



Your Medicare Benefits

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



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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](https://www.Medicare.gov), or call 1-800-MEDICARE (1-800-633-4227) to get the most current information. TTY users can call 1-877-486-2048.

“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.

If you have a question about a test, item, or service that isn't listed in this booklet, visit [Medicare.gov/coverage](https://www.Medicare.gov/coverage) or call 1-800-MEDICARE (1-800-633-4227). TTY users can call 1-877-486-2048.

If you have a Medicare Advantage Plan or other Medicare health plan, you have the same basic benefits as people who have Original Medicare, but each plan's rules can vary. Some services and supplies may not be listed in this booklet because Medicare Advantage Plan 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 this booklet. They explain information that will be important in understanding Medicare Part A and Part B coverage.

What's the Part B deductible?

In 2022, you pay a yearly \$233 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, what you pay may be higher if doctors, other health care providers, or suppliers don't accept assignment. Although the Medicare-approved amount is lower for doctors who don't accept assignment, they can charge you 15% over the Medicare-approved amount. This is called the "limiting charge." The limiting charge only applies 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 Medicare-enrolled suppliers, 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 out-of-pocket. It's important to ask questions, so you understand why your doctor is recommending certain services and if 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, download and read the booklet "Medicare Appeals" at [Medicare.gov/publications](https://www.Medicare.gov/publications), or visit [Medicare.gov/appeals](https://www.Medicare.gov/appeals).

What if an item or service isn't listed in this booklet, or I need more information?

Visit [Medicare.gov/coverage](https://www.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 users can call 1-877-486-2048.

Can I get information on my mobile device?

To get Medicare coverage information on your smart phone or tablet, download Medicare's free "What's covered" mobile app on the App Store or Google Play.



Preventive services

Preventive services help you stay healthy. Throughout this booklet, you'll see a picture of an apple next to preventive services 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 65–75 and have smoked at least 100 cigarettes in your lifetime.

How often

Once in a lifetime.

Costs

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

Things to know

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

More information

Visit [Medicare.gov/coverage/abdominal-aortic-aneurysm-screenings](https://www.Medicare.gov/coverage/abdominal-aortic-aneurysm-screenings).

Acupuncture

Part B covers up to 12 acupuncture visits in 90 days for chronic low back pain. Medicare covers an additional 8 sessions if you show improvement. If your doctor decides your chronic low back pain isn't improving or is getting worse, Medicare won't cover your additional treatments. You can get a maximum of 20 acupuncture treatments in a 12-month period.

Medicare doesn't cover acupuncture (including dry needling) for any condition other than chronic low back pain.

Acupuncture (continued)

Costs

After you meet the Part B deductible, you pay 20% of the Medicare-approved amount.

What it is

Acupuncture is a technique where providers stimulate specific points on the body, most often by inserting thin needles through the skin.

Things to know

Chronic low back pain is defined as:

- Lasting 12 weeks or longer
- Having no known cause (not related to cancer that has spread, or inflammatory or infectious disease)
- Having no association with surgery or pregnancy

You must get acupuncture from a doctor, or by another health care provider (like a nurse practitioner or physician assistant) who has both of these:

- A masters or doctoral level degree in acupuncture or Oriental Medicine from a school accredited by the Accreditation Commission on Acupuncture and Oriental Medicine.
- A current, full, active, and unrestricted license to practice acupuncture in the state where you're getting care.

More information

Visit [Medicare.gov/coverage/acupuncture](https://www.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 98–99. 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 it's given as part of your yearly “Wellness” visit. If it's provided as part of your medical treatment, the Part B deductible and coinsurance apply.

Advance care planning (continued)

What it is

This is planning for care you would get if you become unable to speak for yourself. As part of advance care planning, you may choose to complete an advance directive. This is an important legal document that records your wishes about medical treatment at a future time, if you aren't able to make decisions about your care. You can talk about an advance directive with your health care provider, and they can help you fill out the forms, if you prefer.

Things to know

Consider carefully who you want to speak for you and what direction you want to give. You shouldn't feel forced to go against your values or preferences, and you have the right to carry out plans without discrimination based on your age or disability. For help with advance directives, visit the Eldercare Locator at eldercare.acl.gov.

More information

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



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 provider determines you're misusing alcohol, you can get up to 4 brief face-to-face counseling sessions each year (if you're competent and alert during counseling).

How often

Medicare covers an alcohol misuse screening once each year.

Costs

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

Things to know

A qualified primary care doctor or other primary care provider 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 traveling in any other vehicle could endanger your health, and you need medically necessary services from a:

- Hospital
- Critical access hospital, or
- Skilled nursing facility

Medicare may pay for emergency ambulance transportation in an airplane or helicopter if you need immediate and rapid transport 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 the transportation is medically necessary. For example, someone with End-Stage Renal Disease (ESRD) may need medically necessary ambulance transport to a kidney dialysis facility.

Costs

After you meet the Part B deductible, you pay 20% of the Medicare-approved amount.

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](https://www.medicare.gov/coverage/ambulance-services).
- Visit [Medicare.gov/publications](https://www.medicare.gov/publications) to download and read the booklet "Medicare Coverage of Ambulance Services."

Ambulatory surgical centers

Ambulatory surgical centers are outpatient facilities that perform surgical procedures. In most cases, patients at ambulatory surgical centers are released within 24 hours. Part B covers facility service fees related to approved surgical procedures you get in these centers.

Costs

After you meet the Part B deductible, you pay 20% of the Medicare-approved amount to both the ambulatory surgical center and the doctor(s) who treat you. You pay nothing for certain preventive services (like a screening colonoscopy) if the doctor or other health care provider accepts assignment. However, you may have to pay other costs associated with the preventive services. For example, if your doctor removes a polyp during a screening colonoscopy, you may have to pay 20% of the Medicare-approved amount. You also pay all facility service fees for non-covered procedures you get in ambulatory surgical centers.

Ambulatory surgical centers (continued)

More information

- Visit [Medicare.gov/coverage/ambulatory-surgical-centers](https://www.medicare.gov/coverage/ambulatory-surgical-centers).
- To get cost estimates for ambulatory surgical center outpatient procedures, visit [Medicare.gov/procedure-price-lookup](https://www.medicare.gov/procedure-price-lookup).

Anesthesia

Part A covers anesthesia services you get as an inpatient in a hospital. Part B covers anesthesia services you get as an outpatient in a hospital or a patient in a freestanding ambulatory surgical center.

Costs

After you meet the Part B deductible, you pay 20% of the Medicare-approved amount for the anesthesia services you get from a doctor or certified registered nurse anesthetist. 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](https://www.medicare.gov/coverage/anesthesia).

Artificial eyes & limbs

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

Costs

After you meet the Part B deductible, you pay 20% of the Medicare-approved amount.

More information

Visit [Medicare.gov/coverage/artificial-eyes-limbs](https://www.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 predict your costs in advance. This is because you won't know what services you need until you meet with your provider. If you need weight loss surgery or a procedure, you may be able to estimate how much you'll have to pay. For help estimating costs on surgical procedures in certain settings, visit [Medicare.gov/procedure-price-lookup](https://www.medicare.gov/procedure-price-lookup).

Bariatric surgery (continued)

More information

Visit [Medicare.gov/coverage/bariatric-surgery](https://www.Medicare.gov/coverage/bariatric-surgery).



Barium enemas

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

How often

Medicare covers the test once every 48 months if you're 50 or older when your doctor uses it instead of a flexible sigmoidoscopy or colonoscopy. If you're at high risk for colorectal cancer and are 50 or older, Medicare covers this test once every 24 months.

Costs

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

What it is

An X-ray exam that can detect changes or abnormalities in your large intestine (colon).

More information

Visit [Medicare.gov/coverage/barium-enemas](https://www.Medicare.gov/coverage/barium-enemas).

Behavioral health integration services

Medicare may pay to help manage a behavioral health condition (like depression, anxiety, or another mental 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.

Behavioral health integration services (continued)

What it is

The Psychiatric Collaborative Care Model is a set of integrated behavioral health services, including care management support such as:

- Care planning for behavioral health conditions
- Ongoing assessment of your condition
- Medication support
- Counseling
- Other treatments your provider recommends

Your health care provider will ask you to sign an agreement for you to get this set of services on a monthly basis.

More information

Visit [Medicare.gov/coverage/behavioral-health-integration-services](https://www.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

Your provider may get blood from a blood bank at no charge. For more information, visit [Medicare.gov/coverage/blood](https://www.medicare.gov/coverage/blood) for cost information.

More information

Visit [Medicare.gov/coverage/blood](https://www.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

After you meet the Part B deductible, 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](https://www.medicare.gov/coverage/blood-processing-handling).



Blood-based biomarker tests

Medicare covers a blood-based biomarker lab test if you meet all of these conditions:

- You're between 50–85.
- You show no symptoms of colorectal disease (including, but not limited to, lower gastrointestinal pain, blood in stool, or 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

Medicare covers a blood-based biomarker test (if available) once every 3 years.

Costs

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

More information

Visit [Medicare.gov/coverage/colorectal-cancer-blood-based-biomarker-screenings](https://www.Medicare.gov/coverage/colorectal-cancer-blood-based-biomarker-screenings).



Bone mass measurements

Part B covers this test if you meet one or more of these conditions:

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

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 find out if you're at risk for broken bones.

More information

Visit [Medicare.gov/coverage/bone-mass-measurement](https://www.Medicare.gov/coverage/bone-mass-measurement).

Braces (arm, leg, back, & neck)

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

Costs

After you meet the Part B deductible, you pay 20% of the Medicare-approved amount.

Things to know

If you live in or visit a competitive bidding area and need an off-the-shelf (OTS) back or knee brace, you generally must use specific suppliers called “contract suppliers,” if you want Medicare to help pay for the OTS brace. Contract suppliers must provide the brace to you and accept assignment as a term of their Medicare contract.

Visit [Medicare.gov/supplier](https://www.Medicare.gov/supplier) to see if you live in or are visiting a competitive bidding area, or to find suppliers who accept assignment. You can also call 1-800-MEDICARE (1-800-633-4227). TTY users can call 1-877-486-2048.

More information

Visit [Medicare.gov/coverage/braces-arm-leg-back-neck](https://www.Medicare.gov/coverage/braces-arm-leg-back-neck).



Breast cancer screenings

See “Mammograms” on page 71.

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.

Breast prostheses (continued)

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

- Part A covers surgeries to implant breast prostheses in a hospital inpatient setting. See “Inpatient hospital care” on pages 61–63.
- Part B covers surgeries to implant breast prostheses in a hospital outpatient setting. See “Outpatient hospital services” on pages 85–86.
- Visit [Medicare.gov/coverage/breast-prostheses](https://www.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 42–44.
- Visit [Medicare.gov/coverage/canes](https://www.Medicare.gov/coverage/canes).

Cardiac rehabilitation

Part B covers these comprehensive 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 programs that are usually more rigorous or intense than regular cardiac rehabilitation programs. Medicare covers these services in a doctor's office or hospital outpatient setting (including a critical access hospital).

Cardiac rehabilitation (continued)

Costs

You pay 20% of the Medicare-approved amount if you get these 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

Cardiac rehabilitation programs include exercise, education, and counseling if you've experienced a heart attack, heart failure or other heart problems as listed above.

More information

Visit [Medicare.gov/coverage/cardiac-rehabilitation-programs](https://www.Medicare.gov/coverage/cardiac-rehabilitation-programs).



Cardiovascular behavioral therapy

Medicare covers a cardiovascular behavioral therapy visit with your primary care doctor or other qualified 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 primary care practitioner 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 on eating well.

More information

Visit [Medicare.gov/coverage/cardiovascular-behavioral-therapy](https://www.Medicare.gov/coverage/cardiovascular-behavioral-therapy).



Cardiovascular disease screenings

Part B covers blood tests that help detect cardiovascular disease.

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

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

More information

Visit [Medicare.gov/coverage/cardiovascular-disease-screenings](https://www.Medicare.gov/coverage/cardiovascular-disease-screenings).

Cataract surgery

See “Eyeglasses & contact lenses” on page 48.



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 in most cases. 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 30-65 without HPV symptoms.

Cervical & vaginal cancer screenings (continued)

Costs

If your doctor or other qualified health care provider accepts assignment, you pay nothing for the following:

- the lab Pap test
- the lab HPV with Pap test
- the Pap test specimen collection
- the pelvic and breast exams

More information

Visit [Medicare.gov/coverage/cervical-vaginal-cancer-screenings](https://www.Medicare.gov/coverage/cervical-vaginal-cancer-screenings).

Chemotherapy

Medicare covers chemotherapy if you have cancer. Part A covers it if you're a hospital inpatient. Part B covers it if you're a hospital outpatient or get services in a doctor's office or freestanding clinic.

Costs

If you get Part B-covered chemotherapy in a hospital outpatient setting, you pay a copayment. For chemotherapy given in a doctor's office or freestanding clinic, you pay 20% of the Medicare-approved amount after you meet the Part B deductible.

More information

- Part A covers chemotherapy in a hospital inpatient setting. See "Inpatient hospital care" on pages 61–63.
- Visit [Medicare.gov/coverage/chemotherapy](https://www.Medicare.gov/coverage/chemotherapy).

Children's kidney services

Medicare covers dialysis and kidney transplants for children.

More information

- Dialysis: See "Dialysis (children)" on pages 38–39.
- Kidney transplants: See "Kidney transplants (children)" on page 68.
- Visit [Medicare.gov/publications](https://www.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 by a chiropractor or other qualified provider to correct a vertebral subluxation (when the spinal joints fail to move properly, but the contact between the joints remains intact).

Costs

After you meet the Part B deductible, you pay 20% of the Medicare-approved amount.

Things to know

Medicare doesn't cover other services or tests a chiropractor orders, including X-rays, massage therapy, and acupuncture (unless the acupuncture is for the treatment of chronic low back pain).

More information

Visit [Medicare.gov/coverage/chiropractic-services](https://www.Medicare.gov/coverage/chiropractic-services).

Chronic care management services

If you have 2 or more serious chronic conditions (like arthritis and diabetes) that you expect to last at least a year, Medicare may pay for a health care provider's help to manage those conditions.

Costs

You pay a monthly fee, and the Part B deductible and coinsurance apply. If you have supplemental insurance, including Medicaid, it may help cover the monthly fee.

What it is

Chronic care management includes a comprehensive care plan that lists your health problems and goals, other 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 chronic care management.

If you agree to get this service, your provider 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 providers if they offer chronic care management services.

More information

Visit [Medicare.gov/coverage/chronic-care-management-services](https://www.Medicare.gov/coverage/chronic-care-management-services).

Clinical laboratory tests

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

Costs

You pay nothing for Medicare-approved clinical diagnostic laboratory tests.

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](https://www.Medicare.gov/coverage/clinical-laboratory-services).

Clinical research studies

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

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 different types of medical care, including new treatments, to find out how well they work and if they're safe. For example, a clinical research study might test how well a new cancer drug works.

More information

Visit [Medicare.gov/coverage/clinical-research-studies](https://www.Medicare.gov/coverage/clinical-research-studies).

Cognitive assessment & care plan services

When you see your provider for a visit (including your yearly “Wellness” visit), they may perform a cognitive assessment to look for signs of dementia, including Alzheimer’s disease. Part B also covers a separate visit with your regular doctor or a specialist to fully review your cognitive function, establish or confirm a diagnosis like dementia (including Alzheimer’s disease), and establish a care plan.

Signs of cognitive impairment include trouble remembering, learning new things, concentrating, managing finances, or making decisions about your everyday life.

Costs

After you meet the Part B deductible, you pay 20% of the Medicare-approved amount.

What it is

During a cognitive assessment, your doctor may:

- Perform an exam, talk with you about your medical history, and review your medications.
- Create a care plan to help address and manage your symptoms.
- Help you develop or update your advance care plan.
- Refer you to a specialist, if needed.
- Help you understand more about community resources, like rehabilitation services, adult day health programs, and support groups.

More information

Visit [Medicare.gov/coverage/cognitive-assessment-care-plan-services](https://www.Medicare.gov/coverage/cognitive-assessment-care-plan-services).



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, Medicare covers the test once every 120 months, or 48 months after a previous flexible sigmoidoscopy. There's no minimum age requirement.

Costs

If your doctor or other qualified health care provider accepts assignment, you pay nothing for a screening colonoscopy.

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

More information

Visit [Medicare.gov/coverage/colonoscopies](https://www.Medicare.gov/coverage/colonoscopies).



Colorectal cancer screenings

Part B may cover one or more of these screening tests:

- Barium enemas: See page 12.
- Blood-based biomarker tests: See page 14.
- Colonoscopies: See above.
- Fecal occult blood tests: See page 48.
- Flexible sigmoidoscopies: See page 49.
- Multi-target stool DNA tests: See pages 78–79.

What it is

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

Commode chairs

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

More information

- See “Durable medical equipment (DME)” on pages 42–44.
- Visit [Medicare.gov/coverage/commode-chairs](https://www.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.

What it is

Concierge care is when a doctor or group of doctors charges you a membership fee before they'll see you or accept you into their practice. After you pay the membership fee, you may get some services or amenities that Medicare doesn't cover.

Concierge care may also be called concierge medicine, retainer-based medicine, boutique medicine, platinum practice, or direct care.

More information

Visit [Medicare.gov/coverage/concierge-care](https://www.medicare.gov/coverage/concierge-care).

Contact lenses

See "Eyeglasses & contact lenses" on page 48.

Continuous glucose monitors

If your doctor determines that you meet all the coverage requirements, Medicare covers continuous glucose monitors and related supplies for making diabetes treatment decisions (like changes in diet and insulin dosage).

More information

- See "Diabetes services" & "Diabetes supplies" on pages 35–36.
- See "Insulin" on page 65.
- Visit [Medicare.gov/coverage/therapeutic-continuous-glucose-monitors](https://www.medicare.gov/coverage/therapeutic-continuous-glucose-monitors).

Continuous Passive Motion (CPM) machines

If you meet certain conditions, Medicare covers knee CPM machines as durable medical equipment (DME) that your doctor prescribes for use in your home. For example, if you have knee replacement surgery, Medicare covers CPM machines for up to 21 days for use in your home.

More information

- See "Durable medical equipment (DME)" on pages 42–44.
- Visit [Medicare.gov/coverage/continuous-passive-motion-machines](https://www.medicare.gov/coverage/continuous-passive-motion-machines).

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

Medicare may cover a 3-month trial of CPAP therapy (including devices and accessories) if you've been diagnosed with obstructive sleep apnea. After the trial period, Medicare may continue to cover CPAP therapy, devices and accessories if you meet with your doctor in person, and your doctor documents in your medical record that you meet certain conditions and the therapy is helping you.

Costs

After you meet the Part B deductible, you pay 20% of the Medicare-approved amount for the machine rental and purchase of related supplies (like masks and tubing).

What it is

CPAP therapy is an in-home treatment for people with sleep apnea.

Things to know

- If you had a CPAP machine before you got Medicare and you meet certain requirements, Medicare may cover a rental or replacement CPAP machine and/or CPAP accessories.
- Medicare pays the supplier to rent a CPAP machine for 13 months if you've been using it without interruption. After Medicare makes rental payments for 13 continuous months, you'll own the machine.

More information

Visit [Medicare.gov/coverage/continuous-positive-airway-pressure-devices-accessories-therapy](https://www.medicare.gov/coverage/continuous-positive-airway-pressure-devices-accessories-therapy).

Cosmetic surgery

Medicare usually doesn't cover cosmetic surgery unless you need it 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 pages 16–17.

Costs

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

Cosmetic surgery (continued)

Things to know

Medicare requires prior authorization before you get these hospital outpatient services that are sometimes considered cosmetic:

- **Blepharoplasty**—Surgery on your eyelid to remove “droopy,” fatty, or excess tissue.
- **Botulinum toxin injections (or “Botox”)**—Injections used to treat muscle disorders, like spasms and twitches.
- **Panniculectomy**—Surgery to remove excess skin and tissue from your lower abdomen.
- **Rhinoplasty (or “nose job”)**—Surgery to change the shape of your nose.
- **Vein ablation**—Surgery to close off veins.

If your procedure requires prior authorization before Medicare will pay for it, you don’t need to do anything. Your provider will send a prior authorization request and documentation to Medicare for approval before performing the procedure. If Medicare approves your prior authorization request, you should only need to pay your deductible and coinsurance.

More information

Visit [Medicare.gov/coverage/cosmetic-surgery](https://www.medicare.gov/coverage/cosmetic-surgery).



Counseling to prevent tobacco use & tobacco-caused disease

If you use tobacco, Part B covers smoking and tobacco-use cessation counseling.

How often

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

Costs

If your doctor or other qualified health care provider accepts assignment, you pay nothing for the counseling sessions.

What it is

Counseling to help you stop smoking or using tobacco.

More information

Visit [Medicare.gov/coverage/counseling-to-prevent-tobacco-use-tobacco-caused-disease](https://www.medicare.gov/coverage/counseling-to-prevent-tobacco-use-tobacco-caused-disease).

COVID-19 antibody tests

Part B covers FDA-authorized COVID-19 antibody tests (coverage could change when the public health emergency ends).

Costs

You pay nothing for the antibody tests during the COVID-19 public health emergency.

What it is

These tests help see if you've developed an immune response to COVID-19.

More information

- For more information on other COVID-19 services: see “COVID-19 diagnostic tests” below, “COVID-19 monoclonal antibody treatments” on the next page, and “COVID-19 vaccines” on page 30.
- Visit [Medicare.gov/medicare-coronavirus](https://www.medicare.gov/medicare-coronavirus).
- For more information on COVID-19, visit [CDC.gov/coronavirus](https://www.cdc.gov/coronavirus).

COVID-19 diagnostic tests

Part B covers FDA-authorized COVID-19 diagnostic tests (coverage could change when the public health emergency ends).

Costs

You pay nothing for a diagnostic test during the COVID-19 public health emergency when you get it from a laboratory, pharmacy, doctor, or hospital, and when Medicare covers this test in your local area.

What it is

These tests check to see if you have COVID-19.

More information

- For more information on other COVID-19 services: see “COVID-19 antibody tests” above, “COVID-19 monoclonal antibody treatments” on the next page, and “COVID-19 vaccines” on page 30.
- Visit [Medicare.gov/medicare-coronavirus](https://www.medicare.gov/medicare-coronavirus).
- For more information on COVID-19, visit [CDC.gov/coronavirus](https://www.cdc.gov/coronavirus).

COVID-19 monoclonal antibody treatments

Part B covers FDA-authorized COVID-19 monoclonal antibody treatments.

Costs

You pay nothing for a monoclonal antibody treatment during the COVID-19 public health emergency (and for the rest of the calendar year in which the COVID-19 public health emergency ends) when you get it from a Medicare provider or supplier. You must meet certain conditions to qualify.

What it is

These treatments can help fight the disease and keep you out of the hospital, if you test positive for COVID-19 and have mild to moderate symptoms.

More information

- For more information on other COVID-19 services: see “COVID-19 antibody tests” on the previous page, “COVID-19 diagnostic tests” on the previous page, and “COVID-19 vaccines” on the next page.
- Visit [Medicare.gov/medicare-coronavirus](https://www.medicare.gov/medicare-coronavirus).
- For more information on COVID-19, visit [CDC.gov/coronavirus](https://www.cdc.gov/coronavirus).

COVID-19 vaccines

Part B covers COVID-19 vaccines.

Costs

You pay nothing for the vaccine, booster shot, or additional dose (if you're immunocompromised).

What it is

Vaccines help reduced the risk of illness from COVID-19 by working with the body's natural defenses to safely develop protection (immunity) to the virus.

Things to know

Bring your red, white, and blue Medicare card with you when you get the vaccine so your health care provider or pharmacy can bill Medicare.

More information

- For more information on other COVID-19 services: see “COVID-19 antibody tests” on page 28, “COVID-19 diagnostic tests” on page 28, and “COVID-19 monoclonal antibody treatments” on the previous page.
- Visit [Medicare.gov/medicare-coronavirus](https://www.Medicare.gov/medicare-coronavirus).
- For more information on COVID-19, visit [CDC.gov/coronavirus](https://www.CDC.gov/coronavirus).

Crutches

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

More information

- See “Durable medical equipment (DME)” on pages 42–44.
- Visit [Medicare.gov/coverage/crutches](https://www.Medicare.gov/coverage/crutches).

CT scans

See “Diagnostic non-laboratory tests” on page 37.

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](https://www.Medicare.gov/coverage/defibrillators) for cost information.

More information

- Part A covers surgeries to implant defibrillators in the hospital inpatient setting. See “Inpatient hospital care” on pages 61–63.
- Visit [Medicare.gov/coverage/defibrillators](https://www.Medicare.gov/coverage/defibrillators).

Dental services

Medicare doesn't cover most dental care (including procedures and 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 it doesn't cover dental care.

Costs

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

More information

Visit [Medicare.gov/coverage/dental-services](https://www.medicare.gov/coverage/dental-services).



Depression screenings

Part B covers depression screenings to find out if you have symptoms of depression.

How often

Once each year.

Costs

If your doctor accepts assignment, you pay nothing for the screening.

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](https://www.medicare.gov/coverage/depression-screenings).

If you or someone you know is in crisis, call the National Suicide Prevention Lifeline at 1-800-273-TALK (1-800-273-8255). TTY users can call 1-800-799-4TTY (1-800-799-4889). You can call and speak with a counselor 24 hours a day, 7 days a week. Call 911 if you're in immediate medical crisis.



Diabetes screenings

Part B covers glucose laboratory test screenings (with or without a carbohydrate challenge) if your doctor determines you're at risk for developing diabetes. Part B covers these screenings if you have any of these risk factors:

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

Part B also covers these screenings if 2 or more of these conditions apply to you:

- You're 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 screenings if your doctor or other qualified health care provider accepts assignment.

More information

Visit [Medicare.gov/coverage/diabetes-screenings](https://www.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 in each calendar year that falls after the year you got your initial training.

Costs

After you meet the Part B deductible, you pay 20% of the Medicare-approved amount.

What it is

DSMT teaches you to cope with and manage your diabetes. The program may include tips for eating healthy and being active, monitoring blood sugar, taking prescription drugs, and reducing risks. Some patients may also be eligible for medical nutritional therapy training.

Things to know

To get DSMT, you must have a written order from your doctor or other qualified non-doctor provider.

Some exceptions apply if group sessions aren't available in your area, or if your doctor or qualified non-doctor provider says you would benefit more from having individual training sessions.

If you're in a rural area, you may be able to get DSMT services from a provider (like a Registered Dietitian) virtually through telehealth. See "Telehealth" on page 110.

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](https://www.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 34.
- Eye exams (for diabetes): See page 47.
- Foot care (for diabetes): See page 51.
- Glaucoma tests: See page 52.
- Nutrition therapy services: See page 80.

More information

- Covered supplies if you have diabetes: See “Diabetes supplies” below.

Diabetes supplies

Part B covers some diabetes supplies, including:

- Blood sugar (glucose) testing meters
- Blood sugar test strips
- Blood sugar control solutions (for checking test strip and monitor accuracy)
- Continuous glucose monitors and related supplies, like sensors
- Lancets and lancet holders
- Insulin and related supplies, like tubing, insertion sets, and pumps
- Therapeutic shoes or inserts

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 42–44.

Costs

If your supplier accepts assignment, you pay 20% of the Medicare-approved amount after you meet the Part B deductible.

Diabetes supplies (continued)

Things to know

If you have Medicare drug coverage (Part D), your plan may cover injectable insulin that isn't used with an insulin pump, certain medical supplies used to inject insulin (like syringes, gauze, and alcohol swabs), and some oral diabetes drugs. Check with your plan for more information.

More information

- See “Durable medical equipment (DME)” on pages 42–44.
- Covered services if you have diabetes: See “Diabetes services” on page 35.
- Blood sugar monitors: Visit [Medicare.gov/coverage/blood-sugar-meters](https://www.Medicare.gov/coverage/blood-sugar-meters).
- Blood sugar test strips: Visit [Medicare.gov/coverage/blood-sugar-test-strips](https://www.Medicare.gov/coverage/blood-sugar-test-strips).
- Blood sugar control solutions: Visit [Medicare.gov/coverage/glucose-control-solutions](https://www.Medicare.gov/coverage/glucose-control-solutions).
- Certain continuous glucose monitors and related supplies: Visit [Medicare.gov/coverage/therapeutic-continuous-glucose-monitors-cgms](https://www.Medicare.gov/coverage/therapeutic-continuous-glucose-monitors-cgms).
- Lancets and lancet holders: Visit [Medicare.gov/coverage/lancet-devices-lancets](https://www.Medicare.gov/coverage/lancet-devices-lancets).
- Insulin: See page 65.
- Therapeutic shoes or inserts: See pages 111–112.

Diagnostic laboratory tests

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

Costs

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

What it is

Diagnostic laboratory tests look for changes in your health and 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 or find a medical problem. For more information, see “Preventive & screening services” on pages 96–97.

More information

Visit [Medicare.gov/coverage/diagnostic-laboratory-tests](https://www.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 to treat a medical problem.

Costs

After you meet the Part B deductible, 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. You pay a copayment for diagnostic non-laboratory tests done in a hospital outpatient setting.

What it is

Tests 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 or find a medical problem. For more information, see “Preventive & screening services” on pages 96–97.

More information

Visit [Medicare.gov/coverage/diagnostic-non-laboratory-tests](https://www.Medicare.gov/coverage/diagnostic-non-laboratory-tests).

Dialysis (children)

Part A and Part B cover different items and services for children's (pediatric) 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-certified dialysis facility)
- Home dialysis equipment and supplies
- Certain home support services
- Most drugs for outpatient or home dialysis (like an erythropoiesis-stimulating agent to treat anemia)
- Doctors' services
- Other services that are part of dialysis, like laboratory tests
- Dialysis when you travel and use a Medicare-certified facility

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 their kidneys no longer work.
- Your child has had a kidney transplant.

Dialysis (children) (continued)

Costs

- Inpatient hospital services: Part A pays for these services after you pay the hospital inpatient deductible.
- Doctors' 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.
- Transportation services: 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 due to permanent kidney failure, Medicare coverage will end:

- 12 months after the last month of your child's dialysis treatment
- 36 months after the month of your child's kidney transplant

Medicare can extend coverage if your child meets certain conditions.

More information

- See "Kidney transplants (children)" on page 68.
- Visit [Medicare.gov/coverage/dialysis-children](https://www.medicare.gov/coverage/dialysis-children).
- Visit [Medicare.gov/publications](https://www.medicare.gov/publications) to download and read the brochure "Medicare for Children with End-Stage Renal Disease."

Dialysis services & supplies

People with End-Stage Renal Disease (ESRD) have permanent kidney failure that requires dialysis or a kidney transplant. Medicare covers many kidney dialysis services and supplies if you have ESRD, including:

- **Inpatient dialysis treatments:** Part A covers dialysis if you're admitted to a hospital for special care. See "Inpatient hospital care" on pages 61–63.
- **Outpatient dialysis treatments & doctors' services:** Part B covers a variety of services in a Medicare-certified dialysis facility or your home. For example, Part B covers ESRD-related laboratory tests and certain drugs (like heparin, topical anesthetics, and erythropoiesis-stimulating agents used to treat anemia related to your ESRD). Part B doesn't cover ESRD-related drugs that are only available in an oral dosage form (drugs taken by mouth that only come in a capsule, tablet, or liquid form). Only Part D covers ESRD-related orally administered drugs.
- **Home dialysis training:** If you're a candidate for home dialysis, Part B covers training for you and the person helping you with your home dialysis treatments. A Medicare-certified home dialysis training facility must provide the training. Only dialysis facilities can bill Medicare (directly or under arrangement) for providing home dialysis training.
- **Home dialysis support services:** Part B covers home dialysis support services you get from your dialysis facility. This may include visits by trained hospital or dialysis facility workers to check on your home dialysis, help in emergencies (when needed), and check your equipment and water supply.
- **Home dialysis equipment & supplies:** Part B covers home dialysis support services you get from your dialysis facility. This may include visits by trained hospital or dialysis facility workers to monitor your home dialysis, help in emergencies (when needed), and check your equipment and water supply.
- **Certain drugs for home dialysis:** Part B covers heparin, the antidote for heparin (when medically necessary), topical anesthetics, and erythropoiesis-stimulating agents (like epoetin alfa or darbepoetin alfa) to treat anemia related to your renal disease.
- **Other dialysis services & supplies:** Part B covers other dialysis-related services and supplies (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

Visit [Medicare.gov/coverage/dialysis-services-supplies](https://www.medicare.gov/coverage/dialysis-services-supplies) for cost information.

Things to know

Medicare doesn't cover:

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

More information

- See “Dialysis (children)” on pages 38–39.
- Visit [Medicare.gov/coverage/dialysis-services-supplies](https://www.medicare.gov/coverage/dialysis-services-supplies).
- Visit [Medicare.gov/publications](https://www.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 & screening services" on pages 96–97. 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 Doctor of Chiropractic (DC).

Medicare also covers services you get from other health care providers, like:

- Physician assistants
- Nurse practitioners
- Clinical social workers
- Physical therapists
- Occupational therapists
- Speech-language pathologists
- Clinical psychologists

More information

Visit [Medicare.gov/coverage/doctor-other-health-care-provider-services](https://www.Medicare.gov/coverage/doctor-other-health-care-provider-services).

Drugs

See "Prescription drugs (outpatient)" on pages 93–96.

Durable medical equipment (DME)

Part B covers medically necessary DME if your Medicare-enrolled doctor or other health care provider prescribes it for use in your home. You must rent most DME, but you can also buy some items. Some items become your property after making a certain number of payments.

Durable medical equipment (DME) (continued)

DME that Medicare covers includes, but isn't limited to:

- Blood sugar meters and test strips
- Canes
- Commode chairs
- Continuous passive motion machines
- Continuous positive airway pressure (CPAP) devices
- Crutches
- Hospital beds
- Infusion pumps and supplies
- Nebulizers and nebulizer medications
- Oxygen equipment and accessories
- Patient lifts
- Pressure-reducing support surfaces
- Suction pumps
- Traction equipment
- Walkers
- Wheelchairs and scooters

Costs

After you meet the Part B deductible, you pay 20% of the Medicare-approved amount for DME (if your supplier accepts assignment). Visit [Medicare.gov/coverage/durable-medical-equipment-dme-coverage](https://www.medicare.gov/coverage/durable-medical-equipment-dme-coverage) for more cost information.

What it is

DME is defined as equipment that meets these criteria:

- Durable (can withstand repeated use)
- Used for a medical reason
- Typically only useful to someone who is sick or injured
- Used in your home
- Has an expected lifetime of at least 3 years

Durable medical equipment (DME) (continued)

Things to know

Make sure your doctors and DME suppliers are enrolled in Medicare. It's also important to ask a supplier if they participate in Medicare before you get DME. To get DME benefits, the doctor or supplier who gives you the DME must be enrolled in Medicare. If suppliers are participating in Medicare, they must accept assignment (which means they can charge you only the coinsurance and the Part B deductible for the Medicare-approved amount). If suppliers aren't participating and don't accept assignment, there's no limit on the amount they can charge you.

More information

- Visit [Medicare.gov/coverage/durable-medical-equipment-dme-coverage](https://www.medicare.gov/coverage/durable-medical-equipment-dme-coverage).
- Visit [Medicare.gov/publications](https://www.medicare.gov/publications) to view the booklet, "Medicare Coverage of Durable Medical Equipment and Other Devices."

E-visits

Part B covers E-visits with your doctors and certain other providers.

Costs

After you meet the Part B deductible, you pay 20% of the Medicare-approved amount for your doctors' services.

What it is

E-visits allow you to talk to your doctor using an online patient portal without going to the doctor's office.

Providers who can give these services include:

- Doctors
- Nurse practitioners
- Physician assistants
- Licensed clinical social workers (in specific circumstances)
- Clinical psychologists (in specific circumstances)
- Physical therapists
- Occupational therapists
- Speech-language pathologists

E-visits (continued)

Things to know

You must talk to your doctor or other provider to start these types of visits.

More information

Visit [Medicare.gov/coverage/e-visits](https://www.medicare.gov/coverage/e-visits).

Electrocardiogram (EKG or ECG) screenings

Part B covers a routine EKG or ECG screening if you get a referral from your doctor or other health care provider during your one-time “Welcome to Medicare” preventive visit. Part B also covers EKGs or ECGs as diagnostic tests.

How often

Once when you get a referral as part of your “Welcome to Medicare” visit, and more often as a diagnostic test if medically necessary.

Costs

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

More information

- See “Preventive visits” on pages 98–99.
- See “Diagnostic non-laboratory tests” on page 37.
- Visit [Medicare.gov/coverage/ekg-or-ecg-screenings](https://www.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 get.
- After you meet the Part B deductible, you also pay 20% of the Medicare-approved amount for your doctor's services.
- If your doctor admits you 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 part of your inpatient stay.

Things to know

Medicare only covers emergency services in foreign countries under rare circumstances. For more information, see "Travel outside the U.S." on page 113.

More information

Visit [Medicare.gov/coverage/emergency-department-services](https://www.medicare.gov/coverage/emergency-department-services).

Enteral nutrition supplies & equipment

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

Costs

After you meet the Part B deductible, you pay 20% of the Medicare-approved amount. Medicare will cover your enteral infusion pump from a Medicare-enrolled doctor or supplier. If a supplier doesn't accept assignment, there's no limit on the amount they can charge you, and you may have to pay the entire bill (both your share and Medicare's share) at the time you get the pump.

More information

- Visit [Medicare.gov/coverage/enteral-nutrition-supplies-equipment](https://www.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 52.
- Macular degeneration tests & treatment: See page 71.

More information

Visit [Medicare.gov/coverage/eye-exams](https://www.Medicare.gov/coverage/eye-exams).

Eye exams (for diabetes)

Part B covers eye exams for diabetic retinopathy if you have diabetes. The exam must be done by an eye doctor who’s legally allowed to do the test in your state.

How often

Once each year.

Costs

After you meet the Part B deductible, you pay 20% of the Medicare-approved amount for your doctor’s services. In a hospital outpatient setting, you pay a copayment.

More information

- Other diabetic services and supplies: See “Diabetes services” and “Diabetes supplies” on pages 35–36.
- Visit [Medicare.gov/coverage/eye-exams-for-diabetes](https://www.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](https://www.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 that implants 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. After you meet the Part B deductible, you pay 20% of the Medicare-approved amount for corrective lenses after each cataract surgery with an intraocular lens. 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](https://www.Medicare.gov/coverage/eyeglasses-contact-lenses).

Eyes

See "Artificial eyes & limbs" on page 11.



Fecal occult blood tests

Medicare covers screening fecal occult blood tests if you get a referral from your doctor, physician assistant, nurse practitioner, or clinical nurse specialist.

How often

If you're 50 or older, Medicare covers this lab test once every 12 months. If you're under 50, Medicare doesn't cover this test.

Costs

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

More information

Visit [Medicare.gov/coverage/fecal-occult-blood-tests](https://www.Medicare.gov/coverage/fecal-occult-blood-tests).

Federally Qualified Health Center (FQHC) services

FQHCs are public health centers that focus on serving at-risk and underserved populations, like those in urban and rural areas. 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. The Part B deductible doesn't apply. All FQHCs offer discounts if your income is limited.

More information

- To find an FQHC near you, visit findahealthcenter.hrsa.gov.
- Visit [Medicare.gov/coverage/federally-qualified-health-center-fghc-services](https://www.Medicare.gov/coverage/federally-qualified-health-center-fghc-services).

Feeding pumps

See “Enteral nutrition supplies & equipment” on page 46.



Flexible sigmoidoscopy screenings

Medicare covers flexible sigmoidoscopy screenings (endoscopic procedures that examine the rectum and lower colon).

How often

Medicare covers this test once every 48 months for most people age 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 you have a lesion or growth biopsied or removed during your screening, Medicare considers the procedure diagnostic and you may have to pay coinsurance and/or a copayment. In these cases, the Part B deductible doesn't apply.

More information

Visit [Medicare.gov/coverage/flexible-sigmoidoscopies](https://www.Medicare.gov/coverage/flexible-sigmoidoscopies).



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](https://www.medicare.gov/coverage/flu-shots).

Foot care

Part B covers podiatrist (foot doctor) foot exams or treatment if you have diabetes-related nerve damage that can increase the risk of limb loss, 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

- After you meet the Part B deductible, you pay 20% of the Medicare-approved amount for medically necessary treatment you get from your doctor.
- 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 pages 111–112 and “Foot care (for diabetes)” on the next page.
- Visit [Medicare.gov/coverage/foot-care](https://www.medicare.gov/coverage/foot-care).

Foot care (for diabetes)

Part B covers foot exams if you have diabetes-related lower leg nerve damage that can increase the risk of limb loss.

How often

Once a year, as long as you haven't seen a foot care professional for another reason between visits.

Costs

- After you meet the Part B deductible, you pay 20% of the Medicare-approved amount for any medically necessary foot treatment your doctor approves,.
- In a hospital outpatient setting, you also pay a copayment.

What it is

Depending on your exam results, foot care may include treatment for foot ulcers and calluses, and toenail management.

More information

- See “Therapeutic shoes or inserts” on pages 111–112.
- Visit [Medicare.gov/coverage/foot-care](https://www.Medicare.gov/coverage/foot-care).

Foot care (routine)

Medicare doesn't usually cover routine foot care.

Costs

In most cases, you pay 100% for routine foot care.

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](https://www.medicare.gov/coverage/foot-care-routine).



Glaucoma tests

Part B covers these tests if you're at high risk for developing the eye disease glaucoma. You're considered high risk if at least one of these conditions 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

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

Things to know

An eye doctor who's legally allowed to do glaucoma tests in your state must do or supervise your screening.

More information

Visit [Medicare.gov/coverage/glaucoma-tests](https://www.medicare.gov/coverage/glaucoma-tests).

Gym memberships & fitness programs

Medicare doesn't cover gym memberships or fitness programs.

Costs

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

More information

Visit [Medicare.gov/coverage/gym-membership-fitness-programs](https://www.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 & counseling: See page 9.
- Counseling to prevent tobacco use & tobacco-caused disease: See page 27.
- Depression screenings: See page 32.
- Diabetes self-management training: See page 34.
- Kidney disease education: See page 65.
- Medicare Diabetes Prevention Program: See pages 72–73.
- Nutrition therapy, if you have diabetes or kidney disease: See page 80.
- Obesity behavioral therapy: See page 81.
- A “Welcome to Medicare” preventive visit: See page 98.
- Yearly “Wellness” visits: See pages 98–99.

Hearing & balance exams

Part B covers diagnostic hearing and balance exams if your doctor or other health care provider orders them to find out if you need medical treatment.

Costs

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

More information

Visit [Medicare.gov/coverage/hearing-balance-exams](https://www.medicare.gov/coverage/hearing-balance-exams).

Hearing aids

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

Costs

You pay 100% of the cost for hearing aids and exams.

More information

Visit [Medicare.gov/coverage/hearing-aids](https://www.medicare.gov/coverage/hearing-aids).



Hepatitis B shots

Part B covers these preventive shots if you're at medium or high risk for Hepatitis B. Your Hepatitis B risk increases if one or more of these conditions 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.

Hepatitis B shots (continued)

Other factors may also increase your risk for Hepatitis B. Check with your doctor to find out if you're at medium or high risk for Hepatitis B.

Costs

You pay nothing for Hepatitis B shots if your doctor or other qualified health care provider accepts assignment.

More information

Visit [Medicare.gov/coverage/hepatitis-b-shots](https://www.medicare.gov/coverage/hepatitis-b-shots).



Hepatitis B Virus (HBV) infection screenings

Medicare covers an HBV screening if your primary care doctor orders one and you meet one of these conditions:

- You're at high risk for HBV infection.
- You're 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
 - At the time of delivery if you have 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 if your doctor or other qualified health care provider accepts assignment.

More information

Visit [Medicare.gov/coverage/hepatitis-b-virus-infection-screenings](https://www.medicare.gov/coverage/hepatitis-b-virus-infection-screenings).



Hepatitis C screening tests

Medicare covers a Hepatitis C screening test if your primary care doctor or other qualified health care provider orders one and you meet one or more of these conditions:

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

How often

Once, if you were born between 1945-1965 and aren't considered high risk. If you're at high risk (for example, you've continued to use illicit injection drugs since your previous negative Hepatitis C screening test), Medicare covers yearly screenings.

Costs

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

More information

Visit [Medicare.gov/coverage/hepatitis-c-screening-tests](https://www.medicare.gov/coverage/hepatitis-c-screening-tests).



HIV (Human Immunodeficiency Virus) screenings

Part B covers an HIV screening if you meet one of these conditions:

- You're 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 one of 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](https://www.medicare.gov/coverage/hiv-screenings).

Home health services

Part A and/or Part B cover eligible home health services if you meet certain conditions.

How often

You can get skilled nursing and home health aide services up to 8 hours a day, with a maximum of 28 hours per week. You may be able to get more frequent care for a short time if your doctor determines it's necessary.

Costs

- For all covered home health services, you pay nothing.
- After you meet the Part B deductible, you pay 20% of the Medicare-approved amount 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 (only if you're also getting skilled nursing care at the same time)
- Physical therapy
- Occupational therapy
- Speech-language pathology services
- Medical social services
- Injectable osteoporosis drugs for women (See "Osteoporosis drugs" on page 84.)
- Durable medical equipment
- Medical supplies for use at home

Medicare **doesn't** pay for:

- 24-hour-a-day care at your home
- Meals delivered to your home
- Custodial or personal care that helps you with daily living activities (like bathing, dressing, and using the bathroom) when this is the only care you need
- Homemaker services (like shopping and cleaning) that aren't related to your care plan

More information

- Visit [Medicare.gov/coverage/home-health-services](https://www.medicare.gov/coverage/home-health-services).
- Visit [Medicare.gov/publications](https://www.medicare.gov/publications) to download and read the booklet "Medicare & Home Health Care."

Home infusion therapy services & supplies

Part B covers home infusion equipment and supplies as durable medical equipment (DME) when used in your home.

Medicare also covers home infusion therapy services, like nursing visits, caregiver training, and patient monitoring.

Costs

You pay 20% of the Medicare-approved amount for home infusion therapy services, and for the equipment and supplies you use in your home. The Part B deductible applies for the equipment and supplies.

What it is

Home infusion supplies include pumps, IV poles, tubing, catheters, and certain infusion drugs. The professional services associated with home infusion therapy include the nursing services, training, education, and patient monitoring needed to administer certain intravenous or subcutaneous drugs safely in your home.

More information

- See “Durable medical equipment (DME)” on pages 42–44.
- Visit [Medicare.gov/coverage/home-infusion-services](https://www.Medicare.gov/coverage/home-infusion-services).

Hospice care

You qualify for hospice care if you have Part A and meet all of these conditions:

- 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 comfort care (palliative care) instead of care to cure your illness.
- You sign a statement choosing hospice care instead of other Medicare-covered treatments for your terminal illness and related conditions.

Costs

- You pay nothing for hospice care.
- You pay a copayment of up to \$5 for each prescription for outpatient drugs for pain and symptom management. In the rare case the hospice benefit doesn’t cover your drug, your hospice provider should contact your plan to see if Part D covers it. The hospice provider will inform you if any drugs or services aren’t covered, and if you’ll be required to pay for them.
- You may pay 5% of the Medicare-approved amount for inpatient respite care.

Hospice care (continued)

Costs

- You may have to pay for room and board if you live in a facility (like a nursing home) and choose to get hospice care.

What it is

Depending on your terminal illness and related conditions, your hospice team will create a plan of care that can include any or all of these services:

- Doctors' services.
- Nursing care and medical services.
- Durable medical equipment for pain relief and symptom management.
- Medical supplies, like bandages or catheters.
- Drugs for pain management.
- Aide and homemaker services.
- Physical therapy services.
- Occupational therapy services.
- Speech-language pathology services.
- Social services.
- Dietary counseling.
- Spiritual and grief counseling for you and your family.
- Short-term inpatient care for pain and symptom management.
- Inpatient respite care, which is care you get in a Medicare-approved facility (like an inpatient facility, hospital, or nursing home), so that your usual caregiver (like a family member or friend) can rest. 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 only on an occasional basis.
- Any other services Medicare covers to manage your pain and other symptoms related to your terminal illness and related conditions, as your hospice team recommends.

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).

Hospice care (continued)

Things to know

Medicare-certified hospice care is usually given in your home or other facility where you live, like a nursing home. 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](https://www.medicare.gov/coverage/hospice-care).
- Visit [Medicare.gov/publications](https://www.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

- Visit [Medicare.gov/coverage/hospital-beds](https://www.medicare.gov/coverage/hospital-beds).
- See “Durable medical equipment (DME)” on pages 42–44.

Human Papillomavirus (HPV) tests

See “Cervical & vaginal cancer screenings” on pages 19–20.

Humidifiers

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

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

Costs

You pay 100% for most humidifiers or other similar items. If it's medically necessary, you won't have to pay a separate amount for an oxygen humidifier. The monthly fee for your oxygen equipment will include the cost of an oxygen humidifier.

More information

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

Hyperbaric oxygen therapy

Medicare covers hyperbaric oxygen therapy, if you meet certain conditions and you get the therapy in a chamber (including a one-person unit).

Costs

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

What it is

Hyperbaric oxygen therapy exposes your entire body to oxygen under increased atmospheric pressure.

More information

Visit [Medicare.gov/coverage/hyperbaric-oxygen-therapy](https://www.Medicare.gov/coverage/hyperbaric-oxygen-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](https://www.Medicare.gov/coverage/incontinence-supplies-adult-diapers).

Inpatient hospital care

Part A covers inpatient hospital care if you meet both of these conditions:

- 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, Part A also covers inpatient hospital care if the hospital's Utilization Review Committee approves your stay while you're admitted.

Inpatient hospital care (continued)

Costs

You pay this for each benefit period (in 2022):

- Days 1-60: \$1,556 deductible.
- Days 61-90: \$389 coinsurance each day.
- Days 91 and beyond: \$778 coinsurance per each “lifetime reserve day” after day 90 for each benefit period (up to a maximum of 60 reserve days over your lifetime).
- Each day after the lifetime reserve days: All costs. Inpatient mental health care in a psychiatric hospital (but not in a Medicare-certified distinct part psychiatric unit of an acute care or critical access hospital) is limited to 190 days in a lifetime.

What it is

Medicare-covered inpatient hospital services include:

- Semi-private rooms
- Meals
- General nursing
- Drugs (including methadone to treat an opioid use disorder)
- Other hospital services and supplies as part of your inpatient treatment

Medicare doesn't cover:

- Private-duty nursing
- A television or phone in your room (if there's a separate charge for these items)
- Personal care items (like razors or slipper socks)
- A private room, unless medically necessary

Things to know

Inpatient hospital care includes care you get in:

- Acute care hospitals
- Critical access hospitals
- Inpatient rehabilitation facilities
- Long-term care hospitals
- Inpatient psychiatric facilities

It also includes inpatient care you get as part of a qualifying clinical research study. Part B covers the doctors' services you get while you're in a hospital.

Inpatient hospital care (continued)

More information

- Mental health care: See pages 74–77.
- Outpatient hospital services: See pages 85–86.
- Visit [Medicare.gov/coverage/inpatient-hospital-care](https://www.Medicare.gov/coverage/inpatient-hospital-care).

Inpatient rehabilitation care

Part A covers medically necessary care you get in an inpatient rehabilitation facility or unit (sometimes called an inpatient “rehab” facility, IRF, acute care rehabilitation center, or rehabilitation hospital). Your doctor must certify that you have a medical condition that requires intensive rehabilitation, continued medical supervision, and coordinated care that comes from your doctors and therapists working together.

Costs

You pay this for each benefit period in 2022:

- Days 1-60: \$1,556 deductible.*
- Days 61-90: \$389 coinsurance each day.
- Days 91 and beyond: \$778 coinsurance per each “lifetime reserve day” after day 90 for each benefit period (up to a maximum of 60 reserve days over your lifetime).
- Each day after the lifetime reserve days: All costs.

*You don’t have to pay a deductible for inpatient rehabilitation care if you were already charged a deductible for care you got in a prior hospitalization within the same benefit period. This is because your benefit period starts on day one of your prior hospital stay, and that stay counts towards your deductible. For example you won’t have to pay a deductible for inpatient rehabilitation care if:

- You’re transferred to an inpatient rehabilitation facility directly from an acute care hospital.
- You’re admitted to an inpatient rehabilitation facility within 60 days of being discharged from a hospital.

Inpatient rehabilitation care (continued)

What it is

Inpatient rehabilitation can help if you're recovering from a serious surgery, illness, or injury, and need an intensive rehabilitation therapy program, physician supervision, and coordinated care from your doctors and therapists.

Medicare-covered inpatient rehabilitation care includes:

- Rehabilitation services, like physical therapy, occupational therapy, and speech-language pathology
- A semi-private room
- Meals
- Nursing services
- Prescription drugs
- Other hospital services and supplies

Medicare doesn't cover:

- Private duty nursing
- A phone or television in your room (if there's a separate charge for these items)
- Personal items, like toothpaste, socks, or razors (except when a hospital gives them as part of your hospital admission pack)
- A private room, unless medically necessary

Things to know

Part B covers doctors' services you get while you're in an inpatient rehabilitation facility.

More information

Visit [Medicare.gov/coverage/inpatient-rehabilitation-care](https://www.Medicare.gov/coverage/inpatient-rehabilitation-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 after you meet the Part B deductible). You pay 100% for syringes, needles, alcohol swabs, and gauze, unless you have Part D.

Things to know

Part D covers injectable insulin that's not used with an insulin pump and certain medical supplies used to inject insulin, like syringes, gauze, and alcohol swabs. However, if you use an external insulin pump, Part B may cover insulin used with the pump and the pump itself as durable medical equipment. See "Durable medical equipment (DME)" on pages 42–44.

You may be able to get Medicare drug coverage that offers savings on your insulin and costs you no more than \$35 for a 30-day supply. Visit [Medicare.gov/plan-compare](https://www.medicare.gov/plan-compare) to find a plan that offers this savings in your area.

More information

- Other diabetic services and supplies: See "Diabetes services" and "Diabetes supplies" on pages 35–36.
- Visit [Medicare.gov/coverage/insulin](https://www.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 usually requires dialysis or a kidney transplant. Medicare covers this if your doctor or other health care provider refers you for the service, and when you get the service from a doctor, certain qualified non-doctor provider, or certain rural provider.

Costs

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

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.

More information

Visit [Medicare.gov/coverage/kidney-disease-education](https://www.medicare.gov/coverage/kidney-disease-education).

Kidney services & supplies

See “Dialysis services & supplies” on pages 40–41.

Kidney transplants

Part A and Part B cover different items and services related to kidney transplants. Medicare covers these services if they’re done by the Medicare-certified hospital where you’ll get your transplant or another hospital that participates in Medicare.

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

- Inpatient services in a Medicare-certified hospital
- A kidney registration fee
- Laboratory and other tests to evaluate your medical condition and the condition of potential kidney donors
- Finding the proper kidney for your transplant surgery (if there’s no kidney donor)
- Any additional inpatient hospital care for your donor in case of problems from surgery
- Blood (whole units of packed red blood cells, blood components, and the cost of processing and giving you blood)

Part A also covers the full cost of care for your kidney donor (including care before surgery, the actual surgery, and care after surgery)

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

- 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 your kidney transplant if both of these apply:

- You’re only eligible for Medicare because of permanent kidney failure.
- You have a pancreas transplant after your kidney transplant.

Kidney transplants (continued)

This is because your Medicare coverage ends 36 months after a successful kidney transplant if you only have Medicare because of permanent kidney failure.

Medicare will continue to pay for your transplant drugs with no time limit if either of these apply:

- You were already eligible for Medicare because of age or disability before you got End-Stage Renal Disease (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 to the living donor for a kidney transplant
- Nothing for Medicare-approved laboratory tests

More information

- See “Organ transplants” on page 83.
- See “Kidney transplants (children)” on the next page.
- Visit [Medicare.gov/coverage/kidney-transplants](https://www.Medicare.gov/coverage/kidney-transplants).
- Visit [Medicare.gov/publications](https://www.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 (pediatric) kidney transplants.

Part A usually covers these transplant services:

- Inpatient services in an approved hospital
- Kidney registry fee
- Laboratory and other tests 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 their hospital stay
- Transplant drugs, usually 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, after you pay a one-time yearly deductible.
- Part B usually pays 80% of the Medicare-approved amount for services, after you pay the Part B yearly deductible. You pay the remaining 20% coinsurance.
- For Part B-covered dialysis services, your costs will vary based on your child's age and dialysis type.
- If your child has other insurance, your costs may be different.

More information

- See "Dialysis (children)" on pages 38–39.
- Visit [Medicare.gov/coverage/kidney-transplants-children](https://www.medicare.gov/coverage/kidney-transplants-children).
- Visit [Medicare.gov/publications](https://www.medicare.gov/publications) to download and read the brochure "Medicare for Children with End-Stage Renal Disease."

Laboratory tests

- Clinical laboratory tests: See page 22.
- Diagnostic laboratory tests: See page 37.
- Diagnostic non-laboratory tests: See page 37.

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, which is care that helps you with daily living activities (like bathing, dressing, and using the bathroom).

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 helps with basic personal tasks of everyday life, sometimes called "activities of daily living."

More information

Visit [Medicare.gov/coverage/long-term-care](https://www.medicare.gov/coverage/long-term-care).

Long-term care hospital services

Part A covers care in long-term care hospitals.

Costs

You pay this for each benefit period in 2022:

- Days 1-60: \$1,556 deductible.*
- Days 61-90: \$389 coinsurance each day.
- Days 91 and beyond: \$778 coinsurance per each "lifetime reserve day" after day 90 for each benefit period (up to a maximum of 60 reserve days over your lifetime).
- Each day after the lifetime reserve days: All costs.

*You don't have to pay a deductible for care you get in the long-term care hospital if you were already charged a deductible for care you got in a prior hospitalization within the same benefit period. This is because your benefit period starts on day one of your prior hospital stay, and that stay counts towards your deductible. For example, you won't have to pay a deductible for your long-term care hospital care if:

- You're transferred there directly from an acute care hospital.
- You're admitted within 60 days of being discharged from a hospital.

Long-term care hospital services (continued)

What it is

Long-term care hospitals provide care to patients with more than one serious medical condition. The patients may improve with time and care, and eventually return home. Long-term care hospitals typically give services like respiratory therapy, head trauma treatment, and pain management.

More information

Visit [Medicare.gov/coverage/long-term-care-hospitals-services](https://www.medicare.gov/coverage/long-term-care-hospitals-services).



Lung cancer screenings

Part B covers lung cancer screenings with Low Dose Computed Tomography 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 each year.

Costs

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

Things to know

Before your first screening, you'll need to schedule a lung cancer screening counseling and shared decision-making visit with your doctor. During your visit, you and your doctor will discuss the benefits and risks of lung cancer screenings, and decide whether a screening is right for you.

More information

Visit [Medicare.gov/coverage/lung-cancer-screenings](https://www.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.

Costs

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

More information

Visit [Medicare.gov/coverage/macular-degeneration-tests-treatment](https://www.medicare.gov/coverage/macular-degeneration-tests-treatment).



Mammograms

Part B covers:

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

How often

- Baseline mammogram: Once in your lifetime.
- 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: After you meet the Part B deductible, you pay 20% of the Medicare-approved amount.

What it is

Mammograms are screenings that check for breast cancer.

More information

Visit [Medicare.gov/coverage/mammograms](https://www.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](https://www.medicare.gov/coverage/massage-therapy).



Medicare Diabetes Prevention Program

Part B covers the Medicare Diabetes Prevention Program if all of these conditions apply to you:

- Within 12 months before attending your first core session, 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).
- 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 in a lifetime.

Costs

You pay nothing for this program if you're eligible.

What it is

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

The program begins with weekly 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 around diet and exercise
- Tips on how to get more exercise
- Strategies for controlling your weight
- A specially trained coach to help keep you motivated
- Support from people with similar goals and challenges

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

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

Things to know

To see if there's a Medicare Diabetes Prevention Program supplier in your area, visit [Medicare.gov/talk-to-someone](https://www.medicare.gov/talk-to-someone).

More information

Visit [Medicare.gov/coverage/diabetes-prevention](https://www.medicare.gov/coverage/diabetes-prevention).

Mental health care (inpatient)

Part A covers mental health care services you get when you're admitted as a hospital inpatient.

Costs

You pay this for each benefit period in 2022:

- \$1,556 deductible.
- Days 1–60: \$0 coinsurance each day.
- Days 61–90: \$389 coinsurance each day.
- Days 91 and beyond: \$778 coinsurance per each “lifetime reserve day” after day 90 for each benefit period (up to a maximum of 60 reserve days over your lifetime).
- Each day after the 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 care services involve diagnosing and treating people with mental health disorders, like depression and anxiety.

Things to know

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

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](https://www.medicare.gov/publications) to download and read the booklet “Medicare & Your Mental Health Benefits.”
- Visit [Medicare.gov/coverage/mental-health-care-inpatient](https://www.medicare.gov/coverage/mental-health-care-inpatient).

Mental health care (outpatient)

Part B helps pay for these outpatient mental health services:

- One depression screening each 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 32.
- Individual and group psychotherapy with doctors (or with certain other licensed professionals, as the state where you get the services allows).
- 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 page 77.
- A one-time “Welcome to Medicare” preventive visit. This visit includes a review of your possible risk factors for depression. See “Preventive visits” on pages 98–99.
- A yearly “Wellness” visit. Talk to your doctor or other health care provider about changes in your mental health since your last visit. See “Preventive visits” on pages 98–99.

Part B also covers outpatient mental health services as part of substance abuse treatment.

Mental health care (outpatient) (continued)

Costs

- You pay nothing for your yearly depression screening if your doctor or health care provider accepts assignment.
- You pay 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 involve diagnosing and treating people with mental health disorders, 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
- Physician assistants

Part B covers outpatient mental health services, including services that are usually provided outside a hospital, in these types of settings:

- A doctor's or other health care provider's office
- A hospital outpatient department
- A community mental health center

More information

- Visit [Medicare.gov/publications](https://www.medicare.gov/publications) to download and read the booklet "Medicare & Your Mental Health Benefits."
- Visit [Medicare.gov/coverage/mental-health-care-outpatient](https://www.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 professional if they accept assignment.
- After you meet the Part B deductible, you also pay coinsurance for each day of partial hospitalization services you get in a hospital outpatient setting or community mental health center.

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. You get this treatment during the day, and you don't have to stay overnight. Medicare helps cover partial hospitalization services you get through a hospital outpatient department or community mental health center.

Things to know

As part of 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](https://www.Medicare.gov/publications) to download and read the booklet "Medicare & Your Mental Health Benefits."
- Visit [Medicare.gov/coverage/mental-health-care-partial-hospitalization](https://www.Medicare.gov/coverage/mental-health-care-partial-hospitalization).

Mental health & substance use disorder services

Medicare covers certain screenings, services, and programs that aid in the treatment and recovery of mental health and substance use disorders, including:

- Alcohol misuse screenings: See page 9.
- Behavioral health integration services: See pages 12–13.
- Counseling to prevent tobacco use & tobacco-caused disease: See page 27.
- Depression screenings: See page 32.
- Mental health care: See pages 74–77.
- Opioid use disorder treatment services: See page 82.
- Telehealth: See page 110.



Multi-target stool DNA tests

Medicare covers at-home multi-target stool DNA tests if you meet all these conditions:

- You're between 50–85.
- You show no symptoms of colorectal disease including, but not limited to, lower gastrointestinal pain, blood in stool, or 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.

Multi-target stool DNA tests (continued)

Costs

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

More information

Visit [Medicare.gov/coverage/multi-target-stool-dna-tests](https://www.Medicare.gov/coverage/multi-target-stool-dna-tests).

MRIs

See “Diagnostic non-laboratory tests” on page 37.

Nebulizers & nebulizer medications

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

More information

- See “Durable medical equipment (DME)” on pages 42–44.
- Visit [Medicare.gov/coverage/nebulizers-nebulizer-medications](https://www.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, which 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](https://www.Medicare.gov/coverage/nursing-home-care).
- Visit [Medicare.gov/publications](https://www.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 services and certain related services if you have diabetes or kidney disease, or if you've had a kidney transplant in the last 36 months.

Costs

You pay nothing for these preventive services if you qualify to get them.

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

Only a Registered Dietitian (or other nutrition professional who meets certain requirements) can provide medical nutrition services, but your doctor can refer you for the service.

If you get dialysis in a dialysis facility, Medicare covers medical nutrition therapy as part of your overall dialysis care.

If you're in a rural area, a Registered Dietitian or other nutrition professional in a different location may be able to provide medical nutrition therapy to you through telehealth.

See "Telehealth" on page 110.

More information

Visit [Medicare.gov/coverage/nutrition-therapy-services](https://www.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. Medicare covers this counseling if your primary care doctor or other qualified practitioner gives the counseling in a primary care setting (like a doctor's office), where they can coordinate your personalized prevention plan with your other care.

Costs

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

What it is

Obesity behavioral therapy includes 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.

More information

Visit [Medicare.gov/coverage/obesity-behavioral-therapy](https://www.Medicare.gov/coverage/obesity-behavioral-therapy).

Observation services

See “Outpatient hospital services” on pages 85–86.

Occupational therapy

Part B helps pay for medically necessary outpatient occupational therapy if your doctor or other health care provider certifies you need it.

Costs

After you meet the Part B deductible, you pay 20% of the Medicare-approved amount.

What it is

Therapy to help you perform activities of daily living (like dressing or bathing). When your doctor or other health care provider certifies you need it, this therapy helps to improve or maintain current capabilities, or slow decline.

Things to know

There's no limit on how much Medicare pays for your medically necessary outpatient occupational therapy services in one calendar year.

More information

Visit [Medicare.gov/coverage/occupational-therapy](https://www.Medicare.gov/coverage/occupational-therapy).

Opioid use disorder treatment services

Part B covers opioid use disorder treatment services in opioid treatment programs.

Costs

You won't have to pay any copayments for these services if you get them from an opioid treatment program provider who's enrolled in Medicare. However, the Part B deductible still applies. Medicare pays doctors and other providers for office-based opioid use disorder treatment, including management, care coordination, psychotherapy, and counseling activities.

What it is

These services, which help people recover from opioid use disorder, include:

- Medication (like methadone, buprenorphine, naltrexone, and naloxone)
- Counseling
- Drug testing
- Individual and group therapy
- Intake activities
- Periodic assessments

Medicare covers counseling, therapy, and periodic assessments both in person and by virtual delivery (using audio and video communication technology, like your phone or a computer).

Things to know

Talk to your doctor or other health care provider to find out where you can go for these services. You can also visit [Medicare.gov/talk-to-someone](https://www.Medicare.gov/talk-to-someone) and select "Opioid Treatment Program Services" to find a program near you.

Medicare Advantage Plans must also cover opioid treatment program services. If you're in a Medicare Advantage Plan, your current opioid treatment program must be Medicare-enrolled to make sure your treatment stays uninterrupted. If not, you may have to switch to a Medicare-enrolled opioid treatment program. Since Medicare Advantage Plans are able to apply copayments to opioid treatment program services, you should check with your plan to see if you have to pay a copayment.

More information

Visit [Medicare.gov/coverage/opioid-use-disorder-treatment-services](https://www.Medicare.gov/coverage/opioid-use-disorder-treatment-services).

Organ transplants

Part B covers:

- Doctors' services associated with heart, lung, kidney, pancreas, intestine, and liver organ transplants

Under certain conditions, Part B also covers:

- Bone marrow transplants
- Cornea transplants
- Immunosuppressive (or “transplant”) drugs associated with Medicare-covered transplants

Part A covers:

- Necessary tests, labs, and exams

Under certain conditions, Part A also covers:

- Services for heart, lung, kidney, pancreas, intestine, and liver organ transplants
- Immunosuppressive (or “transplant”) drugs, follow up care, and procurement of organs
- Stem cell transplants

Costs

You pay:

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

Things to know

You must get an organ transplant in a Medicare-approved facility. Stem cell and cornea transplants aren't limited to Medicare-approved transplant centers.

More information

- Kidney transplants for adults: See “Kidney transplants” on pages 66–67.
- Kidney transplants for children: See “Kidney transplants (children)” on page 68.
- Pancreas transplants: See “Pancreas transplants” on page 90.
- Visit [Medicare.gov/coverage/organ-transplants](https://www.medicare.gov/coverage/organ-transplants).

Orthopedic shoes

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

Costs

After you meet the Part B deductible, you pay 20% of the Medicare-approved amount.

Things to know

For Medicare to cover your orthopedic shoes, you must go to a Medicare-enrolled supplier. Medicare will only pay for orthotic items from a Medicare-enrolled supplier, no matter who submits the claim (you or your supplier).

More information

- See “Therapeutic shoes or inserts” on pages 111–112.
- Visit [Medicare.gov/coverage/orthopedic-shoes](https://www.medicare.gov/coverage/orthopedic-shoes).

Osteoporosis drugs

Part A and Part B help pay for an osteoporosis injectable drug 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 57.
- 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 or caregivers are unable and unwilling to give you the drug by injection.

Costs

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

More information

- Home health services: See page 57.
- Visit [Medicare.gov/coverage/osteoporosis-drugs](https://www.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

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

Things to know

Medicare covers these supplies as prosthetic devices.

More information

Visit [Medicare.gov/coverage/ostomy-supplies](https://www.Medicare.gov/coverage/ostomy-supplies).

Outpatient hospital services

Part B covers many 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 77.
- X-rays and other radiology services billed by the hospital.
- Medical supplies, like splints and casts.
- Preventive and screening services. See pages 96–97.
- Certain drugs and biologicals that you wouldn't usually give yourself that you get as part of your service or procedure (like certain injectable drugs).

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. 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](https://www.Medicare.gov/coverage/outpatient-hospital-services).
- To get cost estimates for outpatient hospital procedures, visit [Medicare.gov/procedure-price-lookup](https://www.Medicare.gov/procedure-price-lookup).

Outpatient medical & surgical services & supplies

Part B covers approved outpatient services and supplies, like X-rays, casts, stitches, or outpatient surgeries.

Costs

You pay 20% of the Medicare-approved amount for doctor or other health care provider services. You also generally pay a copayment for each service you get in a hospital outpatient setting. In most cases, the copayment can't be more than the Part A hospital stay deductible for each service you get. 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](https://www.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 aren't 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

After you meet the Part B deductible, you pay 20% of the Medicare-approved amount.

More information

- See “Durable medical equipment (DME)” on pages 42–44.
- Visit [Medicare.gov/coverage/oxygen-equipment-accessories](https://www.Medicare.gov/coverage/oxygen-equipment-accessories).

Pain management

Part B helps pay for these services that may help you manage your pain and related issues:

- Behavioral health integration services. See pages 12–13.
- Physical therapy. See page 91.
- Occupational therapy. See page 81.
- Chiropractic services. See page 21.
- Alcohol misuse screenings & counseling. See page 9.
- Depression screenings. See page 32.
- Acupuncture for chronic low back pain. See pages 7–8.

If you have a Medicare drug plan, the plan may also have programs in place (like Medication Therapy Management programs or Drug Management programs) to help you use prescription opioid pain medications more safely. Visit [Medicare.gov/drug-coverage-part-d/what-drug-plans-cover/medication-therapy-management-programs-for-complex-health-needs](https://www.medicare.gov/drug-coverage-part-d/what-drug-plans-cover/medication-therapy-management-programs-for-complex-health-needs) for more information.

Costs

- For most pain management services, you pay 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.
- You pay nothing for a yearly depression screening if your doctor or health care provider accepts assignment.

Pain management (continued)

Things to know

There may be other ways to manage your pain. Your doctor may recommend treatment options that Medicare doesn't cover, like massage therapy.

If this happens, or if your doctor or other health care provider recommends you get services more often than Medicare covers, you may have to pay some or all of the costs. Ask questions so you understand why your doctor is recommending certain services and if Medicare will pay for them.

More information

Visit [Medicare.gov/coverage/pain-management](https://www.Medicare.gov/coverage/pain-management).

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 also 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 already eligible for Medicare because of age or disability before you got your transplant.
- 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 your kidney transplant if both of these apply:

- You're only eligible for Medicare because of permanent kidney failure.
- You have your pancreas transplant after a kidney transplant.

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

Costs

You pay:

- 20% of the Medicare-approved amount for doctors' services.
- Various amounts for transplant facility charges.
- Nothing for Medicare-approved laboratory tests.

More information

- Other types of Medicare-covered transplants: See "Organ transplants" on page 83.
- Visit [Medicare.gov/coverage/pancreas-transplants](https://www.Medicare.gov/coverage/pancreas-transplants).

Pap tests

See “Cervical & vaginal cancer screenings” on pages 19–20.

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 42–44.
- Visit [Medicare.gov/coverage/patient-lifts](https://www.Medicare.gov/coverage/patient-lifts).

PET scans

See “Diagnostic non-laboratory tests” on page 37.

Physical therapy

Part B covers evaluation and treatment for injuries and diseases that change your ability to function, or to improve or maintain current function or slow decline, when your doctor or other health care provider certifies you need it.

Costs

After you meet the Part B deductible, you pay 20% of the Medicare-approved amount.

Things to know

There’s no limit on how much Medicare pays for your medically necessary outpatient physical therapy services in one calendar year.

More information

Visit [Medicare.gov/coverage/physical-therapy](https://www.Medicare.gov/coverage/physical-therapy).

Power wheelchairs

See “Wheelchairs & scooters” on page 116.



Pneumococcal shots

Part B covers 2 different pneumococcal shots to help protect against different types of pneumonia.

How often

Part B covers the first pneumococcal 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 shots.

What it is

The 2 shots protect against different strains of the bacteria that cause pneumonia.

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](https://www.Medicare.gov/coverage/pneumococcal-shots).

Prescription drugs (outpatient)

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

Usually, Part B covers drugs you wouldn't typically give to yourself, like those you get at a doctor's office or in a hospital outpatient setting.

Here are some examples of Part B-covered drugs:

- **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, if the drug used with the pump is reasonable and necessary.
- **Some antigens:** Medicare helps pay for antigens if a doctor prepares them and they're given by a properly instructed person (who could be you, the patient) under appropriate supervision.
- **Injectable osteoporosis drugs:** Medicare helps pay for injectable osteoporosis drugs if you meet all of these conditions:
 - You're a woman with osteoporosis who meets the criteria for the Medicare home health benefit.
 - You have a bone fracture that a doctor certifies was related to post-menopausal osteoporosis.
 - Your doctor certifies that you can't give yourself the injection or learn how to give yourself the drug by injection.

In addition, Medicare will cover the home health nurse or aide to provide the injection if your 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 injectable and infused drugs when a licensed medical provider gives them, because these types of drugs aren't usually self-administered.
- **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 Part B ESRD benefit covers it.

Prescription drugs (outpatient) (continued)

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.

- **Parenteral and enteral 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, and your doctor decides that it's medically appropriate for you to get the IVIG in your home. Part B covers the IVIG itself, but 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 or illness.
- **Transplant/immunosuppressive drugs:** Medicare covers transplant drug therapy if Medicare helped pay for your organ transplant.

Part D covers transplant drugs that Part B doesn't cover. If you have Original Medicare, you may join a Medicare drug plan to get Medicare drug coverage (Part D).

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

However, if you're entitled to Medicare because of your age or disability, Medicare will continue to pay for your transplant drugs with no time limit as long as either Medicare paid for your transplant, or your private insurance paid for your transplant (and that insurance was the primary payer ahead of your Part A coverage).

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. If Part B doesn't cover them, Part D does.
- **Oral anti-nausea drugs:** Medicare helps pay for oral anti-nausea drugs you use 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 settings:** Medicare may pay for some self-administered drugs if you need them for the hospital outpatient services you're getting.

Costs

Doctors and pharmacies must accept assignment for Part B-covered drugs, so you should never be asked to pay more than the coinsurance or copayment for the Part B-covered drug itself. In most cases, after you meet the Part B deductible, you pay 20% of the Medicare-approved amount for Part B-covered prescription drugs that you get in a doctor's office or pharmacy. 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.

If you get prescription drugs that Part B doesn't cover in a hospital outpatient setting, you pay 100% for the drugs, unless you have Medicare drug coverage (Part D) or other drug coverage. In that case, what you pay depends on whether your drug plan covers the drug, and whether the hospital is in your plan's network. Contact your plan to find out what you pay if you get drugs in a hospital outpatient setting that Part B doesn't cover.

You pay nothing (and the Part B deductible doesn't apply) for flu, pneumococcal, and Hepatitis B shots.

Prescription drugs (outpatient) (continued)

Things to know

Medicare drug coverage (Part D) covers drugs Part B doesn't cover. If you have drug coverage, check your plan's drug list (also called a formulary) to see what outpatient drugs it covers.

More information

- Visit [Medicare.gov/coverage/prescription-drugs-outpatient](https://www.medicare.gov/coverage/prescription-drugs-outpatient).
- Visit [Medicare.gov/publications](https://www.medicare.gov/publications) to download and read the booklet “Your Guide to Medicare Prescription Drug Coverage,” if you have Part D.

Pressure-reducing support surfaces

Part B covers pressure-reducing support surfaces as durable medical equipment (DME) that your doctor prescribes for use in your home.

Note: If you live in certain states, you may have to get prior approval for 5 types of pressure-reducing support surfaces.

What it is

Pressure-reducing support surfaces include certain beds (like air-fluidized beds), mattresses, and mattress overlays.

More information

- See “Durable medical equipment (DME)” on pages 42–44.
- Visit [Medicare.gov/coverage/pressure-reducing-support-surfaces](https://www.medicare.gov/coverage/pressure-reducing-support-surfaces).
- Visit [Medicare.gov/publications](https://www.medicare.gov/publications) to download and read the booklet “Prior Authorization for Certain Types of Pressure-Reducing Support Surfaces.”



Preventive & screening services

Part B covers many preventive and screening 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, detect health problems early, determine the most effective treatments, and prevent 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.

Preventive & screening services (continued)

Here's a list of preventive and screening services Part B covers:

- Abdominal aortic aneurysm screenings: See page 7.
- Alcohol misuse screenings & counseling: See page 9.
- Blood-based biomarker tests: See page 14.
- Cardiovascular behavioral therapy: See page 18.
- Cardiovascular disease screenings: See page 19.
- Cervical & vaginal cancer screenings: See pages 19–20.
- Colorectal cancer screenings: See page 24.
- Counseling to prevent tobacco use & tobacco-caused disease: See page 27.
- Depression screenings: See page 32.
- Diabetes screenings: See page 33.
- Diabetes self-management training: See page 34.
- Glaucoma tests: See page 52.
- Hepatitis B Virus infection screenings: See page 55.
- Hepatitis C screening tests: See page 56.
- HIV screenings: See page 56.
- Lung cancer screenings: See page 70.
- Mammograms: See page 71.
- Medicare Diabetes Prevention Program: See pages 72–73.
- Nutrition therapy services: See page 80.
- Obesity behavioral therapy: See page 81.
- Preventive visits: See pages 98–99.
- Prostate cancer screenings: See pages 99–100.
- Sexually transmitted infection (STI) screening & counseling: See pages 104–105.
- Shots (or vaccines): See page 105.

More information

Visit [Medicare.gov/coverage/preventive-screening-services](https://www.Medicare.gov/coverage/preventive-screening-services).



Preventive visits

“Welcome to Medicare” preventive visit

Part B covers a “Welcome to Medicare” preventive visit.

How often

Once. You must have this 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 that Medicare doesn't cover under this preventive benefit.

What it is

This visit includes a review of your medical and social history related to your health. It also includes education and counseling about preventive services, including certain screenings, shots or vaccines (like flu, pneumococcal, and other recommended shots or vaccines), and referrals for other care, if needed.

If you have a current prescription for opioids, your provider will review your potential risk factors for opioid use disorder, evaluate your severity of pain and current treatment plan, provide information on non-opioid treatment options, and may refer you to a specialist, if appropriate. Your provider will also review your potential risk factors for substance use disorder and refer you for treatment, if needed.

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](https://www.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 your personalized plan to help prevent disease and disability, based on your current health and risk factors. Your provider will also perform a cognitive impairment assessment. The yearly “Wellness” visit isn't a physical exam.

Preventive visits (continued)

How often

Once every 12 months. Your first yearly “Wellness” visit can’t take place within 12 months of your Part B enrollment or your “Welcome to Medicare” preventive visit. However, you don’t need to have had a “Welcome to Medicare” preventive visit to qualify for a yearly “Wellness” visit.

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 that Medicare doesn’t cover under this preventive benefit. **If Medicare doesn’t cover the additional tests or services (like a routine physical exam), you may have to pay the full amount.**

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. Your provider will also perform a cognitive impairment assessment to look for signs of dementia, including Alzheimer’s disease. Signs of cognitive impairment include trouble remembering, learning new things, concentrating, managing finances, and making decisions about your everyday life. If your provider thinks you may have cognitive impairment, Medicare covers a separate visit to do a more thorough review of your cognitive function and check for conditions like dementia, depression, anxiety, or delirium. See page 23. Your provider may order other tests, if necessary, depending on your general health and medical history.

If you have a current prescription for opioids, your provider will review your potential risk factors for opioid use disorder, evaluate your severity of pain and current treatment plan, provide information on non-opioid treatment options, and may refer you to a specialist, if appropriate. Your provider will also review your potential risk factors for substance use disorder and refer you for treatment, if needed.

More information

Visit [Medicare.gov/coverage/yearly-wellness-visits](https://www.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 (starting the day after your 50th birthday).

Prostate cancer screenings (continued)

How often

Once every 12 months.

Costs

- **Digital rectal exams:** After you meet the Part B deductible, you pay 20% of the Medicare-approved amount for a yearly digital rectal exam and for your doctor's services related to the exam. In a hospital outpatient setting, you also pay a separate hospital visit 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](https://www.medicare.gov/coverage/prostate-cancer-screenings).

Prosthetic devices

Part B covers prosthetic devices needed to replace a body part or function when a Medicare-enrolled doctor or other health care provider orders them.

Costs

After you meet the Part B deductible, you pay 20% of the Medicare-approved amount for external prosthetic devices.

What it is

Examples of prosthetic devices include:

- Breast prostheses (including a surgical bra). See "Breast prostheses" on pages 16–17.
- One pair of conventional eyeglasses or contact lenses provided after a cataract operation.
- Ostomy bags and certain related supplies. See "Ostomy supplies" on page 85.
- Some surgically implanted prosthetic devices, including cochlear implants.
- Urological supplies.

Things to know

For Medicare to pay for your prosthetic device, you must go to a Medicare-enrolled supplier. This is true no matter who submits the claim (you or your provider). Either Part A or Part B covers a surgically implanted prosthetic device, depending on whether the surgery takes place in an inpatient or outpatient setting.

Prosthetic devices (continued)

More information

- See “Inpatient hospital care” on pages 61–63 for Part A-covered surgeries to implant prosthetic devices in a hospital inpatient setting.
- See “Outpatient hospital services” on pages 85–86 for Part B-covered surgeries to implant prosthetic devices in a hospital outpatient setting.
- Visit [Medicare.gov/coverage/prosthetic-devices](https://www.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). Starting January 1, 2022, Medicare will also cover pulmonary rehabilitation if you’ve had confirmed or suspected COVID-19 and experience persistent symptoms that include respiratory dysfunction for at least 4 weeks.

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

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

Things to know

You can get these services in a doctor’s office or a hospital outpatient setting that offers pulmonary rehabilitation programs.

More information

Visit [Medicare.gov/coverage/pulmonary-rehabilitation-programs](https://www.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).

Radiation therapy (continued)

- If you're an outpatient, you pay a set copayment and the Part B deductible applies.
- In a freestanding clinic, you pay 20% of the Medicare-approved amount for the therapy after you meet the Part B deductible.

More information

Visit [Medicare.gov/coverage/radiation-therapy](https://www.medicare.gov/coverage/radiation-therapy).

Rectal exams

See “Prostate cancer screenings” on pages 99–100.

Religious nonmedical health care institution items & services

Religious nonmedical health care institutions provide care and services to people who don't accept conventional medical care because of their religious beliefs. Medicare may cover items and services in religious nonmedical health care institutions only if you qualify for inpatient hospital or skilled nursing facility (SNF) care. Medicare will only cover the inpatient non-religious, nonmedical items and services, like room and board, unmedicated wound dressings, or use of a simple walker (items or services that don't require a doctor's order or prescription).

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

- The religious nonmedical health care institution is currently certified to participate in Medicare.
- The religious nonmedical health care institution Utilization Review Committee agrees that you would require hospital or SNF care if you weren't in the institution.
- You have a written election on file with Medicare that your need for religious nonmedical health 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 religious nonmedical health care services. You're always eligible to get medically necessary Part A services.

Costs

You pay this for each benefit period in 2022:

- \$1,556 deductible.
- Days 1–60: \$0 coinsurance.
- Days 61–90: \$389 coinsurance per day.

Religious nonmedical health care institution items & services (continued)

Costs

- Days 91 and beyond: \$778 coinsurance per each “lifetime reserve day” after day 90 for each benefit period (up to a maximum of 60 reserve days over your lifetime).
- Each day after the lifetime reserve days: All costs.

Things to know

Religious beliefs prohibit conventional and unconventional medical care in religious nonmedical health care institutions.

More information

Visit [Medicare.gov/coverage/religious-non-medical-health-care-institution-items-services](https://www.medicare.gov/coverage/religious-non-medical-health-care-institution-items-services).

Respite care

See “Hospice care” on pages 58–60.

Rural health clinic services

Part B covers a broad range of outpatient primary care and preventive services in rural health clinics.

Costs

After you meet the Part B deductible, you generally pay 20% of the charges. You pay nothing for most preventive services.

What it is

Rural health clinics are located in non-urbanized areas. These clinics provide outpatient primary care and preventive health services to people located in medically underserved or shortage areas.

More information

Visit [Medicare.gov/coverage/rural-health-clinic-services](https://www.medicare.gov/coverage/rural-health-clinic-services).

Scooters

See “Wheelchairs & scooters” on page 116.

Second surgical opinions

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

Costs

After you meet the Part B deductible, you pay 20% of the Medicare-approved amount. The second doctor may ask you to get additional tests as a result of the visit. Medicare will help pay for these tests, just as it helps pay for other services that are medically necessary. If the second opinion is different from 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](https://www.medicare.gov/coverage/second-surgical-opinions).



Sexually transmitted infection 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 face-to-face, high-intensity behavioral counseling sessions if you're a sexually active adult at increased risk for STIs. Each session can be 20-30 minutes long.

How often

Medicare covers STI screenings once every 12 months, or at certain times during pregnancy. Medicare covers up to 2 behavioral counseling sessions each year.

Costs

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

Sexually transmitted infection screenings & counseling (continued)

Things to know

Your primary care provider must order the screening or refer you for behavioral counseling. Medicare will only cover counseling sessions with a primary care doctor in a primary care setting (like a doctor's office). Medicare won't cover counseling in an inpatient setting (like a skilled nursing facility).

More information

Visit [Medicare.gov/coverage/sexually-transmitted-infections-screenings-counseling](https://www.medicare.gov/coverage/sexually-transmitted-infections-screenings-counseling).

Shingles shots

Neither Part A nor Part B cover the shingles shot. Usually, Part D covers all commercially available vaccines needed to prevent illness, including the shingles shot.

More information

- Contact your Medicare drug plan.
- Visit [Medicare.gov/coverage/shingles-shot](https://www.medicare.gov/coverage/shingles-shot).



Shots (or vaccines)

Part B covers:

- Flu shots: See page 50.
- Hepatitis B shots: See pages 54–55.
- Pneumococcal shots: See page 92.
- Coronavirus disease 2019 (COVID-19) vaccine: See page 30.
- Some other vaccines when they're related directly to the treatment of an injury or illness. These aren't considered preventive services.

Part D generally covers all other recommended adult immunizations (like shingles, Tetanus, diphtheria, and pertussis vaccines) to prevent illness. Talk to your provider about which ones are right for you.

Skilled nursing facility (SNF) care

Part A covers skilled nursing facility care 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. You must get the care from, or under the supervision of, skilled nursing or therapy staff.
- You get these skilled services in a Medicare-certified SNF.
- 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.

Costs

In 2022, you pay these amounts 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 coinsurance.
- Days 21–100: Up to \$194.50 coinsurance each day.
- Days 101 and beyond: 100% of all costs.

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

Skilled nursing facility (SNF) care (continued)

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 in a skilled nursing facility include, but aren't limited to:

- A 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 81 and 91.
- Speech-language pathology services, if they're needed to meet your health goal. See page 108.
- Medical social services.
- Medications.
- Medical supplies and equipment used in the facility.
- Ambulance transportation (when other transportation endangers your 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](https://www.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

After you meet the Part B deductible, you pay 20% of the Medicare-approved amount.

Things to know

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

More information

Visit [Medicare.gov/coverage/sleep-studies](https://www.Medicare.gov/coverage/sleep-studies).

Speech-language pathology services

Part B helps pay for medically necessary outpatient speech-language pathology services if your doctor or other health care provider certifies you need it.

Costs

After you meet the Part B deductible, you pay 20% of the Medicare-approved amount.

What it is

These services provide evaluation and treatment to regain and strengthen speech and language skills. This includes cognitive and swallowing skills, or therapy to improve or maintain current function or slow decline.

Things to know

There's no limit on how much Medicare pays for your medically necessary, outpatient speech-language pathology services in one calendar year.

More information

Visit [Medicare.gov/coverage/speech-language-pathology-services](https://www.Medicare.gov/coverage/speech-language-pathology-services).

Supplies

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

Costs

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

More information

Visit [Medicare.gov/coverage/supplies](https://www.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 you won't know what services you need until you meet with your provider. If you need surgery or a procedure, you may be able to estimate how much you'll have to pay. For help estimating costs on surgical procedures in certain settings, visit [Medicare.gov/procedure-price-lookup](https://www.Medicare.gov/procedure-price-lookup).

More information

Visit [Medicare.gov/coverage/surgery](https://www.Medicare.gov/coverage/surgery).

Surgical dressing services

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

Costs

You pay 20% of the Medicare-approved amount for your doctor or other health care provider's services, and you usually pay nothing additional for the supplies. You also pay a separate 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](https://www.Medicare.gov/coverage/surgical-dressing-services).

Swing bed services

Medicare covers swing bed services in certain hospitals and critical access hospitals when the facility has entered into a “swing-bed agreement” with the Department of Health and Human Services.

Costs

When swing beds provide SNF-level care, the same coverage and cost-sharing rules apply as though the services were provided in an SNF.

What it is

A 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](https://www.Medicare.gov/coverage/swing-bed-services).

Tdap shots

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

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.

More information

- Contact your Medicare drug plan.
- Visit [Medicare.gov/coverage/tdap-shots](https://www.Medicare.gov/coverage/tdap-shots).

Telehealth

Part B covers certain telehealth services.

Costs

After you meet the Part B deductible, you pay 20% of the Medicare-approved amount for your doctor or other health care provider's services. For many telehealth services, you'll pay the same amount that you would if you got the services in person.

What it is

Telehealth includes certain medical or health services that you get from your doctor or other health care provider using audio and video communications technology, like your phone or a computer (or audio-only telehealth services in some cases). Some examples of Medicare-covered telehealth services include:

- Therapy and online counseling
- Prescription management
- Urgent care issues, like colds, coughs and stomach aches
- Post-surgical follow-up
- Treatment of recurring conditions, like migraines or urinary tract infections
- Treatment of skin conditions
- Lab test or X-ray result consultations

Things to know

Medicare Advantage Plans and providers who are part of certain Medicare Accountable Care Organizations (ACOs) may offer more telehealth benefits than Original Medicare. These benefits will be available in a variety of places, and you can use them to get services at home instead of going to a health care facility. Check with your plan to see what additional telehealth benefits it may offer. If your provider participates in an ACO, check with them to see what telehealth benefits may be available.

More information

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

Therapeutic shoes or inserts

Part B covers the furnishing and fitting of either custom 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, you can get either one pair of custom shoes or inserts, or one pair of extra depth shoes. You can also get either 2 or 3 additional pairs of inserts each calendar year, depending on your shoe type.

Costs

After you meet the Part B deductible, you pay 20% of the Medicare-approved amount.

Things to know

The doctor who treats your diabetes must certify your need for therapeutic shoes or inserts. A podiatrist (foot doctor) or other qualified doctor must prescribe the shoes or inserts, and you must get the shoes or inserts from a podiatrist, orthotist, prosthetist, pedorthist, or other qualified individual.

More information

- Other diabetic services and supplies: See “Diabetes services” and “Diabetes supplies” on pages 35–36.
- Visit [Medicare.gov/coverage/therapeutic-shoes-or-inserts](https://www.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 42–44.
- Visit [Medicare.gov/coverage/traction-equipment](https://www.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'll work with you, your family, caregivers, and other 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
- Help you with referrals or arrangements for follow-up care or community resources
- Help you with scheduling
- Manage your medications

More information

Visit [Medicare.gov/coverage/transitional-care-management-services](https://www.Medicare.gov/coverage/transitional-care-management-services).

Travel outside the U.S.

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 U.S. state when a medical emergency occurs, and the Canadian hospital is closer than the nearest U.S. hospital that can treat the emergency.
- You live in the U.S. and the foreign hospital is closer to your home than the nearest U.S. hospital that can treat your medical condition, regardless of whether an emergency exists.

Costs

In most cases, you pay 100% of the costs. In the situations described above, you pay the coinsurance or copayments and deductibles you would pay if you got the same services or supplies inside the U.S.

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](https://www.medicare.gov/coverage/travel).

Urgently needed care

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

Costs

After you meet the Part B deductible, you pay 20% of the Medicare-approved amount for your doctor or other health care provider's services. In a hospital outpatient setting, you also pay a copayment.

More information

Visit [Medicare.gov/coverage/urgently-needed-care](https://www.medicare.gov/coverage/urgently-needed-care).

Vaccinations

See "Shots (or vaccines)" on page 105.

Vaginal cancer screenings

See "Cervical & vaginal cancer screenings" on pages 19–20.

Virtual check-ins

Part B covers virtual check-ins (also called "brief communication technology-based services") with your doctors and certain other providers.

Costs

After you meet the Part B deductible, you pay 20% of the Medicare-approved amount for your doctor or other provider's services.

What it is

Virtual check-ins allow you to talk to your doctor or certain other providers (like nurse practitioners or physician assistants) using audio and video communication technology, like your phone or a computer, without going to the doctor's office. Your doctor can also conduct remote assessments using photo or video images you send for review to see whether you need to go to the doctor's office.

Your doctor or other provider can respond to you using a phone, virtual delivery, secure text messages, email, or a patient portal.

Virtual check-ins (continued)

Things to know

You can have a virtual check-in if you meet these conditions:

- You've talked to your doctor or other provider about starting these types of services.
- The virtual check-in doesn't relate to a medical visit you've had within the past 7 days, and doesn't lead to a medical visit within the next 24 hours (or the soonest appointment available).
- You verbally consent to the virtual check-in, and your doctor documents your consent in your medical record. Your doctor may get one consent for a year's worth of these services.

More information

Visit [Medicare.gov/coverage/virtual-check-ins](https://www.medicare.gov/coverage/virtual-check-ins).

Walkers

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

More information

- See “Durable medical equipment (DME)” on pages 42–44.
- Visit [Medicare.gov/coverage/walkers](https://www.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. Part B covers power wheelchairs only when they're medically necessary.

More information

- See “Durable medical equipment (DME)” on pages 42–44.
- Visit [Medicare.gov/coverage/wheelchairs-scooters](https://www.medicare.gov/coverage/wheelchairs-scooters).

X-rays

Part B covers medically necessary diagnostic X-rays when your treating doctor or other health care provider orders them.

Costs

After you meet the Part B deductible, you pay 20% of the Medicare-approved amount. In a hospital outpatient setting, you also pay a separate facility copayment.

More information

- See “Diagnostic non-laboratory tests” on page 37.
- Visit [Medicare.gov/coverage/x-rays](https://www.medicare.gov/coverage/x-rays).

It may be helpful to understand these terms as you read this booklet (visit [Medicare.gov/glossary](https://www.Medicare.gov/glossary) for additional terms):

Assignment:

An agreement by your doctor, provider, or supplier to be paid directly by Medicare, to accept the payment amount Medicare approves for the service, and not to bill you for any more than the Medicare deductible and coinsurance.

Coinsurance:

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

Copayment:

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

Deductible:

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

Medicare-approved amount:

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

CMS Accessible Communications

The Centers for Medicare & Medicaid Services (CMS) provides free auxiliary aids and services, including information in accessible formats like braille, large print, data or audio files, relay services and TTY communications. If you request information in an accessible format from CMS, you won't be disadvantaged by any additional time necessary to provide it. This means you'll get extra time to take any action if there's a delay in fulfilling your request.

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

1. Call us:

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

TTY: 1-877-486-2048

2. Send us a fax: 1-844-530-3676

3. Send us a letter:

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

7500 Security Boulevard, Mail Stop S1-13-25

Baltimore, MD 21244-1850

Attn: Customer Accessibility Resource Staff

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

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

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

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

1. Online:

hhs.gov/civil-rights/filing-a-complaint/complaint-process/index.html.

2. By phone:

Call 1-800-368-1019. TTY users can call 1-800-537-7697.

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

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

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

7500 Security Boulevard
Baltimore, Maryland 21244-1850

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Your Medicare Benefits

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

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

Esta publicación está disponible en Español. Para obtener una copia gratis, visite Medicare.gov o llame al 1-800MEDICARE (18006334227). Los usuarios de TTY pueden llamar al 18774862048.