manage your diabetes. The program may include tips for eating healthy, being active, monitoring blood sugar, taking medication, and reducing risks. You must have diabetes and a written order from your doctor or other qualified health care provider who's treating your diabetes. You pay 20% of the Medicare-approved amount, and the Part B deductible applies.

Diabetes supplies

Medicare covers blood sugar testing monitors, blood sugar test strips, lancet devices and lancets, blood sugar control solutions, and therapeutic shoes (in some cases). Medicare only covers insulin if it's medically necessary and you use an external insulin pump to administer the insulin. You pay 20% of the Medicare-approved amount, and the Part B deductible applies.

Note: Medicare prescription drug coverage (Part D) may cover insulin, certain medical supplies used to inject insulin (like syringes), and some oral diabetes drugs. Check with your plan for more information.

Doctor and other health care provider services

Medicare covers medically necessary doctor services (including outpatient services and some doctor services you get when you're a hospital inpatient) and covered preventive services. Medicare also covers services provided by other health care providers, like physician assistants, nurse practitioners, clinical nurse specialists, certified nurse-midwives, clinical social workers, physical therapists, and clinical psychologists. Except for certain preventive services (for which you may pay nothing), you pay 20% of the Medicare-approved amount, and the Part B deductible applies.

Durable medical equipment (DME)

Medicare covers items like oxygen equipment and supplies, wheelchairs, walkers, and hospital beds ordered by a doctor or other health care provider enrolled in Medicare for use in the home. Some items must be rented. You pay 20% of the Medicare-approved amount, and the Part B deductible applies.

Make sure your doctors and DME suppliers are enrolled in Medicare. Doctors and suppliers have to meet strict standards to enroll and stay enrolled in Medicare. If your doctors or suppliers aren't enrolled, Medicare won't pay the claims they submit. It's also important to ask your suppliers if they participate in Medicare before you get DME. If suppliers are participating suppliers, they must accept assignment (that is, they're limited to charging you only coinsurance and the Part B deductible for the Medicare-approved amount). If suppliers aren't participating and don't accept assignment, there's no limit on the amount they can charge you. To find suppliers who accept assignment, visit **Medicare.gov/supplierdirectory** or call 1-800-MEDICARE (1-800-633-4227). TTY users can call 1-877-486-2048. You can also call 1-800-MEDICARE if you're having problems with your DME supplier, or you need to file a complaint.

For more information, visit **Medicare.gov/publications** to view the booklet "Medicare Coverage of Durable Medical Equipment and Other Devices."

EKG or ECG (electrocardiogram) screening

Medicare covers a one-time screening EKG/ECG if referred by your doctor or other health care provider as part of your one-time "Welcome to Medicare" preventive visit. See page 48. You pay 20% of the Medicare-approved amount, and the Part B deductible applies. An EKG/ECG is also covered as a diagnostic test. See page 46. If you have the test at a hospital or a hospital-owned clinic, you also pay the hospital a copayment.

Emergency department services

These services are covered when you have an injury, a sudden illness, or an illness that quickly gets much worse. You pay a specified copayment for the hospital emergency department visit, and you pay 20% of the Medicare-approved amount for the doctor's or other health care provider's services. The Part B deductible applies. However, your costs may be different if you're admitted to the hospital as an inpatient.

Eyeglasses (after cataract surgery)

Medicare covers one pair of eyeglasses with standard frames (or one set of contact lenses) after cataract surgery that implants an intraocular lens. You pay 20% of the Medicare-approved amount, and the Part B deductible applies.

Note: Medicare will only pay for contact lenses or eyeglasses provided by a supplier enrolled in Medicare, no matter who submits the claim (you or your provider).

Federally Qualified Health Center (FQHC) services

FQHCs provide many outpatient primary care and preventive health services. There's no deductible, and generally, you're responsible for paying 20% of the charges. You pay nothing for most preventive services. All FQHCs offer discounts if your income is limited. To find an FQHC near you, visit **findahealthcenter.hrsa.gov**.

Flu shots

Medicare covers one flu shot per flu season. You pay nothing for the flu shot if the doctor or other qualified health care provider accepts assignment for giving the shot.

Foot exams and treatment

Medicare covers foot exams and treatment if you have diabetes-related nerve damage and/or meet certain conditions. You pay 20% of the Medicare-approved amount, and the Part B deductible applies. In a hospital outpatient setting, you also pay the hospital a copayment.

Glaucoma tests

These tests are covered once every 12 months for people at high risk for the eye disease glaucoma. You're at high risk if you have diabetes, a family history of glaucoma, are African American and 50 or older, or are Hispanic and 65 or older. An eye doctor who's legally allowed by the state must do the tests. You pay 20% of the Medicare-approved amount, and the Part B deductible applies. In a hospital outpatient setting, you also pay the hospital a copayment.

Hearing and balance exams

Medicare covers these exams if your doctor or other health care provider orders them to see if you need medical treatment. You pay 20% of the Medicare-approved amount, and the Part B deductible applies. In a hospital outpatient setting, you also pay the hospital a copayment.

Note: Original Medicare doesn't cover hearing aids or exams for fitting hearing aids.

Hepatitis B shots

Medicare covers these shots for people at medium or high risk for Hepatitis B. Some risk factors include hemophilia, End-Stage Renal Disease (ESRD), diabetes, if you live with someone who has Hepatitis B, or if you're a health care worker and have frequent contact with blood or body fluids. Check with your doctor to see if you're at medium or high risk for Hepatitis B. You pay nothing for the shot if the doctor or other qualified health care provider accepts assignment.

Hepatitis B Virus (HBV) infection screening

Medicare covers HBV infection screenings if you meet one of these conditions:

- You're at high risk for HBV infection.
- You're pregnant.

Medicare will only cover HBV infection screenings if they're ordered by a primary care provider.

HBV infection screenings are covered:

- Annually only for those with continued high risk who don't get a Hepatitis B vaccination.
- For pregnant women:
  - At the first prenatal visit for each pregnancy.
  - At the time of delivery for those with new or continued risk factors.
  - At the first prenatal visit for future pregnancies, even if you previously got the Hepatitis B shot or had negative HBV screening results.

You pay nothing for the screening test if the doctor or other qualified health care provider accepts assignment.

Hepatitis C screening test

Medicare covers one Hepatitis C screening test if you meet one of these conditions:

- You're at high risk because you have a current or past history of illicit injection drug use.
- You had a blood transfusion before 1992.
- You were born between 1945–1965.

Medicare also covers yearly repeat screenings for certain people at high risk.

Medicare will only cover Hepatitis C screening tests if they're ordered by your health care provider. You pay nothing for the screening test if the doctor or other qualified health care provider accepts assignment.

HIV (Human Immunodeficiency Virus) screening

Medicare covers HIV screenings once every 12 months if you're:

- Between the ages of 15–65.
- Younger than 15 and older than 65, and at increased risk.

Note: Medicare also covers this test up to 3 times during a pregnancy.

You pay nothing for the HIV screening if the doctor or other qualified health care provider accepts assignment.

Home health services

You can use your home health benefits under Part A and/or Part B to pay for home health services. Medicare covers medically necessary part-time or intermittent skilled nursing care, and/or physical therapy, speech-language pathology services, or continued occupational therapy services. A doctor, or certain health care professionals who work with a doctor, must see you face-to-face before a doctor can certify that you need home health services. A doctor must order your care, and a Medicare-certified home health agency must provide it.

Home health services may also include medical social services, part-time or intermittent home health aide services, durable medical equipment, and medical supplies for use at home. You must be homebound, which means:

- You have trouble leaving your home without help (like using a cane, wheelchair, walker, or crutches; special transportation; or help from another person) because of an illness or injury.
- Leaving your home isn't recommended because of your condition.
- You're normally unable to leave your home because it's a major effort.

You pay nothing for covered home health services. You pay 20% of the Medicare-approved amount, and the Part B deductible applies, for Medicare-covered medical equipment.

Kidney dialysis services and supplies

Generally, Medicare covers 3 dialysis treatments per week if you have End-Stage Renal Disease (ESRD). This includes most ESRD-related drugs and biologicals, and all laboratory tests, home dialysis training, support services, equipment, and supplies. The dialysis facility is responsible for coordinating your dialysis services (at home or in a facility). You pay 20% of the Medicare-approved amount, and the Part B deductible applies.

Kidney disease education services

Medicare covers up to 6 sessions of kidney disease education services if you have Stage IV chronic kidney disease, and your doctor or other health care provider refers you for the service. You pay 20% of the Medicare-approved amount, and the Part B deductible applies.

Laboratory services

Medicare covers laboratory services including certain blood tests, urinalysis, certain tests on tissue specimens, and some screening tests. You generally pay nothing for these services.

Lung cancer screening

Medicare covers a lung cancer screening with Low Dose Computed Tomography (LDCT) once per year if you meet all of these conditions:

- You're 55–77.
- You're asymptomatic (don't have signs or symptoms of lung cancer).
- You're either a current smoker or have quit smoking within the last 15 years.
- You have a tobacco smoking history of at least 30 "pack years" (an average of one pack a day for 30 years).
- You get a written order from a doctor or other qualified health care provider.

You generally pay nothing for this service if the health care provider accepts assignment.

Note: Before your first lung cancer screening, you'll need to schedule an appointment with your doctor to discuss the benefits and risks of lung cancer screening. You and your doctor can decide whether lung cancer screening is right for you.

Medical nutrition therapy services

Medicare may cover medical nutrition therapy and certain related services if you have diabetes or kidney disease, or you've had a kidney transplant in the last 36 months, and your doctor or other health care provider refers you for the service. You pay nothing for these services if the doctor or other qualified health care provider accepts assignment.

Mental health care (outpatient)

Medicare covers mental health care services to help with conditions like depression or anxiety. Coverage includes services generally provided in an outpatient setting (like a doctor's or other health care provider's office, hospital outpatient department, or community mental health center), including visits with a psychiatrist or other doctor, clinical psychologist, nurse practitioner, physician assistant, clinical nurse specialist, or clinical social worker. Laboratory tests are also covered. Certain limits and conditions may apply.

Generally, you pay 20% of the Medicare-approved amount and the Part B deductible applies for mental health care services.

Note: Inpatient mental health care is covered under Part A.

Obesity screening and counseling

If you have a body mass index (BMI) of 30 or more, Medicare covers face-to-face individual behavioral therapy sessions to help you lose weight. This counseling may be covered if you get it in a primary care setting (like a doctor's office), where it can be coordinated with your other care and a personalized prevention plan. You pay nothing for this service if the doctor or other qualified health care provider accepts assignment.

Occupational therapy

Medicare covers evaluation and treatment to help you perform activities of daily living (like dressing or bathing) to maintain current capabilities or slow decline when your doctor or other health care provider certifies you need it. You pay 20% of the Medicare-approved amount, and the Part B deductible applies.

Outpatient hospital services

Medicare covers many diagnostic and treatment services in hospital outpatient departments. Generally, you pay 20% of the Medicare-approved amount for the doctor's or other health care provider's services. You may pay more for services you get in a hospital outpatient setting than you'll pay for the same care in a doctor's office. In addition to the amount you pay the doctor, you'll also usually pay the hospital a copayment for each service you get in a hospital outpatient setting, except for certain preventive services that don't have a copayment. In most cases, the copayment can't be more than the Part A hospital stay deductible for each service. The Part B deductible applies, except for certain preventive services. If you get hospital outpatient services in a critical access hospital, your copayment may be higher and may exceed the Part A hospital stay deductible.

Outpatient medical and surgical services and supplies

Medicare covers approved procedures like X-rays, casts, stitches, or outpatient surgeries. You pay 20% of the Medicare-approved amount for the doctor's or other health care provider's services. You generally pay the hospital a copayment for each service you get in a hospital outpatient setting. In most cases, for each service provided, the copayment can't be more than the Part A hospital stay deductible. The Part B deductible applies, and you pay all costs for items or services that Medicare doesn't cover.

Physical therapy

Medicare covers evaluation and treatment for injuries and diseases that change your ability to function, or to maintain current function or slow decline, when your doctor or other health care provider certifies your need for it. You pay 20% of the Medicare-approved amount, and the Part B deductible applies.

Pneumococcal shots

Medicare covers pneumococcal shots to help prevent pneumococcal infections (like certain types of pneumonia). The two shots protect against different strains of the bacteria. Medicare covers the first shot at any time, and also covers a different second shot if it's given one year (or later) after the first shot. Talk with your doctor or other health care provider to see if you need one or both of the pneumococcal shots. You pay nothing for these shots if the doctor or other qualified health care provider accepts assignment for giving the shots.

Prescription drugs (limited)

Medicare covers a limited number of drugs like injections you get in a doctor's office, certain oral anti-cancer drugs, drugs used with some types of durable medical equipment (like a nebulizer or external infusion pump), immunosuppressant drugs (see page 47), and, under very limited circumstances, certain drugs you get in a hospital outpatient setting. You pay 20% of the Medicare-approved amount for these covered drugs, and the Part B deductible applies.

If the covered drugs you get in a hospital outpatient setting are part of your outpatient services, you pay a copayment for the services. However, other types of drugs in a hospital outpatient setting (sometimes called "self-administered drugs" or drugs you'd normally take on your own) aren't covered by Part B. What you pay depends on whether you have Part D or other prescription drug coverage, whether your drug plan covers the drug, and whether the hospital's pharmacy is in your drug plan's network. Contact your prescription drug plan to find out what you pay for drugs you get in a hospital outpatient setting that aren't covered under Part B.

Other than the examples above, you pay 100% for most prescription drugs, unless you have Part D or other drug coverage. See pages 73–82 for more information about Part D.

Prostate cancer screenings

Medicare covers a Prostate Specific Antigen (PSA) test and a digital rectal exam once every 12 months for men over 50 (beginning the day after your 50th birthday). You pay nothing for the PSA test. For the digital rectal exam, you pay 20% of the Medicare-approved amount, and the Part B deductible applies. In a hospital outpatient setting, you also pay the hospital a copayment.

Prosthetic/orthotic items

Medicare covers arm, leg, back, and neck braces; artificial eyes; artificial limbs (and their replacement parts); some types of breast prostheses (after a mastectomy); and prosthetic devices needed to replace an internal body part or function (including ostomy supplies, and parenteral and enteral nutrition therapy) when ordered by a doctor or other health care provider enrolled in Medicare.

For Medicare to cover your prosthetic or orthotic, you must go to a supplier that's enrolled in Medicare. You pay 20% of the Medicare-approved amount, and the Part B deductible applies.

Pulmonary rehabilitation

Medicare covers a comprehensive pulmonary rehabilitation program if you have moderate to very severe chronic obstructive pulmonary disease (COPD) and have a referral from the doctor treating this chronic respiratory disease. You pay 20% of the Medicare-approved amount if you get the service in a doctor's office. You also pay the hospital a copayment per session if you get the service in a hospital outpatient setting. The Part B deductible applies.

Rural Health Clinic (RHC) services

RHCs furnish many outpatient primary care and preventive health services. RHCs are located in rural and underserved areas. Generally, you're responsible for paying 20% of the charges, and the Part B deductible applies. You pay nothing for most preventive services.

Second surgical opinions

Medicare covers second surgical opinions for surgery that isn't an emergency. In some cases, Medicare covers third surgical opinions. You pay 20% of the Medicare-approved amount, and the Part B deductible applies.

Sexually transmitted infection (STI) screening and counseling

Medicare covers STI screenings for chlamydia, gonorrhea, syphilis, and Hepatitis B. These screenings are covered if you're pregnant or at increased risk for an STI when the tests are ordered by a primary care provider. Medicare covers these tests once every 12 months or at certain times during pregnancy.

Medicare also covers up to 2 individual, 20–30 minute, face-to-face, high-intensity behavioral counseling sessions each year for sexually active adults at increased risk for STIs. Medicare will only cover these counseling sessions if they're provided by a primary care doctor or other primary care practitioner and take place in a primary care setting (like a doctor's office). Counseling conducted in an inpatient setting, like a skilled nursing facility, won't be covered as a preventive service.

You pay nothing for these services if the primary care doctor or other qualified health care provider accepts assignment.

Shots

Part B covers:

- Flu shots. See page 38.
- Hepatitis B shots. See page 39.
- Pneumococcal shots. See page 43.

Note about the shingles shot: The shingles shot isn't covered by Part A or Part B. Generally, Medicare Prescription Drug Plans (Part D) cover the shingles shot, as well as all commercially available vaccines needed to prevent illness. Contact your Medicare drug plan for more information about coverage.

Smoking and tobacco-use cessation (counseling to stop smoking or using tobacco products)

Medicare covers up to 8 face-to-face visits in a 12-month period. All people with Medicare who use tobacco are covered. You pay nothing for the counseling sessions if the doctor or other qualified health care provider accepts assignment.

Speech-language pathology services

Medicare covers evaluation and treatment to regain and strengthen speech and language skills, including cognitive and swallowing skills, or to maintain current function or slow decline, when your doctor or other health care provider certifies you need it. You pay 20% of the Medicare-approved amount, and the Part B deductible applies.

Surgical dressing services

Medicare covers medically necessary treatment of a surgical or surgically treated wound. You pay 20% of the Medicare-approved amount for the doctor's or other health care provider's services. You pay a fixed copayment for these services when you get them in a hospital outpatient setting. The Part B deductible applies. You pay nothing for the supplies.

Telehealth

Medicare covers services like office visits, psychotherapy, consultations, and certain other medical or health services provided using an interactive, two-way telecommunications system (like real-time audio and video) by an eligible provider who isn't at your location. These services are available in rural areas, under certain conditions, but only if you're located at: a doctor's office, hospital, critical access hospital, Rural Health Clinic, Federally Qualified Health Center, hospital-based dialysis facility, skilled nursing facility, or community mental health center. For most of these services, you'll pay the same amount that you would if you got the services in person.

Tests (other than lab tests)

Medicare covers X-rays, MRIs, CT scans, EKG/ECGs, and some other diagnostic tests. You pay 20% of the Medicare-approved amount, and the Part B deductible applies. If you get the test at a hospital as an outpatient, you also pay the hospital a copayment that may be more than 20% of the Medicare-approved amount, but, in most cases, this amount can't be more than the Part A hospital stay deductible. See Laboratory services on page 41 for other Part B-covered tests.

Transitional care management services

Medicare may cover this service if you're returning to your community after a stay at certain facilities, like a hospital or skilled nursing facility. The health care provider who's managing your transition back into the community will work to coordinate and manage your care for the first 30 days after you return home. He or she will work with you, your family, and caregiver(s), as appropriate, and other health care providers. You'll also be able to get an in-person office visit within 2 weeks of your return home. The health care provider may also review information on the care you received in the facility, provide information to help you transition back to living at home, work with other care providers, help you with referrals or arrangements for follow-up care or community resources, assist you with scheduling, and help you manage your medications. The Part B deductible and coinsurance apply.

Transplants and immunosuppressive drugs

Medicare covers doctor services for heart, lung, kidney, pancreas, intestine, and liver transplants under certain conditions but only in Medicare-certified facilities. Medicare also covers bone marrow and cornea transplants under certain conditions.

Note: The transplant surgery may be covered as a hospital inpatient service under Part A. See pages 27–28 for more information.

Medicare covers immunosuppressive drugs if the transplant was covered by Medicare or an employer or union group health plan was required to pay before Medicare paid for the transplant. You must have Part A at the time of the covered transplant, and you must have Part B at the time you get immunosuppressive drugs. You pay 20% of the Medicare-approved amount for the drugs, and the Part B deductible applies.

If you're thinking about joining a Medicare Advantage Plan (like an HMO or PPO) and are on a transplant waiting list or believe you need a transplant, check with the plan before you join to make sure your doctors, other health care providers, and hospitals are in the plan's network. Also, check the plan's coverage rules for prior authorization.

Note: Medicare drug plans (Part D) may cover immunosuppressive drugs if they aren't covered by Original Medicare.

Medicare pays the full cost of care for your kidney donor. You and your donor won't have to pay a deductible, coinsurance, or any other costs for their hospital stay.

Travel (health care needed when traveling outside the U.S.)

Medicare generally doesn't cover health care while you're traveling outside the U.S. (The "U.S." includes the 50 states, the District of Columbia, Puerto Rico, the U.S. Virgin Islands, Guam, the Northern Mariana Islands, and American Samoa.) There are some exceptions, including cases where Medicare may pay for services you get while on board a ship within the territorial waters adjoining the land areas of the U.S. Medicare may pay for inpatient hospital, doctor, or ambulance services you get in a foreign country in these rare cases:

- You're in the U.S. when an emergency occurs, and the foreign hospital is closer than the nearest U.S. hospital that can treat your medical condition.
- You're traveling through Canada without unreasonable delay by the most direct route between Alaska and another U.S. state when a medical emergency occurs, and the Canadian hospital is closer than the nearest U.S. hospital that can treat the emergency.
- You live in the U.S. and the foreign hospital is closer to your home than the nearest U.S. hospital that can treat your medical condition, regardless of whether an emergency exists.

Medicare may cover medically necessary ambulance transportation to a foreign hospital only with admission for medically necessary covered inpatient hospital services. You pay 20% of the Medicare-approved amount, and the Part B deductible applies.

Urgently needed care

Medicare covers urgently needed care to treat a sudden illness or injury that isn't a medical emergency. You pay 20% of the Medicare-approved amount for the doctor's or other health care provider's services, and the Part B deductible applies. In a hospital outpatient setting, you also pay the hospital a copayment.

"Welcome to Medicare" preventive visit

During the first 12 months that you have Part B, you can get a "Welcome to Medicare" preventive visit. This visit includes a review of your medical and social history related to your health, and education and counseling about preventive services, including certain screenings, flu and pneumococcal shots, and referrals for other care, if needed. When you make your appointment, let your doctor's office know that you'd like to schedule your "Welcome to Medicare" preventive visit. You pay nothing for the "Welcome to Medicare" preventive visit if the doctor or other qualified health care provider accepts assignment.

Important! If your doctor or other health care provider performs additional tests or services during the same visit that aren't covered under this preventive benefit, you may have to pay coinsurance, and the Part B deductible may apply.

Yearly "Wellness" visit

If you've had Part B for longer than 12 months, you can get a yearly "Wellness" visit to develop or update a personalized plan to prevent disease or disability based on your current health and risk factors. This visit is covered once every 12 months.

Your provider will ask you to fill out a questionnaire, called a "Health Risk Assessment," as part of this visit. Answering these questions can help you and your provider develop a personalized prevention plan to help you stay healthy and get the most out of your visit. When you make your appointment, let your doctor's office know that you'd like to schedule your yearly "Wellness" visit.

Note: Your first yearly "Wellness" visit can't take place within 12 months of your enrollment in Part B or your "Welcome to Medicare" preventive visit. However, you don't need to have had a "Welcome to Medicare" preventive visit to qualify for a yearly "Wellness" visit.

You pay nothing for the yearly "Wellness" visit if the doctor or other qualified health care provider accepts assignment.

Important! If your doctor or other health care provider performs additional tests or services during the same visit that aren't covered under this preventive benefit, you may have to pay coinsurance, and the Part B deductible may apply.

What's NOT covered by Part A and Part B?

Medicare doesn't cover everything. If you need certain services that aren't covered under Medicare Part A or Part B, you'll have to pay for them yourself unless:

- You have other coverage (including Medicaid) to cover the costs.
- You're in a Medicare Advantage Plan that covers these services.

Some of the items and services that Medicare doesn't cover include:

- ✖ Most dental care.
- ✖ Eye examinations related to prescribing glasses.
- ✖ Dentures.
- ✖ Cosmetic surgery.
- ✖ Massage therapy.
- ✖ Acupuncture.
- ✖ Hearing aids and exams for fitting them.
- ✖ Long-term care. See the next page for more information about paying for long-term care.
- ✖ Concierge care (also called concierge medicine, retainer-based medicine, boutique medicine, platinum practice, or direct care).

Some Medicare Advantage Plans may choose to cover these services. See page 65.

Paying for long-term care

Long-term care (sometimes called "long-term services and supports") includes non-medical care for people who have a chronic illness or disability. This includes non-skilled personal care assistance, like help with everyday activities, including dressing, bathing, and using the bathroom. **Medicare and most health insurance plans, including Medicare Supplement Insurance (Medigap) policies, don't pay for this type of care, sometimes called "custodial care." You may be eligible for this type of care through Medicaid, or you can choose to buy private long-term care insurance.** Long-term care can be provided at home, in the community, in an assisted living facility, or in a nursing home. It's important to start planning for long-term care now to maintain your independence and to make sure you get the care you may need, in the setting you want, in the future.

Long-term care resources

Use these resources to get more information about long-term care:

- Visit **longtermcare.gov** to learn more about planning for long-term care.
- Call your State Insurance Department to get information about long-term care insurance. Visit **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.
- Call the National Association of Insurance Commissioners at 1-866-470-6242 to get a copy of "A Shopper's Guide to Long-Term Care Insurance."
- Call your State Health Insurance Assistance Program (SHIP). See pages 109–112 for the phone number.
- Visit the Eldercare Locator, a public service of the U.S. Administration on Aging, at **eldercare.acl.gov** to find help in your community.