

Large Print Edition

Medicare Coverage of Diabetes Supplies, Services, & Prevention Programs

This **official government booklet** has important information about:

- What Medicare covers
- Ways to stay healthy
- Where to get information

[Medicare.gov](https://www.medicare.gov)



Medicare

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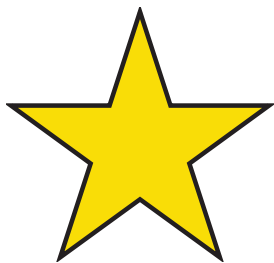
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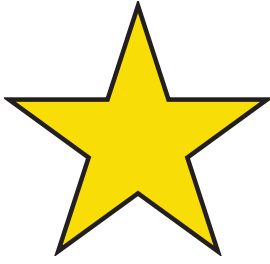
Section 1: Introduction

This booklet explains Medicare coverage of diabetes supplies and services in Original Medicare and Medicare drug coverage (Part D).

Medicare is the federal health insurance program for people 65 or older, certain people under 65 who have disabilities, and people with End-Stage Renal Disease (permanent kidney failure requiring dialysis or a transplant, sometimes called ESRD).

Original Medicare includes Part A (Hospital Insurance) and Part B (Medical Insurance). You can join a separate Medicare drug plan to get Medicare drug coverage (Part D). Medicare covers most—but not all—of the costs for approved health care services and supplies.

Medicare Advantage (also known as Part C) is a Medicare-approved plan from a private company that offers an alternative to Original Medicare for your health and drug coverage. These “bundled” plans include Part A, Part B, and usually Medicare drug coverage (Part D). If you’re in a Medicare Advantage Plan, contact your plan to find out more about coverage of diabetes supplies and services.



Section 2: Medicare Coverage for Diabetes at-a-Glance

This section provides an overview of some of the diabetes services and supplies covered by Medicare Part B (Medical Insurance) and Medicare drug coverage (Part D).

Anti-diabetic drugs

Go to page 31.

What Medicare covers

Part D covers anti-diabetic drugs to maintain blood sugar (glucose).

What you pay

- Coinsurance or copayment
- Part D deductible may also apply

Underlined words are defined on pages 49 – 50.

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Diabetes screenings

Go to pages 34 – 35.

What Medicare covers

Part B covers these screenings if your doctor determines you're at risk for diabetes. You may be eligible for up to 2 diabetes screenings each year.

What you pay

No coinsurance, copayment, or Part B deductible for screenings.

Medicare Diabetes Prevention Program

Go to pages 36 – 37.

What Medicare covers

Part B covers a once-per-lifetime health behavior change program to help you prevent diabetes.

What you pay

Nothing for these services if you're eligible.

Diabetes self-management training

Go to pages 37 – 40.

What Medicare covers

Part B covers diabetes self-management training services for people diagnosed with diabetes. For Medicare to cover these services, your doctor or other health care provider must order it, and an accredited individual or program must provide the services.

What you pay

20% of the **Medicare-approved amount** after the yearly Part B **deductible**.

Diabetes equipment & supplies

Go to pages 19 – 28.

What Medicare covers

Part B covers home blood sugar (glucose) monitors and the supplies you use with the equipment, including blood sugar test strips, lancet devices, and lancets.

There may be limits on how much or how often you get these supplies. Part B also covers insulin pumps that are considered durable medical equipment.

What you pay

- 20% of the Medicare-approved amount after the yearly Part B deductible.
- If you take insulin through a traditional pump that's covered under Medicare's durable medical equipment benefit, you don't have to pay more than \$35 for a month's supply of insulin. The Part B deductible doesn't apply.

Diabetes supplies

Go to page 31.

What Medicare covers

Part D covers certain medical supplies to administer insulin (like syringes, needles, alcohol swabs, gauze, and insulin pump devices that aren't covered under the Part B durable medical equipment benefit).

What you pay

- Coinsurance or copayment.
- Part D deductible may also apply.

Flu & pneumococcal shots

Go to page 43.

What Medicare covers

- **Flu shot:** Part B covers this shot once a flu season in the fall or winter to help prevent influenza or flu virus.
- **Pneumococcal shot:** Part B covers this shot to help prevent pneumococcal infections (like certain types of pneumonia).

What you pay

No coinsurance, copayment, or Part B deductible if your doctor or health care provider accepts assignment.

Foot exams & treatment

Go to page 42.

What Medicare covers

Part B covers a foot exam every 6 months if you have diabetic peripheral neuropathy and loss of protective sensation, as long as you haven't seen a foot care professional for another reason between visits.

What you pay

20% of the Medicare-approved amount after the yearly Part B deductible.

Glaucoma screenings

Go to page 43.

What Medicare covers

Part B covers this screening once every 12 months if you're at high risk for glaucoma. A doctor legally authorized by the state must do the screening.

What you pay

20% of the Medicare-approved amount after the yearly Part B deductible.

Insulin

Go to page 30.

What Medicare covers

Part D covers insulin that isn't administered with an insulin pump.

What you pay

The cost of a one-month supply of each Part D-covered insulin is capped at \$35. You don't have to pay a deductible.

Insulin pumps

Go to page 25.

What Medicare covers

Part B covers external durable insulin pumps and the insulin the pump uses under **durable medical equipment** if you meet certain conditions.

What you pay

- 20% of the **Medicare-approved amount** after the yearly Part B **deductible**.
- If you take insulin through a traditional pump that's covered under Medicare's durable medical equipment benefit, you don't have to pay more than \$35 for a month's supply of insulin. The Part B deductible doesn't apply.

Medical nutrition therapy services

Go to page 41.

What Medicare covers

Part B may cover medical nutrition therapy and certain related services if you have diabetes or kidney disease. A doctor must refer you for these services.

What you pay

No copayment, coinsurance, or Part B deductible if your doctor or health care provider accepts assignment.

Therapeutic shoes or inserts

Go to pages 26 –27.

What Medicare covers

Part B covers therapeutic shoes or inserts if you have diabetes and severe diabetic foot disease.

What you pay

20% of the Medicare-approved amount after the yearly Part B deductible.

“Welcome to Medicare” preventive visit

Go to page 44.

What Medicare covers

Within the first 12 months you have Part B, Medicare covers a one-time review of your health, education, and counseling about preventive services, including certain screenings, shots, and referrals for other care, if needed.

What you pay

No copayment, coinsurance, or Part B deductible if your doctor or health care provider accepts assignment.

Yearly “Wellness” visit

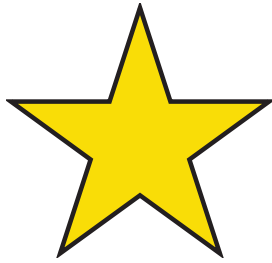
Go to page 44.

What Medicare covers

If you’ve already had Part B for longer than 12 months, you can get a yearly “Wellness” visit to develop or update a personalized prevention plan based on your current health and risk factors.

What you pay

- No copayment, coinsurance or Part B deductible if your doctor or health care provider accepts assignment.
- If you had a “Welcome to Medicare” visit, you’ll have to wait 12 months before you can get your first yearly “Wellness” visit.



Section 3: Medicare Coverage for Diabetes Supplies

This section provides information about Part B (Medical Insurance) and its coverage of diabetes supplies. Medicare covers certain supplies if you have diabetes and Part B, including:

- **Blood sugar self-testing equipment & supplies.** Go to pages 20 – 24.
- **Insulin pumps.** Go to page 25.
- **Therapeutic shoes or inserts.** Go to pages 26 – 27.

Underlined words are defined on pages 49 – 50.

Blood sugar self-testing equipment & supplies

Part B covers blood sugar (also called blood glucose) self-testing equipment and supplies as durable medical equipment.

Self-testing supplies include:

- Blood sugar testing meters
- Blood sugar test strips
- Lancets and lancet holders
- Glucose control solutions for checking the accuracy of testing equipment and test strips

However, the amount of supplies that Part B covers varies.

- If you use insulin, you may be able to get up to 300 test strips and 300 lancets every 3 months.
- If you don't use insulin, you may be able to get 100 test strips and 100 lancets every 3 months.

If your doctor says it's medically necessary, and you meet other requirements, **Medicare will allow you to get additional test strips and lancets**. You may need to keep a record that shows how often you're actually testing yourself.

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Medicare may cover a continuous glucose monitor (receiver) and related supplies (sensors and transmitters) if your doctor says you meet all the requirements for Medicare coverage.

The continuous glucose monitor requirements include:

- You have diabetes mellitus.
- You take insulin or have a history of problems with low blood sugar.
- Your doctor has given you a prescription for testing supplies and instructions on how often to test your blood glucose.
- You or your caregiver have been trained to use a continuous glucose monitor as prescribed by your doctor.

You must also make routine in-person or Medicare-approved telehealth visits with your doctor.

If you have questions about Medicare coverage of diabetes supplies, visit [Medicare.gov/coverage](https://www.medicare.gov/coverage). You can also call 1 800 633 - 4227. TTY users can call 1 877 486 - 2048.

What do I need from my doctor to get these covered supplies?

Medicare will only cover your blood sugar self-testing equipment and supplies if you get a prescription from your doctor. The prescription should include:

- Whether you have diabetes.
- What kind of blood sugar monitor you need and why you need it. (If you need a special monitor because of vision problems, your doctor must explain that.)
- Whether you use insulin.
- How often you should test your blood sugar.
- How many test strips and lancets you need for one month.

Keep in mind:

- You must ask for refills for your supplies.
- You need a new prescription from your doctor for your lancets and test strips every 12 months.

Where can I get these supplies?

- You can order and pick up your supplies at your pharmacy.
- You can order your supplies from a medical equipment supplier. Generally, a “supplier” is any company, person, or agency that gives you a medical item or service, except when you’re an inpatient in a hospital or skilled nursing facility. If you get your supplies this way, you must place the order yourself. You’ll need a prescription from your doctor to place your order, but your doctor can’t order the supplies for you.

What supplier or pharmacy should I use?

You must get supplies from a pharmacy or supplier that’s enrolled in Medicare. If you go to a pharmacy or supplier that isn’t enrolled in Medicare, Medicare won’t pay. **You’ll have to pay the entire bill for any supplies from non-enrolled pharmacies or non-enrolled suppliers.**

Before you get any supplies, it’s important to ask the supplier or pharmacy these questions to be sure Medicare covers your purchase:

- Are you enrolled in Medicare?
- Do you accept assignment?

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To find a supplier that's enrolled in Medicare, visit [Medicare.gov/medical-equipment-suppliers](https://www.medicare.gov/medical-equipment-suppliers). Or, call 1 800 633 - 4227. TTY users can call 1 877 486 - 2048.

Note: Medicare won't pay for any supplies you didn't ask for, or for any supplies that were sent to you automatically from suppliers, including blood sugar monitors, test strips, and lancets. If you're getting supplies sent to you automatically, are getting misleading advertisements, or suspect fraud related to your diabetes supplies, call 1 800 633 - 4227.

Who's responsible for submitting claims?

All Medicare-enrolled pharmacies and suppliers must submit claims for blood sugar (glucose) monitors, test strips, and other items covered under durable medical equipment.

What do I have to pay?

You pay no more than your coinsurance amount when you get your supplies from a pharmacy or supplier that accepts assignment. If your pharmacy or supplier **doesn't** accept assignment, charges may be higher, and you may pay more. You may also have to pay the entire charge at the time of service, and wait for Medicare to send you its share of the cost.

Insulin pumps

Your cost for a month's supply of Part B-covered insulin for your **durable medical equipment** pump can't be more than \$35, and the Part B **deductible** doesn't apply.

If you have Medicare Supplement Insurance (Medigap) that pays your Part B **coinsurance**, that plan should cover the \$35 (or less) cost for insulin. Check with your plan to find out if it pays your Part B coinsurance.

If you use an insulin pump worn outside the body (external) that isn't disposable, Part B may cover insulin used with the pump and cover the pump itself as durable medical equipment. If you live in certain areas of the country, you may have to use specific insulin pump suppliers for Medicare to pay for a durable insulin pump.

How do I get an insulin pump?

If you need an insulin pump, your doctor will prescribe it for you.

Note: In Original Medicare, you pay 100% for insulin-related supplies (like syringes, needles, alcohol swabs, and gauze), unless you have Medicare drug coverage (Part D). For pumps, tubing, and any other supplies, you pay 20% of the **Medicare-approved amount** after the yearly Part B deductible.

Therapeutic shoes or inserts

If you have Part B, have diabetes and meet certain conditions, Medicare will cover therapeutic shoes if you need them.

The types of shoes Part B covers each year include **one** of these:

- One pair of depth-inlay shoes and 3 pairs of inserts
- One pair of custom-molded shoes (including inserts) if you can't wear depth-inlay shoes because of a foot deformity, and 2 more pairs of inserts

Note: In certain cases, Medicare may also cover separate inserts or shoe modifications instead of inserts.

How do I get therapeutic shoes?

For Medicare to pay for your therapeutic shoes, the doctor treating your diabetes must certify that you meet these 3 conditions:

1. You have diabetes.
2. You have at least one of these conditions in one or both feet:
 - Partial or complete foot amputation
 - Past foot ulcers
 - Calluses that could lead to foot ulcers

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- Nerve damage because of diabetes with signs of problems with calluses
 - Poor circulation
 - A deformed foot
3. You're being treated under a comprehensive diabetes care plan and need therapeutic shoes and/or inserts because of diabetes.

Medicare also requires:

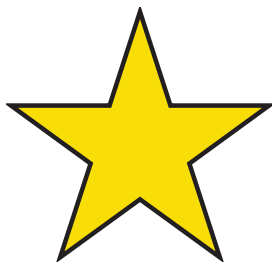
- A podiatrist or other qualified health care provider prescribes the shoes.
- A doctor or other qualified individual, like a pedorthist, orthotist, or prosthetist, fits and provides the shoes.

Replacing lost or damaged durable medical equipment or supplies in a disaster or emergency

If Original Medicare already paid for durable medical equipment (like a traditional insulin pump) or supplies (like diabetic supplies) and they're damaged or lost due to an emergency or disaster:

- In certain cases, Medicare will cover the cost to repair or replace your equipment or supplies.
- Generally, Medicare will also cover the cost of rentals for items (like wheelchairs) while your equipment is being repaired.

For more information, visit [Medicare.gov/what-medicare-covers/durable-medical-equipment-replacement-in-disaster-or-emergency](https://www.medicare.gov/what-medicare-covers/durable-medical-equipment-replacement-in-disaster-or-emergency), or call 1 800 633 - 4227. TTY users can call 1 877 486 - 2048.



Section 4: Medicare Coverage for Diabetes Drugs

This section provides information about Medicare drug coverage (Part D) for people with Medicare who have or are at risk for diabetes. To get Medicare drug coverage, you must join a Medicare drug plan or a Medicare Advantage Plan with drug coverage. Medicare drug coverage covers insulin, anti-diabetic drugs, and some supplies related to your insulin.

Underlined words are defined on pages 49 – 50.

Insulin

The cost of a one-month supply of each Part D-covered insulin is capped at \$35, and you don't have to pay a **deductible** for insulin. This applies to everyone who takes insulin, even if you get Extra Help (a Medicare program to help people with limited income and resources pay Medicare Part D premiums, deductibles, **coinsurance**, and other costs). If you get a 60-day or 90-day supply of insulin, your costs can't be more than \$35 for each month's supply of each covered insulin. For example, if you get a 60-day supply of a Part D-covered insulin, you'll generally pay no more than \$70. Similar caps on costs apply for insulin used in traditional insulin pumps covered under Part B. Go to page 25.

If you take insulin, you can get help comparing Medicare drug plans and costs:

- Call 1 800 633 - 4227. TTY users can call 1 877 486 - 2048.
- Contact your local State Health Insurance Assistance Program (SHIP) to get free personalized health insurance counseling.

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Anti-diabetic drugs

Blood sugar (glucose) that isn't controlled by insulin is maintained by anti-diabetic drugs. Medicare Part D can cover a variety of anti-diabetic drugs. Check with your plan to find out which drugs they cover.

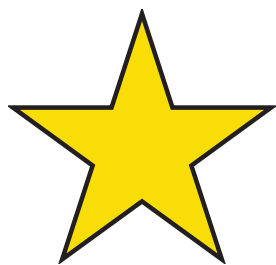
Diabetes supplies

Supplies directly associated with delivering insulin to the body are covered if you have Medicare drug coverage and diabetes, like:

- Alcohol swabs
- Gauze
- Needles
- Syringes

For more information

- Visit [Medicare.gov/drug-coverage-part-d](https://www.medicare.gov/drug-coverage-part-d)
- Call 1 800 633 - 4227.
- Call your State Health Insurance Assistance Program (SHIP) for free health insurance counseling. To get their phone number, visit [shiphelp.org](https://www.shiphelp.org), or call 1 800 633 - 4227.



Section 5: Medicare Coverage for Diabetes Screenings & Services

Part B covers certain services, screenings, and trainings to help you prevent, detect, and treat diabetes.

In general, your doctor must refer you to get these services, including:

- **Diabetes screenings.** Go to page 34 – 35.
- **Medicare Diabetes Prevention Program.** Go to pages 36 – 37.
- **Diabetes self-management training.** Go to pages 37 – 40.
- **Medical nutrition therapy services.** Go to page 41.
- **Hemoglobin A1C tests.** Go to page 42.

You can get some Medicare-covered services without a referral. Go to pages 41 – 44.

Underlined words are defined on pages 49 – 50.

Diabetes screenings

Part B pays for diabetes screenings if you're at risk for diabetes. You may be at risk for diabetes if you have:

- High blood pressure
- Dyslipidemia (history of abnormal cholesterol and triglyceride levels)
- Obesity (defined as a body mass index (BMI) ≥ 30)
- Impaired glucose (blood sugar) tolerance
- High fasting glucose (blood sugar)

You also may be at risk if you have 2 or more of these risk factors:

- You're overweight (defined as BMI > 25 , but < 30)
- You have a family history of diabetes
- You have a history of gestational diabetes or gave birth to a baby weighing more than 9 pounds
- You're 65 or older

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Medicare may pay for up to 2 diabetes screenings in a 12-month period. After your initial diabetes screening test, your doctor will determine if you need a second test. Medicare covers these diabetes screenings:

- Fasting glucose (sugar) blood tests
- Hemoglobin A1C tests
- Other glucose blood tests approved by Medicare as appropriate

If you think you may be at risk for diabetes, talk with your doctor to find out if you should get these tests.

Medicare Diabetes Prevention Program

Part B covers a once-per-lifetime health behavior change program to help you prevent type 2 diabetes. The program begins with up to 16 weekly group sessions over a 6-month period. In these sessions, you'll get:

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

You can choose to attend sessions in person, virtually, or both. Once you complete the core sessions, you'll get 6 monthly follow-up sessions.

To qualify, you must have:

- Part B (or a Medicare Advantage Plan)
- Within 12 months of your first session, you have either a:
 - Hemoglobin A1C test result between 5.7 and 6.4%
 - Fasting plasma glucose of 110–125mg/dL
 - 2-hour plasma glucose of 140–199 mg/dL (oral glucose tolerant test)

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- A body mass index (BMI) of 25 or more (BMI of 23 or more if you're Asian)
- No history of type 1 or type 2 diabetes
- No End-Stage Renal Disease (ESRD)
- Never participated in the Medicare Diabetes Prevention Program

You pay nothing for these services if you qualify.

Visit [Medicare.gov/coverage/medicare-diabetes-prevention-program](https://www.medicare.gov/coverage/medicare-diabetes-prevention-program) to find programs in your area.

Diabetes self-management training

Diabetes self-management training helps you learn how to successfully manage your diabetes. Your doctor or other qualified health care practitioner must prescribe this training for Part B to cover it.

You can get diabetes self-management training if you were diagnosed with diabetes.

Your doctor or other qualified health care practitioner will usually give you information about where to get diabetes self-management training. You must get this training from an approved individual or program as part of a plan of care prepared by your doctor or other qualified health care practitioner.

How much training is covered?

Medicare will cover up to 10 hours of initial training and 2 hours of follow-up training if you need it.

You must complete the initial training no more than 12 months from the time you start it. The initial training includes 1 hour of one-on-one training. The other 9 hours of training are usually in a group setting.

Important: Your doctor or other health care provider may prescribe up to 10 hours of one-on-one training, rather than group sessions. You may get one-on-one training if you have low-vision, a hearing impairment, a language or other communication difficulty, or cognitive limitations. Medicare also covers one-on-one training if no groups are available within 2 months of the date of the order.

Medicare covers up to 2 hours of follow-up training each year, after the year you get the first training, if you need it. The follow-up training can be in group or one-on-one sessions. Your doctor or other health care provider must prescribe this follow-up training each year for Medicare to cover it.

Note: Diabetes self-management training is available in many Federally Qualified Health Centers (FQHCs). FQHCs provide primary health services and qualified preventive services in medically underserved rural and urban areas. Some types of FQHCs are Community Health Centers,

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Migrant Health Centers, Health Care for the Homeless Programs, Public Housing Primary Care Centers, and outpatient health programs/facilities operated by a tribe or tribal organization or by an urban Indian organization. You don't have to pay a Part B **deductible**. Visit **findahealthcenter.hrsa.gov** to find a health center near you.

Telehealth: You may be able to get diabetes self-management training from a doctor or other health care provider who's located elsewhere using audio-only (like your phone) or audio and video communication technology (like your computer). For more information about telehealth services, call 1 800 633 - 4227. TTY users can call 1 877 486 - 2048.

What will I learn in this training?

The first diabetes self-management training session is an individual assessment to help the instructors better understand your needs.

Classroom training will cover topics like:

- General information about diabetes, the benefits of blood sugar control, and the risks of poor blood sugar control
- Nutrition and how to manage your diet
- Options to manage and improve blood sugar control

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- Exercise and why it's important to your health
- How to take your medications properly
- Blood sugar testing and how to use the information to improve your diabetes control
- How to prevent, recognize, and treat acute and chronic complications from your diabetes
- Foot, skin, and dental care
- How diet, exercise, and medication affect blood sugar
- Behavior changes, goal setting, risk reduction, and problem solving
- How to adjust emotionally to having diabetes
- Family involvement and support
- The use of the health care system and community resources

Medical nutrition therapy services

In addition to diabetes self-management training, Part B covers medical nutrition therapy services if you have diabetes or kidney disease and meet certain criteria. A doctor must prescribe these services for you, but a registered dietitian (or certain other nutrition professionals) can provide:

- An initial nutrition and lifestyle assessment
- Nutrition counseling (what foods to eat and how to follow an individualized diabetic meal plan)
- Tips on how to manage lifestyle factors that affect your diabetes
- Follow-up visits to check on your progress in managing your diet

Note: Medical nutrition therapy is available in many Federally Qualified Health Centers. Go to page 38. Visit findahealthcenter.hrsa.gov to find a health center near you.

Telehealth: You may be able to get medical nutrition therapy from a registered dietitian or other health care provider via telehealth. Find out more on page 39.

Foot exams & treatment

If you have diabetes-related nerve damage in either of your feet, Part B will cover one foot exam every 6 months by a podiatrist or other foot care specialist, unless you've seen a foot care specialist for some other foot problem during the past 6 months. Medicare may cover more frequent visits if you've had a non-traumatic (not because of an injury) amputation of all or part of your foot, or your feet have changed in appearance which may indicate you have serious foot disease.

Hemoglobin A1C tests

A hemoglobin A1C test is a lab test that measures how well your blood sugar has been controlled over the past 3 months. If you have diabetes, Part B covers this test if your doctor orders it.

Glaucoma screenings

Part B will pay for you to have your eyes checked for glaucoma once every 12 months if you're at increased risk of glaucoma because you:

- Have diabetes
- Have a family history of glaucoma
- Are African-American and 50 or older
- Are Hispanic and 65 or older

This test must be done or supervised by an eye doctor who's legally allowed to give this service in your state.

Flu & pneumococcal shots

If you have diabetes, you have a higher risk of complications from the flu and pneumonia. It's important to get vaccinated to reduce this risk. Part B will pay for you to get a flu shot generally once a flu season. Part B will also pay for pneumococcal shots to prevent pneumococcal infections (like certain types of pneumonia). Talk with your doctor or other health care provider to find out if you need these shots.

“Welcome to Medicare” preventive visit

Part B covers a one-time review of your health and education and counseling about preventive services within the first 12 months you have Part B. This includes information about certain screenings, shots, and referrals for other care if needed. The “Welcome to Medicare” preventive visit is a good opportunity to talk with your doctor about the preventive services you may need, like diabetes screenings.

Yearly “Wellness” visit

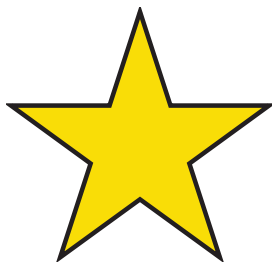
If you’ve had Part B for longer than 12 months, you can get a yearly “Wellness” visit to develop or update a personalized prevention plan based on your current health and risk factors. This includes:

- A review of medical and family history
- A list of current providers and prescription drugs
- Your height, weight, blood pressure, and other routine measurements
- A screening schedule for appropriate preventive services
- A list of risk factors and treatment options for you

Supplies & services that Medicare doesn't cover

Original Medicare and Medicare drug coverage (Part D) don't cover:

- Eyeglasses and exams for glasses, except after cataract surgery
- Orthopedic shoes (shoes for people whose feet are impaired, but intact)
- Cosmetic surgery



Section 6: Helpful tips & resources

More information is available to help you make health care choices and decisions that meet your needs.

For more information about Medicare coverage of diabetes, visit [Medicare.gov/coverage](https://www.medicare.gov/coverage) or call 1 800 633 - 4227. TTY users can call 1 877 486 - 2048.

Phone numbers & websites

Centers for Disease Control and Prevention (CDC), Department of Health and Human Services (HHS)

[CDC.gov/diabetes](https://www.cdc.gov/diabetes)

1 800 232 - 4636

Find a Health Center

findahealthcenter.hrsa.gov

Indian Health Service

[IHS.gov/diabetes](https://www.ihs.gov/diabetes)

MyHealthfinder

[healthfinder.gov](https://www.healthfinder.gov)

National Diabetes Prevention Program

[CDC.gov/diabetes/prevention](https://www.cdc.gov/diabetes/prevention)

**National Institute of Diabetes & Digestive
& Kidney Diseases (NIDDK) of the National
Institutes of Health (NIH), HHS**

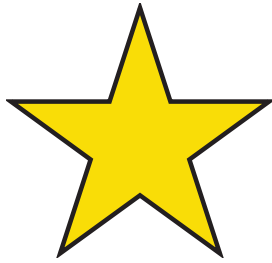
[NIDDK.nih.gov/health-information/diabetes](https://www.niddk.nih.gov/health-information/diabetes)

1 800 860 - 8747

**State Health Insurance Assistance Program
(SHIP)**

[shiphelp.org](https://www.shiphelp.org)

1 800 860 - 8747



Section 7: Definitions

Assignment

An agreement by your doctor, provider, or 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.

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 benefits after you pay any deductibles. A copayment is a fixed amount, like \$30.

Deductible

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

Durable medical equipment

Items like oxygen and oxygen equipment, wheelchairs, walkers, and hospital beds that your doctor or other health care provider orders for use in the home.

Medicare-approved amount

The payment amount that Original Medicare sets for a covered service or item. When your provider accepts assignment, Medicare pays its share and you pay your share of that amount.

CMS Accessible Communications

Medicare provides free auxiliary aids and services, including information in accessible formats like braille, large print, data or audio files, relay services and TTY communications. If you request information in an accessible format, 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: 1 800 633 - 4227

TTY: 1 877 486 - 2048

For Marketplace: 1 800 318 - 2596

TTY: 1 855 889 - 4325

2. Email us: 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 DO-01-20

Baltimore, MD 21244-1850

Attn: Customer Accessibility Resource Staff (CARS)

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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 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 (including sexual orientation and gender identity), 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.

54 _ Nondiscrimination Notice

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 drug plan, state or local Medicaid office, or Marketplace Qualified Health Plans. There are 3 ways to file a complaint with the U.S. Department of Health & Human Services, Office for Civil Rights:

1. Online:

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

2. By phone:

Call 1 800 368 - 1019.

TTY users can call 1 800 537 - 7697.

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

Office for Civil Rights

U.S. Department of Health & Human Services

200 Independence Avenue, SW

Room 509F, HHH Building

Washington, D.C. 20201

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 1 800 633 - 4227 to get the most current information. TTY users can call 1 877 486 - 2048.

“Medicare Coverage of Diabetes Supplies, Services, & Prevention Programs” isn’t a legal document. Official Medicare Program legal guidance is contained in the relevant statutes, regulations, and rulings.

You have the right to get Medicare information in an accessible format, like large print, braille, or audio. You also have the right to file a complaint if you feel you’ve been discriminated against. Visit [Medicare.gov/about-us/accessibility-nondiscrimination-notice](https://www.medicare.gov/about-us/accessibility-nondiscrimination-notice), or call 1 800 633 - 4227 for more information. TTY users can call 1 877 486 - 2048.

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Need a copy of this booklet in Spanish?

This booklet is available in Spanish. To get a free copy, visit **Medicare.gov** or call 1 800 633 - 4227. TTY users can call 1 877 486 - 2048.

Esta publicación está disponible en español. Para obtener una copia gratis, visite **es.Medicare.gov** o llame al 1 800 633 - 4227.



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