Your Medicare Benefits

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

Medicare.gov

Medicare

About This Booklet

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

If you have a Medicare Advantage Plan (Part C), another Medicare health plan, or both Medicare and Medicaid:

- You might get other services and supplies that Original Medicare doesn't cover.
- Your costs may be different.
- You might have different coverage rules (like how often you can get an item or service).

For more information about specific costs and coverage information, contact your plan or state Medicaid office. You can usually find your plan's contact information on your plan membership card. Visit **Medicaid.gov/about-us/where-can-people-get-help-medicaid-chip** to get the phone number for your state's Medicaid office.

Helpful terms to understand:

Assignment:

An agreement by your doctor, other health care provider, or supplier to be paid directly by Medicare, to accept the payment amount Medicare approves for the service as payment in full, and not to bill you for any more than the Medicare deductible and coinsurance. Go to page 4 for more information.

Benefit period:

The way that Original Medicare measures your use of hospital and skilled nursing facility services. A benefit period begins the day you're admitted as an inpatient in a hospital or skilled nursing facility. The benefit period ends when you haven't gotten any inpatient hospital care (or skilled care in a skilled nursing facility) for 60 days in a row. If you go into a hospital or skilled nursing facility after one benefit period has ended, a new one begins. You must pay the inpatient hospital deductible for each benefit period. There's no limit to the number of benefit periods. Go to pages 3–4 for more information.

Coinsurance:

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

Copayment:

An amount you may be required to pay as your share of the cost for benefits after you pay any deductibles. A copayment is a fixed amount, like $30.

Deductible:

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

Medically necessary:

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

Medicare Advantage Plan (Part C):

A type of Medicare health plan offered by a private company that contracts with Medicare. Medicare Advantage Plans provide all of your Part A and Part B benefits, with a few exclusions, for example, certain aspects of clinical trials which are covered by Original Medicare even though you're still in the plan. Medicare Advantage Plans include:

- Health Maintenance Organizations
- Preferred Provider Organizations
- Private Fee-for-Service Plans
- Special Needs Plans
- Medicare Medical Savings Account Plans

If you're enrolled in a Medicare Advantage Plan:

- Most Medicare services are covered through the plan
- Most Medicare services aren't paid for by Original Medicare
- Most Medicare Advantage Plans offer prescription drug coverage

Medicare drug coverage (Part D):

Optional benefits for prescription drugs available to all people with Medicare for an additional charge. This coverage is offered by insurance companies and other private companies approved by Medicare.

Medicare-approved amount:

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

Section 1:

Understanding Medicare Part A & Part B

If you have Original Medicare, you can get Medicare-covered services from any doctor or hospital that takes Medicare, anywhere in the U.S.

What are the parts of Original Medicare?

Part A (Hospital Insurance) helps cover:

- Inpatient hospital care
- Skilled nursing facility care
- Hospice care
- Home health care

What do I pay for Part A-covered services?

What you pay for Part-A covered services depends on where you're getting care, how long you get care, and if you have other coverage (in addition to Medicare).

When you get inpatient hospital care, your care is measured in benefit periods, which are related to the number of days in a row you get care. Each time you start a new benefit period, you must pay the Part A deductible ($1,736 in 2026) before Medicare starts to pay.

Your benefit period ends once you've been out of the hospital for 60 days in a row. If you're admitted to the hospital again after those 60 days, a new benefit period will start. There's no limit to the number of benefit periods you can have in a calendar year (January–December). This means you could pay the Part A deductible more than once a year.

Part B (Medical Insurance) helps cover:

- Services from doctors and other health care providers
- Outpatient care
- Home health care
- Durable medical equipment (like wheelchairs, walkers, hospital beds, and other equipment)
- Many preventive services (like screenings, vaccines, and yearly "Wellness" visits)

What do I pay for Part B-covered services?

In 2026, you pay a yearly $283 deductible for Part B-covered services and supplies. After you meet the Part B deductible, Medicare will pay its share and you typically pay 20% of the Medicare-approved amount (if your doctor or other health care provider accepts assignment).

Why is assignment important?

Most doctors, providers, and suppliers accept assignment, but always check to make sure yours do. If your doctor, provider, or supplier accepts assignment:

- Your out-of-pocket costs may be less.
- They agree to charge you only the Medicare deductible and coinsurance amount (if any) and usually wait for Medicare to pay its share before asking you to pay your share.
- They have to submit your claim directly to Medicare and can't charge you for submitting the claim.

Depending on the service or supply, the amount you pay may be higher if the doctor, provider, or other supplier doesn't accept assignment. Doctors and other health care providers who don't accept assignment can charge you 15% over the Medicare-approved payment amount for most Part B-covered services. 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 if you get them from suppliers who are enrolled in Medicare and accept assignment, 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 health care provider 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 Medicare coverage or payment decisions. Visit Medicare.gov/providers-services/claims-appeals-complaints/appeals for more information on filing an appeal.

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

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

How can I protect myself from Medicare fraud and medical identity theft?

Don't share your Medicare Number or other personal information with anyone except your doctors, insurers acting on your behalf, or trusted people in the community who work with Medicare (like your State Health Insurance Assistance Program, or SHIP). Protect your Medicare card, and check your Medicare Summary Notices (MSNs) regularly.

If you find an error on your MSN or a provider bills you for a service you didn't get, call 1-800-MEDICARE or visit oig.hhs.gov/fraud/report-fraud. You can also visit Medicare.gov/basics/reporting-medicare-fraud-and-abuse for more information about reporting Medicare fraud.

Section 2:

Items & Services

This section lists many of the health care items and services Original Medicare covers in alphabetical order. References to "doctors," "other health care providers," and "suppliers" refer generally to providers who participate in Medicare and accept assignment. If your doctor, provider, or supplier doesn't accept assignment, you might have to pay more for the items and services you get.

Look for these symbols to help you find information you may need:

Preventive services

An apple icon is next to preventive services that Medicare covers. Preventive services are health care services that help you prevent or find health problems at an early stage, and stay healthy. Talk with your doctor about which preventive services are right for you.

Durable Medical Equipment (DME)

A wheelchair icon is next to DME items that Part B covers. DME is medical equipment that is:

- Durable (can withstand repeated use)
- Used for a medical reason (typically only useful if you're sick or injured)
- Used in your home
- Expected to last at least 3 years

Abdominal aortic aneurysm screenings

Abdominal aortic aneurysm screenings check for aneurysms (bulges in blood vessels) in the abdominal area. Part B covers an abdominal aortic aneurysm 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 between 65–75 and have smoked at least 100 cigarettes in your lifetime.

How often

Once in your lifetime.

Costs

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

Things to know

You must get a referral from your health care provider.

More information

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

Acupuncture

Acupuncture is a technique where providers stimulate specific points on the body, most often by inserting thin needles through the skin. Medicare only covers acupuncture (including dry needling) for chronic low back pain defined as:

- Lasting 12 weeks or longer
- Having no known cause (for example, it isn't related to cancer that has spread, or an inflammatory or infectious disease)
- Pain that isn't associated with surgery or pregnancy

How often

Medicare covers up to 12 acupuncture treatments in 90 days for chronic low back pain.

If you show improvement, Medicare covers an additional 8 sessions (for a maximum of 20 acupuncture treatments in a 12-month period). If you aren't showing improvement, Medicare won't cover your additional treatments and you'll pay all costs if you continue getting them.

Costs

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

Things to know

Not all providers can give acupuncture, and Medicare can't pay licensed acupuncturists directly for their services. You must get acupuncture from a doctor or another health care provider (like a nurse practitioner or physician assistant) who has **both** a:

- Master's or doctoral degree in acupuncture or Oriental Medicine from a school accredited by the Accreditation Commission for Acupuncture and Herbal Medicine (formerly the Accreditation Commission on Acupuncture and Oriental Medicine).
- Current, full, active, and unrestricted license to practice acupuncture in the state where you're getting care.

More information

Visit Medicare.gov/coverage/acupuncture.

Advance care planning

Advance care planning involves discussing and preparing for care you would get in the future if you need help making decisions for yourself. Part B covers voluntary advance care planning as part of your "Welcome to Medicare" and yearly preventive "Wellness" visits. Medicare may also cover this service as part of your medical treatment.

As part of advance care planning, you may choose to complete an advance directive. This important legal document records your wishes about medical treatment in the future, if you aren't able to make decisions about your care.

Advance directives include 2 parts:

1. Your **health care proxy** (sometimes called "durable power of attorney") names someone you trust to make decisions about your health if you can't.
2. Your **living will** describes which treatment(s) you want if your life is threatened, including dialysis, breathing machines, resuscitation, and tube feeding. It also states if you want your organs or tissues donated after you die.

You can talk about an advance directive with an attorney or your health care provider, and they can help you prepare your documents. You can update your advance directive at any time.

Costs

You pay nothing if your doctor or other health care provider accepts assignment and this planning is part of your "Welcome to Medicare" or yearly "Wellness" visit. If you get it as part of other medical treatment, the Part B deductible and coinsurance apply.

Things to know

Consider carefully who you want to speak for you and what direction you want to give. You have the right to carry out your plans as you choose without discrimination.

More information

- Go to "Preventive visits" on pages 93–95 for more information about "Welcome to Medicare" and yearly "Wellness" visits.
- Visit **Medicare.gov/coverage/advance-care-planning**.
- For help with advance directives, visit the Eldercare Locator at **eldercare.acl.gov** or contact your state health department at **usa.gov/state-health**.

Advanced Primary Care Management services

Advanced Primary Care Management is a patient-focused approach to care. Part B covers Advanced Primary Care Management services to help your doctor and other health care providers coordinate and tailor care to your needs each month.

Health care providers who offer Advanced Primary Care Management services take extra steps to actively manage all your health care needs. When you get these services, you and your primary care provider (or care team) agree that they'll be your main point of ongoing care. They'll talk to you about your care plan and coordinate all your health care needs, including care you get from other doctors, hospitals, and providers.

Providers that offer these services must provide you with:

- 24/7 access to your care team or provider through the phone, an online portal, email, and virtual check-ins
- Chronic care management
- A personalized care plan that lists your current conditions and treatments
- Comprehensive care coordination to quickly connect you with specialists and other providers
- Transitional care between health care settings (like follow-up care after you're discharged from a hospital)
- Medication management
- Behavioral health integration services (including the Psychiatric Collaborative Care Model)

Costs

After you meet the Part B deductible, you pay 20% of the Medicare-approved amount. Many people who have both Medicare and Medicaid pay nothing for these services.

Things to know

- Check with your primary care provider to make sure they offer these services. Then, give your provider **verbal or written consent** to be your main point of care for all your health needs. They'll document your consent on your medical record. You must also have an initial visit with your provider unless:
  - You've gone to the provider or another provider in the same practice within the last 3 years.
  - You got another type of care management (like chronic care management) from the provider or another provider in the same practice within the last year.
- You can stop getting these services at any time. Talk to your provider to stop participating.

More information

- Go to "Behavioral health integration services" on page 13.
- Visit Medicare.gov/coverage/advanced-primary-care-management-services.

Alcohol misuse screenings & counseling

Alcohol misuse screening tests include questions about your alcohol use. Your primary care doctor or other health care provider reviews your responses to check for alcohol misuse and alcohol use disorders. Part B covers an alcohol misuse screening for adults who use alcohol, but don't meet the medical conditions for alcohol dependency.

How often

Medicare covers an alcohol misuse screening once a year. If your health care provider determines you're misusing alcohol, you can also get up to 4 brief, face-to-face counseling sessions each year (if you're competent and alert during counseling).

Costs

You pay nothing if your provider accepts assignment.

Things to know

You must get the counseling in a primary care setting (like a doctor's office).

More information

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

Ambulance services

Ambulance services transport you to a medical facility (like a hospital) for care. Part B covers ground ambulance transportation when traveling in any other vehicle could endanger your health, and you need medically necessary services from one of the following:

- A hospital
- A critical access hospital
- A rural emergency hospital
- A 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 medically necessary, non-emergency ambulance transportation if you have a written order from your doctor or other health care provider that says the ambulance transportation is medically necessary. For example, someone with End-Stage Renal Disease (ESRD) may need a medically necessary ambulance transport from their home to and from a 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.
- The ambulance company must give you an "Advance Beneficiary Notice of Non-coverage (ABN)" when both of these apply:
  - You get ambulance services in a non-emergency situation.
  - The ambulance company believes that Medicare may not pay for your specific ambulance service.

More information

Visit Medicare.gov/coverage/ambulance-services.

Ambulatory surgical centers

Ambulatory surgical centers are outpatient facilities that perform surgical procedures. In most cases, ambulatory surgical centers release patients within 24 hours. Part B covers facility service fees for 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 your 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 health care provider removes a polyp during a screening colonoscopy, you may have to pay 15% of the Medicare-approved amount.
- You also pay all facility fees for non-covered procedures you get in ambulatory surgical centers.

More information

- Visit Medicare.gov/coverage/ambulatory-surgical-centers.
- To get average costs for a surgery in an ambulatory surgical center, visit Medicare.gov/procedure-price-lookup.

Anesthesia

Anesthesia is a type of medication that keeps you from feeling pain during surgery or other medical procedures. Part A covers anesthesia services you get as a hospital inpatient. Part B covers anesthesia services you get as an outpatient in a hospital or as 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.
- For Part A inpatient hospital cost information, go to pages 58–59.

More information

Visit Medicare.gov/coverage/anesthesia.

Artificial eyes & limbs

Artificial eyes and limbs (also called "prosthetics") are devices that replace a missing body part. Part B covers medically necessary artificial eyes, legs, and arms when a doctor or other health care provider 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.

Bariatric surgery

Bariatric surgery may help people with extreme obesity lose weight. Medicare covers some bariatric surgical procedures (like gastric bypass surgery and laparoscopic banding surgery) when you meet certain conditions related to morbid obesity.

Costs

- It's hard to predict your costs for surgeries or procedures in advance because you won't know what services you need until you meet with your provider. To compare average costs for this surgery in both a hospital outpatient department and an ambulatory surgical center, visit Medicare.gov/procedure-price-lookup.
- Medicare doesn't cover your transportation costs to get to a bariatric surgery center.

More information

Visit Medicare.gov/coverage/bariatric-surgery.

Behavioral health integration services

If you have a behavioral health condition (like depression, anxiety, or another mental health condition), Medicare may pay your doctor or other health care provider to help manage that condition. Some health care providers may offer integrated care services, like the Psychiatric Collaborative Care Model (a set of integrated behavioral health services that may include care planning, ongoing assessments, medication support, and counseling).

Costs

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

Things to know

Your provider will ask you to sign an agreement to get behavioral health integration services on a monthly basis.

More information

- Go to "Mental health & substance use disorder services" on page 70 to learn about other Medicare-covered services that treat mental health, behavioral health, and substance use disorders.
- Visit **Medicare.gov/coverage/behavioral-health-integration-services**.

Blood services

If you lose blood because of a condition, injury, or surgical procedure, you might need a blood transfusion (a procedure that delivers blood into your veins through an intravenous (IV) line). Part A covers blood you get as a hospital inpatient. Part B covers blood you get as a hospital outpatient.

Hospitals follow certain procedures to make sure blood is safe for transfusions. These procedures are known as blood processing and handling. Hospitals usually charge for blood processing and handling for each unit of blood you get as part of a transfusion, whether the blood is donated or purchased. Part A covers these services if you're an inpatient. Part B covers these services if you're an outpatient.

Costs

- **For blood:** If your health care provider gets blood from a blood bank at no charge, you won't have to pay for it or replace it. If your provider has to buy blood for you, you must either pay the provider costs for the first 3 units of blood you get in a calendar year, or you or someone else can donate the blood.
- **For blood processing and handling:** After you meet the Part A deductible, there's no copayment for blood you get as an inpatient. After you meet the Part B deductible, you pay a copayment for the blood processing and handling services for each unit of blood you get as a hospital outpatient. The Part B copayment varies depending on the services you get, but it won't be more than the inpatient deductible amount ($1,736 in 2026).

More information

Visit Medicare.gov/coverage/blood-services.

Blood-based biomarker tests for colorectal cancer (screening)

Blood-based biomarker screening tests can help find cancer in the colon or rectum early, when treatment is most effective. Part B covers a blood-based biomarker screening test if you meet all these conditions:

- You're between 45–85.
- 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 (if available).

Costs

- You pay nothing for the test if your doctor or other health care provider accepts assignment.
- If you get a positive result after a blood-based biomarker screening test, Medicare also covers a follow-up colonoscopy as a screening test.

More information

Visit Medicare.gov/coverage/blood-based-biomarker-tests.

Bone mass measurements

A bone mass measurement can help find out if you're at risk for broken bones. Part B covers this test if you meet one or more of these conditions:

- You're a woman whose doctor or other health care provider 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 find out if your osteoporosis drug therapy is working.

How often

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

Costs

You pay nothing if your health care provider accepts assignment.

More information

Visit Medicare.gov/coverage/bone-mass-measurements.

Braces (arm, leg, back, & neck)

Braces are rigid and semi-rigid devices that help support weak or deformed body part(s), or stop the movement of an injured body part. Part B covers arm, leg, back, and neck braces when medically necessary and when a doctor or other health care provider orders them.

Costs

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

More information

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

Breast cancer screenings

Go to:

- "Cervical & vaginal cancer screenings" on page 20.
- "Mammograms" on page 67.

Breast prostheses

Breast prostheses replace the natural breast shape and appearance following a mastectomy (surgical removal of the breast) or other breast surgery. 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. Part B also covers some external breast prostheses (including a post-surgical bra) after a mastectomy.

Costs

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

More information

- Go to:
  - "Inpatient hospital care" on pages 58–59.
  - "Outpatient hospital services" on pages 82–83.
- Visit Medicare.gov/coverage/breast-prostheses.

Canes

Go to "Durable medical equipment (DME)" on pages 41–42.

Cardiac rehabilitation programs

Regular and intensive cardiac rehabilitation programs include exercise, education, and counseling if you've experienced a heart attack, heart failure, or certain other heart problems. 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
- Stable angina pectoris (chest pain)
- A heart valve repair or replacement
- A coronary angioplasty (a medical procedure used to open a blocked artery) or a coronary stenting (a procedure used to keep an artery open)
- A heart or heart and lung transplant
- Stable chronic heart failure

Costs

- **For services you get in a doctor's office:** After you meet the Part B deductible, you pay 20% of the Medicare-approved amount.
- **For services you get in a hospital outpatient setting:** After you meet the Part B deductible, you also pay the hospital a copayment.

Things to know

You can get these services in a doctor's office or a hospital outpatient setting (including a critical access hospital) that offers regular and intensive cardiac rehabilitation programs.

More information

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

Cardiovascular behavioral therapy

Cardiovascular behavioral therapy helps lower your risk for cardiovascular disease (conditions that affect the heart and blood vessels). Part B covers a cardiovascular behavioral therapy visit with your primary care doctor or other primary care practitioner in a primary care setting (like their office). During therapy, your primary care practitioner may discuss aspirin use, check your blood pressure, and give you tips on diet and exercise.

How often

Once a year.

Costs

You pay nothing if your primary care practitioner accepts assignment.

More information

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

Cardiovascular disease screenings

Cardiovascular disease screenings check for problems with your heart and blood vessels, and find out if you're at risk for heart disease. Part B covers screenings that include blood tests for cholesterol, lipid, and triglyceride levels that help find conditions that may lead to a heart attack or stroke.

How often

Once every 5 years.

Costs

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

More information

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

Cardiovascular risk assessment & management services

If you haven't been diagnosed with cardiovascular disease, Part B may cover a cardiovascular risk assessment if your doctor or other health care provider determines you're at risk for developing the disease. The assessment calculates your risk level using:

- Demographic data (like age and sex)
- Routine measurements (like blood pressure and weight)
- Smoking history and alcohol use
- Physical activity levels
- Laboratory data (like lipid panels to check your cholesterol levels)

As part of your risk assessment, you'll get a 10-year estimate of your risk for developing cardiovascular disease. For people at intermediate, medium, or high risk, Part B may also cover risk management services. These services might help lower your risk of cardiovascular disease and may include:

- Blood pressure management
- Cholesterol management
- Help to stop smoking

Costs

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

More information

Visit Medicare.gov/coverage/cardiovascular-risk-assessment-management-services.

Caregiver training services

If you're a caregiver, this training teaches you skills to help care for someone with Medicare, including how to:

- Give medications and help with daily tasks
- Move the patient safely
- Communicate effectively with the patient
- Better understand and manage the patient's medical condition(s)
- Give personalized care and emotional support
- Prevent bedsores and infections, and care for wounds

Part B covers caregiver training services if both of these conditions apply:

- The training focuses on helping the patient meet the health and treatment goals they set with their doctor or other health care provider.
- The patient needs a caregiver's help for their treatment to succeed.

Costs

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

Things to know

- If a health care provider determines that caregiver training is appropriate for a patient's treatment plan, the caregiver can get individual or group training sessions from the provider without the patient present.
- Caregiver(s) can get this training from Medicare providers, including:
  - Doctors
  - Nurse practitioners
  - Clinical nurse specialists
  - Certified nurse-midwives
  - Physician assistants
  - Clinical psychologists
  - Therapists (like physical, occupational, and speech)

More information

- Go to:
  - "Chronic care management services" on page 22.
  - "Cognitive assessment & care plan services" on pages 23–24.
  - "Home infusion therapy services, equipment, & supplies" on pages 54–55.
  - "Hospice care" on pages 55–57.
  - "Telehealth" on page 108.
- Visit **Medicare.gov/coverage/caregiver-training-services**.

Cataract surgery

Cataract surgery removes a cloudy natural lens from your eye and, in most cases, replaces it with a clear artificial lens. Medicare may cover cataract surgery that implants conventional intraocular lenses, depending on where you live.

Medicare doesn't usually cover eyeglasses or contact lenses. However, Part B covers one pair of eyeglasses with standard frames (or one set of contact lenses) after each cataract surgery that implants an intraocular lens.

Costs

- **For covered cataract surgery you get in a hospital outpatient setting or ambulatory surgical center:** After you meet the Part B deductible, you pay 20% of the Medicare-approved amount to both the facility and the doctor who performs your surgery.
- **For covered cataract surgery you get in a doctor's office:** After you meet the Part B deductible, you pay 20% of the Medicare-approved amount for both the intraocular lens and the surgery to implant it.

Things to know

If Medicare covers cataract surgery in your area, you can get it using traditional surgical techniques or lasers.

More information

Visit Medicare.gov/coverage/cataract-surgery.

Cervical & vaginal cancer screenings

Cervical and vaginal cancer screenings check for cancer in the cervix and vagina. Part B covers Pap tests and pelvic exams. As part of the pelvic exam, Part B also covers a clinical breast exam to check for breast cancer.

How often

Part B 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, Part B 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 between 30–65 and don't have HPV symptoms.

Costs

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

- Lab Pap test
- Lab HPV test with the Pap test
- Pap test specimen collection
- Pelvic and breast exams

More information

Visit Medicare.gov/coverage/cervical-vaginal-cancer-screenings.

Chemotherapy

Chemotherapy is a drug treatment that kills fast-growing cells (including cancer cells) in your body. If you have cancer, Part B covers chemotherapy if you're a hospital outpatient or get services in a doctor's office or freestanding clinic. Part A covers it if you're a hospital inpatient.

Costs

- After you meet the Part B deductible, you typically pay 20% of the Medicare-approved amount for chemotherapy you get in a doctor's office, freestanding clinic, or hospital outpatient setting. If you get chemotherapy in a hospital outpatient setting, your copayment won't be more than the inpatient deductible amount ($1,736 in 2026).
- For Part A inpatient hospital cost information, go to pages 58–59.

More information

Visit Medicare.gov/coverage/chemotherapy.

Children's kidney services

Medicare covers dialysis and kidney transplants for children who qualify for Medicare.

More information

- Go to:
  - "Dialysis (children)" on page 37.
  - "Kidney transplants (children)" on pages 63–64.
- Visit Medicare.gov/basics/children-and-end-stage-renal-disease.

Chiropractic services

Chiropractic services include techniques (like adjustments to the spine or other parts of the body) to relieve body pain. Part B covers manual manipulation of the spine by a chiropractor to correct a vertebral subluxation (when the spinal joints fail to move properly, but the contact between the joints remains intact).

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

Costs

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

More information

- Go to "Acupuncture" on pages 7–8.
- Visit Medicare.gov/coverage/chiropractic-services.

Chronic care management services

If you have 2 or more serious chronic conditions (like arthritis or diabetes) that you expect to last at least a year, Part B may pay for a doctor or other health care provider to help manage your care for those conditions.

Costs

After you meet the Part B deductible, you pay coinsurance for these services.

Things to know

- 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.
  - 24/7 access for urgent care needs.
  - Support when you go from one health care setting to another.
  - Review of your medicines and how to take them.
  - Help with other chronic care needs.
- Your health care provider will ask you to sign an agreement for you to get this set of services on a monthly basis. If you agree to get these services, your provider will prepare a care plan for you or your caregiver that explains the care you need and how your providers will coordinate it.
- To get started, ask your providers if they offer chronic care management services.

More information

- Go to:
  - "Advanced Primary Care Management services" on pages 9–10.
  - "Caregiver training services" on pages 18–19.
  - "Principal illness navigation services" on pages 95–96.
- Visit Medicare.gov/coverage/chronic-care-management-services.

Chronic pain management & treatment services

If you have chronic pain (persistent or recurring pain lasting longer than 3 months), management and treatment services can help reduce your pain. Part B covers monthly services for people living with chronic pain. Services may include pain assessment, medication management, and care coordination and planning.

Costs

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

More information

Visit Medicare.gov/coverage/chronic-pain-management-treatment-services.

Clinical research studies

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.

For certain 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.

More information

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

Cognitive assessment & care plan services

Cognitive assessments check for problems with a person's mental abilities, including things like memory and decision-making. Part B covers a separate visit with a doctor or health care provider to fully review your cognitive function, establish or confirm a diagnosis like dementia or Alzheimer's disease, and develop a care plan. Your health care provider might also give you a cognitive assessment to look for signs of dementia when you go for other visits, including your yearly preventive "Wellness" visit.

Signs of cognitive impairment may include trouble remembering, learning new things, concentrating, or managing finances. Conditions like depression, anxiety, and delirium can also cause confusion, so it's important to understand why you may be having symptoms.

Costs

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

Things to know

You can bring someone with you (like a spouse, friend, or caregiver) to help listen to information and answer questions. During a cognitive assessment, your provider may:

- Perform an exam, talk with you about your medical history, and review your medications.
- Identify your social support, including care that your usual caregiver can provide.
- 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.

Some people living with dementia and their unpaid caregivers may be able to get additional support through the Guiding an Improved Dementia Experience (GUIDE) Model pilot program. Talk to your provider for more information about this program and to find out if they're participating.

More information

- Go to:
  - "Caregiver training services" on pages 18–19.
  - "Preventive visits" on pages 93–95 for more information about the yearly preventive "Wellness" visit.
- Visit Medicare.gov/coverage/cognitive-assessment-care-plan-services.

Colonoscopies (screening)

Colonoscopy screening tests check for precancerous polyps (growths in the colon), cancer, and other diseases inside the rectum and colon. Part B covers screening colonoscopies. There's no minimum age requirement to get a screening.

How often

Part B covers this screening test once every 24 months if you're at high risk for colorectal cancer. If you aren't at high risk, Part B covers the test once every 120 months, or 48 months after a previous flexible sigmoidoscopy.

If you initially have a Medicare-covered, non-invasive stool-based colorectal cancer screening test (fecal occult blood test or multi-target stool DNA test) or a blood-based biomarker screening test and get a positive result, Part B covers a follow-up colonoscopy as a screening test.

Costs

- If your doctor or other health care provider accepts assignment, you pay nothing for screening test(s), including follow-up colonoscopies you get after a positive result from a Medicare-covered blood-based biomarker test or non-invasive stool-based test.
- If your health care provider finds and removes a polyp or other tissue during the colonoscopy, you pay 15% of the Medicare-approved amount for your provider's services. In a hospital outpatient setting or ambulatory surgical center, you also pay the facility a 15% coinsurance. The Part B deductible doesn't apply.

More information

Visit Medicare.gov/coverage/colonoscopies.

Colorectal cancer screenings

Colorectal cancer screenings help find precancerous polyps (growths in the colon) or find cancer early, when treatment is most effective. Medicare may cover one or more of these screening tests:

- Colonoscopies (screening): Go to page 24.
- Blood-based biomarker tests (screening): Go to page 14.
- Computed tomography (CT) colonography (screening): Go to page 26.
- Fecal occult blood tests (screening): Go to page 46.
- Flexible sigmoidoscopy (screening): Go to page 47.
- Multi-target stool DNA tests (screening): Go to page 76.

Commode chairs

Go to “Durable medical equipment (DME)” on page 41–42.

Community health integration services

Your doctor or other health care provider might find that certain conditions (like limited access to food or your living environment) are impacting your health or access to care. In these cases, Part B covers community health integration services to address your needs and help your health care provider diagnose or treat your medical conditions. Some community health integration services include:

- An assessment to better understand your life story
- Care coordination
- Health education
- Patient self-advocacy training
- Health system navigation
- Social and emotional support

You must have an initial visit with your provider (separate from your yearly “Wellness” visit) before you can start getting community health integration services. After your initial visit, you can get these services every month. Your provider or their staff can give you the community health integration services or refer you to other trained personnel (including community health workers) for the services.

Costs

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

More information

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

Computed tomography (CT) colonography (screening)

A CT colonography screening (also called a virtual colonoscopy) is a test that uses X-rays and computers to help find polyps (growths in the colon), ulcers (sores), and cancer in your colon and rectum. Part B covers this screening test if your doctor, physician assistant, nurse practitioner, or clinical nurse specialist orders it.

How often

If you're 45 or older and at high risk for colorectal cancer, Part B covers this screening test once every 24 months. If you aren't at high risk, Part B covers the test once every 60 months, or 48 months after a previous flexible sigmoidoscopy or colonoscopy.
If you're under 45, Part B doesn't cover this test.

Costs

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

More information

- Go to:
  - "Colonoscopies (screening)" on page 24.
  - "Flexible sigmoidoscopy (screening)" on page 47.
- Visit Medicare.gov/coverage/computed-tomography-ct-colonography.

Concierge care

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.

Medicare doesn't cover membership fees for concierge care (also called concierge medicine, retainer-based medicine, boutique medicine, platinum practice, or direct care).

Costs

You pay all costs for non-covered services, including the membership fee for concierge care.

More information

Visit Medicare.gov/coverage/concierge-care.

Contact lenses

Go to "Eyeglasses & contact lenses" on page 45.

Continuous glucose monitors

Continuous glucose monitors track your glucose (blood sugar) levels through a device that's attached to your body. If you have diabetes, Medicare may cover a continuous glucose monitor and related supplies (like sensors). Before your doctor or other health care provider orders a continuous glucose monitor, they must evaluate you and make sure that you meet the following conditions:

- You take insulin or have a history of problems with low blood sugar (hypoglycemia).
- You or your caregiver have had enough training to use a continuous glucose monitor as directed.

More information

- Go to:
  - "Diabetes services" and "Diabetes supplies" on page 35.
  - "Durable medical equipment (DME)" on pages 41–42.
  - "Insulin" on page 61.
- Visit Medicare.gov/coverage/continuous-glucose-monitors.

Continuous Positive Airway Pressure (CPAP) therapy

CPAP therapy is an in-home treatment for people with sleep apnea. Medicare may cover a 12-week 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 if you meet with your doctor or other health care provider in person, and they document 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 related supplies (like masks and tubing).

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, as long as you're using it continuously. After Medicare makes rental payments for 13 continuous months, you'll own the machine.

More information

- Go to "Durable medical equipment (DME)" on pages 41–42.
- Visit Medicare.gov/coverage/continuous-positive-airway-pressure-devices.

Cosmetic surgery

Cosmetic surgery usually focuses on changing a person's physical appearance rather than treating a medical condition. 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.

Costs

You pay all costs for non-covered services, including most cosmetic surgery.

Things to know

Medicare usually requires prior authorization before you get these services that are sometimes (but not always) considered cosmetic:

- **Blepharoplasty:** Surgery on your eyelid to remove "droopy," fatty, or excess tissue.
- **Botulinum toxin injections:** 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.

Medicare might require prior authorization for these services whether you get them in a hospital outpatient department or ambulatory surgical center. If your procedure requires prior authorization before Medicare will pay for it, you don't need to do anything. Your doctor or other health care provider will send a prior authorization request and documentation to Medicare for approval before the procedure. If Medicare approves your prior authorization request, you should only need to pay your deductible and coinsurance.

More information

- Go to "Breast prostheses" on page 16.
- Visit Medicare.gov/coverage/cosmetic-surgery.

Counseling to prevent tobacco use & tobacco-caused disease

Part B covers counseling to help you stop smoking or using tobacco.

How often

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

Costs

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

More information

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

COVID-19 antibody tests

COVID-19 antibody tests check to find out if you've developed immunity (protection) against COVID-19 and may not be at immediate risk of reinfection. Part B covers FDA-authorized COVID-19 antibody tests.

Costs

You usually pay nothing when your doctor or other health care provider orders these tests, and you get them from a laboratory (including at a pharmacy, clinic, or doctor's office) or hospital that takes Medicare.

More information

- Go to:
  - "COVID-19 diagnostic laboratory tests" below.
  - "COVID-19 monoclonal antibody treatments & products" on page 30.
  - "COVID-19 vaccines" on pages 30–31.
- Visit **Medicare.gov/coverage/covid-19-antibody-tests**.
- For more on COVID-19, visit **CDC.gov/covid**.

COVID-19 diagnostic laboratory tests

COVID-19 diagnostic laboratory tests check to find out if you have COVID-19. Part B covers FDA-authorized COVID-19 diagnostic laboratory tests.

Costs

You usually pay nothing when your doctor or other health care provider orders this diagnostic test, and you get it from a laboratory (including at a pharmacy, clinic, or doctor's office) or hospital that takes Medicare.

More information

- Go to:
  - "COVID-19 antibody tests" above.
  - "COVID-19 monoclonal antibody treatments & products" on page 30.
  - "COVID-19 vaccines" on pages 30–31.
- Visit **Medicare.gov/coverage/covid-19-diagnostic-laboratory-tests**.
- For more on COVID-19, visit **CDC.gov/covid**.

COVID-19 monoclonal antibody treatments & products

COVID-19 monoclonal antibody treatments and products can help you fight mild to moderate COVID-19 symptoms and keep you out of the hospital. Part B covers FDA-authorized or FDA-approved COVID-19 monoclonal antibody treatments and products if you have COVID-19 symptoms.

Costs

You pay nothing when you get them from a Medicare provider or supplier. You must meet certain conditions to qualify.

Note: Certain FDA-authorized or FDA-approved monoclonal antibody products can protect you before you're exposed to COVID-19. If you have Part B and your doctor or other health care provider decides this type of product could work for you (like if you have a weakened immune system), you pay nothing when you get the product from a Medicare provider or supplier.

More information

- Go to:
  - "COVID-19 antibody tests" on page 29.
  - "COVID-19 diagnostic laboratory tests" on page 29.
  - "COVID-19 vaccines" below.
- Visit Medicare.gov/coverage/covid-19-monoclonal-antibody-treatments-products.
- For more on COVID-19, visit CDC.gov/covid.

COVID-19 vaccines

COVID-19 vaccines help lower your chances of becoming sick from COVID-19 by working with the body's natural defenses to safely develop immunity (protection) against the virus. Part B covers FDA-approved and FDA-authorized COVID-19 vaccines.

Costs

You pay nothing if your doctor or other health care provider accepts assignment for giving you the vaccine.

Things to know

You don't need a prescription to get the vaccine at your pharmacy.

More information

- Go to:
  - "COVID-19 antibody tests" on page 29.
  - "COVID-19 diagnostic laboratory tests" on page 29.
  - "COVID-19 monoclonal antibody treatments & products" on page 30.
- Visit Medicare.gov/coverage/covid-19-vaccine.
- For more on COVID-19, visit CDC.gov/covid.

Crutches

Go to "Durable medical equipment (DME)" on pages 41–42.

CT scans

Go to "Diagnostic non-laboratory tests" on page 36.

Defibrillators

Medicare may cover an implantable cardioverter defibrillator if you've been diagnosed with heart failure. Part A covers the surgery to implant a defibrillator in a hospital inpatient setting. Part B covers the surgery if you get it in a hospital outpatient setting.

Costs

- After you meet the Part B deductible, you pay 20% of the Medicare-approved amount for your doctor's services.
- If you get the surgery in a hospital outpatient setting, the Part B deductible applies and you'll also pay the hospital a copayment. In most cases, the hospital copayment can't be more than the Part A hospital stay deductible ($1,736 in 2026).
- For Part A inpatient hospital cost information, go to pages 58–59.

More information

Visit Medicare.gov/coverage/defibrillators.

Dental services

In most cases, Medicare **doesn't** cover dental services like routine cleanings, fillings, tooth extractions (removals), or items like dentures and implants.

Medicare may cover:

- Some dental services you get when you're admitted as a hospital inpatient for your dental procedure, either because of your underlying medical condition or the severity of the procedure.
- Specific inpatient or outpatient dental services directly related to certain covered medical treatments. In these cases, you must get the dental service because it's linked to the success of the medical treatment you need, like:
  - An oral exam and dental treatment before you get a heart valve replacement or a bone marrow, organ, or kidney transplant.
  - A procedure (like a tooth extraction) to treat a mouth infection before you get cancer treatment services like chemotherapy.
  - Treatment for a complication you experience while getting head and neck cancer treatment services.
  - Dental or oral exams before or while getting Medicare-covered dialysis services (if you have End-Stage Renal Disease (ESRD)).
  - Medically necessary tests and treatments to remove an oral or dental infection before or while getting Medicare-covered dialysis services (if you have ESRD).

Costs

- You pay all costs for non-covered services, including most dental care.
- For Part B-covered dental services, you pay 20% of the Medicare-approved amount after you meet the Part B deductible. If you get the covered service in an outpatient hospital or other facility setting, you'll also pay a copayment to the facility.
- For Part A inpatient hospital cost information, go to pages 58–59.

More information

Visit Medicare.gov/coverage/dental-services.

Depression screenings

Part B covers depression screenings. During the screening, your doctor or other health care provider will ask you questions to find out if you have depression.

How often

Once a year.

Costs

You pay nothing if your health care provider accepts assignment.

Things to know

You must get the screening in a primary care setting (like a doctor's office) where you can get follow-up treatment and/or referrals to a mental health care provider.

More information

- Go to:
  - "Behavioral health integration services" on page 13.
  - "Mental health & substance use disorder services" on page 70.
- Visit Medicare.gov/coverage/depression-screening.

If you or someone you know is struggling or in crisis, call or text 988, the free and confidential Suicide & Crisis Lifeline. You can call and speak with a trained crisis counselor 24 hours a day, 7 days a week. You can also connect with a counselor through web chat at 988lifeline.org. Call 911 if you're in an immediate medical crisis.

Diabetes screenings

Diabetes screenings are blood tests that check if you have or are at risk for diabetes. These screenings may be fasting or non-fasting glucose tests, A1C tests, or other Medicare-approved glucose tests. Part B covers diabetes screenings if your doctor or other health care provider determines you're at risk for developing diabetes. Part B covers these screenings if you have any of these risk factors:

- High blood pressure
- History of abnormal cholesterol and triglyceride levels
- Obesity
- History of high blood sugar

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

If you qualify to get diabetes screenings, you can get up to 2 each year (within 12 months of your most recent screening).

Costs

You pay nothing if your health care provider accepts assignment.

More information

- Go to:
  - "Diabetes services" on page 35.
  - "Medicare Diabetes Prevention Program" on page 69.
- Visit Medicare.gov/coverage/diabetes-screenings.

Diabetes self-management training

If you've been diagnosed with diabetes, Part B covers outpatient diabetes self-management training to help you manage your disease. The program may include tips for eating healthy and being active, monitoring blood glucose (blood sugar), taking prescription drugs, and reducing risks. Some patients may also be eligible for medical nutritional therapy services. Go to "Medical nutrition therapy services" on page 68.

Medicare may cover up to 10 hours of initial training—1 hour of individual training and 9 hours of group training. You may also qualify for up to 2 hours of follow-up training each calendar year, after the year you got your first training.

Costs

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

Things to know

- To get this training, you must have an order from your doctor or other health care provider.
- Some exceptions apply if group sessions aren't available in your area, or if your health care provider says you would benefit more from having individual training sessions.

More information

- Go to:
  - "Diabetes services" and "Diabetes supplies" on page 35.
  - "Telehealth" on page 108.
- Visit Medicare.gov/coverage/diabetes-self-management-training.

Diabetes services

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

- Diabetes screenings: Go to page 33.
- Diabetes self-management training: Go to page 34.
- Eye exams (for diabetes): Go to page 45.
- Foot care (for diabetes): Go to page 48.
- Glaucoma screenings: Go to page 49.
- Medical nutrition therapy services: Go to page 68.
- Medicare Diabetes Prevention Program: Go to page 69.

Diabetes supplies

Part B covers some diabetes supplies, including:

- Home blood glucose meters and related supplies, like test strips, lancet and lancet holders, and control solutions
- Continuous glucose monitors and related supplies, like sensors
- Insulin and related supplies, like tubing, insertion sets, and pumps
- Therapeutic shoes or inserts

Things to know

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

More information

- Go to:
  - "Continuous glucose monitors" on page 27.
  - "Diabetes services" above.
  - "Durable medical equipment (DME)" on pages 41–42.
  - "Insulin" on page 61.
  - "Therapeutic shoes or inserts" on page 109.
- Glucose monitors: Visit **Medicare.gov/coverage/blood-sugar-monitors**.
- Test strips: Visit **Medicare.gov/coverage/blood-sugar-test-strips**.
- Control solutions: Visit **Medicare.gov/coverage/blood-sugar-control-solutions**.
- Lancets and lancet holders: Visit **Medicare.gov/coverage/lancets-lancet-holders**.

Diagnostic laboratory tests

Diagnostic laboratory tests look for changes in your health and help your doctor or other health care provider diagnose or rule out a suspected illness or condition. Part B covers medically necessary diagnostic laboratory tests when your health care provider orders them. These tests may include certain blood tests, urinalysis, and certain tests on tissue specimens.

Costs

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

Things to know

Medicare also covers some preventive tests and screenings to help prevent or find a medical problem. Go to "Preventive & screening services" on page 92.

More information

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

Diagnostic non-laboratory tests

Diagnostic non-laboratory tests help your doctor or other health care provider find or rule out an illness or condition. Part B covers these tests (like CT scans, MRIs, EKGs or ECGs, X-rays, and PET scans) when your health care provider orders them to find or treat a medical problem.

Costs

- After you meet the Part B deductible, you pay 20% of the Medicare-approved amount for covered diagnostic non-laboratory tests you get in your doctor's office or in an independent diagnostic testing facility.
- If you get the test at a hospital as an outpatient, you also pay the hospital a copayment that may be more than 20% of the Medicare-approved amount. In most cases, this amount can't be more than the Part A hospital stay deductible ($1,736 in 2026).
- If you get certain diagnostic non-laboratory tests (advanced diagnostic imaging services including CT, MRI, nuclear medicine, or PET scans) outside of a hospital, including from a provider, medical practice, clinic, or free-standing radiology center, check with the provider before you get your test to make sure they're accredited. Medicare will only pay for your test if you get it from an accredited provider. If Medicare doesn't pay for your test because the provider isn't accredited, the provider can't bill you for the test.

More information

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

Dialysis (children)

Dialysis is a treatment that cleans the blood when the kidneys don't work. If your child qualifies for Medicare due to permanent kidney failure, 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 covers these dialysis services:

- Outpatient dialysis treatments (in a Medicare-certified dialysis facility)
- Home dialysis equipment and supplies
- Certain home support services
- Drugs and biological products 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 within the U.S. and use a Medicare-certified facility

Costs

- **Inpatient hospital services:** Part A pays for these services after you pay the hospital inpatient deductible.
- **Doctors' services:** After you meet the Part B deductible, you pay 20% of the Medicare-approved amount.
- **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.

More information

- Go to:
  - "Inpatient hospital care" on pages 58–59.
  - "Kidney transplants (children)" on pages 63–64.
- Visit Medicare.gov/coverage/dialysis-children.

Dialysis services & supplies

People with End-Stage Renal Disease (ESRD) have permanent kidney failure that requires dialysis or a kidney transplant. Dialysis is a treatment that cleans the blood when the kidneys don't work. Generally, Medicare covers 3 hemodialysis (or equivalent peritoneal dialysis) treatments each week if you have ESRD.

If you have Original Medicare, you need both Part A and Part B to get the full benefits available under Medicare for people with ESRD. Part A covers inpatient dialysis treatments when you're in a hospital. Go to "Inpatient hospital care" on pages 58–59.

Part B helps cover:

- Outpatient dialysis treatments and doctors' services you get in a Medicare-certified dialysis facility or your home. This includes dialysis treatments for acute kidney injury.
- 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 Medicare-certified dialysis facilities can bill Medicare for providing home dialysis training.
- Home dialysis equipment and supplies (like the dialysis machine, water treatment system, basic recliner, alcohol, wipes, sterile drapes, rubber gloves, and scissors).
- Certain home support services you get from your dialysis facility. This may include:
  - Visits from trained hospital or dialysis facility workers to monitor your home dialysis, help in emergencies (when needed), and check your equipment and water supply.
  - A face-to-face visit between you and your doctor (or certain non-doctor providers, like physician assistants and nurse practitioners) once a month.
- Drugs for outpatient and home dialysis, including 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 ESRD. Part B also covers phosphate binders and other phosphate-lowering treatments if they're used to control phosphorous levels in people who have ESRD. Talk with your doctor or health care team about the use of any drugs, including over-the-counter products.
- Other dialysis services and supplies (like laboratory tests that are renal dialysis services).

Note: Part B only covers ambulance services from your home to and from the nearest renal dialysis facility when traveling in any other vehicle could endanger your health.

Costs

- **Dialysis services in a dialysis facility:** After you meet the Part B deductible, you'll pay 20% of the Medicare-approved amount.
- **Dialysis services in a hospital:** Part A pays for these services after you pay the hospital inpatient deductible.
- **Outpatient doctors' services:** After you meet the Part B deductible, you pay 20% of the Medicare-approved amount.
- **Home dialysis training services:** After you meet the Part B deductible, you pay 20% of the Medicare-approved amount.

If you have other insurance, your costs may be different. Read your plan materials or call your benefits administrator to get your 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 doctor's service

More information

- Go to:
  - "Ambulance services" on pages 10–11.
  - "Dialysis (children)" on page 37.
- Visit Medicare.gov/coverage/dialysis-services-supplies.

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 many preventive services.

If you haven't gotten services from your doctor or group practice in the last 3 years, they may consider you a new patient. Check with the doctor or group practice to find out if they're accepting new patients.

Costs

After you meet the Part B deductible, you pay 20% of the Medicare-approved amount for most services. You pay nothing for certain preventive services if your doctor or other health care provider accepts assignment.

Things to know

A doctor can be a Doctor of Medicine (MD), a Doctor of Osteopathic Medicine (DO), and in some cases, a dentist, podiatrist (foot doctor), optometrist (eye doctor), or chiropractor.

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

- Clinical nurse specialists
- Clinical psychologists
- Clinical social workers
- Marriage and family therapists
- Mental health counselors
- Nurse practitioners
- Occupational therapists
- Physician assistants
- Physical therapists
- Speech-language pathologists

More information

- Go to "Preventive & screening services" on page 92.
- Visit **Medicare.gov/coverage/doctor-other-health-care-provider-services**.

Drugs

Go to:

- “Chemotherapy” on page 21.
- “Insulin” on page 61.
- “Monoclonal antibodies for treating early Alzheimer’s disease” on page 75.
- “Opioid Use Disorder treatment services” on pages 78–79.
- “Osteoporosis drugs” on page 81.
- “Pre-exposure prophylaxis (PrEP) for HIV prevention” on pages 88–89.
- “Prescription drugs (outpatient)” on pages 89–91.
- “Vaccines” on pages 111–112.

Durable medical equipment (DME)

Part B covers medically necessary DME if your doctor or other health care provider orders it for use in your home. You must rent most items, but you can also buy some items. Some items become your property after you’ve made a certain number of rental payments. More expensive equipment, like wheelchairs and hospital beds, become yours after 13 months of rental payments.

Medicare-covered DME includes, but isn’t limited to:

- Canes
- Commode chairs
- Continuous Positive Airway Pressure (CPAP) therapy
- Crutches
- Glucose monitors and related supplies
- High frequency chest oscillation devices
- Hospital beds
- Infusion pumps and supplies
- Lymphedema powered compression devices
- Oxygen equipment and accessories (including oxygen humidifiers)
- Respiratory assist devices
- 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).

Things to know

It's important to ask a supplier if they participate in Medicare or will accept assignment of your claims before you get DME. If a supplier participates in Medicare, they must accept assignment (which means they can charge you only the Part B deductible and the coinsurance for the Medicare-approved amount).

A non-participating provider doesn't have to accept assignment, but may choose to do so in your case. If a DME supplier doesn't participate in Medicare or won't accept assignment, you may be charged more. For rented DME, make sure the supplier is willing to accept assignment for all rental months, otherwise you'll have to pay the full cost of your DME upfront. If this happens, Medicare will pay you later for the amount it covers after your claims have been submitted and processed by Medicare.

More information

- Visit **Medicare.gov/coverage/durable-medical-equipment-dme-coverage**.
- To find medical equipment and DME suppliers near you, visit **Medicare.gov/medical-equipment-suppliers**.

Electrocardiogram (EKG or ECG) screenings

EKG or ECG screenings help find problems with your heart. Part B covers a routine EKG or ECG screening if your doctor or other health care provider gives you a referral for this screening 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

- Go to:
  - "Diagnostic non-laboratory tests" on page 36.
  - "Preventive visits" on pages 93–95.
- Visit **Medicare.gov/coverage/electrocardiogram-ekg-or-ecg-screenings**.

Emergency department services

Part B usually covers services you get in a hospital emergency department 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 or other health care provider admits you to the same hospital for a related condition within 3 days of your emergency department visit, you don't pay the copayment(s) because Medicare considers your visit part of your inpatient stay.

Things to know

Medicare only covers emergency services outside the U.S. in rare situations.

More information

- Go to "Travel outside the U.S." on pages 110–111.
- Visit Medicare.gov/coverage/emergency-department-services.

Enteral & parenteral nutrition (nutrients, supplies & equipment)

Part B covers enteral and parenteral nutrition, nutrients, 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 for enteral and parenteral nutrition, nutrients, supplies, and equipment.
- Medicare will cover your enteral infusion pump from a doctor, other health care provider, or supplier who accepts assignment. 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) when you get the pump.

More information

- Visit Medicare.gov/coverage/enteral-parenteral-nutrition-nutrients-supplies-equipment.
- To find medical equipment and suppliers near you, visit Medicare.gov/medical-equipment-suppliers.

E-visits

E-visits are non-face-to-face communications you have with your doctor or other health care provider using an online patient portal (instead of going to their office). Medicare covers e-visits. To get an e-visit, you must ask your health care provider for one. Providers that can give these services include:

- Doctors
- Nurse practitioners
- Clinical nurse specialists
- Physician assistants
- Physical therapists
- Occupational therapists
- Speech-language pathologists

Medicare also covers e-visits with the following providers If you're getting mental health care services:

- Licensed clinical social workers
- Clinical psychologists
- Marriage and family therapists
- Mental health counselors

Costs

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

Things to know

E-visits, a type of telehealth, are different than virtual check-ins (brief, real-time communications that usually last 10 minutes or less).

More information

- Go to:
  - "Telehealth" on page 108.
  - "Virtual check-ins" on pages 112–113.
- Visit **Medicare.gov/coverage/e-visits**.

Eye exams

Medicare covers certain eye exams, including:

- Eye exams if you have diabetes: Go to the next page.
- Glaucoma screenings: Go to page 49.
- Macular degeneration tests and treatment: Go to page 67.

Eye exams (for diabetes)

Part B covers eye exams for diabetic retinopathy. You must get the exam from an eye doctor who's legally allowed to do the test in your state.

How often

Once a 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 also pay a copayment.

More information

- Go to "Diabetes services" and "Diabetes supplies" on page 35.
- Visit Medicare.gov/coverage/eye-exams-for-diabetes.

Eye exams (routine)

Eye exams check for overall eye health and look for signs of vision problems or disease. Medicare doesn't cover routine eye exams (sometimes called "eye refractions") for eyeglasses or contact lenses.

Costs

You pay all costs for non-covered services, including routine eye exams for eyeglasses or contact lenses.

More information

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

Eyeglasses & contact lenses

Medicare doesn't usually cover eyeglasses or contact lenses. However, Part B covers one pair of eyeglasses with standard frames (or one set of contact lenses) after each cataract surgery that implants an intraocular lens.

Costs

- You pay all costs 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 covered 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 that participates in Medicare, whether you or your provider submits the claim.

More information

- Go to "Cataract surgery" on page 20.
- Visit Medicare.gov/coverage/eyeglasses-contact-lenses.

Eyes

Go to "Artificial eyes & limbs" on page 12.

Fecal occult blood tests (screening)

Fecal occult blood screening tests can help find cancer in the colon or rectum early, when treatment is most effective. Part B covers these screening tests if you get a referral from your doctor, physician assistant, nurse practitioner, or clinical nurse specialist.

How often

If you're 45 or older, once every 12 months. If you're under 45, Medicare doesn't cover this test.

Costs

- You pay nothing for the test if your doctor or other health care provider accepts assignment.
- If you get a positive result after a fecal occult blood screening test, Medicare also covers a follow-up colonoscopy as a screening test.

More information

- Go to "Colorectal cancer screenings" on page 25.
- Visit Medicare.gov/coverage/fecal-occult-blood-tests.

Federally Qualified Health Center services

Federally Qualified Health Centers are public health centers that offer health care services to medically underserved people and others who don't have adequate access to health care. Part B covers a broad range of outpatient primary care and preventive services you can get in Federally Qualified Health Centers.

Costs

You usually pay 20% of the cost of any services you get at a Federally Qualified Health Center. You pay nothing for most preventive services. The Part B deductible doesn't apply. Federally Qualified Health Centers offer lower fees if you have limited income.

More information

- Visit Medicare.gov/coverage/federally-qualified-health-center-services.
- To find a Federally Qualified Health Center near you, visit findahealthcenter.hrsa.gov.

Feeding pumps

Go to "Enteral & parenteral nutrition (nutrients, supplies & equipment)" on page 43.

Flexible sigmoidoscopy (screening)

A flexible sigmoidoscopy is an endoscopic procedure that helps find cancer in the colon or rectum early, when treatment is most effective. Part B covers flexible sigmoidoscopy screenings.

How often

For most people 45 or older, 48 months after a previous flexible sigmoidoscopy or computed tomography (CT) colonography. If you aren't at high risk for colorectal cancer but have had a screening colonoscopy, 120 months after the previous screening colonoscopy.

Costs

- You pay nothing for the test if your doctor or other health care provider accepts assignment.
- If your health care provider finds and removes a lesion or growth during your flexible sigmoidoscopy screening, you'll pay 15% of the Medicare-approved amount for your doctor's services. In a hospital outpatient setting or ambulatory surgical center, you also pay the facility a 15% coinsurance. In these cases, the Part B deductible doesn't apply.

More information

- Go to "Colorectal cancer screenings" on page 25.
- Visit Medicare.gov/coverage/flexible-sigmoidoscopies.

Flu vaccine

Flu vaccines can keep you from getting sick with seasonal influenza (flu) viruses during the fall and winter. Part B covers the seasonal flu vaccine.

How often

Usually one vaccine each flu season.

Costs

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

More information

Visit Medicare.gov/coverage/flu-shots.

Foot care (other)

Foot care can help prevent or treat conditions of the foot and ankle. Part B covers podiatrist (foot doctor) foot exams or treatment if you 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 or other health care provider.
- In a hospital outpatient setting, you also pay a copayment for **medically necessary** treatment.
- In most cases, you pay all costs for non-covered services, including **routine** foot care. If (in very limited circumstances) Medicare covers your routine foot care, you pay 20% of the Medicare-approved amount after you meet the Part B deductible.

More information

- If you have diabetes, go to "Therapeutic shoes or inserts" on page 109 and "Foot care (for diabetes)" below.
- Visit Medicare.gov/coverage/foot-care-other.

Foot care (for diabetes)

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

How often

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

Costs

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

More information

- Go to "Therapeutic shoes or inserts" on page 109.
- Visit Medicare.gov/coverage/foot-care-for-diabetes.

Glaucoma screenings

Glaucoma screenings painlessly check your vision and optic nerve health to look for signs of the eye disease glaucoma. Part B covers this screening if you're at high risk for developing 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 50 or older.
- You're Hispanic and 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-screenings.

Gym memberships & fitness programs

Original Medicare doesn't cover gym memberships or fitness programs.

Costs

You pay all costs for non-covered services, including gym memberships and fitness programs.

More information

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

Health education & wellness programs

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

- Alcohol misuse screenings and counseling: Go to page 10.
- Caregiver training services: Go to pages 18–19.
- Counseling to prevent tobacco use and tobacco-caused disease: Go to page 28.
- Depression screenings: Go to page 33.
- Diabetes self-management training: Go to page 34.
- Kidney disease education: Go to page 62.
- Medical nutrition therapy services, if you meet certain conditions: Go to page 68.
- Medicare Diabetes Prevention Program: Go to page 69.
- Obesity behavioral therapy: Go to page 77.
- A "Welcome to Medicare" preventive visit: Go to page 93.
- Yearly "Wellness" visits: Go to pages 94–95.

Hearing & balance exams

These exams evaluate your hearing and balance to diagnose or manage various conditions. Part B covers diagnostic hearing and balance (fall risk) exams if your doctor or other health care provider orders them to find out if you need medical treatment.

You can also visit an audiologist once every 12 months without an order from your health care provider, but only for:

- Non-acute hearing conditions (like hearing loss that happens over many years).
- Diagnostic services related to hearing loss treated with surgically implanted hearing devices.

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.

Hearing aids

Hearing aids are electronic devices that help people with hearing loss hear better. Medicare doesn't cover hearing aids or exams for fitting hearing aids.

Costs

You pay all costs for non-covered services, including hearing aids and exams.

More information

Visit Medicare.gov/coverage/hearing-aids.

Hepatitis B vaccines

Hepatitis B vaccines help protect against the hepatitis B virus (HBV). Part B covers these vaccines if you meet at least **one** of these conditions:

- You've never gotten a complete series of hepatitis B vaccines.
- You don't know your vaccination history.
- You have a health condition or situation that puts you at medium or high risk for hepatitis B (like diabetes, End-Stage Renal Disease or ESRD, or living with someone who has hepatitis B).

Costs

You pay nothing if your health care provider accepts assignment for giving the vaccine.

More information

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

Hepatitis B virus (HBV) infection screenings

These screenings help to find out if you're infected with HBV. Medicare covers an HBV screening test if your doctor or other health care provider 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 vaccine.
- If you're pregnant, at the following times, even if you previously got the hepatitis B vaccine or had negative HBV screening results:
  - First prenatal visit
  - Time of delivery if you have new or continued risk factors

Costs

You pay nothing if your health care provider accepts assignment.

More information

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

Hepatitis C virus screenings

These screenings help to find out if you're infected with the hepatitis C virus. Medicare covers a hepatitis C screening if your primary care doctor or other health care provider orders one, and you meet at least one of these conditions:

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

How often

- Once a year, if you're at high risk because you've continued to use illicit injection drugs since your previous negative hepatitis C screening test.
- Once in your lifetime, if you're at high risk because:
  - You had a blood transfusion before 1992.
  - You used illicit injection drugs in the past.
- Once in your lifetime, if you were born between 1945–1965 and aren't considered high risk.

Costs

You pay nothing if your health care provider accepts assignment.

More information

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

High frequency chest oscillation devices

Go to "Durable medical equipment (DME)" on pages 41–42.

Home health services

Home health includes a wide range of health care services that you can get in your home for an illness or injury to help you get better, maintain your current condition or level of function, or slow your rate of decline. Home health care is usually less expensive and more convenient than care you get in a hospital or skilled nursing facility (SNF). Depending on your needs, it can also be just as effective.

Part A and/or Part B cover eligible home health services as long as you need part-time or intermittent skilled services and you're "homebound," which means you must meet both of these conditions:

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

Covered home health services include:

- Medically necessary part-time or intermittent skilled nursing care, like:
  - Wound care for pressure sores or a surgical wound
  - Patient and caregiver education
  - Intravenous or nutrition therapy
  - Injections
  - Monitoring serious illness and unstable health status
- Physical therapy, occupational therapy, and speech-language pathology services (if you meet certain conditions)
- Medical social services
- Part-time or intermittent home health aide care (only if you're also getting skilled nursing care, physical therapy, speech-language pathology services, or occupational therapy at the same time), like:
  - Help with walking
  - Bathing or grooming
  - Changing bed linens
  - Feeding
- Injectable osteoporosis drugs for women who meet certain criteria
- Durable medical equipment
- Medical supplies for use at home

Medicare **doesn't** pay for:

- 24-hour-a-day care at your home
- Home meal delivery
- Homemaker services (like shopping and cleaning) unrelated to your care plan
- Custodial or personal care that helps you with daily living activities (like bathing, dressing, or using the bathroom) when this is the only care you need

You won't qualify for the home health benefit if you need more than part-time or intermittent skilled care. You may leave home for medical treatment or short, infrequent absences for non-medical reasons, like attending religious services. You can still get home health care if you attend adult day care.

How often

- If you qualify, you can get unlimited home health visits.
- In most cases, "part-time or intermittent" means you may be able to get skilled nursing care and home health aide services up to 8 hours a day (combined), for a maximum of 28 hours a week.
- You may be able to get more frequent care for a short time (less than 8 hours a day and up to 35 hours a week) if your doctor or other health care provider determines it's necessary.

Costs

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

Before you start getting your home health care, the home health agency should tell you how much Medicare will pay. The agency should also tell you (both verbally and in writing) if Medicare won't pay for any items or services they give you, and how much you'll have to pay for them. The home health agency must give you a notice called the "Advance Beneficiary Notice" (ABN) before giving you services and supplies that Medicare doesn't cover.

Things to know

- A health care provider (like a nurse practitioner) must assess you face-to-face before certifying that you need home health services. A health care provider must order your care, and a Medicare-certified home health agency must provide it.
- If your provider decides you need home health care, they should give you a list of agencies that serve your area. Your provider must tell you if their organization has a financial interest in any agency listed. You can also visit **Medicare.gov/care-compare** to find home health agencies near you.
- Once your provider refers you for home health services, the home health agency will schedule an appointment to talk to you about your needs and health.

More information

Visit **Medicare.gov/coverage/home-health-services**.

Home infusion therapy services, equipment, & supplies

Infusion therapy delivers medicine or other treatment intravenously (through your veins) or subcutaneously (under your skin). Home infusion therapy allows you to get these services at your home instead of a hospital or clinic. Part B covers home infusion equipment and supplies as durable medical equipment (DME).

Part B also covers home infusion therapy services needed to safely administer certain intravenous or subcutaneous drugs in your home, like nursing visits, caregiver training, and patient monitoring.

Costs

In most cases, 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.

Things to know

Home infusion equipment and supplies include pumps, IV poles, tubing, and catheters for infusion therapy to administer certain infusion drugs at home.

More information

- Go to:
  - "Caregiver training services" on pages 18–19.
  - "Durable medical equipment (DME)" on pages 41–42.
- Visit **Medicare.gov/coverage/home-infusion-therapy-services-equipment-supplies**.
- To find medical equipment and suppliers near you, visit **Medicare.gov/medical-equipment-suppliers**.

Hospice care

Hospice is end-of-life care for people with illnesses that can't be cured. You can usually get Medicare-approved hospice care in your home or other facility where you live, like an assisted living facility or a nursing home. If you meet certain conditions, you can also get hospice care in an inpatient hospice facility. You qualify for hospice care if you have Part A and meet all 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 terminal illness and related conditions.
- You sign a statement choosing hospice care instead of other Medicare-covered treatments for your terminal illness and related conditions.

If you qualify, you can get hospice care for two 90-day benefit periods, followed by an unlimited number of 60-day benefit periods. You have the right to change your hospice provider once during each benefit period.

Costs

- You pay nothing for hospice care if you get your care from a Medicare-approved hospice provider.
- 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 find out if Part D covers it. The hospice provider must inform you if any drugs or services aren't covered and why, and if you'll be required to pay for them.
- You may pay 5% of the Medicare-approved amount for inpatient respite care (short-term care to help give your caregivers a rest). Your copayment can't be more than the inpatient deductible amount ($1,736 in 2026).

- Original Medicare will still pay for covered benefits for any health problems that aren't part of your terminal illness and related conditions, but you'll owe any deductible and coinsurance amounts that apply. Once you choose hospice care, your hospice benefit will usually cover everything you need.
- 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.
- If your hospice care team determines you need inpatient care at a hospital, they must make the arrangements for your stay. If they don't, you might be responsible for the entire cost of your hospital care.

Things to know

Only your hospice doctor and your regular doctor (if you have one) can certify that you're terminally ill and have a life expectancy of 6 months or less. After 6 months, you can continue to get hospice care as long as the hospice medical director or hospice doctor recertifies (after a face-to-face meeting with the hospice doctor or hospice nurse practitioner) that you're still terminally ill.

When you decide to get hospice care, the hospice will have you read and sign a "Hospice Election Statement." This document identifies the hospice providing your care and informs you of important information about hospice services, including the start date of the services and who you decide to be your attending doctor. This document must be completed before you get any hospice services.

You can ask for an addendum to the "Hospice Election Statement" that lists any items, services, and drugs your hospice won't cover because they're unrelated to your terminal illness. If your coverage changes, your hospice provider will give you an updated addendum so you can make treatment decisions that best meet your needs.

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 and symptom 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.

More information

- Go to "Caregiver training services" on page 18–19.
- Visit Medicare.gov/coverage/hospice-care.

Hospital beds

Go to "Durable medical equipment (DME)" on pages 41–42.

Human immunodeficiency virus (HIV) screenings

HIV screenings check to find out if you've been infected with HIV. Part B covers an HIV screening if you meet one of these conditions:

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

How often

Once a 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 if your doctor or other health care provider accepts assignment.

More information

- Go to "Pre-exposure prophylaxis (PrEP) for HIV prevention" on pages 88–89.
- Visit Medicare.gov/coverage/hiv-human-immunodeficiency-virus-screenings.

Human Papillomavirus (HPV) tests

Go to "Cervical & vaginal cancer screenings" on page 20.

Hyperbaric oxygen therapy

Hyperbaric oxygen therapy exposes your entire body to oxygen under increased atmospheric pressure. Medicare may cover this therapy if you have certain conditions, and you get it in a chamber (including a one-person unit).

Costs

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

More information

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

Infusion pumps & supplies

Infusion pumps are medical devices that help deliver medications into your body in a controlled manner, over an extended period. When you meet certain requirements, Part B covers certain infusion pumps worn outside the body (external) and certain infusion pumps placed surgically (implantable).

Some examples of Part B-covered infusion pumps and supplies are:

- External pump to treat iron poisoning with deferoxamine or for cancer pain management with morphine
- Implantable pump to treat certain liver cancers with chemotherapy

Costs

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

More information

Go to "Durable medical equipment (DME)" on pages 41–42.

Inpatient hospital care

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

- You're admitted to the hospital as an inpatient with a doctor's order, which says you need inpatient hospital care to treat your illness or injury.
- The hospital accepts Medicare.

Medicare-covered inpatient hospital services include:

- Semi-private rooms
- Meals
- General nursing
- Certain drugs (including methadone to treat an Opioid Use Disorder)
- Other hospital services and supplies you might get as part of your inpatient treatment

Medicare **doesn't** cover these items and services:

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

Costs

What you pay for each benefit period in 2026 depends on how long you're getting care:

- **Days 1–60:** After you pay the $1,736 deductible, you pay $0 each day.
- **Days 61–90:** You pay $434 each day.
- **Days 91–150:** You pay $868 each day while using your 60 lifetime reserve days. These are additional days that Medicare will pay for when you're in a hospital for more than 90 days. You have a total of 60 reserve days that can be used once during your lifetime.
- **After Day 150:** You pay all costs.

Part A only pays for up to 190 days of inpatient mental health care in a freestanding psychiatric hospital during your lifetime. The 190-day limit doesn't apply to care you get in a Medicare-certified "distinct part" psychiatric unit (a physically separate section of an acute care or critical access hospital that provides inpatient psychiatric care).

If you also have Part B, it generally covers 80% of the Medicare-approved amount for doctors' services you get while you're in a hospital.

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.

Note: Hospitals must now share the standard charges for all their items and services (including the standard charges that Medicare Advantage Plans negotiate) on a public website to help you make more informed decisions about your care.

More information

- Go to:
  - "Inpatient rehabilitation care" below.
  - "Mental health & substance use disorder services" on page 70.
  - "Organ transplants" on pages 79–80.
  - "Outpatient hospital services" on pages 82–83.
  - "What do I pay for Part-A covered services?" on pages 3–4 to learn more about benefit periods.
- Visit **Medicare.gov/coverage/inpatient-hospital-care.**

Inpatient rehabilitation care

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 other health care providers (including therapists).

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 or other health care provider must certify that you have a medical condition requiring intensive rehabilitation, continued medical supervision, and coordinated care from your providers.

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

Costs

What you pay for each benefit period in 2026 depends on how long you're getting care:

- **Days 1-60:** After you pay the $1,736 deductible, you pay $0 each day.
- **Days 61-90:** You pay $434 each day.
- **Days 91-150:** You pay $868 each day while using your 60 lifetime reserve days. These are additional days that Medicare will pay for when you're in a hospital for more than 90 days. You have a total of 60 reserve days that can be used once during your lifetime.
- **After Day 150:** You pay all costs.

Note: You don't pay a deductible for inpatient rehabilitation care if Medicare already charged you 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 toward 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.

Things to know

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 these items and services:

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

More information

- Go to "What do I pay for Part-A covered services?" on pages 3–4 to learn more about benefit periods.
- Visit Medicare.gov/coverage/inpatient-rehabilitation-care.

Insulin

Insulin is a natural hormone that helps maintain healthy blood sugar levels. If you use an insulin pump covered under Part B's Durable Medical Equipment (DME) benefit, Part B covers insulin used with the pump and the pump itself. Part B doesn't cover insulin that's self-administered using pens, disposable insulin pumps (also known as patch pumps) or the insulin used with them, or insulin-related supplies (like syringes, needles, alcohol swabs, or gauze).

If you have a Part D plan, it may cover:

- Injectable insulin (insulin you inject with a pen or a needle)
- Insulin you use with pumps that **aren't** DME, like:
  - Pumps that are typically changed after 2-3 days (like patch pumps)
  - Reusable pumps that use disposable insulin cartridges
- Insulin that's inhaled
- Certain medical supplies used for insulin injections, like syringes, needles, gauze, and alcohol swabs

Costs

- The cost of a one-month supply of each Part D- and Part B-covered insulin product is no more than $35, and you don't have to pay a deductible for insulin. If you get a three-month supply of insulin, your costs can't be more than $35 for each month's supply of each covered insulin product. This means you'll generally pay no more than $105 for a three-month supply of covered insulin.
- Under Part D, the $35 limit applies to everyone who takes insulin, even if you get Extra Help (a Medicare program that helps people with limited income and resources pay Part D costs).
- If your Part D plan covers disposable insulin patch pumps, the insulin for your pump won't cost more than $35 for a one-month supply of Part D-covered insulin. However, the pump itself might cost more than $35.
- If you have Part B and Medicare Supplement Insurance (Medigap) that pays your Part B coinsurance, your Medigap policy should cover the cost ($35 or less) for insulin.

More information

- Go to:
  - "Diabetes services" and "Diabetes supplies" on page 35.
  - "Durable medical equipment (DME)" on pages 41–42.
- Visit Medicare.gov/coverage/insulin.
- To learn more about Medicare's Extra Help program, visit Medicare.gov/basics/costs/help/drug-costs.

Intensive outpatient program services

Go to "Mental health care (outpatient): Intensive outpatient program services" on pages 73–74.

Kidney disease education

Kidney disease education teaches you how to take the best possible care of your kidneys and helps you make informed decisions about your care. Medicare covers up to 6 sessions of kidney disease education services if you have stage 4 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 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 each session if you get the service from a health care provider.

More information

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

Kidney services & supplies

Go to "Dialysis services & supplies" on pages 38–39.

Kidney transplants

A kidney transplant is a surgical procedure that places a healthy kidney from a donor into a person whose kidneys have failed. Part A and Part B cover different items and services related to kidney transplants. Medicare covers these services if you get them from 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). You and your donor won't have to pay a deductible, coinsurance, or any other costs for the donor's hospital stay.

Part B covers transplant services and pays part of the costs for blood, and doctors' services for:

- Kidney transplant surgery (including care before surgery, the actual surgery, and care after surgery)
- Your kidney donor during their hospital stay

If Medicare helped pay for your transplant, Part B also covers transplant drug therapy (including standard and compounded immunosuppressive drugs) to prevent organ rejection.

Costs

For the transplant and related services, you pay:

- 20% of the Medicare-approved amount for Part B services, after you meet the Part B deductible.
- Nothing for the services provided to the donor for a kidney transplant.
- Nothing for Medicare-approved laboratory tests.

For Part A inpatient hospital cost information, go to pages 58–59.

Things to know

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

More information

- Go to:
  - "Kidney disease education" on page 62.
  - "Kidney transplants (children)" below.
  - "Organ transplants" on pages 79–80.
  - "Prescription drugs (outpatient)" on pages 89–91 for more on immunosuppressive drugs.
- Visit Medicare.gov/coverage/kidney-transplants.

Kidney transplants (children)

A kidney transplant is a surgical procedure that places a healthy kidney from a donor into a child whose kidneys have failed. 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 covers these transplant services:

- Doctors' services for kidney transplant surgery
- Doctors' services for the kidney donor during their hospital stay
- Blood (if a transfusion is needed)

If Medicare helped pay for your child's transplant, Part B also covers transplant drug therapy (including standard and compounded immunosuppressive drugs) to prevent organ rejection.

Costs

- After you pay the Part B deductible, you pay 20% of the Medicare-approved amount for Part B services.
- If your child has other insurance, your costs may be different.
- For Part A inpatient hospital cost information, go to pages 58–59.

More information

- Go to:
  - "Dialysis (children)" on page 37.
  - "Prescription drugs (outpatient)" on pages 89–91 for more on immunosuppressive drugs.
- Visit Medicare.gov/coverage/kidney-transplants-children.

Laboratory tests

- Diagnostic laboratory tests: Go to page 36.
- Diagnostic non-laboratory tests: Go to page 36.

Long-term care

Long-term care (also called "custodial care" or "long-term services and support") includes medical and non-medical care for people who have a chronic illness or disability. Most long-term care helps with basic personal tasks of everyday life, sometimes called "activities of daily living." This includes things like dressing, bathing, and using the bathroom. Long-term care may also include home-delivered meals, adult day health care, transportation, and other services.

Long-term care is different from skilled nursing facility care. Since most long-term care is non-medical, **Medicare and most health insurance, including Medicare Supplement Insurance (Medigap), don't pay for long-term care**.

Costs

You pay all costs for non-covered services, including most long-term care.

Things to know

- You may qualify for long-term care through Medicaid (if you meet eligibility requirements in your state), or you can choose to buy private long-term care insurance.
- You can get long-term care at home, in the community, in an assisted living facility, or in a nursing home. It's important to start planning for long-term care now so you can maintain your independence and make sure you get the care you may need, in the setting you want, now and in the future.

More information

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

Long-term care hospital services

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

Costs

What you pay for each benefit period in 2026 depends on how long you're getting care:

- **Days 1-60:** After you pay the $1,736 deductible, you pay $0 each day.
- **Days 61-90:** You pay $434 each day.
- **Days 91-150:** You pay $868 each day while using your 60 lifetime reserve days. These are additional days that Medicare will pay for when you're in a hospital for more than 90 days. You have a total of 60 reserve days that can be used once during your lifetime.
- **After Day 150:** You pay all costs.

Note: You don't have to pay the Part 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 hospital care if:

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

More information

- Go to "What do I pay for Part-A covered services?" on pages 3–4 to learn more about benefit periods.
- Visit Medicare.gov/coverage/long-term-care-hospital-services.

Lung cancer screenings

These screenings check for early signs of lung cancer in adults who are at risk of getting the disease. Part B covers lung cancer screenings with low dose computed tomography (also known as "CT scans") if you meet all these conditions:

- You're between 50–77.
- You don't have signs or symptoms of lung cancer (you're asymptomatic).
- You're either a current smoker, or you quit smoking within the last 15 years.
- You have a tobacco smoking history of at least 20 "pack years" (an average of one pack (20 cigarettes) per day for 20 years).
- You get an order from your doctor or other health care provider.

How often

Once a year.

Costs

You pay nothing if your health care provider accepts assignment.

Things to know

Before your first lung cancer screening, you'll need to schedule an appointment with your provider to discuss the benefits and risks and decide if a screening is right for you.

More information

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

Lymphedema powered compression devices

Go to "Durable medical equipment (DME)" on pages 41–42.

Lymphedema compression treatment items

Lymphedema compression treatment items help control and reduce swelling caused by lymphedema (a chronic condition that causes swelling in the body's tissues). If you've been diagnosed with lymphedema, Part B may cover your gradient compression garments (standard and custom-fitted) and gradient compression wraps with adjustable straps and compression bandaging supplies. Your doctor or other health care provider must order the items.

Costs

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

More information

Visit Medicare.gov/coverage/lymphedema-compression-treatment-items.

Macular degeneration tests & treatment

Macular degeneration is an eye disease that can blur or reduce your central vision. Part B may cover certain diagnostic tests and treatments (including treatment with certain injectable drugs) if you have age-related macular degeneration.

Costs

- In most cases, 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.

Mammograms

Mammograms are x-ray pictures of the breast that check for breast cancer. There are different types of mammograms. A baseline mammogram (usually your first mammogram) creates a record of your breast tissue that's compared to all future mammograms. A screening mammogram monitors your breast health every year. Diagnostic mammograms investigate abnormalities, including symptoms or signs of breast cancer. Part B covers:

- A baseline mammogram if you're a woman between 35–39
- Screening mammograms if you're a woman 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

- **Baseline and screening mammograms:** You pay nothing if your doctor or other health care provider accepts assignment.
- **Diagnostic mammograms:** After you meet the Part B deductible, you pay 20% of the Medicare-approved amount.

Things to know

Your health care provider may order a breast ultrasound after a mammogram to check specific areas of your breast. Medicare only covers medically necessary breast ultrasounds when your provider orders them.

More information

Visit Medicare.gov/coverage/mammograms.

Medical nutrition therapy services

Part B covers medical nutrition therapy services if you have diabetes or kidney disease, or if you've had a kidney transplant in the last 36 months. A doctor must refer you for the services.

The services you get 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

How often

- Initial coverage includes 3 hours of medical nutrition therapy services in the first calendar year. These hours can't be carried over to the next calendar year.
- If your doctor decides a change in your medical condition requires a change in your diet, they can give you a referral for more hours beyond the initial coverage. You may get up to 2 hours of follow-up services each calendar year, after the year you got your initial coverage.

Costs

You pay nothing if you qualify to get these services.

Things to know

- Only a registered dietitian or nutrition professional who meets certain requirements can provide medical nutrition therapy services.
- If you get dialysis in a dialysis facility, Medicare covers medical nutrition therapy services as part of your overall dialysis care.
- If you have diabetes, you may also qualify to get diabetes self-management training, which offers similar services to the ones you can get through medical nutrition therapy. You must meet certain requirements to get both diabetes self-management training and medical nutrition therapy services.

More information

- Go to:
  - "Diabetes self-management training" on page 34.
  - "Telehealth" on page 108.
- Visit Medicare.gov/coverage/medical-nutrition-therapy-services.

Medicare Diabetes Prevention Program

The Medicare Diabetes Prevention Program is a health behavior change program to help you prevent type 2 diabetes. The program begins with 16 weekly core sessions offered in a group setting over a six-month period. In these sessions, you'll get:

- Training to make realistic, lasting behavior changes around diet and exercise
- Tips for getting more exercise
- Strategies to control 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.

Part B covers the Medicare Diabetes Prevention Program if you're at risk for developing type 2 diabetes and meet all these requirements:

- 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 between 110-125 mg/dL, or a 2-hour plasma glucose between 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).

How often

There's no limit to the number of times you can participate.

Costs

You pay nothing if you qualify for this program.

Things to know

- Through December 31, 2029, you can participate in person or virtually through distance learning (you attend live sessions online), or a combination of both. You can also participate online at any time (non-live sessions). You can get these services from an approved Medicare Diabetes Prevention Program supplier. These suppliers may be traditional health care providers or organizations like community centers or faith-based organizations.
- If you're in a Medicare Advantage Plan, you may have to go to an in-network provider to participate in this program. Contact your plan for more information.

More information

Visit Medicare.gov/coverage/medicare-diabetes-prevention-program.

Mental health & substance use disorder services

Medicare covers certain screenings, services, and programs that help diagnose or treat mental health, behavioral health, and substance use disorders:

- Alcohol misuse screening and counseling: Go to page 10.
- Behavioral health integration services: Go to page 13.
- Counseling to prevent tobacco use and tobacco-caused disease: Go to page 28.
- Depression screenings: Go to page 33.
- Mental health care (inpatient): Go to the section below.
- Mental health care (outpatient): Go to pages 71–73.
- Mental health care (outpatient): Intensive outpatient program services. Go to pages 73–74.
- Mental health care (outpatient): Partial hospitalization. Go to pages 74–75.
- Opioid Use Disorder treatment services: Go to pages 78–79.
- Telehealth for mental health care: Go to page 108.

Mental health care (inpatient)

Mental health care services involve diagnosing and treating people with mental health disorders, like depression and anxiety. Part A covers mental health care services you get when you're admitted as a hospital inpatient. Part B covers the services you get from a doctor or other health care provider while you're in the hospital.

Costs

What you pay for each benefit period in 2026 depends on how long you're getting care:

- **Days 1–60:** After you pay the $1,736 deductible, you pay $0 each day.
- **Days 61–90:** You pay $434 each day.
- **Days 91–150:** You pay $868 each day while using your 60 lifetime reserve days. These are additional days that Medicare will pay for when you're in a hospital for more than 90 days. You have a total of 60 reserve days that can be used once during your lifetime.
- **After Day 150:** You pay all costs.
- You also pay 20% of the Medicare-approved amount for mental health services you get from health care providers while you're a hospital inpatient.

Things to know

You can get these inpatient 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 these items and services:

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

More information

- Go to:
  - "Inpatient hospital care" on pages 58–59.
  - "Mental health care (outpatient)" below.
  - "What do I pay for Part-A covered services?" on pages 3–4 to learn more about benefit periods.
- Visit Medicare.gov/coverage/mental-health-care-inpatient.

Mental health care (outpatient)

Outpatient mental health services involve diagnosing and treating people with mental health conditions, like depression and anxiety. These visits are often called counseling or psychotherapy, and can be done individually, in group psychotherapy or family settings, and in crisis situations. They're services you usually get outside of a hospital, in settings like:

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

Part B covers a wide range of outpatient mental health services, including:

- Partial hospitalization.
- Intensive outpatient program services.
- One depression screening each year. You must get the screening in a primary care doctor's office or primary care clinic that can provide follow-up treatment and referrals.

- A one-time "Welcome to Medicare" preventive visit. This visit includes a review of your possible risk factors for depression.
- Individual and group psychotherapy with doctors (or with certain other Medicare-enrolled 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.
- Diagnostic tests.
- Safety planning interventions if you're at risk of suicide or overdose.
- A follow-up phone call after you're discharged from the emergency department for a behavioral health service or other crisis.
- Certain FDA-cleared or -authorized digital mental health treatment devices (including devices that treat Attention Deficit/Hyperactivity Disorder) if you get them from your doctor or certain other qualified mental health providers and you meet other conditions.
- Psychiatric evaluation.
- Certain prescription drugs that aren't usually "self-administered" (drugs you would normally take on your own), like some injections.
- Medication management.
- Medications used for substance use disorder.
- Mental health services you get as part of substance use disorder treatment.
- A yearly "Wellness" visit. Talk to your doctor or other health care provider about changes in your mental health since your last visit.

Costs

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

Things to know

Part B covers mental health services and visits with these types of providers:

- Psychiatrists or other doctors
- Clinical psychologists
- Clinical social workers
- Clinical nurse specialists
- Nurse practitioners
- Physician assistants
- Marriage and family therapists
- Mental health counselors

More information

- Go to:
  - "Depression screenings" on page 33.
  - "Mental health care (outpatient): Intensive outpatient program services" below.
  - "Mental health care (outpatient): Partial hospitalization" on pages 74–75.
  - "Mental health & substance use disorder services" on page 70.
  - "Outpatient hospital services" on pages 82–83.
  - "Preventive visits" on pages 93–95.
- Visit **Medicare.gov/coverage/mental-health-care-outpatient**.

Mental health care (outpatient): Intensive outpatient program services

Intensive outpatient programs offer a level of care for mental health conditions (including substance use disorders) between traditional once-weekly therapy or counseling, and inpatient or partial hospitalization psychiatric care. The services are more intensive than care you'd get in a doctor's or therapist's office and may include things like group and individual therapy sessions, mental health education, and medication management. You may benefit from intensive outpatient program services if your care plan states you require at least 9 hours of therapeutic services each week.

You can get these services in hospitals, community mental health centers, Federally Qualified Heath Centers, or Rural Health Clinics. Part B also covers these services at Opioid Treatment Programs (when you're getting treatment for Opioid Use Disorder).

Costs

- You pay a percentage of the Medicare-approved amount for each service you get from a qualified mental health professional if they accept assignment.
- If you're getting treatment for Opioid Use Disorder, you usually won't have to pay any copayments for these services if you get them from an Opioid Treatment Program provider that participates in Medicare and meets other requirements. If you have a Medicare Advantage Plan, check with your plan to find out if you have to pay a copayment.
- After you meet the Part B deductible, you also pay coinsurance for each day of intensive outpatient program services you get in a hospital outpatient setting or community mental health center.

Things to know

You don't need to qualify for inpatient treatment to get intensive outpatient program services.

More information

- Go to:
  - "Mental health care (inpatient)" on pages 70–71.
  - "Mental health (outpatient)" on pages 71–73.
- Visit Medicare.gov/coverage/mental-health-care-intensive-outpatient-program-services.

Mental health care (outpatient): Partial hospitalization

Partial hospitalization is a structured program that provides outpatient psychiatric services as an alternative to inpatient psychiatric care. The services are more intensive than care you get in a doctor's or therapist's office, and usually include between 4-8 hours of care each day. You may benefit from partial hospitalization if your care plan states that you require at least 20 hours of therapeutic services each week.

Part B may cover partial hospitalization services you get through a hospital outpatient setting or community mental health center if you meet certain requirements and your doctor or other qualified mental health professional 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 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.

Things to know

As part of your partial hospitalization program, Medicare may cover:

- Occupational therapy that's part of your mental health treatment
- Individual patient training and education about your condition
- Caregiver training services
- Principal illness navigation services

Medicare only covers partial hospitalization if the doctor (or other qualified mental health professional) 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

- Go to:
  - "Caregiver training services" on pages 18–19.
  - "Mental health care (inpatient)" on pages 70–71.
  - "Mental health (outpatient)" on pages 71–73.
  - "Principal illness navigation services" on pages 95–96.
- Visit **Medicare.gov/coverage/mental-health-care-partial-hospitalization**.

Monoclonal antibodies for treating early Alzheimer's disease

Part B may cover FDA-approved monoclonal antibodies (like Leqembi, generic name lecanemab, or Kisunla, generic name donanemab) that target beta-amyloid plaques for treating Alzheimer's disease if you meet certain criteria. Your doctor or other health care provider must confirm you have beta-amyloid plaques consistent with Alzheimer's disease, and they must diagnose you with one of the following:

- Mild cognitive impairment due to Alzheimer's disease
- Mild dementia due to Alzheimer's disease

Medicare coverage also requires your health care provider to collect evidence about how well the monoclonal antibodies work for a qualifying study or registry. The information your provider collects will help answer treatment questions and describe how well the monoclonal antibodies works for you. Talk to your provider to find out if monoclonal antibodies for treating early Alzheimer's disease are right for you.

Costs

- After you meet the Part B deductible, you pay 20% of the Medicare-approved amount for Part B-covered monoclonal antibodies.
- You may need scans and tests before or during treatment that might add to your costs. Talk to your provider for more information.

Things to know

- Monoclonal antibodies may slow or delay symptoms of Alzheimer's disease, but they don't cure or reverse the disease.
- If you don't meet the Part B coverage criteria for an FDA-approved monoclonal antibody for treating early Alzheimer's disease, your Part D plan might cover it. Contact your plan for more information.

More information

- Go to "Cognitive assessment & care plan services" on pages 23–24.
- Visit **Medicare.gov/coverage/monoclonal-antibodies-for-the-treatment-of-early-alzheimers-disease**.

Multi-target stool DNA tests (screening)

Multi-target stool DNA screening tests check for genetic changes in a sample of your stool to look for signs of cancer in the colon or rectum. Part B covers these at-home screening tests if you meet all these conditions:

- You're between 45–85.
- You show no symptoms of colorectal disease including, but not limited to, lower gastrointestinal pain, blood in stool, or a 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.

Costs

- You pay nothing for the test if your doctor or other health care provider accepts assignment.
- If you get a positive result after a multi-target stool DNA screening test, Medicare also covers a follow-up colonoscopy as a screening test.

More information

- Go to "Colorectal cancer screenings" on page 25.

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

MRIs

Go to "Diagnostic non-laboratory tests" on page 36.

Nursing home care

Nursing homes are facilities for people who usually need 24-hour care. Nursing homes can provide:

- Short-term care for people who need rehabilitation after surgery (like physical therapy after a hip or knee replacement) or skilled nursing to recover from an illness (like pneumonia)
- Long-term care (also called "custodial care" or "long-term services and support") for people who need help with activities of daily living, like bathing, dressing, or eating. Medicare generally **doesn't** cover long-term nursing home stays, unless you're receiving skilled nursing care.

Part A may cover short-term nursing home or rehab care (up to 100 days) in a Medicare-certified nursing home after hospitalization. It must be medically necessary for you to get skilled nursing care (like if you need help changing sterile dressings).

Part B covers doctor visits and physical, speech, or occupational therapy, even if you get these services while in a nursing home.

More information

- Go to:
  - "Home health services" on pages 52–54.
  - "Long-term care" on pages 64–65.
  - "Skilled nursing facility (SNF) care" on pages 103–105.
- Visit Medicare.gov/coverage/nursing-home-care.

Obesity behavioral therapy

Obesity behavioral therapy includes an initial screening for body mass index (BMI) and behavioral therapy sessions that include a dietary assessment and counseling to help you lose weight by focusing on diet and exercise.

Part B covers obesity screenings and behavioral counseling if:

- You have a BMI of 30 or more.
- You get the counseling from your primary care doctor or other primary care provider in a primary care setting (like a doctor's office), where they can coordinate your personalized plan with your other care.

You must meet certain weight loss requirements for Medicare to continue to cover this counseling.

Costs

You pay nothing if your primary care practitioner accepts assignment.

More information

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

Observation services

Go to "Outpatient hospital services" on pages 82–83.

Occupational therapy services

Occupational therapy helps you perform activities of daily living (like dressing or bathing). You can get this therapy to help improve or maintain your current capabilities, or to slow your rate of decline. Part B covers medically necessary outpatient occupational therapy if your doctor or other health care provider (including a nurse practitioner, clinical nurse specialist, or physician assistant) 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 occupational therapy services in one calendar year.

More information

- Go to:
  - "Home health services" on pages 52–54.
  - "Hospice care" on pages 55–57.
  - "Inpatient rehabilitation care" on pages 59–60.
  - "Mental health care (outpatient): Partial hospitalization" on pages 74–75.
  - "Physical therapy services" on page 87.
  - "Skilled nursing facility (SNF) care" on pages 103–105.
  - "Speech-language pathology services" on page 106.
- Visit **Medicare.gov/coverage/occupational-therapy-services**.

Opioid Use Disorder treatment services

If you've been diagnosed with an Opioid Use Disorder, you can get treatment services for as long as they're needed. Part B covers medications for Opioid Use Disorder and treatment services you get from a doctor or other health care provider, or through a more comprehensive Opioid Treatment Program (including Opioid Treatment Program mobile units).

The services you get might be different depending on where you get them. Services may include:

- Medications for Opioid Use Disorder, like methadone, buprenorphine, and naltrexone
- Medications to rapidly reverse the effects of an opioid overdose, like naloxone and nalmefene
- Preparation and help taking medications that are part of your recovery process
- Substance use counseling
- Drug testing
- Individual and group therapy
- Intake activities and other periodic assessments
- Intensive outpatient program services
- Coordinated care and/or referral services
- Peer recovery support services

Costs

- You usually won't have to pay any copayments for these services if you get them from an Opioid Treatment Program provider that participates in Medicare and meets other requirements. The Part B deductible applies for these services, including any supplies and medications you might get as part of your treatment. If you have a Medicare Advantage Plan, check with your plan to find out if you have to pay a copayment.
- If you get Opioid Use Disorder services from a health care provider, you pay the usual copayments for the services after you meet the Part B deductible.

Things to know

- Talk to your provider to find out where you can go for these services.
- Medicare covers counseling, therapy services, and periodic assessments both in person and, in certain circumstances, virtually (using audio and video communication, like your phone or a computer). Medicare may also cover periodic assessments that use audio-only communication.
- You may be able to start methadone and buprenorphine treatment without an in-person exam if your Opioid Treatment Program provider can adequately evaluate you using audio and video communication. You may also be able to start buprenorphine treatment using audio-only communication.
- Medicare Advantage Plans must also cover Opioid Treatment Program services but may require that you go to an in-network Opioid Treatment Program. If you join a Medicare Advantage Plan when you're already getting treatment, your Opioid Treatment Program must participate in both Medicare and your plan to make sure your treatment is covered and stays uninterrupted. If not, you may have to switch to an Opioid Treatment Program that participates with your plan.

More information

Visit Medicare.gov/coverage/opioid-use-disorder-treatment-services.

Organ transplants

An organ transplant is a surgical procedure that replaces a damaged organ with a healthy one from a donor. Part A covers necessary tests, labs, and exams, and generally also covers:

- Services for heart, lung, kidney, pancreas, intestine, and liver transplants
- The costs of finding the proper organ for your transplant surgery

Part B covers:

- Doctors' services associated with heart, lung, kidney, pancreas, intestine, and liver transplants
- Immunosuppressive drugs to prevent organ rejection in certain circumstances

Costs

For your transplant and related services, you pay:

- 20% of the Medicare-approved amount for Part B services, after you meet the Part B deductible
- Nothing for the services provided to a living donor for a kidney transplant
- Nothing for Medicare-certified laboratory tests

For Part A hospital inpatient cost information, go to pages 58–59.

Things to know

- You must get an organ transplant in a Medicare-approved facility.
- If you're thinking about joining a Medicare Advantage Plan and are on a transplant waiting list or think you need a transplant, check with the plan before you join to make sure your doctors, other health care providers, and hospitals are in the plan's network. Also, check the plan's rules for prior authorization.
- Medicare doesn't pay for transportation to a transplant facility.

More information

- Go to:
  - "Kidney transplants" on pages 62–63.
  - "Kidney transplants (children)" on pages 63–64.
  - "Other transplants" on page 82.
  - "Prescription drugs (outpatient)" on pages 89–91 for immunosuppressive drugs.
  - "Pancreas transplants" on page 86.
- Visit 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

Medicare will only pay for orthotic items from a supplier who accepts assignment, no matter who submits the claim (you or your supplier).

More information

- Go to "Therapeutic shoes or inserts" on page 109.
- Visit Medicare.gov/coverage/orthopedic-shoes.

Osteoporosis drugs

If you have osteoporosis, these drugs may prevent further bone loss and help strengthen weak bones. Part A and Part B cover certain osteoporosis injectable drugs and visits by a home health nurse to give you the injections, if you meet all these conditions:

You're a woman with osteoporosis who:

- Meets the criteria for Medicare home health services. Go to "Home health services" on pages 52–54.
- Has a bone fracture that a doctor or other health care provider certifies is related to postmenopausal osteoporosis.
- Has a health care provider who certifies that you can't give yourself the injection or learn how to give yourself the injection, and your family members or caregivers are unable or unwilling to give you the injection.

Costs

- In most cases, after you meet the Part B deductible, you pay up to 20% of the Medicare-approved amount for covered Part B prescription drugs. Your coinsurance amount can change depending on the drug's price. You might pay a lower coinsurance amount for certain Part B-covered drugs and biologicals you get in a doctor's office, pharmacy, or outpatient setting, if their prices have gone up faster than the rate of inflation. The specific drugs and potential savings change every quarter.
- You pay nothing for the home health nurse visit to inject the drug.

More information

Visit Medicare.gov/coverage/osteoporosis-drugs.

Ostomy supplies

Ostomy supplies help people manage bodily waste after having ostomy surgery. If you've had a colostomy, ileostomy, or urinary ostomy, Part B covers medically necessary ostomy supplies under the prosthetic device benefit. Medicare covers the amount of supplies your doctor or other health care provider 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.

More information

Visit Medicare.gov/coverage/ostomy-supplies.

Other transplants

Under certain conditions, Medicare covers transplants that aren't organ transplants:

- Both Part A and Part B may cover stem cell transplants (including bone marrow transplants), and the necessary tests, labs, and exams associated with the transplant.
- Part B may also cover cornea transplants.

Costs

For your transplant and related services, you pay:

- 20% of the Medicare-approved amount for Part B services, after you meet the Part B deductible.
- Nothing for Medicare-certified laboratory tests.

For Part A inpatient hospital cost information, go to pages 58–59.

Things to know

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

More information

Visit Medicare.gov/coverage/other-transplants.

Outpatient hospital services

Part B covers many diagnostic and treatment services you get as an outpatient from a hospital that takes Medicare.

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 or other qualified mental health professional certifies you'd need inpatient treatment without it).
- Intensive outpatient programs for mental health conditions (including substance use disorders).
- X-rays and other radiology services billed by the hospital.
- Medical supplies, like splints and casts.
- Preventive and screening services.
- Certain self-administered drugs and biologicals you get as part of your service or procedure (like certain injectable drugs).

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'd pay for the same care in a doctor's office. However, the hospital outpatient copayment for the service can't be more than the inpatient deductible amount ($1,736 in 2026).
- In addition to the amount you pay the health care provider, you'll 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. 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.
- The Part B deductible applies, except for certain preventive services.

More information

- Go to:
  - "Mental health care (outpatient): Intensive outpatient program services" on pages 73–74.
  - "Mental health care (outpatient): Partial hospitalization" on pages 74–75.
  - "Outpatient medical & surgical services & supplies" below.
  - "Preventive & screening services" on page 92.
- Visit Medicare.gov/coverage/outpatient-hospital-services.
- To get average costs for a surgery in a hospital outpatient department, visit 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

After you meet the Part B deductible, 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.
You pay all costs for items or services that Medicare doesn't cover.

More information

Visit Medicare.gov/coverage/outpatient-medical-surgical-services-supplies.

Oxygen equipment & accessories

Part B covers oxygen and oxygen equipment for use in your home when you meet all these conditions:

- Your health care provider says you aren't getting enough oxygen.
- Your health might improve with oxygen therapy.
- Your arterial blood gas level falls within a certain range.

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

- Systems that give 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.
- If you have Medicare and use oxygen, you'll rent oxygen equipment from a supplier for 36 months. The monthly rental payments cover your oxygen equipment, all refills of tanks or cylinders if you use gaseous or liquid oxygen, and any supplies, accessories, and services necessary for use of the oxygen and oxygen equipment, like:
  - Tubing or a mouthpiece
  - Any other necessary supplies and accessories, including a trans-tracheal oxygen catheter (if needed)
  - Any oxygen equipment maintenance and servicing necessary for the equipment to function properly whenever it's needed
- After Medicare makes rental payments for 36 months, payment for the oxygen equipment ends. However, Medicare will continue to pay your supplier to give you oxygen and oxygen equipment for as long as you need it up to 5 years after you started using the equipment.
  - If you use the oxygen and oxygen equipment for 5 years or more, the supplier of the equipment is no longer obligated to continue giving you oxygen and oxygen equipment. If you still need oxygen and oxygen equipment after 5 years, you must get new equipment and Medicare will begin a new 36-month period of payment for the oxygen and oxygen equipment. There is no limit to the number of times you can get replacement oxygen equipment you need, but every 5 years you must obtain new equipment from a supplier (it doesn't need to be the same supplier you used before, but can be).
  - If you use either an oxygen concentrator or equipment used to fill portable tanks in your home, you may have to pay coinsurance every 6 months for maintenance and servicing of the equipment. If you have to pay for this service, you'll begin to pay coinsurance 6 months after the 36-month period ends. The supplier can't charge you for this service unless they come to your home to inspect and service the equipment.

More information

- Go to "Durable medical equipment (DME)" on pages 41–42.
- Visit Medicare.gov/coverage/oxygen-equipment-accessories.

Pain management

Pain management services offer treatment options that may help you manage pain and related issues. Part B covers these pain management services:

- Acupuncture for chronic low back pain: Go to pages 7–8.
- Alcohol misuse screenings and counseling: Go to page 10.
- Behavioral health integration services: Go to page 13.
- Chiropractic services: Go to page 21.
- Chronic pain management and treatment services: Go to page 22.
- Depression screenings: Go to page 33.
- Mental health and substance use disorder services: Go to page 70.
- Occupational therapy: Go to pages 77–78.
- Opioid Use Disorder treatment services: Go to pages 78–79.
- Physical therapy services: Go to page 87.

Medicare drug coverage (Part D) may cover prescription pain medications to treat certain types of short-term pain. If you have Part D, the plan may also have programs (like Medication Therapy Management Programs or drug management programs) to help you use prescription opioid pain medications safely.

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 health care provider accepts assignment.

Things to know

Your provider may recommend other pain management treatment options that Medicare doesn't cover, like massage therapy. If this happens, or if your 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 provider is recommending certain services and if Medicare will pay for them.

More information

- Visit **Medicare.gov/coverage/pain-management**.
- For information about medication safety, visit **Medicare.gov/health-drug-plans/part-d/what-plans-cover/plan-rules/safety-management-programs**.

Pancreas transplants

A pancreas transplant is a surgical procedure that places a healthy pancreas from a donor into a person whose pancreas has failed. 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 it's done at the same time or after you get a kidney transplant.

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

Costs

- After you meet the Part B deductible, you pay 20% of the Medicare-approved amount for Part B services.
- You pay nothing for Medicare-approved laboratory tests.

For Part A inpatient hospital cost information, go to pages 58–59.

Things to know

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

More information

- Go to:
  - "Kidney transplants" on pages 62–63.
  - "Kidney transplants (children)" on pages 63–64.
  - "Organ transplants" on pages 79-80.
  - "Other transplants" on page 82.
- Visit Medicare.gov/coverage/pancreas-transplants.

Pap tests

Go to "Cervical & vaginal cancer screenings" on page 20.

Partial hospitalization

Go to "Mental health care (outpatient): Partial hospitalization" on pages 74–75.

Pediatric dialysis

Go to "Dialysis (children)" on page 37.

PET scans

Go to "Diagnostic non-laboratory tests" on page 36.

Physical activity & nutrition risk assessment

A physical activity and nutrition risk assessment helps your doctor or other health care provider understand your physical activity and nutritional habits and their impact on your health to better treat you and refer you for appropriate services or support. Part B covers a physical activity and nutrition risk assessment when your health care provider gives it to you during your yearly "Wellness" visit, or as part of another office or behavioral health visit.

How often

You can get this risk assessment from your provider once every 6 months (or more often if you go to more than one provider).

Costs

- You pay nothing for this risk assessment if you get it as part of your yearly "Wellness" visit.
- After you meet the Part B deductible, you pay 20% of the Medicare-approved amount if you get the risk assessment as part of another office or behavioral health visit.

More information

- Go to "Preventive visits" on pages 93–95 for more information about yearly "Wellness" visits.
- Visit Medicare.gov/coverage/physical-activity-nutrition-risk-assessment.

Physical therapy services

Physical therapy helps to restore or improve physical movement in your body after an injury, illness, or surgery. You can also get this therapy to help improve or maintain your current function, or slow your rate of decline. Part B covers medically necessary outpatient physical therapy services when your doctor or other health care provider (including a nurse practitioner, clinical nurse specialist, or physician assistant) certifies you need them.

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-services.

Pneumococcal vaccines

Part B covers pneumococcal vaccines to help protect against different strains of the bacteria that cause pneumonia. Talk with your doctor or other health care provider about which vaccines are right for you.

Costs

You pay nothing if your health care provider accepts assignment for giving the vaccine.

More information

Visit Medicare.gov/coverage/pneumococcal-shots.

Power wheelchairs

Go to "Wheelchairs & scooters" on page 113.

Pre-exposure prophylaxis (PrEP) for HIV prevention

PrEP uses antiretroviral medication to lower your risk of getting HIV (human immunodeficiency virus). If you don't have HIV, but your doctor or other health care provider determines you're at an increased risk for HIV, Part B covers PrEP medication and related services.

If you qualify, covered services include:

- FDA-approved oral or injectable PrEP medication. If you're getting an injectable drug, Part B also covers the fee for injecting the drug.
- Up to 8 individual counseling sessions (including HIV risk assessment, HIV risk reduction, and medication adherence) every 12 months.
- Up to 8 HIV screenings every 12 months.
- A one-time hepatitis B virus (HBV) screening (you may be able to get more screenings if you're at high risk for HBV or you're pregnant).

Costs

If you get PrEP medications from a pharmacy that's enrolled in Part B, you'll pay nothing out of pocket for your medications. Ask your health care provider to include a diagnosis code on your prescription to help the pharmacy. If you're in a Medicare Advantage Plan, you'll usually pay nothing out of pocket for PrEP at any pharmacy in your plan's network. Contact your plan for more specific cost information.

If your provider accepts assignment, you'll also pay nothing out of pocket for injectable PrEP drugs, HIV and HBV screenings, and counseling sessions (because they're preventive services).

Note: Contact your pharmacy to make sure they can bill Medicare Part B. If you don't, you might have to pay the full cost of PrEP yourself. Most pharmacies (including national chains) can bill Part B, but some smaller pharmacies can't. If your regular pharmacy can't bill Part B, we can help you find a pharmacy where you can get your PrEP. Call 1-800-MEDICARE (1-800-633-4227). TTY users can call 1-877-486-2048.

More information

- Go to "Human immunodeficiency virus (HIV) screenings" on page 57.
- Visit Medicare.gov/coverage/pre-exposure-prophylaxis-prep-for-hiv-prevention.

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 some types of durable medical equipment (DME):** If the drug used is medically necessary, Medicare covers certain drugs infused through Part-B covered DME (like an infusion pump or nebulizer).
- **Some antigen allergy tests and treatments:** Medicare covers some antigen tests to check for and treat allergies if a doctor or other health care provider prepares them, and they're given by a properly instructed person (who could be you, the patient) under appropriate supervision.
- **Injectable osteoporosis drugs:** Go to page 81.
- **Erythropoiesis-stimulating agents:** Medicare covers 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:** If you have hemophilia (a genetic bleeding disorder that keeps your blood from clotting properly), Medicare covers injectable clotting factors you give yourself or get in a doctor's office.
- **Injectable and infused drugs:** When a licensed medical provider gives them, Medicare covers most injectable and infused drugs.
- **Oral End-Stage Renal Disease (ESRD) drugs:** Part B covers ESRD drugs you take by mouth.

  Note: Part B covers calcimimetic medications, phosphate binders, and other phosphate-lowering drugs for treating ESRD. Your dialysis facility is responsible for giving you these medications either at the facility or through a pharmacy they work with. You'll need to talk to your dialysis facility staff and your health care provider to find out where you'll get these medications and how much you'll pay.

- **Intravenous Immune Globulin (IVIG):** Medicare covers IVIG you get at home if you've been diagnosed with primary immune deficiency disease, and your provider decides that it's medically appropriate for you. Part B also pays for other items and services related to you getting IVIG at home.
- **Vaccines:** Medicare covers flu, pneumococcal, hepatitis B, and COVID-19 vaccines. Medicare also covers some other vaccines when they're directly related to treating an injury or illness. Go to pages 111–112.
- **Immunosuppressive drugs:** If Medicare helped pay for your organ transplant, Part B covers transplant drug therapy (including standard and compounded immunosuppressive drugs) to prevent organ rejection. You must have Part A at the time of the covered transplant, and you must have Part B at the time you get immunosuppressive drugs.

  If you only have Medicare because of End-Stage Renal Disease (ESRD), your Medicare coverage (including immunosuppressive drug coverage) ends 36 months after a successful kidney transplant. Medicare offers a benefit to help you pay for your immunosuppressive drugs beyond 36 months if you don't have certain types of other health coverage (like a group health plan, TRICARE, or Medicaid that covers immunosuppressive drugs). **This benefit only covers your immunosuppressive drugs and no other items or services. It isn't a substitute for full health coverage**. If you qualify, you can sign up for this benefit any time after your Part A coverage ends. To sign up, call Social Security at 1-877-465-0355. TTY users can call 1-800-325-0788.
- **Oral cancer drugs:** Medicare covers some cancer drugs you take by mouth if the same drug is available in an injectable form or it's a prodrug (an oral form of the injectable drug that breaks down into the same active ingredient after you take it).
- **Oral anti-nausea drugs:** Medicare covers anti-nausea drugs you take by mouth if you take them before, during, or within 48 hours of getting chemotherapy treatment for cancer, or you get them as a full therapeutic replacement for an intravenous anti-nausea drug.
- **Monoclonal antibodies for treating early Alzheimer's disease:** Go to page 75.

Costs

- Doctors, other health care providers, and pharmacies must accept assignment for Part B-covered drugs, so they should never ask you to pay more than the coinsurance or copayment for the Part B drug itself.
- In most cases, after you meet the Part B deductible, you pay up to 20% of the Medicare-approved amount for Part B-covered drugs.
  - Your coinsurance amount can sometimes change depending on your prescription drug's price.
  - You might pay a lower coinsurance for certain Part B-covered drugs and biologicals you get in a doctor's office, pharmacy, or outpatient setting, if their prices have gone up faster than the rate of inflation. The specific drugs and potential savings change every quarter.
  - If the Part B-covered drugs you get in a hospital outpatient setting are part of your outpatient services, you pay a copayment for the services.
- If you get a drug that isn't covered in a hospital outpatient setting, you pay all costs for the drug, unless you have other drug coverage. If you have other coverage (like Part D), what you pay depends on whether your plan covers the drug and if the hospital's pharmacy is in your plan's network. Contact your plan for more specific cost information.
- You pay nothing (and the Part B deductible doesn't apply) for COVID-19, flu, pneumococcal, and hepatitis B vaccines if your provider accepts assignment.
- For immunosuppressive drugs, you'll pay a monthly premium of $121.60 (or higher based on your income) and a $283 deductible in 2026. After you meet the deductible, you pay up to 20% of the Medicare-approved amount for your immunosuppressive drugs.

Things to know

Medicare drug coverage (Part D) covers many drugs that Part B doesn't cover. If you have Original Medicare, you can join a Medicare drug plan to get Medicare drug coverage. If you join a Medicare drug plan, check your plan's drug list (also called a formulary) to find out what outpatient drugs it covers.

More information

Visit Medicare.gov/coverage/prescription-drugs-outpatient.

Preventive & screening services

Part B covers many preventive and screening services that can help you stay healthy, find health problems early, determine the most effective treatments, and prevent certain diseases. Talk with your doctor or other health care provider about which preventive services are right for you.

Preventive services include exams, vaccines, lab tests, and screenings. They also include programs for health monitoring, and counseling and education to help you take care of your own health.

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

- Abdominal aortic aneurysm screenings: Go to page 7.
- Alcohol misuse screenings and counseling: Go to page 10.
- Bone mass measurements: Go to page 15.
- Cardiovascular behavioral therapy: Go to page 17.
- Cardiovascular disease screenings: Go to page 17.
- Cervical and vaginal cancer screenings: Go to page 20.
- Colorectal cancer screenings: Go to page 25.
- Counseling to prevent tobacco use and tobacco-caused disease: Go to page 28.
- Depression screenings: Go to page 33.
- Diabetes screenings: Go to pages 33–34.
- Diabetes self-management training: Go to page 34.
- Glaucoma screenings: Go to page 49.
- Hepatitis B virus (HBV) infection screenings: Go to page 51.
- Hepatitis C virus screenings: Go to page 52.
- Human immunodeficiency virus (HIV) screenings: Go to page 57.
- Lung cancer screenings: Go to pages 66.
- Mammograms: Go to page 67.
- Medical nutrition therapy services: Go to page 68.
- Medicare Diabetes Prevention Program: Go to pages 69.
- Obesity behavioral therapy: Go to page 77.
- Pre-exposure prophylaxis (PrEP) for HIV prevention: Go to pages 88–89.
- Preventive visits: Go to pages 93–95.
- Prostate cancer screenings: Go to page 96.
- Sexually transmitted infection screenings and counseling: Go to page 102.
- Vaccines (or shots): Go to pages 111–112.

More information

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

Preventive visits

"Welcome to Medicare" preventive visit

Part B covers one "Welcome to Medicare" preventive visit within the first 12 months you have Part B. **This "Welcome to Medicare" visit isn't a physical exam**. During this visit, your doctor or other health care provider will:

- Review your medical and social history related to your health.
- Give you information about preventive services, including certain screenings and vaccines (like flu, pneumococcal, and other recommended vaccines).
- Review your potential risk factors for substance use disorder (like alcohol and tobacco use), and refer you for treatment, if needed.
- Give you referrals for other care as needed.
- Calculate your body mass index (BMI).
- Give you a simple vision test.
- Review your potential risk for depression.
- Offer to talk with you about creating advance directives. Advance directives are legal documents that record your wishes about future medical treatment, in case you're ever unable to make decisions about your care.
- Give you a written plan (like a checklist) letting you know what screenings, vaccines, and other preventive services you need.

If you have a current prescription for opioids, your health care provider will also:

- Review your potential risk factors for an Opioid Use Disorder.
- Evaluate your pain level and current treatment plan.
- Give you information on non-opioid treatment options.
- Refer you to a specialist, if appropriate.

Costs

You pay nothing if your 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 provider performs additional tests or services during your visit that Medicare doesn't cover under this preventive visit. **If Medicare doesn't cover the additional tests or services (like a routine physical exam), you may have to pay the full amount**.

Things to know

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

More information

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

Yearly "Wellness" visits

If you've had Part B for longer than 12 months, you can get a yearly "Wellness" visit to develop or update your personalized plan to help prevent disease and disability, based on your current health and risk factors. **This yearly "Wellness" visit isn't a physical exam**.

During this visit, your doctor or other health care provider will:

- Take routine measurements (like height, weight, and blood pressure).
- Give you health advice.
- Review your medical and family history.
- Review your current prescriptions.
- Offer to talk with you about creating advance directives. Advance directives are legal documents that record your wishes about future medical treatment, in case you're ever unable to make decisions about your care.
- Give you a written plan (like a checklist) letting you know what screenings, vaccines, and other preventive services you need.
- Give you an optional "Physical activity and nutrition risk assessment" to help your health care provider understand your physical activity and nutritional habits and their impact on your health.

Your provider will also:

- Perform a cognitive 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. Go to "Cognitive assessment & care plan services" on pages 23–24.
- Order other tests, if necessary, depending on your general health and medical history.
- Evaluate your potential risk factors for substance use disorder and refer you for treatment, if needed. If you use opioid medication, your provider will review your pain treatment plan, share information on non-opioid treatment options, and refer you to a specialist, if appropriate.

How often

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

Costs

You pay nothing if your 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 provider performs additional tests or services during your visit that Medicare doesn't cover under this preventive visit. **If Medicare doesn't cover the additional tests or services (like a routine physical exam), you may have to pay the full amount**.

Things to know

Your provider will ask you to fill out a questionnaire, called a "Health Risk Assessment," as part of this visit. Answering the questions can help you and your doctor develop or update a personalized plan to help you stay healthy and get the most out of your visit.

More information

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

Principal care management services

Principal care management includes disease-specific services to help your doctor or other health care provider manage your care for a single, complex chronic condition that puts you at risk of hospitalization, physical or cognitive decline, or death. Part B covers principal care management services if you have one chronic high-risk condition that you expect to last at least 3 months (like cancer) and you aren't being treated for any other complex conditions. Your provider will create a disease-specific care plan and continuously monitor and update it, including any changes to the medicines you take.

Costs

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

More information

- Go to "Principal illness navigation services" below.
- Visit Medicare.gov/coverage/principal-care-management-services.

Principal illness navigation services

Principal illness navigation is a type of care management that helps you understand your medical condition or diagnosis and navigate the health care system to find the care and providers you need. Part B covers principal illness navigation services if you have a serious condition that's expected to last at least 3 months (like cancer, HIV, or substance use disorder) and puts you at a high risk for one or more of the following:

- Hospitalization
- Nursing home placement
- A sudden worsening of pre-existing symptoms
- Physical or mental decline
- Death

How often

You must have an initial visit with your doctor or other health care provider before you can start getting principal illness navigation services. After your initial visit, you can get navigation services monthly for as long as you need them. After a year, you'll need another initial visit if you continue to need these services.

Costs

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

Things to know

- Your health care provider or their staff can give you the navigation services or refer you to other trained personnel (including patient navigators or peer support specialists) for the services.
- If you have more than one serious condition, you can get principal illness navigation services for each condition. For example, if you're getting navigation services for substance use disorder and then you're diagnosed with cancer, you can get navigation services for both conditions.

More information

- Go to:
  - "Chronic care management services" on page 22.
  - "Principal care management services" on the previous page.
- Visit Medicare.gov/coverage/principal-illness-navigation-services.

Prostate cancer screenings

Prostate cancer screenings check for cancer in the prostate, a gland in the male reproductive system. Your doctor or other health care provider may find prostate cancer during a digital rectal exam, or through a test that checks the amount of prostate specific antigen (PSA) in your blood. Part B covers digital rectal exams and prostate specific antigen (PSA) blood tests for men over 50 (starting the day after your 50th birthday).

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 the 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 the PSA blood test. If you get the test from a health care provider that doesn't accept assignment, you may have to pay a fee for your doctor's services, but not for the test itself.

More information

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

Prosthetic devices

Part B covers prosthetic devices needed to replace a body part or function when a doctor or other health care provider orders them. Examples of Part B-covered prosthetic devices include:

- Breast prostheses (including a surgical bra): Go to page 16.
- Enteral and parenteral nutrition: Go to page 43.
- One pair of conventional eyeglasses or contact lenses provided after a covered cataract surgery: Go to page 20.
- Ostomy supplies: Go to page 81.
- Some surgically implanted prosthetic devices, including cochlear implants.
- Urological supplies.

Costs

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

Things to know

Medicare will only pay for a prosthetic device from a supplier that participates in Medicare, whether you or your provider submits the claim. 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.

More information

- Go to:
  - "Inpatient hospital care" on pages 58–59 for Part A-covered surgeries to implant prosthetic devices in a hospital inpatient setting.
  - "Outpatient hospital services" on pages 82–83 for Part B-covered surgeries to implant prosthetic devices in a hospital outpatient setting.
- Visit Medicare.gov/coverage/prosthetic-devices.

Pulmonary rehabilitation programs

Pulmonary rehabilitation programs help you breathe better, get stronger, and live more independently. Part B covers a comprehensive pulmonary rehabilitation program if:

- You have moderate to very severe chronic obstructive pulmonary disease (COPD) and have a referral from the doctor who's treating it.
- You've had confirmed or suspected COVID-19 and experience persistent symptoms, including 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 each session if you get the service in a hospital outpatient setting. The Part B deductible applies.

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

- Go to "Telehealth" on page 108.
- Visit Medicare.gov/coverage/pulmonary-rehabilitation-programs.

Radiation therapy

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

Costs

- **If you're an inpatient:** You pay the Part A deductible and coinsurance (if applicable).
- **If you're an outpatient or in a freestanding clinic:** After you meet the Part B deductible, you pay 20% of the Medicare-approved amount.

More information

Visit Medicare.gov/coverage/radiation-therapy.

Rectal exams

Go to "Prostate cancer screenings" on page 96.

Religious non-medical health care institution items & services

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

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

- You get the care from a Medicare-certified religious non-medical health care institution.
- The Utilization Review Committee at the religious non-medical health care institution agrees that you would require hospital or SNF care if you weren't in the institution.
- You've filed a written election with Medicare that states:
  - You qualify for this type of care based on both your medical needs and religious beliefs.
  - Your election will be cancelled if you decide to accept standard medical care. After cancelling an election, you may have to wait 1–5 years (depending on how many times you may have previously cancelled your election) before you qualify to get religious non-medical health care services again. You're always eligible to get medically necessary Part A services.

Note: Getting the COVID-19 vaccine no longer automatically cancels your election to get religious non-medical health care services. If you previously had your election cancelled because you got the COVID-19 vaccine, you're immediately eligible for a new election. Any previous cancellation for the COVID-19 vaccine won't count against the waiting period for your future elections.

Costs

What you pay for each benefit period in 2026 depends on how long you're getting care:

- **Days 1–60:** After you pay the $1,736 deductible, you pay $0 each day.
- **Days 61–90:** You pay $434 each day.
- **Days 91–150:** You pay $868 each day while using your 60 lifetime reserve days. These are additional days that Medicare will pay for when you're in a hospital for more than 90 days. You have a total of 60 reserve days that can be used once during your lifetime.
- **After Day 150:** You pay all costs.

More information

- Go to "What do I pay for Part-A covered services?" on pages 3–4 to learn more about benefit periods.
- Visit Medicare.gov/coverage/religious-nonmedical-health-care-institution-items-services.

Respiratory assist devices

Respiratory assist devices can help with breathing. Part B covers respiratory assist devices (like home mechanical ventilators and bi-level respiratory assist devices) if you've been diagnosed with chronic obstructive pulmonary disease (COPD) and developed chronic respiratory failure (a condition where you have low oxygen and/or high carbon dioxide levels in your blood, making it difficult to breathe on your own). You must meet certain conditions to qualify, including:

- You have hypercapnia (high levels of carbon dioxide in your blood) of 52 mmHg or more
- Your hypercapnia isn't primarily caused by sleep apnea (a sleeping disorder where your breathing repeatedly stops and starts)

Costs

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

How often

Medicare initially covers respiratory assist devices for 6 months. After that, Medicare may continue to cover the device if your doctor or other health care provider certifies that you meet certain criteria and the device is helping you. You must meet with your health care provider at least twice during the first year you have the device (once within the first 6 months, and again during the next 6 months).

More information

Go to "Durable medical equipment (DME)" on pages 41–42.

Respiratory Syncytial Virus (RSV) vaccine

RSV vaccines can protect you from getting RSV, a respiratory virus that causes cold-like symptoms. Adults 75 and older, and adults between 50–74 with certain conditions are at high risk of having serious health complications from RSV. Medicare drug coverage (Part D) covers the RSV vaccine.

Costs

- You pay nothing for the RSV vaccine if you have Part D.
- Part D covers all adult vaccines recommended by the Advisory Committee on Immunization Practices (ACIP) that aren't covered under Part B, including vaccines for RSV, shingles, whooping cough, measles, and more. Your Part D plan won't charge you a copayment or deductible for vaccines ACIP recommends.

Things to know

- Certain medical conditions and factors increase the risk for severe RSV. Talk to your doctor or other health care provider to find out if you may be at increased risk.
- You can get the RSV vaccine in many places, including your doctor's office and your local pharmacy. If you have a Medicare Advantage Plan, contact your plan to find out where you can go to get the RSV vaccine. Only Medicare Advantage Plans that include drug coverage will cover prescription drug benefits, like the RSV vaccine.

More information

- Contact your Part D plan.
- Visit Medicare.gov/coverage/respiratory-syncytial-virus-rsv-shot.

Respite care

Go to "Hospice care" on pages 55–57.

Rural Health Clinic services

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

More information

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

Scooters

Go to "Wheelchairs & scooters" on page 113.

Second surgical opinions

A second opinion is when another doctor or health care provider gives their view about your health problem and how it should be treated. In some cases, Part B covers a second surgical opinion for medically necessary, non-emergency surgery. Medicare also covers 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 for a second opinion. The second health care provider may ask you to get additional tests as a result of the visit. Medicare will cover these tests, just as it covers other services that are medically necessary.
- You pay 20% of the Medicare-approved amount for a third opinion, if the second opinion is different from the first opinion.

More information

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

Sexually transmitted infection (STI) screenings & counseling

Part B covers 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 these infections. Each session can be 20–30 minutes long.

How often

- One STI screening every 12 months, or at certain times during pregnancy.
- Up to 2 behavioral counseling sessions a year.

Costs

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

Things to know

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

More information

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

Shingles vaccines

The shingles vaccine can protect you against the varicella-zoster virus that causes a painful rash and sometimes serious complications, like long-term pain. Medicare drug coverage (Part D) covers the shingles vaccine.

Costs

- You pay nothing for the shingles vaccine if you have Part D.
- Part D covers all adult vaccines recommended by the Advisory Committee on Immunization Practices (ACIP) that aren't covered under Part B, including the vaccines for shingles, Respiratory Syncytial Virus (RSV), whooping cough, measles, and more. Your Part D plan won't charge you a copayment or apply a deductible for vaccines ACIP recommends.

More information

- Contact your Part D plan.
- Visit Medicare.gov/coverage/shingles-shots.

Shots

Go to "Vaccines" on pages 111–112.

Skilled nursing facility (SNF) care

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 you get when you need skilled nursing or skilled therapy to treat, manage, and observe your condition, and evaluate your care.

Part A covers SNF care for a limited time if you meet all these conditions:

- You have Part A and have days left in your benefit period to use.
- You have a qualifying inpatient hospital stay. This means a prior medically necessary inpatient hospital stay of 3 consecutive days or more, starting with the day the hospital admits you as an inpatient, but not including the day you leave the hospital. Time you spend at the hospital under observation or in the emergency room before you're admitted doesn't count toward the three-day qualifying inpatient hospital stay, even if you're there overnight. You must enter the SNF within a short time (usually 30 days) of leaving the hospital.
- Your doctor or other health care provider certifies that you need daily skilled care (like intravenous fluids/medications or physical therapy). 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 skilled services for one of these:
  - An ongoing condition that was also treated during your qualifying inpatient hospital stay (even if it wasn't the reason you were admitted to the hospital).
  - A new condition that started while you were getting SNF care for the ongoing condition.

Medicare-covered services in a SNF include, but aren't limited to:

- A semi-private room (a room you share with other patients).
- Meals.
- Skilled nursing care.
- Occupational and physical therapy, if they're needed to meet your health goal. Go to "Occupational therapy services" on pages 77–78 and "Physical therapy services" on page 87.
- Speech-language pathology services, if they're needed to meet your health goal. Go to page 106.
- Medical social services.
- Medications.
- Medical supplies and equipment used in the facility.
- Ambulance transportation (when other transportation could endanger your health) to the nearest supplier of needed services that you can't get at the SNF.
- Dietary counseling.

How often

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

Costs

What you pay for each benefit period in 2026 depends on how long you're getting care:

- **Days 1–20:** You pay $0 each day after you pay the $1,736 deductible. You don't have to pay the deductible for skilled nursing facility care if you already paid it for care you got in a hospital during the same benefit period.

  Note: If you're in a Medicare Advantage Plan, you may be charged copayments during the first 20 days. Check with your plan for more information.
- **Days 21–100:** You pay $217 each day.
- **Days 101 and beyond:** You pay all costs.

Part A limits SNF coverage to 100 days in each benefit period.

Things to know

- You may get skilled nursing care or therapy if it's necessary to improve or maintain your current condition, or to prevent or delay it from getting worse.
- If you disagree with your discharge for any reason, you can appeal.
- You may not need a three-day minimum inpatient hospital stay if your health care provider participates in an Accountable Care Organization (ACO) that's approved for a Skilled Nursing Facility Three-Day Rule Waiver. If your provider participates in an ACO, check with them to find out what benefits may be available. Medicare Advantage Plans may also waive the three-day minimum inpatient hospital stay. Contact your plan for more information.
- Medicare doesn't cover non-medical long-term care.

More information

- Go to:
  - "Ambulance services" on pages 10–11.
  - "Long-term care" on pages 64–65.
  - "What do I pay for Part-A covered services?" on pages 3–4 to learn more about benefit periods.
- Visit **Medicare.gov/coverage/skilled-nursing-facility-care**.
- Visit **Medicare.gov/providers-services/coordinating-care**.

Sleep studies

Sleep studies monitor your sleep patterns, breathing, and movement to find out if you have a sleep disorder. 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 you get them in a sleep lab facility. Your doctor or other health care provider must order the sleep test.

More information

Visit **Medicare.gov/coverage/sleep-studies**.

Speech-language pathology services

Speech-language pathology 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 your rate of decline. Part B covers medically necessary outpatient speech-language pathology services if your doctor or other health care provider (including a nurse practitioner, clinical nurse specialist, or physician assistant) 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 speech-language pathology services in one calendar year.

More information

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

Substance use disorder services

Go to "Mental health & substance use disorder services" on page 70.

Supplies

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

Costs

You pay all costs for non-covered services, including most common medical supplies you use at home.

More information

Visit Medicare.gov/coverage/supplies.

Surgery

Medicare covers many medically necessary inpatient and outpatient surgical procedures.

Costs

It's hard to predict your costs for surgeries or procedures in advance, because you won't know what services you need until you meet with your provider. To compare average costs for surgery in both a hospital outpatient department and an ambulatory surgical center, visit Medicare.gov/procedure-price-lookup.

More information

- Go to "Inpatient hospital care" on pages 58–59.
- Visit Medicare.gov/coverage/surgery.

Surgical dressing services

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

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. You also pay a separate copayment for these services when you get them in a hospital outpatient setting.

More information

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

Swing bed services

A rural or critical access hospital with a Medicare agreement can "swing" its beds and provide either acute hospital or Skilled Nursing Facility (SNF)-level care, as needed. Medicare covers swing bed services you get in certain Medicare hospitals.

Costs

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

More information

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

Tdap vaccine

Tdap is the booster vaccine that protects against tetanus, diphtheria, and pertussis (also called whooping cough). Medicare drug coverage (Part D) covers the Tdap vaccine.

Costs

- You pay nothing for the Tdap vaccine if you have Part D.
- Part D covers all adult vaccines recommended by the Advisory Committee on Immunization Practices (ACIP) that aren't covered under Part B, including the vaccines for Tdap, Respiratory Syncytial Virus (RSV), shingles, measles, and more. Your Part D plan won't charge you a copayment or apply a deductible for vaccines ACIP recommends.

More information

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

Telehealth

Telehealth includes medical or health services that you get from a health care provider who's located somewhere else (in the U.S.) using audio and video communication technology (or audio-only communication in some cases), like through your phone or a computer. You can communicate with your provider through telehealth in several ways, including e-visits (non-face-to-face communications that usually happen through an online patient portal) and virtual check-ins (brief, real-time communications that usually last 10 minutes or less).

Telehealth can provide many services that generally occur in-person, including office visits, psychotherapy, consultations, and more. Through December 31, 2027, Medicare covers telehealth services that you can get from anywhere in the U.S., including your home.

Examples of Medicare-covered telehealth services include:

- Advance care planning
- Cardiac rehabilitation services
- Caregiver training services
- Cognitive assessments
- Depression screenings
- Diabetes self-management training
- Medical nutrition therapy services
- Outpatient psychotherapy
- Pulmonary rehabilitation services
- Speech therapy

Medicare may cover more telehealth services than those listed above. Check with your provider for more information about the services you can get through telehealth.

Costs

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

Things to know

Medicare Advantage Plans and some providers in Original Medicare may offer more telehealth benefits than the basic coverage in Original Medicare. If your provider in Original Medicare participates in an Accountable Care Organization (ACO), check with them to find out what telehealth benefits may be available.

More information

- Go to:
  - "E-visits" on page 44.
  - "Virtual check-ins" on pages 112–113.
- Visit **Medicare.gov/coverage/telehealth**.
- Visit **Medicare.gov/providers-services/coordinating-care**.

Therapeutic shoes or inserts

Therapeutic shoes or inserts are custom footwear that support and protect your feet if you have certain medical conditions (like a foot ulcer or deformity). 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 diabetes-related 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 depth-inlay shoes and 3 pairs of inserts
- One pair of custom-molded shoes (including inserts) if you can't wear depth-inlay shoes because of a foot deformity, and 2 more pairs of inserts

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

Costs

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

Things to know

The doctor or other health care provider who treats your diabetes must certify that you need therapeutic shoes or inserts. A podiatrist (foot doctor) or other doctor must order them, and you must get them from a podiatrist, orthotist, prosthetist, pedorthist, or other qualified individual.

More information

- Go to "Diabetes services" and "Diabetes supplies" on page 35.
- Visit Medicare.gov/coverage/therapeutic-shoes-inserts.

Transitional care management services

Part B may cover transitional care management services if you're returning to the community after an inpatient 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

After you meet the Part B deductible, you pay coinsurance for these services.

Things to know

The health care provider who's managing your transition back into the community will work with you, your family, caregivers, and other providers to coordinate and manage your care for the first 30 days after you return home.

The health care provider may also help you:

- Review information on the care you got in the facility
- Get information to help you transition back to living in the community
- Get referrals or make arrangements for follow-up care or community resources
- Schedule appointments
- Manage your medications

More information

- Go to "Caregiver training services" on pages 18–19.
- Visit 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 near the U.S.

Medicare may pay for inpatient hospital, doctor, or ambulance services you get in a foreign country if:

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

Medicare may cover medically necessary ambulance transportation to a foreign hospital only if it's part of your admission to the hospital for medically necessary covered inpatient hospital services.

Costs

In most cases, you pay all costs. In the rare situations described above, you pay the same coinsurance, copayments, and deductibles you'd pay if you got the services or supplies inside the U.S.

Things to know

The "U.S" includes the 50 states, the District of Columbia, Puerto Rico, the U.S. Virgin Islands, Guam, the Northern Mariana Islands, American Samoa, and territorial waters around U.S. land. Anywhere else is considered outside the U.S.

More information

Visit Medicare.gov/coverage/travel-outside-the-u.s.

Urgently needed care

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

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.

Vaccines

Vaccines work with your body's natural defenses to safely develop immunity (protection) against harmful germs (like viruses and bacteria). You usually get vaccines as a shot injected into your arm by a doctor or other health care provider. Part B covers preventive vaccines for:

- COVID-19: Go to pages 30–31.
- Flu: Go to page 47.
- Hepatitis B: Go to page 51.
- Pneumococcal: Go to page 88.

Part B also covers some non-preventive vaccines (like tetanus) when they're related directly to treating an injury or illness.

Medicare drug coverage (Part D) covers all adult vaccines recommended by the Advisory Committee on Immunization Practices (ACIP) that aren't covered under Part B, including vaccines for:

- Respiratory Syncytial Virus (RSV): Go to pages 100–101.
- Shingles: Go to page 103.
- Tdap: Go to page 107.
- Traveling (like yellow fever and chikungunya), measles, and more.

Your Part D plan won't charge you a copayment or apply a deductible for vaccines ACIP recommends. Contact your Part D plan for details, and talk to your provider about which vaccines are right for you.

Vaginal cancer screenings

Go to "Cervical & vaginal cancer screenings" on page 20.

Virtual check-ins

Virtual check-ins allow you to briefly communicate with your doctor or certain other health care providers using real-time audio or video communication technology (like your phone or a computer) without going to the doctor's office. Part B covers most virtual check-ins.

During a virtual check-in, your health care provider can conduct remote assessments using photos or videos you send to decide if you need an office visit or another service. Your provider can respond to you by phone, virtual delivery, secure text message, email, or patient portal.

Medicare Advantage Plans may offer more virtual check-in services than Original Medicare. Check with your plan to find out what they offer.

Costs

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

Things to know

Virtual check-ins are different from an e-visit because they're usually 10 minutes or less and happen in real time. An e-visit is a non-face-to-face communication that usually happens through an online patient portal. Both e-visits and virtual check-ins are specific types of telehealth.

You can have a virtual check-in if you:

- Talked to your provider about starting these types of services.
- Verbally consent to the virtual check-in, and your provider documents your consent in your medical record. Your provider may get one consent for a year's worth of these services.

More information

- Go to
  - "E-visits" on page 44.
  - "Telehealth" on page 108.
- Visit Medicare.gov/coverage/virtual-check-ins.

Walkers

Go to "Durable medical equipment (DME)" on pages 41–42.

Wheelchairs & scooters

Wheelchairs and scooters are mobility devices that can help you get around if you have a limited ability to walk. Part B covers wheelchairs and power-operated vehicles (scooters).

You must have a face-to-face examination and a written prescription from a treating provider before Medicare covers a power wheelchair or scooter. Part B covers power wheelchairs and scooters only when they're medically necessary.

More information

- Go to "Durable medical equipment (DME)" on pages 41–42.
- Visit Medicare.gov/coverage/wheelchairs-scooters.

X-rays

Go to "Diagnostic non-laboratory tests" on page 36.

CMS Accessible Communications

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

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

1. **Call us:**
   For Medicare: 1-800-MEDICARE (1-800-633-4227)
   TTY: 1-877-486-2048
   For Marketplace: 1-800-318-2596
   TTY: 1-855-889-4325
2. **Email us:** altformatrequest@cms.hhs.gov
3. **Send us a letter:**
   Centers for Medicare & Medicaid Services
   Offices of Hearings and Inquiries (OHI)
   7500 Security Boulevard, Mail Stop DO-01-20
   Baltimore, MD 21244-1850
   Attn: Customer Accessibility Resource Staff (CARS)

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

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

Nondiscrimination Notice

The Centers for Medicare & Medicaid Services (CMS) doesn't exclude, deny benefits to, or otherwise discriminate against any person on the basis of race, color, national origin, disability, sex, or age in admission to, participation in, or receipt of the services and benefits under any of its programs and activities, whether carried out by CMS directly or through a contractor or any other entity with which CMS arranges to carry out its programs and activities.

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

You may also file a complaint if you think you've been subjected to discrimination in a CMS program or activity, including experiencing issues with getting information in an accessible format from any Medicare Advantage Plan, Medicare drug plan, state or local Medicaid office, or Marketplace Qualified Health Plans. There are 3 ways to file a complaint with the U.S. Department of Health 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

Notes

U.S. Department of Health and Human Services
Centers for Medicare & Medicaid Services
7500 Security Blvd.
Baltimore, MD 21244-1850

Official Business
Penalty for Private Use, $300

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 es.Medicare.gov o llame al 1-800-MEDICARE (1-800-633-4227). Los usuarios de TTY pueden llamar al 1-877-486-2048.

Medicare

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

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

This product was produced at U.S. taxpayer expense.

CMS Product No. 10116 • March 2026