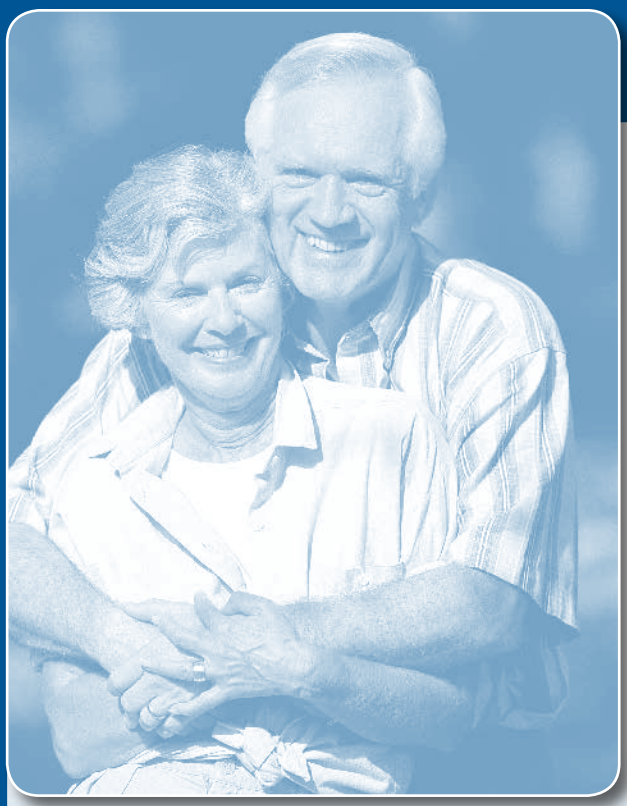
YOUR MEDICARE BENEFITS



This official government guide has important information about:

- The services and supplies Original Medicare covers
- How much you pay
- Where to get more information

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CENTERS FOR MEDICARE & MEDICAID SERVICES

ABOUT THIS BOOKLET

This booklet describes the health care services and supplies that Medicare covers, and how to get those benefits through Medicare Part A (Hospital Insurance) and Medicare Part B (Medical Insurance). It includes:

- The benefits you can get and when (like a yearly "Wellness" visit)
- How much Medicare pays for each service and how much you pay
- Where to get your questions answered

"Your Medicare Benefits" lists many, but not all, of the items and services that Medicare covers. If you have a question about a test, item, or service that isn't listed in this booklet, visit Medicare.gov or call 1-800-MEDICARE (1-800-633-4227). TTY users can call 1-877-486-2048.

The information about services and supplies listed in this booklet applies to all people with Original Medicare. The information in this booklet doesn't apply to you if you have a Medicare Advantage Plan (like an HMO or PPO) or another Medicare health plan. If you have a Medicare Advantage Plan or other Medicare health plan, you have the same basic benefits as people who have Original Medicare, but the rules vary by plan. Some services and supplies may not be listed because the coverage depends on where you live. To find out more, visit Medicare.gov or call 1-800-MEDICARE.

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SECTION 1

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SECTION 2

What Original Medicare covers

The information starting on the next page explains:

- Services and supplies that Original Medicare covers
- Conditions and limits for coverage
- How much you pay

As you read this booklet, keep these 2 points in mind:

1. Unless otherwise noted, in 2018, you pay a yearly $183 deductible for Part B-covered services and supplies before Medicare begins to pay its share, depending on the service or supply.
2. Depending on the service or supply, actual amounts you pay may be higher if doctors, other health care providers, or suppliers don't accept assignment.

Doctors who don't accept assignment may charge you more than the Medicare-approved amount for a service, but they can't charge more than 15% over the Medicare-approved amount for non-participating doctors. This is called the "limiting charge." The limiting charge applies only to certain services and doesn't apply to some supplies and durable medical equipment (DME). When getting certain supplies and DME, Medicare will only pay for them from suppliers enrolled in Medicare, no matter who submits the claim (you or your supplier).

Your doctor or other health care provider may recommend you get services more often than Medicare covers. Or, they may recommend services that Medicare doesn't cover. If this happens, you may have to pay some or all of the costs. It's important to ask questions so you understand why your doctor is recommending certain services and whether Medicare will pay for them.

Preventive Services

Preventive services help you stay healthy. There's a picture of an apple next to each preventive service that Medicare covers. Talk with your doctor about which preventive services are right for you.

Words in blue are defined on pages 61–63.

If you disagree with a Medicare coverage or payment decision, you have the right to appeal. For information on how to file an appeal, see your "Medicare & You" handbook, or visit Medicare.gov/appeals.

SERVICES & SUPPLIES

A

Abdominal aortic aneurysm screening

Part B covers a one-time abdominal aortic aneurysm ultrasound if you're at risk. You're considered at risk if you have a family history of abdominal aortic aneurysms, or you're a man age 65–75 and have smoked at least 100 cigarettes in your lifetime. Medicare covers this screening if you get a referral from your doctor or other practitioner.

In 2018, you pay NOTHING for this screening if your doctor or other qualified health care provider accepts assignment.

Advance care planning

Advance care planning is voluntary planning for care you would want to get if you become unable to speak for yourself. Medicare covers voluntary advance care planning as part of your Yearly "Wellness" visit or as part of your medical treatment. See page 46.

In 2018, you pay NOTHING for this planning if your doctor or other qualified health care provider accepts assignment and this is provided as part of your yearly "Wellness" visit. If it's provided as part of your medical treatment, the Part B deductible and coinsurance apply.

Alcohol misuse screening & counseling

Part B covers one alcohol misuse screening per year if you're an adult (including pregnant women) who uses alcohol, but don't meet the medical criteria for alcohol dependency. If your primary care doctor or other primary care practitioner 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). A qualified primary care doctor or other primary care practitioner must provide the counseling in a primary care setting (like a doctor's office).

In 2018, you pay NOTHING for this screening and counseling if your qualified primary care doctor or other primary care practitioner accepts assignment.

Ambulance services

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

In some cases, Medicare may pay for limited, medically necessary, non-emergency ambulance transportation if you have a written order from your doctor saying that ambulance transportation is medically necessary.

In 2018, you pay 20% of the Medicare-approved amount, and the Part B deductible applies.

Ambulatory surgical centers

Part B covers the facility service fees related to approved surgical procedures provided in an ambulatory surgical center (facility where surgical procedures are performed, and you're expected to be released within 24 hours).

In 2018, you pay the Part B deductible and 20% of the Medicare-approved amount to both the ambulatory surgical center and the doctor who treats you. You pay nothing for certain preventive services. You pay all facility service fees for procedures Medicare doesn't cover in ambulatory surgical centers.

Anesthesia

Part A covers anesthesia services provided by a hospital if you're an inpatient. Part B covers anesthesia services provided by a hospital if you're an outpatient or by a freestanding ambulatory surgical center if you're a patient.

In 2018, you pay 20% of the Medicare-approved amount for the anesthesia services provided by a doctor or certified registered nurse anesthetist, and the Part B deductible applies. The anesthesia service must be associated with the underlying medical or surgical service, and you may have to pay an additional copayment to the facility.

Artificial limbs & eyes

Part B covers artificial limbs and eyes when your doctor orders them.

In 2018, you pay 20% of the Medicare-approved amount, and the Part B deductible applies. See "Orthotics, artificial limbs, & eyes" on page 41.

B

Blood

Part A covers blood you get as a hospital inpatient. Part B covers blood you get as a hospital outpatient.

In 2018, you pay the provider customary charges for the first 3 units of blood you get in a calendar year. If your provider gets blood from a blood bank at no charge, you won't have to pay for it or replace it. If your 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.

Blood processing & handling

Hospitals generally charge for blood processing and handling for each unit of blood you get, whether the blood is donated or purchased. Part A covers this service if you're an inpatient. Part B covers this service if you're an outpatient.

In 2018, you pay a copayment for blood processing and handling services for each unit of blood you get as a hospital outpatient.

Bone mass measurement (bone density)

Part B covers this test, which helps to see if you're at risk for broken bones, if you meet one or more of these conditions:

- You're a woman whose doctor determines you're estrogen deficient and at risk for osteoporosis, based on your medical history and other findings.
- Your X-rays show possible osteoporosis, osteopenia, or vertebral fractures.
- You're taking prednisone or steroid-type drugs or are planning to begin this treatment.
- You've been diagnosed with primary hyperparathyroidism.
- You're being monitored to see if your osteoporosis drug therapy is working.

Bone mass measurement (bone density) (continued)

The test is covered once every 24 months (more often if medically necessary) if you meet one or more of the criteria above.

In 2018, you pay NOTHING for this test if your doctor or other qualified health care provider accepts assignment.

Braces (arm, leg, back, & neck)

Part B covers medically necessary arm, leg, back, and neck braces.

In 2018, you pay 20% of the Medicare-approved amount, and the Part B deductible applies.

Breast cancer screening (mammograms)

Part B covers screening mammograms once every 12 months to check for breast cancer if you're a woman age 40 or older. Part B covers one baseline mammogram for women age 35–39.

Part B covers diagnostic mammograms more frequently than once a year if medically necessary.

In 2018, you pay NOTHING for the test if your doctor or other qualified health care provider accepts assignment. You pay 20% of the Medicare-approved amount for diagnostic mammograms, and the Part B deductible applies.

Breast prostheses

Part B covers external breast prostheses (including a post-surgical bra) after a mastectomy. Part A covers surgically implanted breast prostheses after a mastectomy if the surgery takes place in an inpatient setting, and Part B covers the surgery if it takes place in an outpatient setting.

In 2018, you pay 20% of the Medicare-approved amount for your doctor's services and the external breast prostheses, and the Part B deductible applies. For surgeries to implant breast prostheses in a hospital inpatient setting covered under Part A, see "Inpatient hospital care" on pages 36–37. For surgeries to implant breast prostheses in a hospital outpatient setting covered under Part B, see "Outpatient hospital services" on pages 41–42.

Breast reconstruction

See "Breast prostheses" above.

Canes/crutches

Part B covers canes and crutches. Medicare doesn't cover white canes for the blind. For more information, see "Durable medical equipment" on pages 27–28.

In 2018, you pay 20% of the Medicare-approved amount, and the Part B deductible applies.

Cardiac rehabilitation program

Part B covers comprehensive cardiac rehabilitation programs that include exercise, education, and counseling if you have had 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

Part B also covers intensive cardiac rehabilitation (IRC) programs that, like regular cardiac rehabilitation (CR) programs, include exercise, education, and counseling. Part B covers these programs if your doctor referred you and you had any of the conditions listed above, (with the exception of stable chronic heart failure, which applies only to CR programs). ICR programs are typically more rigorous or more intense than CR programs. These programs may be provided in a hospital outpatient setting (including a critical access hospital) or in a doctor's office.

In 2018, you pay 20% of the Medicare-approved amount if you get the services in your doctor's office. In a hospital outpatient setting, you pay the hospital a copayment. The Part B deductible applies.

Cardiovascular disease (behavioral therapy)

Medicare covers one visit per year with your primary care doctor in a primary care setting (like a doctor's office) to help lower your risk for cardiovascular disease. During this visit, your doctor may discuss aspirin use (if appropriate), check your blood pressure, and give you tips to make sure you're eating well.

In 2018, you pay NOTHING if your doctor or other qualified health care provider accepts assignment.

Cardiovascular disease screenings

Part B covers screening blood tests for cholesterol, lipid, and triglyceride levels every 5 years. These screenings include blood tests and help detect conditions that may lead to a heart attack or stroke.

In 2018, you pay NOTHING for the tests if your doctor or other qualified health care provider accepts assignment.

Cervical & 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. See "Breast cancer screening" on page 15. 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 (as part of Pap tests) once every 5 years if you're age 30-65 without HPV symptoms.

In 2018, you pay NOTHING for the lab Pap test and for the lab HPV with Pap test. You also pay nothing for the Pap test specimen collection and pelvic and breast exams if your doctor accepts assignment.

Chemotherapy

Part A covers chemotherapy if you have cancer, and you're a hospital inpatient. Part B covers chemotherapy if you're a hospital outpatient or a patient in a doctor's office or freestanding clinic.

In 2018, you pay a copayment for chemotherapy covered under Part B 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 "Inpatient hospital care" on pages 36–37.

Chiropractic services

Part B covers manual 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.

Note: Medicare doesn't cover other services or tests ordered by a chiropractor, including X-rays, massage therapy, and acupuncture.

In 2018, you pay 20% of the Medicare-approved amount, and the Part B deductible applies. You pay all costs for any other services or tests ordered by your chiropractor (including X-rays, massage therapy, and acupuncture).

Chronic care management services

If you have 2 or more serious chronic conditions that are expected to last at least a year, Medicare may pay for 2 health care professional's help to manage those conditions. Chronic care management offers additional help managing conditions like arthritis, asthma, diabetes, hypertension, heart disease, and osteoporosis. Services may include:

- At least 20 minutes per month of chronic care management services
- Personalized help from a dedicated health care professional who will work with you to create a care plan based on your needs and goals
- Care coordinated between your doctor, pharmacy, specialists, testing centers, hospitals, and other services
- Emergency access to a health care professional, 24 hours a day, 7 days a week
- Expert help with setting and meeting your health goals

To get started, ask your health care professionals if they provide chronic care management services.

In 2018, you pay a monthly fee, and the Part B deductible and coinsurance apply. If you have supplemental insurance, or have both Medicare and Medicaid, it may help cover the monthly fee.

Clinical research studies

Clinical research studies test how well different types of medical care work and if they're safe, like how well a cancer drug works. These studies help doctors and researchers see if a new treatment works and if it's safe. Part A and/or Part B cover some costs, like office visits and tests, in certain qualifying clinical research studies.

In 2018, you pay 20% of the Medicare-approved amount, depending on the treatment you get. The Part B deductible may apply.

Colorectal cancer screening

Part B covers several types of colorectal cancer screening tests to help find precancerous growths or find cancer early, when treatment is most effective. You're covered if you're 50 or older. However, there's no minimum age for having a screening colonoscopy. One or more of these tests may be covered:

Screening barium enema: When this test is used instead of a flexible sigmoidoscopy or colonoscopy, Medicare covers the test once every 48 months if you're 50 or older and once every 24 months if you're at high risk for colorectal cancer.

In 2018, you pay 20% of the Medicare-approved amount for your doctor's services. In a hospital outpatient setting, you also pay a copayment. The Part B deductible doesn't apply.

Colorectal cancer screening (continued)

Screening colonoscopy: Medicare covers this test once every 24 months if you're at high risk for colorectal cancer. If you aren't at high risk for colorectal cancer, Medicare covers the test once every 120 months, or 48 months after a previous flexible sigmoidoscopy. There's no minimum age.

In 2018, you pay NOTHING for this test if your doctor or other qualified health care provider accepts assignment.

However, if a polyp or other tissue is found and removed during the colonoscopy, you may pay 20% of the Medicare-approved amount of your doctor's services and a copayment in a hospital setting. The Part B deductible doesn't apply.

Screening fecal occult blood test: Medicare covers this lab test once every 12 months if you're 50 or older. This screening test is covered if you get a referral from your doctor, physician assistant, nurse practitioner, or clinical nurse specialist.

In 2018, you pay NOTHING for this test if your doctor or other qualified health care provider accepts assignment.

Multi-target stool DNA test: Medicare covers this at-home multi-target stool DNA lab test once every 3 years if you meet all of these conditions:

- You're age 50–85.
- You show no 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.
- You're at average risk for developing colorectal cancer, meaning:
  - You have no personal history of adenomatous polyps, colorectal cancer, or inflammatory bowel disease, including Crohn's Disease and ulcerative colitis.
  - You have no family history of colorectal cancers or adenomatous polyps, familial adenomatous polyposis, or hereditary nonpolyposis colorectal cancer.

In 2018, you pay NOTHING for this test if your doctor or other qualified health care provider accepts assignment.

Screening flexible sigmoidoscopy: Medicare covers this test once every 48 months for most people 50 or older. If you aren't at high risk, Medicare covers this test 120 months after a previous screening colonoscopy.

In 2018, you pay NOTHING if your doctor or other qualified health care provider accepts assignment.

If a screening flexible sigmoidoscopy results in the biopsy or removal of a lesion or growth during the same visit, the procedure is considered diagnostic and you may have to pay coinsurance and/or a copayment, but the Part B deductible doesn't apply.

Commode chairs

Part B covers commode chairs that your doctor orders for use in your home if you're confined to your bedroom. If you live in certain areas of the country, you may have to use specific suppliers for Medicare to pay for a commode chair. For more information, see "Durable medical equipment" on pages 27–28.

In 2018, you pay 20% of the Medicare-approved amount, and the Part B deductible applies.

Contact lenses

See "Eyeglasses/contact lenses" on page 30.

Continuous passive motion (CPM) machine

Medicare covers CPM machines as durable medical equipment (DME) that your doctor prescribes for use in your home, if you meet certain conditions.

In 2018, you pay 20% of the Medicare-approved amount. See "Durable medical equipment" on pages 27–28.

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 in person with your doctor, and your doctor documents in your medical record that the CPAP therapy is helping you.

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.

In 2018, you pay 20% of the Medicare-approved amount for the machine rental and purchase of related supplies (like masks and tubing), and the Part B deductible applies. If you live in certain areas of the country, you may have to use specific suppliers for Medicare to pay for a CPAP machine and/or accessories. See "Durable medical equipment" on pages 27–28.

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.

Concierge care

Medicare doesn't cover concierge care. Visit Medicare.gov/coverage/concierge-care.html for more information.

In 2018, you pay 100% of the membership fee for concierge care.

Cosmetic surgery

Medicare generally doesn't cover cosmetic surgery unless it's needed because of accidental injury or to improve the function of a malformed body part. Medicare covers breast reconstruction if you had a mastectomy because of breast cancer. See "Breast prostheses" on page 15.

Custodial care (help with activities of daily living, like bathing, dressing, using the bathroom, and eating)

Medicare doesn't cover custodial care when it's the only kind of care you need. Care is considered custodial when it helps you with activities of daily living or personal needs and could be done safely and reasonably by people without professional skills or training.

D

Defibrillator (implantable automatic)

Part A or Part B covers implantable defibrillators for certain people diagnosed with heart failure, depending on whether the surgery takes place in a hospital inpatient or outpatient setting.

In 2018, you pay 20% of the Medicare-approved amount for your doctor's services. If Part B covers the device, the Part B deductible applies. If you get the device as a hospital outpatient, you also pay the hospital a copayment, but no more than the Part A hospital stay deductible. For surgeries to implant defibrillators in the hospital inpatient setting covered under Part A, see "Inpatient hospital care" on pages 36–37.

Dental services

Medicare doesn't cover most dental care, dental procedures, or supplies, like cleanings, fillings, tooth extractions, dentures, dental plates, or other dental devices. Part A will pay for certain dental services that you get when you're in a hospital. Part A can pay for hospital stays if you need to have emergency or complicated dental procedures, even though the dental care isn't covered.

Depression screening

Part B 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/or referrals.

In 2018, you pay NOTHING for this screening if your doctor accepts assignment.

Diabetes screenings

Part B covers these screenings if your doctor determines you're at risk for diabetes or you're diagnosed with pre-diabetes. These lab tests are covered if you have any of these risk factors:

- High blood pressure (hypertension)
- History of abnormal cholesterol and triglyceride levels (dyslipidemia)
- Obesity
- A history of high blood sugar (glucose)

Medicare also covers these tests if 2 or more of these apply to you:

- Age 65 or older
- Overweight
- Family history of diabetes (parents, brothers, sisters)
- A history of gestational diabetes (diabetes during pregnancy) or delivery of a baby weighing more than 9 pounds

Diabetes screenings (continued)

You may be eligible for up to 2 diabetes screenings each year.

In 2018, you pay NOTHING for these tests if your doctor or other qualified health care provider accepts assignment.

Diabetes services & supplies

Part B covers some diabetes supplies, including:

- Blood glucose testing monitors
- Blood sugar (glucose) test strips
- Lancet devices and lancets
- Blood sugar control solutions (for checking test strip and monitor accuracy)

There may be limits on how much or how often you get these supplies. For more information, see "Durable medical equipment" on pages 27–28.

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

In 2018, you pay 20% of the Medicare-approved amount, and the Part B deductible applies.

Insulin: Part B doesn't cover insulin (unless use of an insulin pump is medically necessary), insulin pens, syringes, needles, alcohol swabs, or gauze. Medicare Part D may cover insulin and certain medical supplies used to inject insulin, like syringes, gauze, and alcohol swabs. If you use an external insulin pump, insulin and the pump may be covered as durable medical equipment. If you live in certain areas of the country, you may have to use specific suppliers for Medicare to pay for an insulin pump. See "Durable medical equipment" on pages 27–28.

In 2018, you pay 100% for insulin (unless used with an insulin pump, then you pay 20% of the Medicare-approved amount, and the Part B deductible applies). You pay 100% for syringes and needles, unless you have Part D.

Therapeutic shoes or inserts: Each calendar year, Part B covers the furnishing and fitting of either custom-molded shoes or inserts, or one pair of extra-depth shoes, if you have diabetes and severe diabetic foot disease. The doctor who treats your diabetes must certify your need for therapeutic shoes or inserts. The shoes or inserts must be prescribed by a podiatrist (foot doctor) or other qualified doctor and provided by a podiatrist, orthotist, prosthetist, pedorthist, or other qualified individual.

Diabetes services & supplies (continued)

Therapeutic shoes or inserts: (continued)

Medicare also covers 2 additional pairs of inserts each calendar year for custom-molded shoes and 3 pairs of inserts each calendar year for extra-depth shoes. Medicare will cover shoe modifications instead of inserts.

In 2018, you pay 20% of the Medicare-approved amount, and the Part B deductible applies.

If you get your diabetes supplies delivered to your home, you need to use a Medicare-contract supplier for Medicare to pay for your diabetic testing supplies as part of the national mail-order program for diabetes supplies. See "Durable medical equipment" on pages 27–28. If you don't want your diabetic testing supplies delivered to your home, you can buy them from any local store that's enrolled with Medicare. National mail-order contract suppliers can't charge you more than any unmet deductible and 20% coinsurance. Local stores can't charge more than any unmet deductible and 20% coinsurance if they accept assignment, which means they accept the Medicare-approved amount as payment in full. Local stores that don't accept Medicare assignment may charge you more than 20% coinsurance and any unmet deductible. If you get your supplies from a local store, check with the store to find out what your payment will be.

Medicare also covers these diabetes services:

Diabetes self-management training (DSMT): Part B covers outpatient DSMT if you have diabetes and have a written order from your doctor or qualified non-doctor practitioner. DSMT teaches you to cope with and manage your diabetes. The program may include tips for eating healthy, being active, monitoring blood sugar, taking drugs, and reducing risks. If you've been diagnosed with diabetes, Medicare may cover up to 10 hours of initial DSMT. This training may include 1 hour of individual training and 9 hours of group training. Some exceptions apply if group sessions aren't available or if your doctor or qualified non-doctor practitioner says you have special needs that would be better met by individual training sessions. You may also qualify for up to 2 hours of follow-up training each year if it takes place in a calendar year after the year you got your initial training.

If you're in a rural area, you may be able to get DSMT services from a practitioner, like a Registered Dietitian, in a different location through Telehealth. See "Telehealth" on page 53.

In 2018, you pay 20% of the Medicare-approved amount, and the Part B deductible applies.

Diabetes services & supplies (continued)

Medicare also covers these diabetes services:

Yearly eye exam: Part B covers a yearly eye exam for diabetic retinopathy by an eye doctor who's legally allowed to do the test in your state.

In 2018, you pay 20% of the Medicare-approved amount for your doctor's services, and the Part B deductible applies. In a hospital outpatient setting, you pay a copayment.

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

In 2018, you pay 20% of the Medicare-approved amount for your doctor's services, and the Part B deductible applies. In a hospital outpatient setting, you pay a copayment.

Glaucoma tests: See page 31.

Nutrition therapy services (medical): See page 40.

Diagnostic tests

Diagnostic laboratory tests: Part B covers medically necessary clinical diagnostic **laboratory** tests, when your doctor or practitioner orders them. These tests are done to help your doctor diagnose or rule out a suspected illness or condition. Medicare also covers some preventive tests and screenings to help prevent, find, or manage a medical problem. For more information, see "Preventive services" on page 46.

In 2018, you generally pay NOTHING for Medicare-covered clinical diagnostic laboratory tests.

Diagnostic non-laboratory tests: Part B covers diagnostic **non-laboratory** tests, like CT scans, MRIs, EKGs, X-rays, and PET scans, when your doctor or other health care provider orders them as part of treating a medical problem. These tests are done to help your doctor diagnose or rule out a suspected illness or condition. Medicare also covers some preventive tests and screenings to help prevent, find, or manage a medical problem. For more information, see "Preventive services" on page 46.

In 2018, you pay 20% of the Medicare-approved amount of covered diagnostic non-laboratory tests done in your doctor's office or in an independent testing facility, and the Part B deductible applies. You pay a copayment for diagnostic non-laboratory tests done in a hospital outpatient setting.

Dialysis (kidney) services & supplies

Medicare covers many kidney dialysis services and supplies if you have End-Stage Renal Disease (ESRD) (permanent kidney failure requiring dialysis or a kidney transplant). Your dialysis facility bills and provides (directly or under arrangement) all kidney dialysis services and supplies used to provide outpatient maintenance dialysis treatment.

Inpatient dialysis treatments: Part A covers dialysis if you're admitted to the hospital for special care. See "Inpatient hospital care" on pages 36–37.

Outpatient maintenance dialysis treatments: Part B covers a variety of dialysis services if you get routine maintenance dialysis from a Medicare-certified dialysis facility. For example, Part B covers ESRD-related laboratory tests and drugs (like heparin, topical anesthetics, and erythropoiesis-stimulating agents used to treat anemia related to your ESRD), but excludes ESRD-related drugs that only have an oral form of administration (drugs taken by mouth that only come in capsule, tablet, or liquid forms), which are covered only under Part D (Medicare prescription drug coverage).

Outpatient maintenance dialysis treatments include the cost of dialysis drugs and biologicals (except ESRD-related drugs that only have an oral form of administration, which are covered only under Part D).

In 2018, you pay 20% of the Medicare-approved amount for each dialysis treatment given in a dialysis facility or at home, and the Part B deductible applies.

Training for home dialysis: Part B covers training if you're a candidate for home dialysis. Part B covers training conducted during the course of your regular treatments for you and the person helping you with your home dialysis treatments. A dialysis facility that has been certified by Medicare to provide home dialysis training must conduct the training. Only dialysis facilities can bill Medicare (directly or under arrangement) for providing home dialysis training.

The cost of home training is included as part of the outpatient maintenance dialysis treatment. **In 2018, you pay** 20% of the Medicare-approved amount for the outpatient maintenance dialysis treatment, and the Part B deductible applies.

Home dialysis equipment, supplies, & support services: Part B covers all kidney dialysis equipment and supplies including alcohol, wipes, dialysis machines, sterile drapes, rubber gloves, and scissors. Part B also covers home dialysis support services provided by your dialysis facility. Home dialysis support services can include periodic visits by trained dialysis workers to check on your home dialysis, to help in dialysis emergencies when needed, and to check your dialysis equipment and hemodialysis water supply.

Dialysis (kidney) services & supplies (continued)

The cost of home dialysis equipment, supplies, and support services are included as part of the outpatient maintenance dialysis treatment.

In 2018, you pay 20% of the Medicare-approved amount for the outpatient maintenance dialysis treatment, and the Part B deductible applies. Only dialysis facilities can bill Medicare for providing (directly or under arrangement) home dialysis support services.

Doctor & other health care provider services

Part B covers medically necessary doctor services (including outpatient services and some doctor services you get when you're a hospital inpatient) and covered preventive services. A doctor can be a Doctor of Medicine (MD), a Doctor of Osteopathic Medicine (DO), or, in some cases, a dentist, podiatrist (foot doctor), optometrist (eye doctor), or chiropractor. Medicare also covers services provided by other health care providers, like physician assistants, nurse practitioners, clinical nurse specialists, clinical social workers, physical therapists, occupational therapists, speech language pathologists, and clinical psychologists.

In 2018, you pay 20% of the Medicare-approved amount, except for certain preventive services (for which you may pay nothing if your doctor or other provider accepts assignment). The Part B deductible applies. See "Preventive services" on page 46.

Drugs

See "Prescription drugs (outpatient)" on pages 44–45.

Durable medical equipment (DME)

Part B covers medically necessary durable medical equipment (DME) that your doctor prescribes for use in your home. Only your doctor can prescribe medical equipment for you. DME is defined as equipment that meets these criteria:

- Durable (can withstand repeated use)
- Used for a medical reason
- Not usually useful to someone who isn't sick or injured
- Used in your home
- Has an expected lifetime of at least 3 years

In certain circumstances, the DME that Medicare covers includes, but isn't limited to:

- Air-fluidized beds and other support surfaces (these supplies are only rented)
- Blood sugar monitors and diabetic testing strips
- Canes (except white canes for the blind)

Durable medical equipment (DME) (continued)

- Commode chairs
- Continuous Positive Airway Pressure (CPAP) machines
- Crutches
- Home oxygen equipment and supplies
- Hospital beds
- Infusion pumps and supplies (when necessary to administer certain drugs)
- Manual wheelchairs and power mobility devices
- Nebulizers (and some medicines used in nebulizers if considered reasonable and necessary)
- Oxygen equipment and accessories
- Patient lifts (to lift patient from bed or wheelchair by hydraulic operation)
- Suction pumps
- Traction equipment
- Walkers

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 on the Medicare-approved amount). If suppliers are enrolled in Medicare but aren't "participating," they may choose not to accept assignment.

If suppliers don't accept assignment, there's no limit on the amount they can charge you. To find suppliers who accept assignment, visit Medicare.gov/supplier or call 1-800-MEDICARE (1-800-633-4227). TTY users can call 1-877-486-2048.

In 2018, you pay 20% of the Medicare-approved amount for DME (if your supplier accepts assignment), and the Part B deductible applies.

Note: Medicare pays for different kinds of DME in different ways: some equipment is rented, other equipment is purchased, and some equipment may be either rented or bought. If a DME supplier doesn't accept assignment, Medicare doesn't limit how much the supplier can charge you. You also may have to pay the entire bill (your share and Medicare's share) at the time you get the DME and then submit a claim for reimbursement.

Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Competitive Bidding Program

If you live in a Competitive Bidding Area (CBA) and use equipment or supplies included under the program (or get items while visiting a CBA), you generally must use a Medicare contract supplier if you want Medicare to help pay for the item.

Visit Medicare.gov/supplier to see if you live in a CBA and to find Medicare-approved suppliers in your area. If your ZIP code is in a CBA, items included in the program are marked with an orange star. You can also call 1-800-MEDICARE (1-800-633-4227). TTY users can call 1-877-486-2048.

For more information visit Medicare.gov/publications to view the booklet "Your Guide to Medicare's Durable Medical Equipment Prosthetics, Orthotics, & Supplies (DMEPOS) Competitive Bidding Program."

Medicare also has a nationwide program for mail-order diabetes testing supplies for everyone who gets their diabetes testing supplies delivered to their home. See "Diabetes services & supplies" on page 24. If a supplier plans to give you an item that won't be covered because the supplier isn't a contract supplier, it must give you an "Advance Beneficiary Notice of Noncoverage" (ABN) to inform you of your financial responsibility before furnishing the item.

E

EKG or ECG (electrocardiogram) screening

Part B covers a one-time screening EKG /ECG if you get a referral from your doctor or other health care provider as part of your one-time "Welcome to Medicare" preventive visit. See "Preventive visits" on page 46. EKGs /ECGs are also covered as diagnostic tests. See page 25.

In 2018, you pay 20% of the Medicare-approved amount, and the Part B deductible applies. If you have the test at a hospital or a hospital-owned clinic, you also pay the hospital a copayment.

Emergency department services

Part B covers emergency department services. Generally, these services are covered when you have an injury, a sudden illness, or an illness that quickly gets much worse. Emergency services may be covered in foreign countries only in rare circumstances. For more information, see "Travel" on page 55.

In 2018, you pay a copayment for each emergency department visit and a copayment for each hospital service. You also pay 20% of the Medicare-approved amount for your doctor's services, and the Part B deductible applies. If you're admitted to the same hospital for a related condition within 3 days of your emergency department visit, you don't pay the copayment because your visit is considered to be part of your inpatient stay.

Equipment

See "Durable medical equipment" on pages 27–28.

Eye exams

Medicare doesn't cover eye exams (sometimes called "eye refractions") for eyeglasses or contact lenses. Medicare covers some preventive and diagnostic eye exams:

- See "Yearly eye exam" under "Diabetes services & supplies" on pages 23–25.
- See "Glaucoma tests" on page 31.
- See "Macular degeneration" on pages 38–39.

Eyeglasses/contact lenses

Generally, Medicare doesn't cover eyeglasses or contact lenses. However, following cataract surgery that implants an intraocular lens, Part B helps pay for corrective lenses (one pair of eyeglasses with standard frames or one set of contact lenses). Medicare covers the surgery if it's done using traditional surgical techniques or using lasers.

In 2018, you pay 100% for non-covered services, including most eyeglasses or contact lenses. You pay 20% of the Medicare-approved amount for one pair of eyeglasses or one set of contact lenses after each cataract surgery with an intraocular lens, and the Part B deductible applies. You pay any additional costs for upgraded frames. Medicare will only pay for contact lenses or eyeglasses from a supplier enrolled in Medicare, no matter who submits the claim (you or your supplier).

F

Federally Qualified Health Center (FQHC) Services

Part B covers a broad range of outpatient primary care and preventive services in federally qualified health centers. To find a FQHC near you, visit findahealthcenter.hrsa.gov.

In 2018, you generally pay 20% of the charges or the Medicare-approved amount. You pay nothing for most preventive services.

Flu shots

Part B normally covers one flu shot per flu season.

In 2018, you pay NOTHING for a flu shot if your doctor or other qualified health care provider accepts assignment for giving the shot.

Foot care

Part B covers podiatrist (foot doctor) foot exams or treatment if you have diabetes-related nerve damage. Part B also covers medically necessary treatment of foot injuries or diseases (like hammer toe, bunion deformities, and heel spurs). See "Therapeutic shoes" (on page 23) and "Foot exam" under "Diabetes services & supplies" (on page 25). Part B generally doesn't cover routine foot care (like the cutting or removal of corns and calluses, trimming, cutting, and clipping nails, or hygienic or other preventive maintenance, including cleaning and soaking the feet).

In 2018, you pay 100% for routine foot care, in most cases. You pay 20% of the Medicare-approved amount for medically necessary treatment provided by your doctor, and the Part B deductible applies. In a hospital outpatient setting, you also pay a copayment for medically necessary treatment.

G

Glaucoma tests

Part B covers a glaucoma test once every 12 months if you're at high risk for 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 to do this test in your state must do or supervise the screening.

In 2018, you pay 20% of the Medicare-approved amount, and the Part B deductible applies. In a hospital outpatient setting, you also pay a copayment.

H

Health education/wellness programs

Medicare generally doesn't cover health education and wellness programs. However, Medicare does cover medical nutrition therapy if you have diabetes or kidney disease, diabetes self-management training if you have diabetes (see page 24), kidney disease education services (see page 37), counseling to stop smoking and tobacco use (see page 52), alcohol misuse screenings and counseling (see page 12), depression screenings (see page 22), a one-time "Welcome to Medicare" preventive visit (see page 46), and yearly "Wellness" visits (see page 46).

Hearing & balance exams/hearing aids

Part B covers diagnostic hearing and balance exams if your doctor or other health care provider orders them to see if you need medical treatment. Medicare doesn't cover hearing exams, hearing aids, or exams for fitting hearing aids.

In 2018, you pay 100% for exams and hearing aids. You pay 20% of the Medicare-approved amount for your doctor's services for covered exams, and the Part B deductible applies. In a hospital outpatient setting, you also pay the hospital a copayment.

Hepatitis B shots

Part B covers these shots if you're at medium or high risk for Hepatitis B. Your risk for Hepatitis B increases if you have hemophilia, End-Stage Renal Disease (ESRD) (permanent kidney failure requiring dialysis or a kidney transplant), 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 bodily fluids. Other factors may also increase your risk for Hepatitis B. Check with your doctor to see if you're at high or medium risk for Hepatitis B.

In 2018, you pay NOTHING for the shot if your 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 used or have used illicit injection drugs.
- 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.

In 2018, you pay NOTHING for the screening test if your doctor or other qualified health care provider accepts assignment. Medicare will only cover Hepatitis C screening tests if your primary care doctor or other primary care provider orders them.

HIV screening

Part B covers one HIV (Human Immunodeficiency Virus) screening every 12 months if you meet these conditions:

- You're 15-65.
- You're younger than 15 or older than 65 and are at an increased risk for the virus.

If you're pregnant, you can also get the screening up to 3 times during your pregnancy.

In 2018, you pay NOTHING for the test if your 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 if you meet all of these conditions:

- You must be under the care of a doctor, and you must be getting services under a plan of care established and reviewed regularly by a doctor.
- You must need, and a doctor must certify that you need, one or more of these:
  - Intermittent skilled nursing care (other than drawing blood)
  - Physical therapy
  - Speech-language pathology services
  - Continued occupational therapy
- The home health agency caring for you is approved by Medicare (Medicare certified).
- You must be homebound, and a doctor must certify that you're homebound. To be homebound means either of these is true:
  - 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; or leaving your home isn't recommended because of your condition.
  - You're normally unable to leave your home, but if you do, it requires a major effort.

You may leave home for medical treatment or short, infrequent absences for non-medical reasons, like an occasional trip to the barber, a walk around the block or a drive, or a family reunion, funeral, graduation, or other infrequent or unique event. You can still get home health care if you attend adult day care or religious services.

A doctor, or certain health care professionals who work with a doctor (like a nurse practitioner), must document that they've had a face-to-face encounter with you (like an appointment with your primary care doctor) within required timeframes and that the encounter was related to the reason you need home health care.

Home health services (continued)

Note: Home health services may also include medical social services, part-time or intermittent home health aide services, medical supplies for use at home, durable medical equipment (see pages 27–28), or injectable osteoporosis drugs.

For more information on home health care, visit Medicare.gov to print or view the booklet, "Medicare & Home Health Care."

In 2018, you pay NOTHING for all covered home health visits. You pay 20% of the Medicare-approved amount, and the Part B deductible applies, for Medicare-covered medical equipment.

Osteoporosis drugs for women

Part A and Part B help pay for an injectable drug for osteoporosis if you're a woman who's eligible for Part B, meet the criteria for Medicare home health services, and have a bone fracture that a doctor certifies is related to post-menopausal osteoporosis. Your doctor must also certify that you're unable to learn to give yourself the drug by injection, and that family members and/or caregivers are unable or unwilling to give you the drug by injection. Medicare covers visits by a home health nurse to inject the drug.

In 2018, you pay 20% of the Medicare-approved amount for the cost of the drug, and the Part B deductible applies. You pay nothing for the home health nurse visit to inject the drug.

Hospice care

If you have Part A **and** meet all of these conditions, you can get hospice care:

- Your hospice doctor and your regular doctor (if you have one) certify that you're terminally ill (with a life expectancy of 6 months or less).
- You accept palliative care (for comfort) instead of care to cure your illness.
- You sign a statement choosing hospice care instead of other Medicare-covered benefits to treat your terminal illness and related conditions.

Note: Only your hospice doctor and your regular doctor (if you have one) - not a nurse practitioner that you've chosen to serve as your attending medical professional - can certify that you're terminally ill and have a life expectancy of 6 months or less.

Important: Original Medicare will still pay for covered benefits for any health problems that aren't part of your terminal illness and related conditions, but this is unusual. Once you choose hospice care, your hospice benefit will generally cover everything you need.

Hospice care (continued)

Hospice care is usually given in your home but may also be covered in a hospice inpatient facility. Depending on your terminal illness and related conditions, the plan of care your hospice team creates can include any or all of these services:

- Doctor services
- Nursing care
- Medical equipment (like wheelchairs or walkers)
- Medical supplies (like bandages or catheters)
- Prescription drugs for symptom control or pain relief
- Hospice aide and homemaker services
- Physical therapy services
- Occupational therapy services
- Speech-language pathology services
- Social work services
- Dietary counseling
- Grief and loss counseling for you and your family
- Short-term inpatient care (for pain and symptom management)
- Short-term respite care*
- Any other Medicare-covered services needed to manage your pain and other symptoms related to your terminal illness and related conditions, as recommended by your hospice team

*If your usual caregiver (like a family member) needs a rest, you can get inpatient respite care in a Medicare-approved facility (like a hospice inpatient facility, hospital, or nursing home). Your hospice provider will arrange this for you. You can stay up to 5 days each time you get respite care. You can get respite care more than once, but it can only be provided on an occasional basis.

In 2018, you generally pay NOTHING for hospice care. You may need to pay a copayment of no more than $5 for each prescription drug and other similar product for pain relief and symptom control when you're getting care at home. You may need to pay 5% of the Medicare-approved amount for inpatient respite care. Your cost for respite care may range from $5-$12 per day. Medicare doesn't cover room and board when you get hospice care in your home or another facility where you live (like a nursing home). If your attending doctor isn't employed by the hospice, you pay your usual Part B deductible and coinsurance for his or her services.

Medicare covers the costs of your room and board if the hospice staff determines that your symptoms must be managed in an inpatient setting, like a hospice facility, hospital, or nursing home.

Hospital bed

If you live in certain areas of the country, you may have to use specific suppliers for Medicare to pay for a hospital bed used at home. See "Durable medical equipment" on pages 27–28.

H

Humidifiers

Generally, Medicare doesn't cover humidifiers or other similar items, like room heaters, dehumidifiers, or electric air cleaners.

However, Medicare covers oxygen humidifiers used with certain covered durable medical equipment (DME) when medically necessary.

In 2018, you pay 100% for most humidifiers or other similar items. You won't have to pay a separate amount for an oxygen humidifier. The cost of an oxygen humidifier will be included in the monthly fee for your oxygen equipment.

Hyperbaric oxygen (HBO) therapy

Medicare covers HBO therapy, a process in which your entire body is exposed to oxygen under increased atmospheric pressure, if you have certain conditions. The therapy must be administered in a chamber (including a one-person unit). For the full list of covered conditions, visit Medicare.gov/coverage/hyperbaric-oxygen-therapy.html.

In 2018, you pay 20% of the Medicare-approved amount, and the Part B deductible may apply.

I

Inpatient hospital care

Part A covers inpatient hospital care when all of these are true:

- You're admitted to the hospital as an inpatient after an official doctor's order, which says you need inpatient hospital care to treat your illness or injury.
- The hospital accepts Medicare.
- In certain cases, the Utilization Review Committee of the hospital approves your stay while you're in the hospital.

Medicare-covered hospital services include semi-private rooms, meals, general nursing, 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 mental health care.

Inpatient hospital care (continued)

See "Mental health care" on page 39. 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 covers your doctors' services you get while you're in a hospital.

In 2018, you pay the following for each benefit period:

- Days 1-60: $1,340 deductible.
- Days 61-90: $335 coinsurance each day.
- Days 91 and beyond: $670 coinsurance per each "lifetime reserve day" after day 90 for each benefit period (up to 60 days over your lifetime).
- Each day after the lifetime reserve days: all costs. Inpatient mental health care in a psychiatric hospital is limited to 190 days in a lifetime.

For "Outpatient hospital services," see pages 41–42.

Note: In some cases, the hospital or a Medicare contractor reviewing claims may determine you should've gotten services in an outpatient setting. The hospital may submit a Part B claim for your services, and the amount you owe may change. You'll pay your part for Part B services, but if you already made payments to the hospital for these services under Part A, the hospital must provide you with a refund for any overpayments.

K

Kidney (dialysis)

See "Dialysis (kidney) services & supplies" on pages 26–27.

Kidney disease education

Medicare covers up to 6 sessions of kidney disease education services if you have Stage IV chronic kidney disease that will usually require dialysis or a kidney transplant, if your doctor or other health care provider refers you for the service, and when the service is given by a doctor, certain qualified non-doctor provider, or certain rural provider. Kidney disease education teaches you how to take the best possible care of your kidneys and gives you information you need to make informed decisions about your care.

In 2018, you pay 20% of the Medicare-approved amount per session if you get the service from a doctor or other qualified health care provider, and the Part B deductible applies.

L

Laboratory tests (clinical)

Part B covers medically necessary clinical diagnostic laboratory tests when your treating doctor or practitioner orders them. Laboratory tests include certain blood tests, urinalysis, tests on tissue specimens, and some screening tests. A laboratory that meets Medicare requirements must require them. For more information, see "Diagnostic tests" on page 25.

In 2018, you pay NOTHING for this service if your primary care doctor or other qualified primary care practitioner accepts assignment.

Long-term care

Long-term care includes non-medical care for people who have a chronic illness or disability. Medicare and most health insurance plans, including Medicare Supplement Insurance (Medigap) policies, don't pay for this type of care, sometimes called "custodial care."

In 2018, you generally pay 100% for long-term care. To learn about other options for paying for long-term care (like Medicaid), visit Medicare.gov, or look at your "Medicare & You" handbook.

Lung cancer screening

Part B covers lung cancer screenings with Low Dose Computed Tomography (LDCT) once per year if you meet all of these conditions:

- You're age 55-77.
- You're asymptomatic (you 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 (20 cigarettes) per day for 30 years).
- You get a written order from doctor. (Before your first lung cancer screening, you'll need to schedule a lung cancer screening counseling and shared decision making visit 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.)

In 2018, you pay NOTHING for this service if your doctor accepts assignment.

M

Macular degeneration

Part B covers certain diagnostic tests and treatment of diseases and conditions of the eye for some patients with age-related macular degeneration (AMD), including treatment with certain injected drugs.

Macular degeneration (continued)

In 2018, you pay 20% of the Medicare-approved amount for the drug and your doctor's services, and the Part B deductible applies. In a hospital outpatient setting, you pay a copayment.

Mammograms

Part B covers a screening mammogram once every 12 months (11 full months must have passed since the last screening) if you're a woman with Medicare and are 40 or older. You can also get one baseline mammogram if you're between ages 35–39.

In 2018, you pay NOTHING for the screening test if your doctor or other qualified health care provider accepts assignment.

Part B also covers **diagnostic** mammograms when medically necessary.

In 2018, you pay 20% of the Medicare-approved amount, and the Part B deductible applies.

Medical nutrition therapy services

See "Nutrition therapy services (medical)" on page 40.

Mental health care

Part A and Part B cover mental health services to help with conditions like depression and anxiety in a variety of settings.

Inpatient mental health care: Part A covers mental health care services you get in a hospital that require you to be admitted as an inpatient. You can get these services either in a general hospital or a psychiatric hospital that only cares for people with mental health conditions. Medicare helps pay for inpatient mental health services in the same way it pays for all other inpatient hospital care.

Note: If you're in a freestanding psychiatric hospital, Medicare only helps pay for a total of 190 days of inpatient care during your lifetime.

Outpatient mental health care: Part B covers mental health services on an outpatient basis when provided by a psychiatrist or other doctor, clinical psychologist, clinical social worker, clinical nurse specialist, nurse practitioner, or physician assistant in a doctor or other health care provider's office or hospital outpatient department.

In 2018, you pay 20% of the Medicare-approved amount for visits to your doctor or other health care provider. The Part B deductible applies. If you get treatment services in a hospital outpatient clinic or hospital outpatient department, you may have to pay an additional copayment or coinsurance amount to the hospital.

Mental health care (continued)

Partial hospitalization services: Part B covers partial hospitalization services under a partial hospitalization program, by a hospital to its outpatients or by a community mental health center. A partial hospitalization program is a structured program of outpatient psychiatric services provided to patients as an alternative to inpatient psychiatric care. It's more intense than the care you get in your doctor's or therapist's office. To be eligible for partial hospitalization services, a doctor must certify that you would otherwise need inpatient treatment.

In 2018, you pay a percentage of the Medicare-approved amount for each service you get from a doctor or certain other mental health qualified professionals (as described on the previous page in "Outpatient mental health care") if your health care professional accepts assignment. You also pay coinsurance for each day of partial hospitalization services provided in a hospital outpatient setting or community mental health center, and the Part B deductible applies.

N

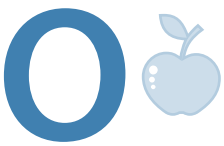
Nursing home care

Most nursing home care is custodial care, like help with bathing or dressing. Medicare doesn't cover custodial care if that's the only care you need. However, if it's medically necessary for you to have skilled care (like changing sterile dressings), Part A may pay for care given in a certified skilled nursing facility if you meet certain requirements. See "Skilled nursing facility (SNF) care" on pages 50–52. For more information on long-term care, see "Long-term care" on page 38.

Nutrition therapy services (medical)

Part B may cover medical nutrition therapy (MNT) services and certain related services if you have diabetes or kidney disease, or you've had a kidney transplant in the last 36 months. A Registered Dietitian or nutrition professional who meets certain requirements can provide MNT services, but only your doctor can refer you for the service. Services may include an initial nutrition and lifestyle assessment, one-on-one nutritional counseling, help managing the lifestyle factors that affect your diabetes, and follow-up visits to check on your progress in managing your diet. If you get dialysis in a dialysis facility, Medicare covers MNT as part of your overall dialysis care. If you're in a rural area, a Registered Dietitian or other nutritional professional in a different location may be able to provide MNT to you through Telehealth. See "Telehealth" on page 53 and "Diabetes services & supplies" on pages 23–25.

In 2018, you pay NOTHING for these preventive services because the Part B deductible and coinsurance don't apply.



Obesity screening & counseling

If you have a body mass index (BMI) of 30 or more, Medicare covers 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.

In 2018, you pay NOTHING for this service if your primary care doctor or other qualified primary care practitioner accepts assignment.

Observation services

See "Outpatient hospital services" on pages 41–42.

Occupational therapy

See "Physical therapy/occupational therapy/speech-language pathology" on pages 43–44.

Orthotics, artificial limbs, & eyes

Part B covers medically necessary artificial limbs and eyes, as well as arm, leg, back, and neck braces. Medicare doesn't pay for orthopedic shoes unless they're a necessary part of the leg brace. See "Diabetes services & supplies (therapeutic shoes)" on page 23. You must go to a supplier that's enrolled in Medicare for Medicare to cover your orthotics. See "Artificial limbs & eyes" on page 14.

In 2018, you pay 20% of the Medicare-approved amount, and the Part B deductible applies. Medicare will only pay for orthotic items furnished by a supplier enrolled in Medicare, no matter who submits the claim (you or your supplier).

Ostomy supplies

Part B covers medically necessary ostomy supplies if you've had a colostomy, ileostomy, or urinary ostomy. Medicare covers the amount of supplies your doctor says you need, based on your condition. Medicare covers these supplies as prosthetic devices.

In 2018, you pay 20% of the Medicare-approved amount for your doctor's services and supplies, and the Part B deductible applies.

Outpatient hospital services

Part B covers medically necessary diagnostic and treatment services you get as an outpatient from a Medicare-participating hospital. Covered outpatient hospital services may include:

- Emergency or observation services which may include an overnight stay in the hospital, or services in an outpatient clinic, including same-day surgery
- Laboratory tests billed by the hospital

Outpatient hospital services (continued)

- Mental health care in a partial hospitalization program, if a doctor certifies that inpatient treatment would be required without it (see "Partial hospitalization services" on page 40)
- X-rays and other radiology services billed by the hospital
- Medical supplies, like splints and casts
- Screenings and preventive services
- Certain drugs and biologicals that you wouldn't usually give yourself

In 2018, you generally 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 & surgical services & supplies

Part B covers approved procedures like X-rays, casts, stitches, or outpatient surgeries.

In 2018, you pay 20% of the Medicare-approved amount for your 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.

Oxygen equipment & accessories

Part B covers the rental of oxygen equipment and accessories that your doctor prescribes for use in your home. If you own your own equipment, Medicare will help pay for oxygen contents and supplies for the delivery of oxygen when all of these conditions are met:

- Your doctor says you have a severe lung disease or you're not getting enough oxygen
- Your health might improve with oxygen therapy
- Your arterial blood gas level falls within a certain range
- Other alternative measures have failed

Oxygen equipment & accessories (continued)

Under the above conditions, Medicare helps pay for:

- Systems that provide oxygen
- Containers that store oxygen
- Tubing and related supplies for the delivery of oxygen and oxygen contents

In 2018, you pay 20% of the Medicare-approved amount, and the Part B deductible applies. If you live in certain areas of the country, you may have to use specific suppliers for Medicare to pay for oxygen, oxygen equipment, and supplies. See "Durable medical equipment" on pages 27–28.

Physical therapy/occupational therapy/speech-language pathology services

Part B helps pay for medically necessary outpatient physical and occupational therapy, and speech-language pathology services. Medicare law limits how much it pays for your medically necessary outpatient therapy services in one calendar year. These limits are called "therapy caps" or "therapy cap limits."

The therapy cap amounts for 2018 are:

- $2,010 for physical therapy (PT) and speech language pathology (SLP) services combined
- $2,010 for occupational therapy (OT) services

If there's a therapy cap exceptions process in place for 2018, and you qualify for an exception, Medicare will continue to pay its share for your therapy services after you reach the therapy cap limits. Your therapist or therapy provider must document in your medical record that you need medically necessary services and their billing office must indicate on your claim for services above the therapy caps that your therapy services are medically reasonable and necessary.

When an exceptions process is in place, a Medicare contractor may review your medical records to check for medical necessity if you get outpatient therapy services in 2018 higher than these amounts:

- $3,700 for PT and SLP combined
- $3,700 for OT

In general, when an exceptions process is in effect, if your therapist or therapy provider gives documentation that your therapy services were medically reasonable and necessary and indicates this on your claim, Medicare will continue to cover its share above the $2,010 therapy cap limits.

Physical therapy/occupational therapy/speech-language pathology services (continued)

Because Medicare doesn't pay for therapy services that aren't reasonable and necessary, your therapist must give you a written notice, called an "Advance Beneficiary Notice of Noncoverage" (ABN) before providing services that aren't medically necessary. The ABN lets you choose whether you want the therapy services. If you choose to get the medically unnecessary services, you agree to pay for them.

In 2018, you pay 20% of the Medicare-approved amount, and the Part B deductible applies. Except for therapy services you get from an outpatient hospital, you pay the entire bill (your share and Medicare's share) for the therapy services over each cap amount.

For more information on therapy caps, visit Medicare.gov/coverage/pt-and-ot-and-speech-language-pathology.html.

Pneumococcal shots

Part B covers a pneumococcal shot to help prevent pneumococcal infections (like certain types of pneumonia). Part B 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 shots.

In 2018, you pay NOTHING for pneumococcal shots if your doctor or other qualified health care provider accepts assignment.

Prescription drugs (outpatient) limited coverage

Part B generally doesn't cover most prescription drugs used at home, but it does cover a limited number of outpatient prescription drugs under limited conditions. Drugs not covered under Part B may be covered under Part D (Medicare prescription drug coverage). If you have Part D, check your plan's formulary (drug list) to see what outpatient drugs are covered.

Generally, drugs covered under Part B are drugs you wouldn't usually give to yourself, like those you get at a doctor's office or hospital outpatient setting. Doctors and pharmacies must accept assignment for Part B drugs, so you should never be asked to pay more than the coinsurance or copayment for the Part B drug itself. The Part B deductible also applies.

Examples of drugs Part B covers:

- **Drugs used with an item of durable medical equipment (DME):** Medicare covers drugs infused through an item of DME, like an infusion pump or drugs given by a nebulizer.
- **Some antigens:** Medicare will help pay for antigens if they're prepared by a doctor and given by a properly instructed person (who could be you, the patient) under appropriate supervision.

Prescription drugs (outpatient) limited coverage (continued)

- **Injectable osteoporosis drugs:** Medicare helps pay for an injectable drug for osteoporosis for certain women. See note for women with osteoporosis under "Home health services" on pages 33–34.
- **Erythropoiesis–stimulating agents:** Medicare will help pay for erythropoietin by injection if you have End-Stage Renal Disease (ESRD) (permanent kidney failure requiring dialysis or a kidney transplant) or need this drug to treat anemia related to certain other conditions.
- **Blood clotting factors:** If you have hemophilia, Medicare will help pay for clotting factors you give yourself by injection.
- **Injectable and infused drugs:** Medicare covers most injectable and infused drugs given by a licensed medical provider.
- **Immunosuppressive drugs:** Part B covers immunosuppressive drug therapy if Medicare helped pay for your organ transplant.

  Note: Medicare Prescription Drug Plans may cover immunosuppressive drugs, even if Medicare didn't pay for the transplant. Part D also may cover other immunosuppressive drugs that Part B doesn't cover.
- **Calcimimetic medications:** Part B covers calcimimetic medications if you have ESRD. Visit Medicare.gov/coverage/prescription-drugs-outpatient.html for more information.
- **Oral cancer drugs:** Medicare will help pay for some cancer drugs you take by mouth if the same drug is available in injectable form or is a prodrug of the injectable drug. A prodrug is an oral form of a drug that when ingested breaks down into the same active ingredient found in the injectable form of the drug. As new oral cancer drugs become available, Part B may cover them.
- **Oral anti-nausea drugs:** Medicare will help pay for oral anti-nausea drugs used as part of an anti-cancer chemotherapeutic regimen. The drugs must be administered immediately before, at, or within 48 hours after chemotherapy, and must be used as a full therapeutic replacement for an intravenous anti-nausea drug.

In 2018, you pay 20% of the Medicare-approved amount for covered Part B prescription drugs that you get in a doctor's office or pharmacy, and the Part B deductible applies. In a hospital outpatient setting, you pay a copayment. However, if you get drugs that Part B doesn't cover in a hospital outpatient setting, you pay 100% for the drugs unless you have Part D or other prescription drug coverage. In that case, what you pay depends on whether your drug plan covers the drug, and whether the hospital 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 Part B doesn't cover.

Preventive services

Part B covers many preventive services. Each covered preventive service in this booklet has a picture of an apple next to it. Talk with your doctor about which preventive services are right for you.

Preventive visits

Medicare covers 2 types of routine preventive visits: one when you're new to Medicare and one each year after that.

"Welcome to Medicare" preventive visit

Part B covers a one-time "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, shots, and referrals for other care, if needed.

Important: You must have the preventive visit within the first 12 months you have Part B. When you make your appointment, let your doctor's office know you would like to schedule your "Welcome to Medicare" preventive visit.

In 2018, you pay NOTHING for the visit if your doctor or other qualified health care provider accepts assignment.

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 to help prevent disease and disability, based on your current health and risk factors. It may include advance care planning. See page 12.

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.

In 2018, you pay NOTHING for this visit if your doctor or other qualified health care provider accepts assignment. This visit is covered once every 12 months.

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, even if you never had a "Welcome to Medicare" preventive visit, you can have a yearly "Wellness" visit after you've had Part B for at least 12 months.

Prostate cancer screenings

Part B covers prostate cancer screening tests once every 12 months for men over 50 (beginning the day after your 50th birthday). Covered screenings include:

Digital rectal exam

In 2018, you pay 20% of the Medicare-approved amount for a yearly digital rectal exam and for your doctor's services related to the exam, and the Part B deductible applies. In a hospital outpatient setting, you pay a copayment.

Prostate specific antigen (PSA) blood test

In 2018, you pay NOTHING for a yearly PSA blood test. If you get the test from a doctor that doesn't accept assignment, you may have to pay an additional fee for your doctor's services, but not for the test itself.

Prosthetic devices

Part B covers prosthetic devices needed to replace a body part or function when a doctor or other health care provider enrolled in Medicare orders them. Prosthetic devices include, for example, one pair of conventional eyeglasses or contact lenses provided after a cataract operation, ostomy bags and certain related supplies (see "Ostomy supplies" on page 41), urological supplies, breast prostheses (including a surgical bra) after a mastectomy (see "Breast prostheses" on page 15), and cochlear implants and certain other surgically implanted prosthetic devices. You must go to a supplier that's enrolled in Medicare for Medicare to pay for your device. Part A or Part B covers surgically implanted prosthetic devices depending on whether the surgery takes place in an inpatient or outpatient setting.

In 2018, you pay 20% of the Medicare-approved amount for external prosthetic devices, and the Part B deductible applies. Medicare will only pay for prosthetic items furnished by a supplier enrolled in Medicare, no matter who submits the claim (you or your supplier). For surgeries to implant prosthetic devices in a hospital inpatient setting covered under Part A, see "Inpatient hospital care" on pages 36–37. For surgeries to implant prosthetic devices in a hospital outpatient setting covered under Part B, see "Outpatient hospital services" on pages 41–42.

Pulmonary rehabilitation

Part B covers a comprehensive pulmonary rehabilitation program if you have moderate to very severe chronic obstructive pulmonary disease (COPD) and have a referral for pulmonary rehabilitation from the doctor treating this chronic respiratory disease. These services are intended to help you breathe better, make you stronger, and be able to live more independently. These services may be provided in a doctor's office or a hospital outpatient setting that offers pulmonary rehabilitation programs.

In 2018, you pay 20% of the Medicare-approved amount if you get the service in your doctor's office. You also pay a copayment per session if you get the service in a hospital outpatient setting. The Part B deductible applies.

R

Radiation therapy

Part A covers radiation therapy for hospital inpatients. Part B covers this therapy for outpatients or patients in freestanding clinics.

In 2018, you pay the Part A deductible and coinsurance (if applicable) as an inpatient.

In 2018, you pay a set copayment as an outpatient, and the Part B deductible applies.

In 2018, you pay 20% of the Medicare-approved amount for the therapy at a freestanding facility, and the Part B deductible applies.

Religious nonmedical health care institution (RNHCI) items & services

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

Medicare doesn't cover the religious portion of RNHCI care. However, Part A covers inpatient non-religious, non-medical care when these conditions are met:

- The RNHCI is currently certified to participate in Medicare.
- The RNHCI Utilization Review Committee agrees that you would require hospital or SNF care if you weren't in the RNHCI.

Religious nonmedical health care institution (RNHCI) items & services (continued)

- You have a written election on file with Medicare indicating that your need for RNHCI care is based on both your eligibility and religious beliefs. The election must also indicate that if you decide to accept standard medical care, you'll cancel the election and may have to wait 1–5 years (depending on how many times you may have previously revoked your election) to be eligible for a new election to get RNHCI services. Please note that you're always eligible to get medically necessary Part A services.

In 2018, for each benefit period **you pay**:

– Days 1–60: $1,340 deductible

– Days 61–90: $335 coinsurance each day

– Days 91–150: $670 coinsurance each day

– Each day beyond 150 days: all costs

Respite care (inpatient)

See "Hospice care" on pages 34–35.

Rural health clinic (RHC) services

Part B covers a broad range of outpatient primary care and preventive services in rural health clinics. RHCs furnish many outpatient primary care and preventive health services. RHCs are located in non-urbanized areas that are in medically underserved or shortage areas.

In 2018, you generally pay 20% of the charges, and the Part B deductible applies. You pay nothing for most preventive services.

S

Second surgical opinions

Part B covers second surgical opinions in some cases for surgery that isn't an emergency. A second opinion is when another doctor gives his or her view about your health problem and how it should be treated. Medicare also will help pay for a third opinion if the first and second opinions are different.

In 2018, you pay 20% of the Medicare-approved amount, and the Part B deductible applies.

Sexually transmitted infections screening & counseling

Medicare covers sexually transmitted infection (STI) screenings for chlamydia, gonorrhea, syphilis, and/or Hepatitis B. These screenings are covered for people with Part B who are pregnant and for certain people who are at increased risk for an STI when a doctor orders the tests. 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 all sexually active adolescents and adults at increased risk for STIs, if referred by a doctor. Medicare will only cover these counseling sessions if they're provided by a doctor and take place in a primary care doctor's office or primary care clinic. Counseling conducted in an inpatient setting, like a skilled nursing facility, won't be covered as a preventive service.

In 2018, you pay NOTHING if the doctor accepts assignment.

Shots (vaccinations)

Part B covers:

- **Flu shots** on page 31
- **Hepatitis B shots** on page 32
- **Pneumococcal shots** on page 44

Skilled nursing facility (SNF) care

Part A covers skilled care provided in a skilled nursing facility (SNF) under certain conditions for a limited time. Skilled care is nursing and therapy care that can only be safely and effectively performed by, or under the supervision of, professionals or technical personnel. It's health care given when you need skilled nursing or skilled therapy to treat, manage, and observe your condition, and evaluate your care. Medicare covers certain daily skilled care services on a short-term basis (up to 100 days in a benefit period).

In 2018, you pay the following for each benefit period (following at least a 3-day medically necessary inpatient hospital stay for a related illness or injury):

- Days 1–20: $0 each benefit period
- Days 21–100: up to $167.50 each day
- Beyond 100 days: 100% of all costs

There's a limit of 100 days of Part A SNF coverage in each benefit period.

Skilled nursing facility (SNF) care (continued)

Medicare will cover SNF care if **all** these conditions are met:

1. You have Part A and have days left in your benefit period to use.
2. You have a qualifying inpatient hospital stay. This means a prior medically necessary inpatient hospital stay of 3 consecutive calendar days or more, including the day you're admitted to the hospital, but not including the day you leave the hospital.

   Note: Time that you spend in a hospital as an outpatient before you're admitted as an inpatient doesn't count toward the 3 inpatient hospital days you need to have a qualifying inpatient hospital stay for SNF benefit purposes. Observation services aren't counted as part of the qualifying inpatient hospital stay. You aren't an inpatient until you're formally admitted as an inpatient. See "Outpatient hospital services" on pages 41–42.

   You must enter the SNF within a short time (generally 30 days) of leaving the hospital and require skilled services related to your hospital stay. See item 5 below. After you leave the SNF, if you re-enter the same or another SNF within 30 days, you don't need another 3-day qualifying inpatient hospital stay to get additional SNF benefits. This is also true if you stop getting skilled care while in the SNF and then start getting skilled care again within 30 days.
3. Your doctor has decided that you need daily skilled care. It must be given by, or under the supervision of, skilled nursing or therapy staff. If you're in the SNF for skilled therapy services only, your care is considered daily care even if these therapy services are offered just 5 or 6 days a week, as long as you need and get the therapy services each day they're offered.
4. You get these skilled services in a SNF that's certified by Medicare.
5. You need these skilled services for a medical condition that's either:
   - An ongoing condition that was also treated during your qualifying 3-day inpatient hospital stay, even if it wasn't the reason you were admitted to the hospital.
   - A new condition that started while you were getting care in the SNF for the ongoing condition. For example, if while you're getting SNF care for a stroke that was also treated during your qualifying 3-day inpatient hospital stay, you develop an infection that requires IV antibiotics, Medicare will cover your SNF care for treating the infection (as long as you also meet the conditions listed in items 1–4).

If you're getting care in a SNF that isn't certified by Medicare, your stay won't be covered by Part A, but some services you get during a non-covered stay may be covered by Part B. Any Part B therapy services (physical therapy, occupational therapy, and speech-language pathology services) furnished during a non-covered stay in a Medicare-certified part of another facility (like an inpatient hospital) must be billed by the facility itself.

Skilled nursing facility (SNF) care (continued)

No other therapy service may be billed during the same time period by another setting, like an outpatient hospital clinic.

Swing-bed services

Medicare covers swing bed services in certain hospitals and critical access hospitals (CAHs) when the hospital or CAH has entered into a "swing-bed" agreement with the Department of Health and Human Services, under which the facility can "swing" its beds and provide either acute hospital or SNF-level care, as needed.

In 2018, when swing beds are used to furnish SNF-level care, the same coverage and cost-sharing rules apply as though the services were furnished in a SNF.

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

Part B covers up to 8 face-to-face smoking and tobacco-use cessation counseling visits in a 12-month period. A qualified doctor or other Medicare-recognized provider must provide these visits.

In 2018, you pay NOTHING for the counseling sessions if your doctor or other qualified health care provider accepts assignment.

Speech-language pathology

See "Physical therapy/occupational therapy/speech-language pathology" on pages 43–44.

Supplies (you use at home)

Part B generally doesn't cover common medical supplies like bandages and gauze. Medicare covers some diabetes and dialysis supplies. See "Diabetes services & supplies" on pages 23–25 and "Dialysis (kidney) services & supplies" on pages 26–27. For items like walkers, oxygen, and wheelchairs, see "Durable medical equipment" on pages 27–28.

In 2018, you pay 100% for most common medical supplies you use at home.

Surgical dressing services

Part B covers medically necessary treatment of a surgical or surgically treated wound.

In 2018, you pay 20% of the Medicare-approved amount for your doctor 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.

T

Telehealth

Part B covers certain services like office visits and consultations that are provided using an interactive 2-way telecommunications system (with real-time audio and video) by a doctor or certain other health care provider who isn't at your location. These services are available in some rural areas, under certain conditions, but only if the patient is located at one of these places: a doctor's office, hospital, critical access hospital, rural health clinic, federally qualified health center, hospital-based or critical access hospital-based dialysis facility, skilled nursing facility, or community mental health center.

In 2018, you pay 20% of the Medicare-approved amount for your doctor or other health care provider's services, and the Part B deductible applies.

Therapeutic shoes

See "Diabetes services & supplies (therapeutic shoes)" on page 23.

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. See pages 50–52.

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 and your family and caregiver(s), as appropriate, and with your 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 got 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.

In 2018, you pay coinsurance and the Part B deductible.

Transplants (doctor services)

Part B covers doctor services for certain organ transplants. See "Transplants (facility charges)" below.

In 2018, you pay 20% of the Medicare-approved amount for your doctor's services, and the Part B deductible applies.

Transplants (facility charges)

Part A covers services for heart, lung, kidney, pancreas, intestine, and liver organ transplants under certain conditions, but only in a Medicare-approved facility. Part A also covers stem cell transplants under certain conditions. Part B covers cornea transplants under some conditions. Stem cell and cornea transplants aren't limited to Medicare-approved transplant centers. Organ transplant coverage includes necessary tests and exams before surgery. It also includes immunosuppressive drugs (under certain conditions), follow-up care, and procurement of organs. Medicare pays for the costs for a living donor for a kidney transplant.

In 2018, you pay various amounts. For inpatient transplants, see "Inpatient hospital care" on pages 36–37.

Transportation (routine)

Medicare doesn't cover transportation to get health care unless an ambulance is necessary because other transportation could endanger your health and other conditions are met. For more information, see "Ambulance services" on page 13.

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 50 states, the District of Columbia, Puerto Rico, the U.S. Virgin Islands, Guam, the Northern Mariana Islands, and American Samoa are considered part of the U.S. There are some exceptions, including some cases where Part B may pay for services that you get 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 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 services.

In 2018, you pay 20% of the Medicare-approved amount for the physician and ambulance services, and the Part B deductible applies.

U

Urgently needed care

Part B covers this care to treat a sudden illness or injury that isn't a medical emergency.

In 2018, you pay 20% of the Medicare-approved amount for your doctor 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.

W

Walker/wheelchair

Part B covers walkers, wheelchairs, and power-operated vehicles (scooters) as durable medical equipment that's medically necessary and prescribed by your doctor or other treating provider for use in your home. If you live in certain areas of the country, you may have to use specific suppliers for Medicare to pay for standard (power and manual) wheelchairs, scooters, walkers, and related accessories. See "Durable medical equipment" on pages 27–28.

Power wheelchair: You must have a face-to-face examination and a written prescription from a doctor or other treating provider before Medicare helps pay for a power wheelchair. Power wheelchairs are covered only when they're medically necessary. You may also have to get prior approval (known as "prior authorization") for certain types of power wheelchairs. Visit Medicare.gov/coverage/manual-wheelchairs-and-power-mobility-devices.html for more information.

In 2018, you pay 20% of the Medicare-approved amount, and the Part B deductible applies.

X

X-rays

Part B covers medically necessary diagnostic X-rays that your treating doctor or other health care provider orders. For more information, see "Diagnostic tests" on page 25.

In 2018, you pay 20% of the Medicare-approved amount, and the Part B deductible applies. In a hospital outpatient setting, you pay a copayment.

SECTION 3

For more information

Visit MyMedicare.gov for personalized information

Register at MyMedicare.gov, Medicare's secure online service for accessing your personal Medicare information. You can use this website to:

- Manage your personal information (like medical conditions, allergies, and implanted devices).
- Manage your personal drug list and pharmacy information.
- Search for, add to, and manage a list of your favorite providers and access quality information about them.
- Track Original Medicare claims and your Part B deductible status.
- Order copies of your "Medicare Summary Notice" (MSN).
- View your MSNs electronically (also called "eMSNs"). If you call 1-800-MEDICARE to sign up, we'll send you an email each month when they're available in your MyMedicare.gov account.

Visit Medicare.gov for general information about Medicare

You can use this website to:

- Get detailed information about the Medicare health and prescription drug plans in your area, including what they cost and what services they provide.
- Find doctors or other healthcare providers and suppliers who participate in Medicare.
- See what Medicare covers, including preventive services.
- Get Medicare appeals information and forms.
- Get information about the quality of care provided by plans, nursing homes, hospitals, home health agencies, and dialysis facilities.
- Look up helpful websites and phone numbers.
- View or print detailed booklets and fact sheets on various Medicare topics.

Call 1-800-MEDICARE for answers to your Medicare questions

1-800-MEDICARE (1-800-633-4227) has a speech-automated system to make it easier for you to get the information you need 24 hours a day, including weekends. TTY users can call 1-877-486-2048.

The system will ask you questions to direct your call automatically. Speak clearly, call from a quiet area, and have your Medicare card in front of you. If you need help, you can say "Agent" at any time to talk to a customer service representative. If you need help in a language other than English or Spanish, say "Agent."

Note: If you want Medicare to give your personal health information to someone other than you, you need to let Medicare know in writing. You can fill out a "Medicare Authorization to Disclose Personal Health Information" form. You can do this online by visiting Medicare.gov/medicareonlineforms, or by calling 1-800-MEDICARE to get a copy of the form.

Other important contacts

Below are phone numbers and websites for organizations that provide nationwide services.

State Health Insurance Assistance Program (SHIP)–Get personalized Medicare counseling at no cost to you.	Visit shiptacenter.org, or call 1-800-MEDICARE (1-800-633-4227) for your SHIP's phone number. TTY: 1-877-486-2048.
Social Security–Get a replacement Medicare card, change your address or name, find out if you're eligible for Part A and/or Part B and how to enroll, apply for Extra Help with Medicare prescription drug costs, ask questions about premiums, and report a death.	1-800-772-1213. TTY: 1-800-325-0778. socialsecurity.gov
Benefits Coordination & Recovery Center (BCRC)– Find out if Medicare or your other insurance pays first, let Medicare know you have other insurance, or report changes in your insurance information.	1-855-798-2627. TTY: 1-855-797-2627.
Department of Defense–Get information about TRICARE for Life and the TRICARE Pharmacy Program.	1-866-773-0404 (TFL). TTY: 1-866-773-0405. 1-877-363-1303 (Pharmacy). TTY: 1-877-540-6261. tricare.mil/mybenefit
Department of Health and Human Services Office for Civil Rights–If you think you were discriminated against or if your health information privacy rights were violated.	1-800-368-1019. TTY: 1-800-537-7697. hhs.gov/ocr
Department of Veterans Affairs–If you're a veteran or have served in the U.S. military.	1-800-827-1000. TTY: 1-800-829-4833. va.gov
Office of Personnel Management–Get information about the Federal Employee Health Benefits Program for current and retired federal employees.	1-888-767-6738. TTY: 1-800-878-5707. opm.gov/insure
Railroad Retirement Board (RRB)–If you have benefits from the RRB, call them to change your address or name, check eligibility, enroll in Medicare, replace your Medicare card, or report a death.	1-877-772-5772. TTY: 1-312-751-4701. rrb.gov
Beneficiary and Family Centered Care Quality Improvement Organization (BFCC-QIO)–Ask questions or report a complaint about the quality of care for a Medicare-covered service or if you think Medicare coverage for your service is ending too soon.	Visit Medicare.gov/contacts, or call 1-800-MEDICARE (1-800-633-4227) for your BFCC-QIO's phone number. TTY: 1-877-486-2048.
Learn about fraud–If you think you've been billed for health care you didn't get, you can report suspected fraud.	Visit Medicare.gov/forms-help-and-resources/report-fraud-and-abuse/fraud-and-abuse.html for more information.

Notes

SECTION 4

Definitions

Ambulatory surgical center—A facility where certain surgeries may be performed for patients who aren't expected to need more than 24 hours of care.

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

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

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

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.

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

Claim—A request for payment that you submit to Medicare or other health insurance when you get items and services that you think are covered.

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

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

Critical access hospital (CAH)—A small facility that provides outpatient services, as well as inpatient services on a limited basis, to people in rural areas.

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

Hospice—A special way of caring for people who are terminally ill. Hospice care involves a team-oriented approach that addresses the medical, physical, social, emotional, and spiritual needs of the patient. Hospice also provides support to the patient's family or caregiver.

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

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

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

Medicare health plan—Generally, a plan offered by a private company that contracts with Medicare to provide Part A and Part B benefits to people with Medicare who enroll in the plan. Medicare health plans include all Medicare Advantage Plans, Medicare Cost Plans, and Demonstration/Pilot Programs. PACE plans can be offered by public or private entities and provide Part D and other benefits in addition to Part A and Part B benefits.

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

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

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

Preventive services—Health care to prevent illness or detect illness at an early stage, when treatment is likely to work best (for example, preventive services include Pap tests, flu shots, and screening mammograms).

Referral—A written order from your primary care doctor for you to see a specialist or get certain medical services. In many Health Maintenance Organizations (HMOs), you need to get a referral before you can get medical care from anyone except your primary care doctor. If you don't get a referral first, the plan may not pay for the services.

Religious nonmedical health care institution (RNHCI)—A facility that provides nonmedical health care items and services to people who need hospital or skilled nursing facility care, but for whom that care would be inconsistent with their religious beliefs.

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Important information about this guide

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

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

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES

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- Medicare.gov
- 1-800-MEDICARE (1-800-633-4227)
- TTY: 1-877-486-2048

¿ Necesita usted una copia en español?
Llame GRATIS al 1-800-MEDICARE (1-800-633-4227).