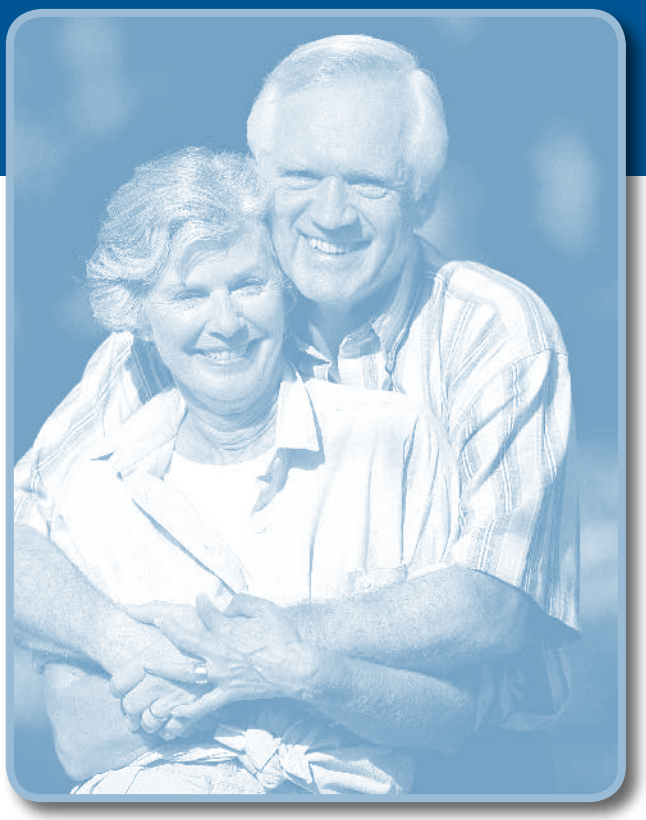
YOUR MEDICARE BENEFITS



This official government guide has important information about the items and services Original Medicare covers.

CENTERS FOR MEDICARE & MEDICAID SERVICES

Your Medicare Benefits

The information in "Your Medicare Benefits" describes the Medicare Program at the time it 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 1-877-486-2-48. "Your Medicare Benefits" isn't a legal document.

Official Medicare Program legal guidance is contained in the relevant statutes, regulations, and rulings.

ABOUT THIS BOOKLET

This booklet describes many, but not all, of the health care items and services covered by Medicare Part A (Hospital Insurance) and Medicare Part B (Medical Insurance). It includes information on how and when you can get these benefits and how much you'll pay.

"Your Medicare Benefits" lists many, but not all, of the items and services that Original 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.

If you have a Medicare Advantage Plan (like an HMO or PPO) 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. For more information, contact your plan.

SECTION 1

Before you read this booklet

Review the questions and answers below before you read "Your Medicare Benefits." They explain information that will be important in understanding Medicare coverage.

What's the Part B deductible?

In 2019, you pay a yearly $185 deductible for Part B-covered services and supplies before Medicare begins to pay its share, depending on the service or supply.

What's assignment, and why is it important?

Assignment is 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.

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).

What if my doctor recommends a service more often than Medicare covers it?

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.

What if I disagree with a coverage or payment decision?

You have the right to appeal. For more information on how to file an appeal, see your "Medicare & You" handbook or visit Medicare.gov/appeals.

What if an item or service isn't listed or I need more information?

Visit Medicare.gov/coverage and type the item or service into the search box for more information. Or, you can call 1-800-MEDICARE (1-800-633-4227). TTY: 1-877-486-2048.

Preventive services

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

SECTION 2

Items & services

Abdominal aortic aneurysm screenings

Part B covers an abdominal aortic screening 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.

How often

Once.

Costs

You pay nothing for this screening if your doctor or other qualified health care practitioner accepts assignment.

Things to know

You must get a referral from your doctor or other qualified health care practitioner.

More information

Visit Medicare.gov/coverage/abdominal-aortic-aneurysm-screenings.

Acupuncture

Medicare doesn't cover acupuncture.

Costs

You pay 100% for non-covered services, including acupuncture.

More information

Visit Medicare.gov/coverage/acupuncture.

Advance care planning

Part B covers voluntary advance care planning as part of your yearly "Wellness" visit. See "Preventive visits" on pages 82–83. Medicare may also cover this service as part of your medical treatment.

Costs

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.

What it is

Advance care planning is planning for care you would get if you become unable to speak for yourself. You can talk about an advance directive with your health care professional, and he or she can help you fill out the forms, if you want to. An advance directive is an important legal document that records your wishes about medical treatment at a future time, if you're not able to make decisions about your care.

Things to know

For help with advance directives, visit the Eldercare Locator at eldercare.acl.gov.

More information

Visit Medicare.gov/coverage/advance-care-planning.

Air-fluidized beds & other support surfaces

Part B covers air-fluidized beds and other support surfaces as durable medical equipment (DME) that your doctor prescribes for use in your home.

More information

- See "Durable medical equipment (DME)" on pages 36–38.
- Visit Medicare.gov/coverage/air-fluidized-beds.

Alcohol misuse screenings & counseling

Part B covers an alcohol misuse screening if you're an adult (including pregnant women) who uses alcohol, but you 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).

How often

Once per year.

Costs

You pay nothing if your qualified primary care doctor or other primary care practitioner accepts assignment.

Things to know

A qualified primary care doctor or other primary care practitioner must provide the counseling in a primary care setting (like a doctor's office).

More information

Visit Medicare.gov/coverage/alcohol-misuse-screenings-counseling.

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.

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

Ambulance services (continued)

Costs

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

Things to know

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

More information

- Visit Medicare.gov/coverage/ambulance-services.
- Visit Medicare.gov/publications to download and read the booklet "Medicare Coverage of Ambulance Services."

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).

Costs

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 if the doctor or other health care provider accepts assignment. You pay all facility service fees for procedures Medicare doesn't cover in ambulatory surgical centers.

More information

Visit Medicare.gov/coverage/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.

Costs

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.

More information

Visit Medicare.gov/coverage/anesthesia.

Artificial eyes & limbs

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

Costs

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

More information

Visit Medicare.gov/coverage/artificial-eyes-limbs.

Bariatric surgery

Medicare covers some bariatric surgical procedures, like gastric bypass surgery and laparoscopic banding surgery, when you meet certain conditions related to morbid obesity.

Costs

For surgeries or procedures, it's hard to know the exact costs in advance. This is because no one knows exactly what services you'll need. If you need surgery or a procedure, you may be able to estimate how much you'll have to pay. Visit Medicare.gov for more information.

More information

Visit Medicare.gov/coverage/bariatric-surgery.

Behavioral health integration services

Medicare may pay for a health care provider's help to manage a behavioral health condition if your provider offers the Psychiatric Collaborative Care Model.

Costs

You pay a monthly fee, and the Part B deductible and coinsurance apply.

What it is

Behavioral health conditions include depression, anxiety, and other health conditions.

The Psychiatric Collaborative Care Model is a set of integrated behavioral health services that includes care management support if you have a behavioral health condition. This care management support may include care planning for behavioral health conditions, ongoing assessment of your condition, medication support, counseling, or other treatments that your provider recommends. Your health care provider will ask you to sign an agreement or provide verbal consent for you to get this set of services on a monthly basis.

More information

Visit Medicare.gov/coverage/behavioral-health-integration-services.

Blood

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

Costs

Visit Medicare.gov/coverage/blood for cost information.

More information

Visit Medicare.gov/coverage/blood.

Blood processing & handling

Hospitals usually 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.

Costs

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

More information

Visit Medicare.gov/coverage/blood-processing-handling.

Bone density

See "Bone mass measurements" below.

Bone mass measurements

Part B covers this test if you meet one of 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.

How often

Once every 24 months or more often, if medically necessary.

Costs

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

What it is

This test helps to see if you're at risk for broken bones.

More information

Visit Medicare.gov/coverage/bone-mass-measurement-bone-density.

Braces (arm, leg, back, & neck)

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

Costs

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

More information

Visit Medicare.gov/coverage/braces-arm-leg-back-neck.

Breast cancer screenings

See "Mammograms" on page 61.

Breast prostheses

Part B covers some 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. Part B covers the surgery if it takes place in an outpatient setting.

Costs

You pay 20% of the Medicare-approved amount for your doctor's services and the external breast prostheses. The Part B deductible applies.

More information

- Surgeries to implant breast prostheses in a hospital inpatient setting covered under Part A: See "Inpatient hospital care" on page 53.
- Surgeries to implant breast prostheses in a hospital outpatient setting covered under Part B: See "Outpatient hospital services" on page 71.
- Visit Medicare.gov/coverage/breast-prostheses.

Canes

Part B covers canes as durable medical equipment (DME). Medicare doesn't cover white canes for the blind.

More information

- See "Durable medical equipment (DME)" on pages 36–38.
- Visit Medicare.gov/coverage/canes.

Cardiac rehabilitation programs

Part B covers these programs if you've 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 (ICR) programs that usually include more rigorous or intense exercise, education, and counseling.

Costs

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

What it is

Programs include exercise, education, and counseling.

Cardiac rehabilitation programs (continued)

Things to know

These programs may be provided in a hospital outpatient setting (including a critical access hospital) or in a doctor's office.

Part B covers ICR programs if your doctor referred you and you had any of the conditions listed above.

More information

Visit Medicare.gov/coverage/cardiac-rehabilitation-programs.

Cardiovascular behavioral therapy

Medicare covers a cardiovascular behavioral therapy visit with your primary care doctor or other primary care practitioner in a primary care setting (like a doctor's office).

How often

One time each year.

Costs

You pay nothing if your doctor or other qualified health care provider accepts assignment.

What it is

Cardiovascular behavioral therapy helps lower your risk for cardiovascular disease. During therapy, your doctor may discuss aspirin use (if appropriate), check your blood pressure, and give you tips to make sure you're eating well.

More information

Visit Medicare.gov/coverage/cardiovascular-behavioral-therapy.

Cardiovascular disease screenings

Part B covers cardiovascular screening blood tests.

How often

Once every 5 years.

Costs

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

What it is

Blood tests for cholesterol, lipid, and triglyceride levels. These screenings include blood tests that help detect conditions that may lead to a heart attack or stroke.

More information

Visit Medicare.gov/coverage/cardiovascular-disease-screenings.

Cataract surgery

See "Eyeglasses & contact lenses" on page 41.

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.

How often

Medicare covers these screening tests once every 24 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, Medicare covers these screening tests once every 12 months.

Part B also covers Human Papillomavirus (HPV) tests (as part of a Pap test) once every 5 years if you're age 30-65 without HPV symptoms.

Cervical & vaginal cancer screenings (continued)

Costs

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

More information

- See "Mammograms" on page 61.
- Visit Medicare.gov/coverage/cervical-vaginal-cancer-screenings.

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.

Costs

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.

More information

- Chemotherapy in a hospital inpatient setting covered under Part A: See "Inpatient hospital care" on page 53.
- Visit Medicare.gov/coverage/chemotherapy.

Children's kidney services

Medicare covers dialysis and kidney transplants for children.

More information

- Dialysis: See "Dialysis (children)" on pages 32–33.
- Kidney transplants: See "Kidney transplants (children)" on page 58.
- Visit Medicare.gov/publications to download and read the booklet "Medicare Coverage of Kidney Dialysis & Kidney Transplant Services."

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.

Costs

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

Things to know

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

More information

Visit Medicare.gov/coverage/chiropractic-services.

Chronic care management services

Medicare may pay for a health care provider's help to manage chronic conditions if you have 2 or more serious chronic conditions that are expected to last at least a year.

Costs

You may 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.

What is it

Chronic care management offers additional help managing chronic conditions like arthritis, asthma, diabetes, hypertension, heart disease, osteoporosis, and mental health and other conditions. This includes a comprehensive care plan that lists your health problems and goals, other health care providers, medications, community services you have and need, and other information about your health. It also explains the care you need and how your care will be coordinated. Your health care provider will ask you to sign an agreement to provide this service. If you agree, he or she will prepare the care plan, help you with medication management, provide 24/7 access for urgent care needs, give you support when you go from one health care setting to another, review your medicines and how you take them, and help you with other chronic care needs.

Chronic care management services (continued)

Things to know

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

More information

Visit Medicare.gov/coverage/chronic-care-management-services.

Clinical laboratory tests

Part B covers medically necessary clinical diagnostic laboratory services when your doctor or practitioner orders them.

Costs

You pay nothing for Medicare-approved covered clinical diagnostic laboratory services.

What it is

Laboratory tests include certain blood tests, urinalysis, tests on tissue specimens, and some screening tests.

More information

Visit Medicare.gov/coverage/clinical-laboratory-services.

Clinical research studies

Part A and/or Part B cover some costs, like office visits and tests, in certain qualifying clinical research studies.

Costs

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

What it is

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.

More information

Visit Medicare.gov/coverage/clinical-research-studies.

Colorectal cancer screenings

Part B covers one or more of these tests:

- Multi-target stool DNA tests: See page 66.
- Screening barium enemas: See page 87.
- Screening colonoscopies: See page 88.
- Screening fecal occult blood tests: See page 88.
- Screening flexible sigmoidoscopies: See page 89.

What it is

Tests to help find precancerous growths or find cancer early, when treatment is most effective.

Colonoscopies

See "Screening colonoscopies" on page 88.

Commode chairs

Part B covers commode chairs as durable medical equipment (DME) when ordered by your doctor for use in your home if you're confined to your bedroom.

More information

- See "Durable medical equipment (DME)" on pages 36–38.
- Visit Medicare.gov/coverage/commode-chairs.

Concierge care

Medicare doesn't cover membership fees for concierge care.

Costs

You pay 100% of the membership fee for concierge care.

More information

Visit Medicare.gov/coverage/concierge-care.

Contact lenses

See "Eyeglasses & contact lenses" on page 41.

Continuous passive motion (CPM) machines

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

More information

- See "Durable medical equipment (DME)" on pages 36–38.
- Visit Medicare.gov/coverage/continuous-passive-motion-machines.

Continuous Positive Airway Pressure (CPAP) devices, accessories, & therapy

Medicare may cover CPAP therapy if you've been diagnosed with obstructive sleep apnea.

How often

Medicare may covers a 3-month trial of CPAP therapy. Medicare may cover it longer if you meet in person with your doctor, and your doctor documents in your medical record that you meet certain conditions about the use of the device and the CPAP therapy is helping you.

Costs

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.

Things to know

- 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.
- 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.
- 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 (DME)" on pages 36–38.

More information

Visit Medicare.gov/coverage/continuous-positive-airway-pressure-devices-accessories-therapy.

Cosmetic surgery

Medicare usually 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 14.

Costs

You pay 100% for non-covered services, including most cosmetic surgery.

More information

Visit Medicare.gov/coverage/cosmetic-surgery.

Counseling to prevent tobacco use & tobacco-caused disease

Part B covers smoking and tobacco-use cessation counseling visits.

How often

Medicare covers up to 8 visits in a 12-month period.

Costs

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

What it is

Counseling to help you stop smoking or using tobacco.

Things to know

A qualified doctor or other Medicare-recognized provider must provide these visits.

More information

Visit Medicare.gov/coverage/counseling-to-prevent-tobacco-use-tobacco-caused-disease.

Crutches

Part B covers crutches as durable medical equipment (DME).

More information

- See "Durable medical equipment (DME)" on pages 36–38.
- Visit Medicare.gov/coverage/crutches.

CT scans

See "Diagnostic non-laboratory tests" on page 32.

Custodial care

See "Nursing home care" on page 67.

Defibrillators

Medicare may cover an implantable automatic defibrillator if you've been diagnosed with heart failure. Part A pays if the surgery takes place in a hospital inpatient setting. Part B pays if the surgery takes place in a hospital outpatient setting.

Costs

Visit Medicare.gov/coverage/defibrillators for cost information.

More information

- Surgeries to implant defibrillators in the hospital inpatient setting covered under Part A: See "Inpatient hospital care" on page 53.
- Visit Medicare.gov/coverage/defibrillators.

Dental services

Medicare doesn't cover most dental care, 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.

Costs

You pay 100% for non-covered services, including most dental care.

More information

Visit Medicare.gov/coverage/dental-services.

Depression screenings

Part B covers depression screenings.

How often

Once per year.

Costs

You pay nothing for this screening if your doctor accepts assignment.

Things to know

The screening must be done in a primary care setting (like a doctor's office) that can provide follow-up treatment and/or referrals.

More information

Visit Medicare.gov/coverage/depression-screenings.

Diabetes prevention program

Part B covers a diabetes prevention program if all of these conditions apply to you:

- You have a hemoglobin A1c test result between 5.7 and 6.4%, a fasting plasma glucose of 110-125mg/dL, or a 2-hour plasma glucose of 140-199 mg/dL (oral glucose tolerant test) within 12 months prior to attending the first core session.
- You have a body mass index (BMI) of 25 or more (BMI of 23 or more if you're Asian).
- You've never been diagnosed with type 1 or type 2 diabetes or End-Stage Renal Disease (ESRD).
- You've never participated in the Medicare Diabetes Prevention Program.

How often

Once.

Costs

You pay nothing for these services.

Diabetes prevention program (continued)

What it is

Medicare's Diabetes Prevention Program is a proven health behavior change program to help you prevent type 2 diabetes.

The program begins with 16 core sessions offered in a group setting over a 6-month period. In these sessions, you'll get:

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

Once you complete the core sessions, you'll get:

- 6 more months of less intensive monthly follow-up sessions to help you maintain healthy habits
- An additional 12 months of ongoing maintenance sessions if you meet certain weight loss and attendance goals

Things to know

To find a Medicare Diabetes Prevention Program supplier in your area, visit Medicare.gov/coverage/diabetes-prevention.

More information

Visit Medicare.gov/coverage/diabetes-prevention.

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 if 2 or more of these apply to you:

- You're age 65 or older.
- You're overweight.
- You have a family history of diabetes (parents or siblings).
- You have a history of gestational diabetes (diabetes during pregnancy) or delivery of a baby weighing more than 9 pounds.

How often

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

Costs

You pay nothing for these tests if your doctor or other qualified health care provider accepts assignment.

More information

Visit Medicare.gov/coverage/diabetes-screenings.

Diabetes self-management training (DSMT)

Part B covers outpatient DSMT if you've been diagnosed with diabetes.

Medicare may cover up to 10 hours of initial DSMT – 1 hour of individual training and 9 hours of group training. 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.

Costs

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

What is it

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.

Things to know

You must have a written order from your doctor or qualified non-doctor practitioner.

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.

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 95.

More information

- Other diabetic services and supplies: See "Diabetes services" and "Diabetes supplies" on the next 2 pages.
- Visit Medicare.gov/coverage/diabetes-self-management-training.

Diabetes services

Medicare may cover one or more of these items or services:

- Diabetes self-management training: See page 29.
- Eye exams (for diabetes): See page 41.
- Foot exams (for diabetes): See page 43.
- Glaucoma tests: See page 44.
- Nutrition therapy services: See page 68.

More information

- Covered supplies if you have diabetes: See "Diabetes supplies" below.
- Visit Medicare.gov.

Diabetes supplies

Part B covers some diabetes supplies, including:

- Blood sugar (glucose) testing monitors: Visit Medicare.gov/coverage/blood-sugar-monitors.
- Blood sugar test strips: Visit Medicare.gov/coverage/blood-sugar-test-strips.
- Blood sugar control solutions (for checking test strip and monitor accuracy): Visit Medicare.gov/coverage/glucose-control-solutions.
- Continuous glucose monitors and related supplies: Visit Medicare.gov/coverage/therapeutic-continuous-glucose-monitors-cgms.
- Lancet devices and lancets: Visit Medicare.gov/coverage/lancet-devices-lancets.
- Insulin: See page 54.
- Therapeutic shoes or inserts: See page 96.

How often

There may be limits on how much or how often you get these supplies. For more information, see "Durable medical equipment (DME)" on pages 36–38.

Costs

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

Diabetes supplies (continued)

Things to know

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.

More information

- See "Durable medical equipment (DME)" on pages 36–38.
- Covered services if you have diabetes: See "Diabetes services" on page 30.
- Visit Medicare.gov.

Diagnostic laboratory tests

Part B covers medically necessary clinical diagnostic laboratory tests, when your doctor or practitioner orders them.

Costs

You usually pay nothing for Medicare-covered clinical diagnostic laboratory tests.

What it is

Tests done to help your doctor diagnose or rule out a suspected illness or condition.

Things to know

Medicare also covers some preventive tests and screenings to help prevent, find, or manage a medical problem. For more information, see "Preventive services" on pages 80–81.

More information

Visit Medicare.gov/coverage/diagnostic-laboratory-tests.

Diagnostic non-laboratory tests

Part B covers these 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.

Costs

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.

What it is

Tests done to help your doctor diagnose or rule out a suspected illness or condition.

Things to know

Medicare also covers some preventive tests and screenings to help prevent, find, or manage a medical problem. For more information, see "Preventive services" on pages 80–81.

More information

Visit Medicare.gov/coverage/diagnostic-non-laboratory-tests.

Dialysis (children)

Part A and Part B cover different items and services for children's dialysis.

If your child is in a hospital:

- Part A covers dialysis treatments.
- Part B covers doctors' services.

If your child isn't in a hospital, Part B helps pay for these dialysis services:

- Outpatient dialysis treatments (in a Medicare-approved dialysis facility)
- Home dialysis equipment and supplies
- Certain home support services
- Most injectable drugs and their oral forms for outpatient or home dialysis (like an erythropoiesis-stimulating agent to treat anemia)
- Doctors' services (inpatient or outpatient)
- Other services that are part of dialysis, like laboratory tests
- Dialysis when you travel and use a Medicare-certified facility

Dialysis (children) (continued)

Your child is eligible for Medicare if both you and your child meet these conditions:

One of these conditions applies to **you**:

- You (or your spouse) have earned at least 6 credits within the last 3 years by working and paying Social Security taxes.
- You (or your spouse) are getting, or are eligible for Social Security or Railroad Retirement Board benefits.

One of these conditions applies to **your child**:

- Your child needs regular dialysis because his or her kidneys no longer work.
- Your child has had a kidney transplant.

Costs

- Inpatient hospital services: Part A pays for these services. You pay a deductible.
- Doctor's services: Part B generally pays 80% of the Medicare-approved amount, after you pay the Part B yearly deductible. You pay the remaining 20% coinsurance. This is in addition to the Part B monthly premium.
- Dialysis services: The amount you pay may vary based on your child's age and the type of dialysis they need.
- In most cases, Medicare doesn't pay for transportation to dialysis facilities.

If your child has other insurance, your costs may be different.

Things to know

If your child is eligible for Medicare only because of permanent kidney failure, Medicare coverage will end:

- 12 months after the last month of dialysis treatments
- 36 months after the month of a kidney transplant

Medicare coverage can be extended if your child meets certain conditions.

More information

- Children's kidney transplants: See "Kidney transplants (children)."
- Visit Medicare.gov/coverage/dialysis-children.
- Visit Medicare.gov/publications to download and read the booklet "Medicare Coverage of Kidney Dialysis & Kidney Transplant Services."

Dialysis 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), including:

- **Inpatient dialysis treatments**: Part A covers dialysis if you're in a Medicare-approved hospital. See "Inpatient hospital care" on page 53.
- **Outpatient maintenance dialysis treatments**: Part B covers a variety of services if you get routine dialysis in 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.
- **Training for self-dialysis**: Part B covers training if you're a candidate for self-dialysis. Part B covers training provided during the course of your regular treatments for you and the person helping you with your self-dialysis treatments. A dialysis facility that's been certified by Medicare to provide self-dialysis training must provide the training. Only dialysis facilities can bill Medicare (directly or under arrangement) for providing home dialysis training.
- **Self-dialysis support services**: Part B covers self-dialysis support services provided by your dialysis facility. This may include visits by trained hospital or dialysis facility workers to check on your self-dialysis, help in emergencies (when needed), and check your equipment and water supply.
- **Self-dialysis equipment & supplies**: Part B covers all dialysis equipment and supplies for as long as you need dialysis at home. Covered equipment and supplies include alcohol, wipes, dialysis machines, sterile drapes, rubber gloves, and scissors.
- **Certain drugs for self-dialysis**: Part B covers heparin, the antidote for heparin (when medically necessary), topical anesthetics, and erythropoiesis-stimulating agents (ESAs) (like epoetin alfa or darbepoetin alfa) to treat anemia related to your renal disease.
- **Outpatient doctors' services**: Part B covers outpatient doctors' services.
- **Other dialysis services & supplies**: Part B covers other services and supplies that are a part of dialysis (like laboratory tests).
- **Ambulance transportation**: In some cases, Medicare may cover ambulance transportation when you have ESRD, need dialysis, and need ambulance transportation to or from a dialysis facility.

Dialysis services & supplies (continued)

Costs

- **Inpatient dialysis treatments**: If you have Original Medicare, Medicare pays most kidney doctors a monthly amount. After you pay the Part B yearly deductible, Medicare pays 80% of the monthly amount. You pay the remaining 20% coinsurance. In some cases, your doctor may be paid per day if you get services for less than one month.
- **Outpatient maintenance dialysis treatments**: Outpatient maintenance dialysis treatments include the cost of most dialysis drugs and biologicals. You pay 20% of the Medicare-approved amount for each dialysis treatment given in a dialysis facility or at home. The Part B deductible applies.
- **Self-dialysis training, support services, equipment, & supplies**: Outpatient maintenance dialysis treatment includes the cost of these. You pay 20% of the Medicare-approved amount, and the Part B deductible applies. Only dialysis facilities can bill Medicare (directly or under arrangement) for providing self-dialysis training.
- **Certain drugs for self-dialysis**: Outpatient maintenance dialysis treatment includes the costs of self-dialysis drugs and biologicals. You pay 20% of the Medicare-approved amount. ESRD-related drugs that only have an oral form of administration are covered only by Medicare prescription drug coverage (Part D). This means drugs taken by mouth that only come in capsule, tablet, or liquid forms.

Things to know

Medicare **doesn't** cover these:

- Paid dialysis aides to help you with self-dialysis
- Any lost pay to you or the person who may be helping you during self-dialysis training
- A place to stay during your treatment
- Blood or packed red blood cells for self-dialysis unless part of a doctors' service

There are some types of insurance that may pay some of the health care costs that Medicare doesn't pay.

More information

- Visit Medicare.gov/coverage/dialysis-services-supplies.
- For information on dialysis for **children**, visit Medicare.gov/coverage/dialysis-children.
- Visit Medicare.gov/publications to download and read the booklet "Medicare Coverage of Kidney Dialysis & Kidney Transplant 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.

Costs

You pay 20% of the Medicare-approved amount for most services. You pay nothing for certain preventive services if your doctor or other provider accepts assignment. See "Preventive services" on pages 80–81. The Part B deductible applies.

Things to know

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.

More information

Visit Medicare.gov/coverage/doctor-other-health-care-provider-services.

Drugs

See "Prescription drugs (outpatient)" on pages 77–80.

Durable medical equipment (DME)

Part B covers medically necessary DME if your doctor prescribes it for use in your home. Only your doctor can prescribe medical equipment for you.

Durable medical equipment (DME) (continued)

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 test strips
- Canes
- Commode chairs
- Continuous passive motion machines, devices, & accessories
- Continuous Positive Airway Pressure
- Crutches
- Enteral nutrition supplies & equipment (feeding pumps)
- Glucose control solutions
- Hospital beds
- Hyperbaric oxygen (HBO) therapy
- Infusion pumps and supplies
- Nebulizers and nebulizer medications
- Oxygen equipment and accessories
- Patient lifts
- Suction pumps
- Traction equipment
- Walkers
- Wheelchairs and scooters

Costs

You pay 20% of the Medicare-approved amount for DME (if your supplier accepts assignment), and the Part B deductible applies. Visit Medicare.gov/coverage/durable-medical-equipment-dme-coverage for more cost information.

Durable medical equipment (DME) (continued)

What it is

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

Things to know

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: 1-877-486-2048.

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.

More information

Visit Medicare.gov/coverage/durable-medical-equipment-dme-coverage.

EKG or ECG screenings

Part B covers an electrocardiogram screening if you get a referral from your doctor or other health care provider as part of your one-time "Welcome to Medicare" preventive visit. EKGs are also covered as diagnostic tests.

How often

Once when part of the "Welcome to Medicare" visit. More often when a diagnostic test.

Costs

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.

More information

- "Welcome to Medicare" visit: See "Preventive visits" pages 82–83.
- Diagnostic tests: See "Diagnostic non-laboratory tests" on page 32.
- Visit Medicare.gov/coverage/ekg-or-ecg-screenings.

Emergency department services

Part B usually covers emergency department services when you have an injury, a sudden illness, or an illness that quickly gets much worse.

Costs

- 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.

Things to know

Medicare only covers emergency services in foreign countries only in rare circumstances. For more information, see "Travel" on pages 98–99.

More information

Visit Medicare.gov/coverage/emergency-department-services.

Enteral nutrition supplies & equipment

Part B covers enteral nutrition supplies and equipment (feeding pumps) under the prosthetic device benefits.

Costs

You pay 20% of the Medicare-approved amount. Medicare will cover your enternal infusion pump if your doctor or supplier is enrolled in Medicare. If a supplier doesn't accept assignment, Medicare doesn't limit how much the supplier can charge you. You may also have to pay the entire bill (your share and Medicare's share) at the time you get the pump.

More information

- See "Durable medical equipment (DME)" on pages 36–38.
- Visit Medicare.gov/coverage/enteral-nutrition-supplies-equipment.

Eye exams

Medicare covers these preventive and diagnostic eye exams:

- Eye exams, if you have diabetes: See "Eye exams (for diabetes)" below.
- Glaucoma tests: See page 44.
- Macular degeneration tests & treatment: See page 61.

More information

Visit Medicare.gov/coverage/eye-exams.

Eye exams (for diabetes)

Part B covers eye exams for diabetic retinopathy if you have diabetes.

How often

Once a year.

Costs

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.

Things to know

The exam must be done by an eye doctor who's legally allowed to do the test in your state.

Eye exams (for diabetes) (continued)

More information

- Other diabetic services and supplies: See "Diabetes services" and "Diabetes supplies" on pages 31–32.
- Visit Medicare.gov/coverage/eye-exams-for-diabetes.

Eye exams (routine)

Medicare doesn't cover eye exams (sometimes called "eye refractions") for eyeglasses or contact lenses.

Costs

You pay 100% for eye exams for eyeglasses or contact lenses.

More information

Visit Medicare.gov/coverage/eye-exams-routine.

Eyeglasses & contact lenses

Medicare doesn't usually cover eyeglasses or contact lenses.

However, Part B helps pay for corrective lenses if you have cataract surgery to implant an intraocular lens. Corrective lenses include one pair of eyeglasses with standard frames or one set of contact lenses.

Costs

You pay 100% for non-covered services, including most eyeglasses or contact lenses. You pay 20% of the Medicare-approved amount for corrective 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 if you or your supplier submits the claim.

Things to know

Medicare covers cataract surgery if it's done using traditional surgical techniques or using lasers.

More information

Visit Medicare.gov/coverage/eyeglasses-contact-lenses.

Eyes

See "Artificial eyes & limbs" on page 11.

Federally Qualified Health Center (FQHC) services

Part B covers a broad range of outpatient primary care and preventive services in FQHCs.

Costs

You usually pay 20% of the charges or the Medicare-approved amount. You pay nothing for most preventive services.

More information

- To find a FQHC near you, visit findahealthcenter.hrsa.gov.
- Visit Medicare.gov/coverage/federally-qualified-health-center-fghc-services.

Feeding pumps

See "Enteral nutrition supplies & equipment" on page 40.

Flu shots

Part B covers flu shots.

How often

One shot per flu season.

Costs

You pay nothing for a flu shot if your doctor or other qualified health care provider accepts assignment for giving the shot.

More information

Visit Medicare.gov/coverage/flu-shots.

Foot care

Part B covers podiatrist (foot doctor) foot exams or treatment if you have diabetes-related nerve damage or need medically necessary treatment for foot injuries or diseases, like hammer toe, bunion deformities, and heel spurs.

Medicare doesn't usually cover routine foot care, like cutting or removing corns and calluses, trimming, cutting, or clipping nails, or hygienic or other preventive maintenance, like cleaning and soaking your feet.

Costs

- 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.

More information

- If you have diabetes, see "Therapeutic shoes or inserts" on page 96 and "Foot care (for diabetes)" below.
- Visit Medicare.gov/coverage/foot-care.

Foot care (for diabetes)

Part B covers foot exams if you have diabetic peripheral neuropathy and loss of protective sensations.

How often

Every 6 months, as long as you haven't seen a foot care professional for another reason between visits.

Costs

- 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.

More information

- See "Therapeutic shoes or inserts" on page 96.
- Visit Medicare.gov/coverage/foot-care-for-diabetes.

Foot care (routine)

Medicare doesn't usually cover routine foot care.

Costs

You pay 100% for routine foot care, in most cases.

What it is

Routine foot care includes:

- Cutting or removing corns and calluses.
- Trimming, cutting, or clipping nails.
- Hygiene or other preventive maintenance, like cleaning or soaking your feet.

More information

Visit Medicare.gov/coverage/foot-care-routine.

Glaucoma tests

Part B covers glaucoma tests if you're at high risk for glaucoma. You're at high risk if one or more of these applies to you:

- You have diabetes.
- You have a family history of glaucoma.
- You're African American and age 50 or older.
- You're Hispanic and age 65 or older.

How often

Once every 12 months.

Costs

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

Things to know

An eye doctor who's legally allowed to do this test in your state must do or supervise the screening.

More information

Visit Medicare.gov/coverage/glaucoma-tests.

Gym memberships & fitness programs

Medicare doesn't cover gym membership or fitness programs.

Costs

You pay 100% for non-covered services, including gym membership and fitness programs.

More information

Visit Medicare.gov/coverage/gym-membership-fitness-programs.

Health education & wellness programs

Medicare usually doesn't cover health education and wellness programs, but it does cover:

- Alcohol misuse screenings and counseling: See page 9.
- Counseling to prevent tobacco use and tobacco-caused disease: See page 24.
- Diabetes prevention program: See pages 26–27.
- Diabetes self-management training: See page 29.
- Depression screenings: See page 26.
- Kidney disease education: See page 55.
- Nutrition therapy, if you have diabetes or kidney disease: See page 68.
- Obesity behavioral therapy: See page 69.
- A "Welcome to Medicare" preventive visit: See page 82.
- Yearly "Wellness" visits: See pages 82–83.

Hearing & balance exams

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.

Costs

- 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.

More information

Visit Medicare.gov/coverage/hearing-balance-exams.

Hearing aids

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

Costs

You pay 100% for hearing aids and exams.

More information

Visit Medicare.gov/coverage/hearing-aids.

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 one or more of these applies to you:

- You have hemophilia.
- You have End-Stage Renal Disease (ESRD) (permanent kidney failure requiring dialysis or a kidney transplant).
- You have diabetes.
- You live with someone who has Hepatitis B.
- 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.

Costs

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

More information

Visit Medicare.gov/coverage/hepatitis-b-shots.

Hepatitis B Virus (HBV) infection screenings

Medicare covers HBV infection screenings if you're at high risk or pregnant.

How often

- Once a year if you're at continued high risk and don't get a Hepatitis B shot.
- If you're pregnant:
  - At the first prenatal visit for each pregnancy.
  - At the time of delivery for those with new or continued risk factors.
  - At the first prenatal visit for future pregnancies, even if you previously got the Hepatitis B shot or had negative HBV screening results.

Costs

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

Things to know

Your primary care doctor must order the infection screening.

More information

Visit Medicare.gov/coverage/hepatitis-b-virus-infection-screenings.

Hepatitis C screening tests

Medicare covers a screening test if you meet one or more of these conditions:

- You're at high risk because you use or have used illicit injection drugs.
- You had a blood transfusion before 1992.
- You were born between 1945-1965.

Medicare usually covers repeat screenings for people at high risk.

How often

Once, if you meet one of the conditions listed above. If you're at high risk, Medicare covers yearly screenings.

Costs

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

Hepatitis C screening tests (continued)

Things to know

Medicare will only cover Hepatitis C screening tests if your primary care doctor or other primary care provider orders them.

More information

Visit Medicare.gov/coverage/hepatitis-c-screening-tests.

HIV screenings

Part B covers an HIV (Human Immunodeficiency Virus) screening if you meet one of these conditions:

- You're age 15–65.
- You're younger than 15 or older than 65 and are at an increased risk for HIV.

How often

Once per year, if you meet the conditions above. If you're pregnant, you can get the screening up to 3 times during your pregnancy.

Costs

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

More information

Visit Medicare.gov/coverage/hiv-screenings.

Home health services

Part A and/or Part B cover eligible home health services if you meet certain conditions. Visit Medicare.gov/coverage/home-health-services for more information.

Costs

- 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.

What it is

Eligible home health services include:

- Part-time or intermittent skilled nursing care
- Part-time or intermittent home health aide care
- Physical therapy
- Occupational therapy
- Speech-language pathology services
- Medical social services

Medicare **doesn't** pay for:

- 24-hour-a-day care at home
- Meals delivered to your home
- Custodial or personal care (help bathing, dressing, and using the bathroom) when this is the only care you need
- Homemaker services

Things to know

Home health services may also include injectable osteoporosis drugs for women. See "Osteoporosis drugs" on page 68.

More information

- Visit Medicare.gov/coverage/home-health-services.
- Visit Medicare.gov/publications to download and read the booklet "Medicare & Home Health Care."

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.

Costs

- You pay nothing for hospice care.
- You may need to pay a copayment of no more than $5 for each prescription drug and other similar products for pain relief and symptom control while you're at home. In the rare case your drug isn't covered by the hospice benefit, your hospice provider should contact your Medicare drug plan to see if it's covered under Part D.
- You may need to pay 5% of the Medicare-approved amount for inpatient respite care.
- 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).

What it is

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

Hospice care (continued)

- Grief and loss counseling for you and your family
- Short-term inpatient care for pain and symptom management
- Short-term respite care. 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.
- 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.

Things to know

Hospice care is usually given in your home but may also be covered in a hospice inpatient facility. 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 usually cover everything you need.

More information

- Visit Medicare.gov/coverage/hospice-care.
- Visit Medicare.gov/publications to download and read the booklet "Medicare Hospice Benefits."

Hospital beds

Part B covers hospital beds as durable medical equipment (DME) that your doctor prescribes for use in your home.

More information

- See "Durable medical equipment (DME)" on pages 36–38.
- Visit Medicare.gov/coverage/hospital-beds.

Human Papillomavirus (HPV) tests

See "Cervical & vaginal cancer screenings" on pages 17–18.

Humidifiers

Medicare doesn't usually 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.

Costs

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.

More information

Visit Medicare.gov/coverage/humidifiers.

Hyperbaric oxygen (HBO) therapy

Medicare covers HBO therapy, if you meet certain conditions. Visit Medicare.gov/coverage/hyperbaric-oxygen-hbo-therapy for the full list of covered conditions.

Costs

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

What it is

HBO therapy is a process in which your entire body is exposed to oxygen under increased atmospheric pressure.

Things to know

The therapy must be administered in a chamber (including a one-person unit).

More information

Visit Medicare.gov/coverage/hyperbaric-oxygen-hbo-therapy.

Incontinence supplies & adult diapers

Medicare doesn't cover incontinence supplies or adult diapers.

Costs

You pay 100% for incontinence supplies and adult diapers.

More information

Visit Medicare.gov/coverage/incontinence-supplies-adult-diapers.

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.

Costs

You pay this for each benefit period (in 2019):

- Days 1-60: $1,364 deductible.
- Days 61-90: $341 coinsurance each day.
- Days 91 and beyond: $682 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.

What it is

Medicare-covered hospital services include:

- Semi-private rooms
- Meals
- General nursing, drugs as part of your inpatient treatment
- Other hospital services and supplies

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.

Things to know

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.

Part B covers your doctors' services you get while you're in a hospital.

More information

- Mental health care: See page 62.
- Outpatient hospital services: See pages 71–72.
- Visit Medicare.gov/coverage/inpatient-hospital-care.

Insulin

Part B doesn't cover insulin (unless use of an insulin pump is medically necessary), insulin pens, syringes, needles, alcohol swabs, or gauze.

Costs

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.

Things to know

Part D may cover insulin and certain medical supplies used to inject insulin, like syringes, gauze, and alcohol swabs. However, if you use an external insulin pump, insulin and the pump may be covered as durable medical equipment under Part B. "Durable medical equipment (DME)" on pages 36–38.

More information

- Other diabetic services and supplies: See "Diabetes services" and "Diabetes supplies" on pages 30–31.
- Visit Medicare.gov/coverage/insulin.

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.

Costs

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.

What it is

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.

Things to know

This is covered 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.

More information

Visit Medicare.gov/coverage/kidney-disease-education.

Kidney services & supplies

See "Dialysis services & supplies" on pages 34–35.

Kidney transplants

Part A and Part B cover different items and services related to kidney transplants.

Part A covers transplant services and pays part of the costs for these:

- Inpatient services in a Medicare-certified hospital.
- Kidney registration fee.
- Laboratory and other tests needed to evaluate your medical condition and the medication condition of potential kidney donors.
- Finding the proper kidney for your transplant surgery (if there's no kidney donor).
- The full cost of care for your kidney donor (including care before surgery, the actual surgery, and care after surgery).
- Any additional inpatient hospital care for your donor in case of problems due to surgery.
- Blood (whole units of packed red blood cells, blood components, and the cost of processing and giving you blood).

Part B covers transplant services and pays part of the costs for these:

- Doctors' services for kidney transplant surgery (including care before surgery, the actual surgery, and care after surgery).
- Doctors' services for your kidney donor during their hospital stay.
- Transplant drugs also called immunosuppressive drugs (for a limited time after you leave the hospital following a transplant).
- Blood.

Medicare will only pay for your transplant drug therapy for 36 months after the month of the kidney transplant if both of these apply:

- You're entitled to Medicare only because of permanent kidney failure.
- You have the pancreas transplant after the kidney transplant.

Kidney transplants (continued)

This is because your Medicare coverage will end 36 months after a successful kidney transplant if you only have Medicare due to permanent kidney failure.

Medicare will continue to pay for your transplant drugs (also called immunosuppressive drugs) with no time limit if either of these apply:

- You were already entitled to Medicare because of age or disability before you got ESRD.
- You became eligible for Medicare because of age or disability after getting a transplant.

Costs

You pay:

- 20% of the Medicare-approved amount.
- Various amounts for transplant facility charges.
- Nothing for a living donor for a kidney transplant.
- Nothing for Medicare-approved laboratory tests.

Things to know

These services are covered if they're done by the Medicare-certified hospital where you'll get your transplant or another hospital that participates in Medicare.

More information

- Other types of Medicare-covered transplants: See "Transplants" on pages 97–98.
- Kidney transplants for children: See "Kidney transplants (children)" on the next page.
- Visit Medicare.gov/coverage/kidney-transplants.
- Visit Medicare.gov/publications to download and read the booklet "Medicare Coverage of Kidney Dialysis & Kidney Transplant Services."

Kidney transplants (children)

Part A and Part B cover different items and services related to children's kidney transplants.

Part A usually covers these transplant services:

- Inpatient services in an approved hospital
- Kidney registry fee
- Laboratory and other tests needed to evaluate your child's medical condition and the condition of possible kidney donors
- The costs of finding the proper kidney for your child's transplant surgery
- The full cost of care for your child's kidney donor
- Blood (if a transfusion is needed)

Part B helps pay for these transplant services:

- Doctors' services for kidney transplant surgery
- Doctors' services for the kidney donor during his or her hospital stay
- Immunosuppressive drugs (generally for a limited time after your child leaves the hospital following a transplant)
- Blood (if a transfusion is needed)

Costs

- Part A usually pays for inpatient hospital services, and you pay a one-time yearly deductible.
- For Part B services, Medicare generally pays 80% of the Medicare-approved amount, after you pay the Part B yearly deductible. You pay the remaining 20% coinsurance. This is in addition to the Part B monthly premium.
- For dialysis services covered under Part B, the amount you pay may vary based on your age and the type of dialysis your child needs.
- If your child has other insurance, your costs may be different.

More information

- Children's dialysis: See "Dialysis (children)" on pages 32–33.
- Visit Medicare.gov/coverage/kidney-transplants-children.
- Visit Medicare.gov/publications to download and read the booklet "Medicare Coverage of Kidney Dialysis & Kidney Transplant Services."

Laboratory tests

- Clinical laboratory tests: See page 20.
- Diagnostic laboratory tests: See page 31.
- Diagnostic non-laboratory tests: See page 32.

Long-term care

Medicare doesn't cover long-term care (also called custodial care), if that's the only care you need. Most nursing home care is custodial care.

Costs

You pay 100% for non-covered services, including most long-term care.

What it is

Long-term care is a range of services and support for your personal care needs. Most long-term care isn't medical care. Instead, most long-term care is help with basic personal tasks of everyday life, sometimes called activities of daily living.

More information

Visit Medicare.gov/coverage/long-term-care.

Long-term care hospital services

Part A covers care in long-term care hospitals (LTCHs).

Costs

You won't usually pay more for care in a LTCH than in an acute care hospital. Under Medicare, you're only responsible for one deductible for any benefit period. This applies whether you're in an acute care hospital or a LTCH.

You don't have to pay a second deductible for your care in a LTCH if:

- You're transferred to a LTCH directly from an acute care hospital
- You're admitted to a LTCH within 60 days of being discharged from an inpatient hospital stay

If you're admitted to the LTCH more than 60 days after any previous hospital stay:

- A new benefit period begins.
- You'll have to pay a deductible and coinsurance because you're in a new benefit period. These charges are the same as if you were being admitted to an acute care hospital.

Long-term care hospital services (continued)

What it is

LTCHs specialize in treating patients when both of these apply:

- They may have more than one serious condition.
- They may improve with time and care, and return home.

More information

Visit Medicare.gov/coverage/long-term-care-hospitals-services.

Lung cancer screenings

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

- You're age 55–77.
- You don't have signs or symptoms of lung cancer (asymptomatic).
- 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 your doctor.

How often

Once per year.

Costs

You pay nothing for this service if your doctor accepts assignment.

Things to know

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

More information

Visit Medicare.gov/coverage/lung-cancer-screenings.

Macular degeneration tests & treatment

Part B may cover certain diagnostic tests and treatment (including treatment with certain injected drugs) of eye diseases and conditions if you have age-related macular degeneration (AMD).

Costs

- 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.

More information

Visit Medicare.gov/coverage/macular-degeneration-tests-treatment.

Mammograms

Part B covers:

- A baseline mammogram if you're a woman between ages 35–39.
- Screening mammograms if you're a woman age 40 or older.
- Diagnostic mammograms.

How often

- Baseline mammogram: One time.
- Screening mammograms: Once every 12 months.
- Diagnostic mammograms: More frequently than once a year, if medically necessary.

Costs

- Screening mammograms: You pay nothing for the test if your doctor or other qualified health care provider accepts assignment.
- Diagnostic mammograms: You pay 20% of the Medicare-approved amount, and the Part B deductible applies.

What it is

These screenings checks for breast cancer.

More information

Visit Medicare.gov/coverage/mammograms.

Massage therapy

Medicare doesn't cover massage therapy.

Costs

You pay 100% for non-covered services, including massage therapy.

More information

Visit Medicare.gov/coverage/massage-therapy.

Mental health care (inpatient)

Part A covers mental health care services you get in a hospital that require you to be admitted as an inpatient.

Costs

- $1,364 deductible for each benefit period.
- Days 1–60: $0 coinsurance per day of each benefit period.
- Days 61–90: $341 coinsurance per day of each benefit period.
- Days 91 and beyond: $682 coinsurance per each "lifetime reserve day" after day 90 for each benefit period (up to 60 days over your lifetime).
- Beyond lifetime reserve days: all costs.
- 20% of the Medicare-approved amount for mental health services you get from doctors and other providers while you're a hospital inpatient.

What it is

Mental health services help with conditions like depression and anxiety.

Things to know

You can get these services either in a general hospital or a psychiatric hospital that only cares for people with mental health conditions.

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

Medicare **doesn't** cover:

- Private duty nursing
- A phone or television in your room
- Personal items, like toothpaste, socks, or razors
- A private room, unless medically necessary

Mental health care (inpatient) (continued)

More information

- Visit Medicare.gov/publications to download and read the booklet "Medicare & Your Mental Health Benefits."
- Visit Medicare.gov/coverage/mental-health-care-inpatient.

Mental health care (outpatient)

Part B helps pay for these covered outpatient mental health services:

- One depression screening per year. The screening must be done in a primary care doctor's office or primary care clinic that can provide follow-up treatment and referrals. See "Depression screenings" on page 26.
- Individual and group psychotherapy with doctors or certain other licensed professionals allowed by the state where you get the services.
- Family counseling, if the main purpose is to help with your treatment.
- Testing to find out if you're getting the services you need and if your current treatment is helping you.
- Psychiatric evaluation.
- Medication management.
- Certain prescription drugs that aren't usually "self administered" (drugs you would normally take on your own), like some injections.
- Diagnostic tests.
- Partial hospitalization. See "Mental health care (partial hospitalization)" on the next page.
- A one-time "Welcome to Medicare" preventive visit. This visit includes a review of your possible risk factors for depression. See "Preventive visits" on page 82.
- A yearly "Wellness" visit. Talk to your doctor or other health care provider about changes in your mental health. They can evaluate your changes year to year. See "Preventive visits" on page 82.

Part B also covers outpatient mental health services for treatment of inappropriate alcohol and drug use.

Mental health care (outpatient) (continued)

Costs

- You pay nothing for your yearly depression screening if your doctor or health care provider accepts assignment.
- 20% of the Medicare-approved amount for visits to your doctor or other health care provider to diagnose or treat your condition. The Part B deductible applies.
- If you get your services in a hospital outpatient clinic or hospital outpatient department, you may have to pay an additional copayment or coinsurance amount to the hospital.

What it is

Mental health services help with conditions like depression and anxiety. These visits are often called counseling or therapy.

Things to know

Part B covers mental health services and visits with these types of health professionals: psychiatrists or other doctors, clinical psychologists, clinical social workers, clinical nurse specialists, nurse practitioners, and physician assistants.

Part B covers outpatient mental health services, including services that are usually provided outside a hospital, like in these settings: a doctor's or other health care provider's office, a hospital outpatient department, or a community mental health center.

More information

- Visit Medicare.gov/publications to download and read the booklet "Medicare & Your Mental Health Benefits."
- Visit Medicare.gov/coverage/mental-health-care-outpatient.

Mental health care (partial hospitalization)

Part B may cover services under a partial hospitalization program if you meet certain requirements and your doctor certifies that you would otherwise need inpatient treatment.

Costs

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

What it is

Partial hospitalization provides a structured program of outpatient psychiatric services as an alternative to inpatient psychiatric care. It's more intense than care you get in a doctor's or therapist's office. This treatment is provided during the day and doesn't require an overnight stay. Medicare helps cover partial hospitalization services when they're provided through a hospital outpatient department or community mental health center.

Things to know

Along with your partial hospitalization program, Medicare may cover occupational therapy that's part of your mental health treatment and individual patient training and education about your condition.

Medicare only covers partial hospitalization if the doctor and the partial hospitalization program accept assignment. Medicare **doesn't** cover:

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

More information

- Visit Medicare.gov/publications to download and read the booklet "Medicare & Your Mental Health Benefits."
- Visit Medicare.gov/coverage/mental-health-care-partial-hospitalization.

Multi-target stool DNA tests

Medicare covers this at-home multi-target stool DNA lab test 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.

How often

Once every 3 years.

Cost

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

More information

Visit Medicare.gov/coverage/multi-target-stool-dna-tests.

MRIs

See "Diagnostic non-laboratory tests" on page 32.

Nebulizers & nebulizer medications

Part B covers nebulizers (and some medicines used in nebulizers if considered reasonable and necessary). These are covered as durable medical equipment (DME) that your doctor prescribes for use in your home.

More information

- See "Durable medical equipment (DME)" on pages 36–38.
- Visit Medicare.gov/coverage/nebulizers-nebulizer-medications.

Nursing home care

Medicare doesn't cover custodial care if it's the only care you need. Most nursing home care is custodial care. Custodial care helps you with activities of daily living (like bathing, dressing, using the bathroom, and eating) or personal needs that could be done safely and reasonably without professional skills or training.

Part A may cover care in a certified skilled nursing facility (SNF). It must be medically necessary for you to have skilled nursing care (like changing sterile dressings).

More information

- Visit Medicare.gov/coverage/nursing-home-care.
- Visit Medicare.gov/publications to download and read the booklet "Your Guide to Choosing a Nursing Home or Other Long Term Services & Supports."

Nutrition therapy services

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.

Costs

You pay nothing for these preventive services because the Part B deductible and coinsurance don't apply.

What it is

Services may include:

- An initial nutrition and lifestyle assessment
- Individual and/or group nutritional therapy services
- Help managing the lifestyle factors that affect your diabetes
- Follow-up visits to check on your progress in managing your diet

Things to know

A Registered Dietitian or nutrition professional who meets certain requirements can provide MNT services, but only your doctor can refer you for the service.

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 95.

More information

Visit Medicare.gov/coverage/nutrition-therapy-services.

Obesity behavioral therapy

Medicare covers obesity screenings and behavioral counseling if you have a body mass index (BMI) of 30 or more.

Costs

You pay nothing for this service if your primary care doctor or other qualified primary care practitioner accepts assignment.

What it is

An initial screening for BMI and behavioral therapy sessions that include a dietary assessment and counseling to help you lose weight by focusing on diet and exercise.

Things to know

This counseling may be covered if you get it from your doctor or other primary care practitioner in a primary care setting (like a doctor's office).

More information

Visit Medicare.gov/coverage/obesity-screening-behavioral-therapy.

Observation services

See "Outpatient hospital services" on page 71.

Occupational therapy

Part B helps pay for medically necessary outpatient occupational therapy.

Costs

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

Things to know

Medicare law no longer limits how much it pays for your medically necessary outpatient therapy services in one calendar year.

More information

Visit Medicare.gov/coverage/occupational-therapy.

Orthopedic shoes

Medicare covers orthopedic shoes if they're a necessary part of a leg brace.

Costs

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

Things to know

You must go to a supplier that's enrolled in Medicare for Medicare to cover your orthotics. Medicare will only pay for orthotic items furnished by a supplier enrolled in Medicare, no matter who submits the claim (you or your supplier).

More information

- See "Therapeutic shoes or inserts" on page 96.
- Visit Medicare.gov/coverage/orthopedic-shoes.

Osteoporosis drugs

Part A and Part B help pay for an injectable drug for osteoporosis and visits by a home health nurse to inject the drug if you meet these conditions:

- You're a woman.
- You're eligible for Part B and meet the criteria for Medicare home health services. See "Home health services" on page 49.
- You have a bone fracture that a doctor certifies is related to postmenopausal osteoporosis.
- Your doctor certifies that you're unable to learn to give yourself the drug by injection and your family members and/or caregivers are unable and unwilling to give you the drug by injection.

Costs

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.

More information

- Home health care: See page 49.
- Visit Medicare.gov/coverage/osteoporosis-drugs.

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.

Costs

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

Things to know

Medicare covers these supplies as prosthetic devices.

More information

Visit Medicare.gov/coverage/ostomy-supplies.

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.
- Mental health care in a partial hospitalization program, if a doctor certifies that inpatient treatment would be required without it. See "Mental health care (partial hospitalization)" on page 65.
- X-rays and other radiology services billed by the hospital.
- Medical supplies, like splints and casts.
- Screenings and preventive services. See page 80.
- Certain drugs and biologicals that you wouldn't usually give yourself.

Outpatient hospital services (continued)

Costs

- You usually pay 20% of the Medicare approved amount for the doctor's or other health care provider's services. For services that can also be provided in a doctor's office, 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. However, the hospital outpatient copayment for the service is capped at the inpatient deductible amount.
- 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.

More information

Visit Medicare.gov/coverage/outpatient-hospital-services.

Outpatient medical & surgical services & supplies

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

Costs

You pay 20% of the Medicare-approved amount for your doctor's or other health care provider's services. You usually pay the hospital a copayment for each service you get in a hospital outpatient setting. There are exceptions for costly surgical procedures (called "comprehensive services"), like total knee replacements. For these services, you pay 20% for the entire episode of care, including any drugs, laboratory tests, and other services.

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.

More information

Visit Medicare.gov/coverage/outpatient-hospital-services.

Oxygen equipment & accessories

Part B covers the rental of oxygen equipment and accessories as durable medical equipment (DME) 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.

If you meet the conditions above, Medicare helps pay for:

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

Costs

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

More information

- See "Durable medical equipment (DME)" on pages 36–38.
- Visit Medicare.gov/coverage/oxygen-equipment-accessories.

Pancreas transplants

Medicare covers pancreas transplants under certain conditions. If you have End-Stage Renal Disease (ESRD) and need a pancreas transplant, Medicare covers the transplant if one of these applies:

- It's done at the same time you get a kidney transplant.
- It's done after a kidney transplant.

In some cases, Medicare may cover a pancreas transplant even if you don't need a kidney transplant.

Part B will pay for your transplant drugs (also called immunosuppressive drugs) with no time limit if either of these apply:

- You were entitled to Medicare because of age or disability.
- You became eligible for Medicare because of age or disability after getting a transplant.

Part B will only pay for your transplant drug therapy for 36 months after the month of the kidney transplant if both of these apply:

- You're entitled to Medicare only because of permanent kidney failure.
- You have the pancreas transplant after the kidney transplant.

This is because your Medicare coverage will end 36 months after a successful kidney transplant if you only have Medicare due to permanent kidney failure.

Costs

You pay:

- 20% of the Medicare-approved amount for doctors' services.
- Various amounts for transplant facility charges. You pay nothing for a living donor for a kidney transplant.
- Nothing for Medicare-approved laboratory tests.

More information

- Other types of Medicare-covered transplants: See "Transplants" on pages 97–98.
- Visit Medicare.gov/coverage/pancreas-transplants.

Pap tests

See "Cervical & vaginal cancer screenings" on pages 17–18.

Patient lifts

Part B covers patient lifts as durable medical equipment (DME) that your doctor prescribes for use in your home.

More information

- See "Durable medical equipment (DME)" on pages 36–38.
- Visit Medicare.gov/coverage/patient-lifts.

PET scans

See "Diagnostic non-laboratory tests" on page 32.

Physical therapy

Part B helps pay for medically necessary outpatient physical therapy.

Costs

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

Things to know

Medicare law no longer limits how much it pays for your medically necessary outpatient therapy services in one calendar year.

More information

Visit Medicare.gov/coverage/physical-therapy.

Power wheelchairs

See "Walkers & wheelchairs" on page 100.

Pneumococcal shots

Part B covers 2 different pneumococcal shots.

How often

Part B covers the first shot at any time and a different, second shot if it's given at least one year after the first shot.

Costs

You pay nothing for pneumococcal shots if your doctor or other qualified health care provider accepts assignment for giving the shot.

What it is

The 2 shots protect against different strains of the bacteria.

Things to know

Talk with your doctor or other health care provider to see if you need one or both shots.

More information

Visit Medicare.gov/coverage/pneumococcal-shots.

Prescription drugs (outpatient)

Part B covers a limited number of outpatient prescription drugs under limited conditions.

Usually, 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.

Here are some examples of drugs covered by Part B:

- **Drugs used with an item of durable medical equipment (DME)**: Medicare covers drugs infused through DME, like an infusion pump or drugs given by a nebulizer.
- **Some antigens**: Medicare helps pay for antigens if they're prepared by a doctor and are given by a properly instructed person (who could be you, the patient) under appropriate supervision.
- **Injectable osteoporosis drugs**: Medicare helps pay for an injectable drug if you're a woman with osteoporosis who meets the criteria for the Medicare home health benefit and has a bone fracture that a doctor certifies was related to post-menopausal osteoporosis. A doctor must certify that you can't give yourself the injection or learn how to give yourself the drug by injection. The home health nurse or aide won't be covered to provide the injection unless family and/or caregivers are unable or unwilling to give you the drug by injection.
- **Erythropoiesis-stimulating agents**: Medicare helps pay for erythropoietin by injection if you have End-Stage Renal Disease (ESRD) or you need this drug to treat anemia related to certain other conditions.
- **Blood clotting factors**: Medicare helps pay for clotting factors you give yourself by injection, if you have hemophilia.
- **Injectable and infused drugs**: Medicare covers most of these when given by a licensed medical provider.
- **Oral End-Stage Renal Disease (ESRD) drugs**: Medicare helps pay for some oral ESRD drugs if the same drug is available in injectable form and the drug is covered under the Part B ESRD benefit.

  Note: Part B covers calcimimetic medications under the ESRD payment system, including the intravenous medication Parsabiv, and the oral medication Sensipar. Your ESRD facility is responsible for giving you these medications. They can give them to you at their facility, or through a pharmacy they work with. You'll need to work with your ESRD facility and your doctor to find out where you'll get these medications and how much you'll pay.

Prescription drugs (outpatient) (continued)

- **Parental and enternal nutrition (intravenous and tube feeding)**: Medicare helps pay for certain nutrients if you can't absorb nutrition through your intestinal tract or take food by mouth.
- **Intravenous Immune Globulin (IVIG) provided in home**: Medicare helps pay for IVIG if you have a diagnosis of primary immune deficiency disease. A doctor must decide that it's medically appropriate for the IVIG to be given in your home. Part B covers the IVIG itself. But, Part B doesn't pay for other items and services related to you getting the IVIG at home.
- **Shots (vaccinations)**: Medicare covers flu shots, pneumococcal shots, Hepatitis B shots, and some other vaccines when they're related directly to the treatment of an injury of illness.
- **Transplant / immunosuppressive drugs**: Medicare covers transplant drug therapy if Medicare helped pay for your organ transplant. Medicare won't pay for any services or items, including transplant drugs, for patients who aren't entitled to Medicare.

  Part D may cover other transplant drugs that Part B doesn't cover, even if Medicare didn't pay for the transplant. If you have ESRD and Original Medicare, you may join a Medicare drug plan.

  If you're entitled to Medicare only because of ESRD, your Medicare coverage ends 36 months after the month of the transplant.

  Medicare will pay for your transplant drugs with no time limit if you were already entitled to Medicare because of age or disability before you got ESRD or you became entitled to Medicare because of your age or disability after getting a transplant that was paid for by Medicare or private insurance that paid primary to your Part A coverage, in a Medicare-certified facility.

  Transplant drugs can be very costly. If you're worried about paying for them after your Medicare coverage ends, talk to your doctor, nurse, or social worker. There may be other ways to help you pay for these drugs.

Prescription drugs (outpatient) (continued)

- **Oral cancer drugs**: Medicare helps pay for some oral cancer drugs you take by mouth if the same drug is available in injectable form or the drug 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 drug. As new oral cancer drugs become available, Part B may cover them.
- **Oral anti-nausea drugs**: Medicare helps pay for oral anti-nausea drugs used as part of an anti-cancer chemotherapeutic regimen if they're administered before, at, or within 48 hours of chemotherapy or are used as a full therapeutic replacement for an intravenous anti-nausea drug.
- **Self-administered drugs in hospital outpatient savings**: Medicare may pay for some self-administered drugs, like drugs given through an IV. Medicare pays for these drugs if you need them for the hospital outpatient services you're getting.

Costs

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 of 20%. If your hospital is participating in a certain outpatient drug discount program (called "340B"), your copayment will be 20% of the lower price, with some exceptions. 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.

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.

Prescription drugs (outpatient) (continued)

Things to know

Drugs not covered under Part B may be covered under Medicare Part D (Medicare prescription drug coverage). If you have Part D, check your plan's drug list (formulary) to see what outpatient drugs are covered.

More information

- Visit Medicare.gov/coverage/prescription-drugs-outpatient.
- Visit Medicare.gov/publications to download and read the booklet "Your Guide to Medicare Prescription Drug Coverage."

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.

What it is

Preventive services help you stay healthy, can find health problems early, when treatment works best, and can keep you from getting certain diseases. Preventive services include exams, shots, lab tests, and screenings. They also include programs for health monitoring, and counseling and education to help you take care of your own health. Talk with your doctor about which preventive services are right for you.

Here's the full list of all covered preventive and screening services:

- Abdominal aortic aneurysm screenings: See page 7.
- Alcohol misuse screenings & counseling: See page 9.
- Bone mass measurements: See page 13.
- Cardiovascular behavioral therapy: See page 16.
- Cardiovascular disease screenings: See page 17.
- Cervical & vaginal cancer screenings: See pages 17–18.
- Colorectal cancer screening: See page 21.
- Counseling to prevent tobacco use and tobacco-caused disease: See page 24.
- Depression screenings: See page 26.
- Diabetes prevention program: See pages 26–27.

Preventive services (continued)

- Diabetes screenings: See page 28.
- Diabetes self-management training: See page 29.
- Glaucoma tests: See page 44.
- Hepatitis B Virus (HBV) infection screenings: See page 47.
- Hepatitis C screening tests: See pages 47–48.
- HIV screenings: See page 48.
- Lung cancer screenings: See page 60.
- Mammograms screening: See page 61.
- Obesity behavioral therapy: See page 69.
- Preventive visits: See page 82.
- Prostate cancer screenings: See page 83.
- Shots: See page 91.
- Sexually transmitted infection screening & counseling: See page 90.

More information

Visit Medicare.gov/coverage/preventive-screening-services.

Preventive visits

"Welcome to Medicare" preventive visits

Part B covers a "Welcome to Medicare" preventive visit.

How often

Once. You must have the preventive visit within the first 12 months you have Part B.

Costs

You pay nothing for the visit if your doctor or other qualified health care provider accepts assignment. The Part B deductible doesn't apply. However, you may have to pay coinsurance, and the Part B deductible may apply if:

- Your doctor or other health care provider performs additional tests or services during the same visit.
- These additional tests or services aren't covered under the preventive benefits.

What it is

This visit includes a review of your medical and social history related to your health education, and counseling about preventive services.

Things to know

When you make your appointment, let your doctor's office know you would like to schedule your "Welcome to Medicare" preventive visit.

More information

Visit Medicare.gov/coverage/welcome-to-medicare-preventive-visit.

Yearly "Wellness" visits

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.

How often

Once every 12 months.

Preventive visits (continued)

Costs

You pay nothing for this visit if your doctor or other qualified health care provider accepts assignment. The Part B deductible doesn't apply. However, you may have to pay coinsurance, and the Part B deductible may apply if:

- Your doctor or other health care provider performs additional tests or services during the same visit.
- These additional tests or services aren't covered under the preventive benefits.

What it is

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. Visit Medicare.gov/coverage/yearly-wellness-visits for more information.

More information

Visit Medicare.gov/coverage/yearly-wellness-visits.

Prostate cancer screenings

Part B covers digital rectal exams and prostate specific antigen (PSA) blood tests for men over 50 (beginning the day after your 50th birthday).

How often

Once every 12 months.

Costs

- **Digital rectal exams**: 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.
- **PSA blood tests**: 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.

More information

Visit Medicare.gov/coverage/prostate-cancer-screenings.

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.

Costs

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

What it is

Prosthetic devices include:

- Breast prostheses (including a surgical bra). See "Breast prostheses" on page 14.
- One pair of conventional eyeglasses or contact lenses provided after a cataract operation.
- Ostomy bags and certain related supplies. See "Ostomy supplies" on page 71.
- Some surgically implanted prosthetic devices, including cochlear implants.
- Urological supplies.

Things to know

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.

Medicare will only pay for prosthetic items furnished by a supplier enrolled in Medicare, no matter who submits the claim (you or your supplier).

More information

- Surgeries to implant prosthetic devices in a hospital inpatient setting covered under Part A: See "Inpatient hospital care" on page 53.
- For surgeries to implant prosthetic devices in a hospital outpatient setting covered under Part B: See "Outpatient hospital services" on page 71.
- Visit Medicare.gov/coverage/prosthetic-devices.

Pulmonary rehabilitation programs

Part B covers a comprehensive pulmonary rehabilitation program if you have moderate to very severe chronic obstructive pulmonary disease (COPD).

Costs

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.

What it is

These programs help you breathe better, get stronger, and be able to live more independently.

Things to know

These services may be provided in a doctor's office or a hospital outpatient setting that offers pulmonary rehabilitation programs. You need a referral for pulmonary rehabilitation from the doctor treating this chronic respiratory disease.

More information

Visit Medicare.gov/coverage/pulmonary-rehabilitation-programs.

Radiation therapy

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

Costs

- If you're an inpatient, you pay the Part A deductible and coinsurance (if applicable).
- If you're an outpatient, you pay a set copayment. The Part B deductible applies.
- In a freestanding clinic, you pay 20% of the Medicare-approved amount for the therapy. The Part B deductible applies.

More information

Visit Medicare.gov/coverage/radiation-therapy.

Rectal exams

See "Prostate cancer screenings" on page 83.

Religious nonmedical health care institution items & services

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

Medicare doesn't cover the religious portion of religious nonmedical health care institution (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.
- 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 revoke 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. You're always eligible to get medically necessary Part A services.

Costs

- $1,364 deductible for each benefit period.
- Days 1–60: $0 coinsurance for each benefit period.
- Days 61–90: $341 coinsurance per day of each benefit period.
- Days 91 and beyond: $682 coinsurance per each "lifetime reserve day" after day 90 for each benefit period (up to 60 days over your lifetime).
- Beyond lifetime reserve days: all costs.

Things to know

Religious beliefs prohibit conventional and unconventional medical care in RNHCIs.

More information

Visit Medicare.gov/coverage/religious-non-medical-health-care-institution-items-services.

Respite care

See "Hospice care" on pages 50–51.

Rural health clinic (RHC) services

Part B covers a broad range of outpatient primary care and preventive services in RHCs.

Costs

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

What it is

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.

More information

Visit Medicare.gov/coverage/rural-health-clinic-rhc-services.

Scooters

See "Walkers & wheelchairs" on page 100.

Screening barium enemas

Part B covers this test if you're age 50 or older.

How often

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

Costs

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.

More information

Visit Medicare.gov/coverage/screening-barium-enemas.

Screening colonoscopies

Medicare covers screening colonoscopies.

How often

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 requirement.

Costs

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.

More information

Visit Medicare.gov/coverage/screening-colonoscopies.

Screening fecal occult blood tests

Medicare covers screening fecal occult blood tests.

How often

Medicare covers this lab test once every 12 months if you're 50 or older.

Costs

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

Things to know

You must get a referral from your doctor, physician assistant, nurse practitioner, or clinical nurse specialist.

More information

Visit Medicare.gov/coverage/screening-fecal-occult-blood-tests.

Screening flexible sigmoidoscopies

Medicare covers screening flexible sigmoidoscopies.

How often

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.

Costs

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.

More information

Visit Medicare.gov/coverage/screening-flexible-sigmoidoscopies.

Second surgical opinions

Part B covers a second surgical opinion in some cases for surgery that isn't an emergency. Medicare also will help pay for a third opinion if the first and second opinions are different.

Costs

You pay 20% of the Medicare-approved amount, and the Part B deductible applies. If the second opinion doesn't agree with the first opinion, you pay 20% of the Medicare-approved amount for a third opinion.

What it is

A second opinion is when another doctor gives their view about your health problem and how it should be treated.

More information

Visit Medicare.gov/coverage/second-surgical-opinions.

Sexually transmitted infections screenings & counseling

Part B covers sexually transmitted infection (STI) screenings for chlamydia, gonorrhea, syphilis, and/or Hepatitis B if you're pregnant or at increased risk for an STI.

Medicare also covers up to 2 individual 20-30 minute, face-to-face, high-intensity behavioral counseling sessions if you're a sexually active adolescent or adult at increased risk for STIs.

How often

Medicare covers these tests once every 12 months or at certain times during pregnancy. Medicare covers behavioral counseling sessions once each year.

Costs

You pay nothing if your doctor accepts assignment.

Things to know

You doctor must order the test or refer you for behavioral counseling. Medicare will only cover 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.

More information

Visit Medicare.gov/coverage/sexually-transmitted-infections-screenings-counseling.

Shingles shots

Part A and Part B don't cover the shingles shot. Usually, Part D plans cover all commercially available vaccines needed to prevent illness.

More information

- Contact your Medicare drug plan.
- Visit Medicare.gov/coverage/shingles-shot.

Shots

Part B covers:

- Flu shots: See page 42.
- Hepatitis B shots: See page 46.
- Pneumococcal shots: See page 76.
- Some other vaccines when they're related directly to the treatment of an injury of illness. These aren't considered preventive services.

Skilled nursing facility (SNF) care

Part A covers skilled nursing care provided in a SNF in certain conditions for a limited time if all of these conditions are met:

- You have Part A and have days left in your benefit period to use.
- You have a qualifying inpatient hospital stay.
- 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.
- You get these skilled services in a SNF that's certified by Medicare.
- You need these skilled services for a medical condition that's either:
  - A hospital-related medical condition.
  - A condition that started while you were getting care in the SNF for a hospital-related medical condition.

How often

Medicare covers certain daily skilled care services on a short-term basis.

Skilled nursing facility (SNF) care (continued)

Costs

You pay these amounts (in 2019) for each benefit period (following at least a 3-day medically necessary inpatient hospital stay for a related illness or injury or for a condition that started while you were getting care in the SNF for a hospital-related medical condition):

- Days 1–20: $0 each benefit period
- Days 21–100: up to $170.50 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.

What it is

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-covered services include, but aren't limited to:

- Semi-private room (a room you share with other patients).
- Meals.
- Skilled nursing care.
- Physical and occupational therapy, if they're needed to meet your health goal. See pages 69 and 75.
- Speech-language pathology services, if they're needed to meet your health goal. See page 93.
- Medical social services.
- Medications.
- Medical supplies and equipment used in the facility.
- Ambulance transportation (when other transportation endangers health) to the nearest supplier of needed services that aren't available at the SNF.
- Dietary counseling.

More information

Visit Medicare.gov/coverage/skilled-nursing-facility-snf-care.

Sleep studies

Part B covers Type I, II, III, and IV sleep tests and devices if you have clinical signs and symptoms of sleep apnea.

Costs

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

Things to know

Medicare only covers Type I tests if they're done in a sleep lab facility. Your doctor must order the test.

More information

Visit Medicare.gov/coverage/sleep-studies.

Speech-language pathology services

Part B helps pay for medically necessary outpatient speech-language pathology services.

Costs

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

Things to know

Medicare law no longer limits how much it pays for your medically necessary outpatient therapy services in one calendar year.

More information

Visit Medicare.gov/coverage/speech-language-pathology-services.

Supplies

Part B usually doesn't cover common medical supplies, like bandages and gauze, which you use at home.

Costs

You pay 100% for most common medical supplies you use at home.

More information

Visit Medicare.gov/coverage/supplies.

Surgery

Medicare covers many medically necessary surgical procedures.

Costs

For surgeries or procedures, it's hard to know the exact costs in advance. This is because no one knows exactly what services you'll need. If you need surgery or a procedure, you may be able to estimate how much you'll have to pay. Visit Medicare.gov/coverage/surgery for more cost information

More information

Visit Medicare.gov/coverage/surgery.

Surgical dressing services

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

Costs

You pay nothing for the supplies and 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.

More information

Visit Medicare.gov/coverage/surgical-dressing-services.

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.

Costs

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.

What it is

The facility can "swing" its beds and provide either acute hospital or skilled nursing facility (SNF)-level care, as needed.

More information

Visit Medicare.gov/coverage/swing-bed-services.

Tdap shots

Part A and Part B don't cover the Tdap shot. Usually, Part D plans cover all commercially available vaccines needed to prevent illness.

What it is

Tdap is the adolescent and adult booster shot for tetanus, diphtheria, and pertussis (also called whooping cough). The childhood shot is called DTaP. Both protect against tetanus, diphtheria, and pertussis (whooping cough).

More information

- Contact your Medicare drug plan.
- Visit Medicare.gov/coverage/tdap-shots.

Telehealth

Part B covers certain telehealth services.

Costs

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

What it is

Telehealth services include 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.

More information

Visit Medicare.gov/coverage/telehealth.

Therapeutic shoes or inserts

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.

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

How often

Each calendar year.

Costs

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

Things to know

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.

More information

- Other diabetic services and supplies: See "Diabetes services" and "Diabetes supplies" on pages 30–31.
- Visit Medicare.gov/coverage/therapeutic-shoes-or-inserts.

Traction equipment

Part B covers traction equipment that your doctor prescribes for use in your home. It's covered as durable medical equipment (DME).

More information

- See "Durable medical equipment (DME)" on pages 36–38.
- Visit Medicare.gov/coverage/traction-equipment.

Transitional Care Management Services

Medicare may cover these services if you're returning to your community after a stay at certain facilities, like a hospital or skilled nursing facility. You'll also be able to get an in-person office visit within 2 weeks of your return home.

Costs

You pay coinsurance and the Part B deductible.

Things to know

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. They will work with you and your family and caregiver(s), as appropriate, and with your other health care providers.

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
- Help you with scheduling and managing your medications.

More information

Visit Medicare.gov/coverage/transitional-care-management-services.

Transplants

Part B covers:

- Doctor's services associated with heart, lung, kidney, pancreas, intestine, and liver organ transplants.
- Cornea transplants, in certain conditions.
- Immunosuppressive (or "transplant") drugs, in certain conditions, associated with Medicare-covered transplants.

Part A covers:

- Services for heart, lung, kidney, pancreas, intestine, and liver organ transplants, in certain conditions.
- Necessary tests, labs, and exams.
- Immunosuppressive (or "transplant") drugs, in certain conditions, follow up care, and procurement of organs.
- Stem cell transplants, in certain conditions.

Transplants (continued)

Costs

You pay:

- 20% of the Medicare-approved amount for your doctor's services, and the Part B deductible applies.
- Various costs for transplant facility charges.
- Nothing for a living donor for a kidney transplant.
- Nothing for Medicare-certified laboratory tests.

Things to know

Transplants must be performed in Medicare-approved facilities. Stem cell and cornea transplants aren't limited to Medicare-approved transplant centers.

More information

- Kidney transplants for adults: See "Kidney transplants" on pages 56–57.
- Kidney transplants for children: See "Kidney transplants (children)" on page 58.
- Pancreas transplants: See "Pancreas transplants" on page 74.
- Visit Medicare.gov/coverage/transplants.

Travel

Medicare usually doesn't cover health care while you're traveling outside 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.

Visit Medicare.gov/coverage/travel for more details.

Travel (continued)

Costs

You pay 100% of the costs, in most cases. In the situations described on the previous page, you pay 20% of the Medicare-approved amount, and the Part B deductible applies. Visit Medicare.gov/coverage/travel for more cost information.

Things to know

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.

More information

Visit Medicare.gov/coverage/travel.

Therapeutic continuous glucose monitors (CGMs)

Medicare covers therapeutic CGMs and related supplies instead of blood sugar monitors for making diabetes treatment decisions, like changes in diet and insulin dosage.

If you use insulin and require frequent adjustments to your insulin regimen/dosage, a continuous glucose monitor may be covered if your doctor determines that you meet all of the requirements for Medicare coverage, including the need to frequently check your blood sugar (4 or more times a day) and the need to either use an insulin pump or receive 3 or more insulin injections per day.

More information

- See “Diabetes services” & “Diabetes supplies”: on pages 30–31.
- See “Insulin”: on page 54.
- Visit Medicare.gov/coverage/therapeutic-continuous-glucose-monitors-cgms.

Urgently needed care

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

Costs

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.

More information

Visit Medicare.gov/coverage/urgently-needed-care.

Vaccinations

See "Shots" on page 91.

Vaginal cancer screenings

See "Cervical & vaginal cancer screenings" on pages 17–18.

Walkers

Medicare Part B covers walkers, including rollators, as durable medical equipment (DME). The walker must be medically necessary and prescribed by your doctor or other treating provider for use in your home.

More information

- See "Durable medical equipment (DME)" on pages 36–38.
- Visit Medicare.gov/coverage/walkers.

Wheelchairs & scooters

Medicare Part B covers power-operated vehicles (scooters) and manual wheelchairs as durable medical equipment (DME) that your doctor prescribes for use in your home.

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.

More information

- See "Durable medical equipment (DME)" on pages 36–38.
- Visit Medicare.gov/coverage/wheelchairs-scooters.

X-rays

Part B covers medically necessary diagnostic X-rays.

Costs

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

Things to know

Your treating doctor or other health care provider must order the X-rays.

More information

- See "Diagnostic non-laboratory tests" on page 32.
- Visit Medicare.gov/coverage/x-rays.

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Note: You can get the "Medicare & You" handbook electronically in standard print, large print, or as an eBook.

For general Medicare inquiries and Medicare publications, call us at 1-800-MEDICARE (1-800-633-4227). TTY: 1-877-486-2048.

For all other CMS publications and documents in accessible formats, you can contact our Customer Accessibility Resource Staff:

Call 1-844-ALT-FORM (1-844-258-3676). TTY: 1-844-716-3676.

- Send a fax to 1-844-530-3676.
- Send an email to altformatrequest@cms.hhs.gov.
- Send a letter to:

  Centers for Medicare & Medicaid Services
  Offices of Hearings and Inquiries (OHI)
  7500 Security Boulevard, Mail Stop S1-13-25
  Baltimore, MD 21244-1850
  Attn: Customer Accessibility Resource Staff

You can also contact the Customer Accessibility Resource staff:

- To inquire about a request for accessible formats.
- To submit concerns and issues about accessible communications, including the quality and timeliness of your request.

Note: Your request for a CMS publication or document should include:

- Your name, phone number, and the mailing address where we should send the publications or documents.
- The publication title and CMS Product No., if known.
- The format you need, like Braille, large print, or data/audio CD.

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1. Online at hhs.gov/civil-rights/filing-a-complaint/complaint-process/index.html.
2. By phone: Call 1-800-368-1019. TDD user can call 1-800-537-7697.
3. In writing: Send information about your complaint to:

   Office for Civil Rights
   U.S. Department of Health and Human Services
   200 Independence Avenue, SW
   Room 509F, HHH Building
   Washington, D.C. 20201

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