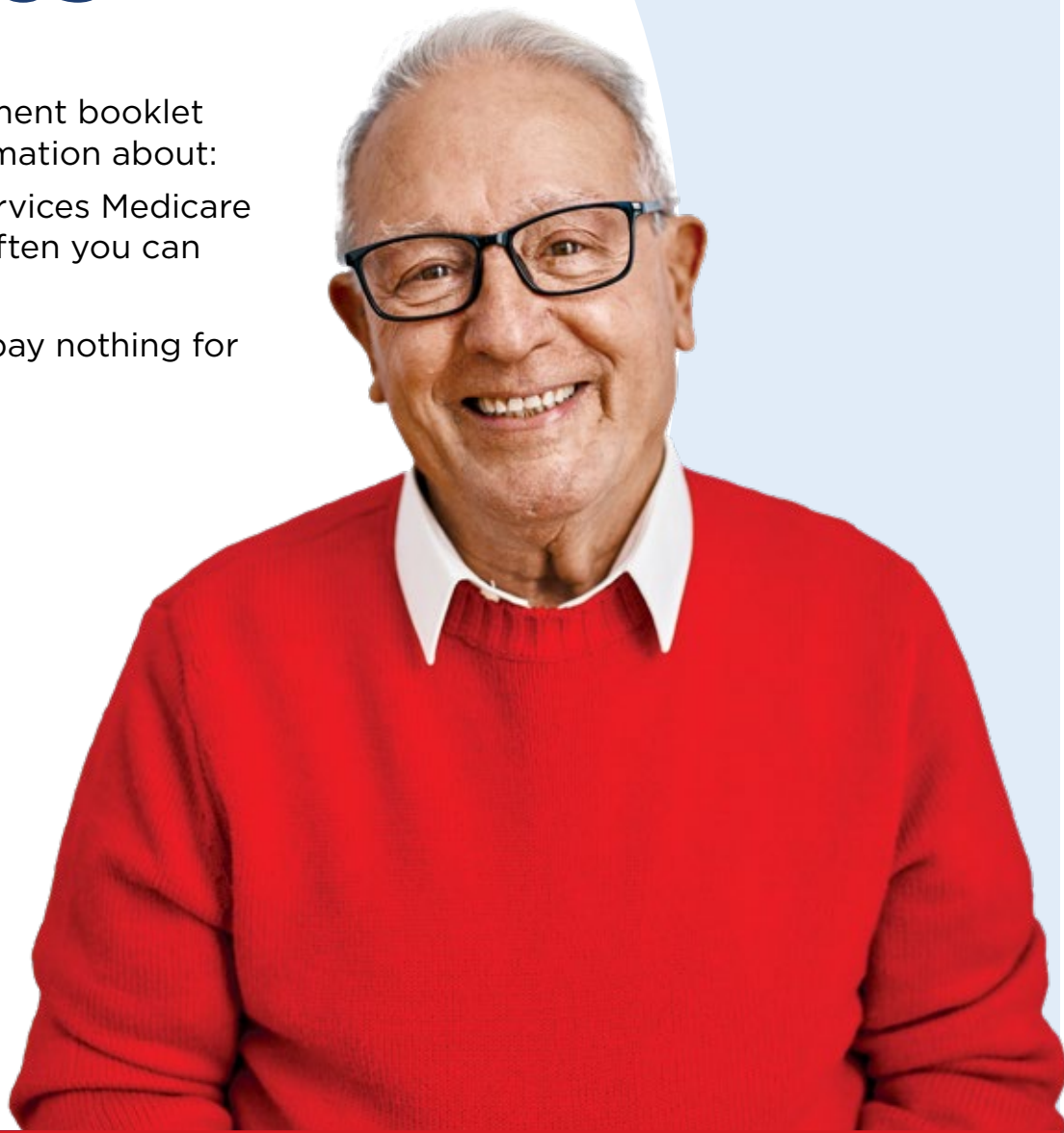


Your Guide to Medicare Preventive Services

This official government booklet has important information about:

- The preventive services Medicare covers and how often you can get them
- Your costs - you pay nothing for many services

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



Medicare

About this booklet

This booklet describes the preventive services that Medicare covers. Preventive services include exams, shots, lab tests, and screenings. They also include programs for health monitoring, and counseling and education to help you take care of your own health.

“Your Guide to Medicare Preventive Services” isn’t a legal document. Official Medicare Program legal guidance is contained in the relevant statutes, regulations and rulings.

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





Section 1:

Introduction

Medicare pays for many preventive services to keep you healthy. For example, if you have Medicare Part B (Medical Insurance), you can get a yearly “Wellness” visit and many other covered preventive services, like colorectal cancer screenings and mammograms. Preventive services can find health problems early, when treatment works best. Talk to your doctor or other provider to find out which preventive services are right for you and how often you need them. Your provider may order exams or tests that Medicare doesn’t cover. They also may recommend that you have tests more or less often than Medicare covers them.

If you get a service that Medicare doesn’t cover and you think it should, you may appeal this decision. To file an appeal, follow the instructions on your “Medicare Summary Notice” (MSN). For more information on filing an appeal, visit [Medicare.gov/appeals](https://www.medicare.gov/appeals), or call 1-800-MEDICARE (1-800-633-4227). TTY users can call 1-877-486-2048.

This booklet explains your costs under Original Medicare (Part A and Part B). Your costs for preventive services may be different if you're in a Medicare health plan, have other insurance, or visit providers that don't accept assignment. Contact your plan or benefits administrator directly to find out about costs. For more information about Medicare health plans, visit [Medicare.gov/health-drug-plans/health-plans](https://www.Medicare.gov/health-drug-plans/health-plans).

Things to know when reading this booklet

Symbols

To find out if Medicare covers a service or test for men, women or both men and women, look for one of these symbols next to each preventive service:



Risk factors

With some services, you'll see lists of factors that increase your risk of developing a certain disease. If you're not sure if you're at high risk, talk to your doctor.

Part B deductible

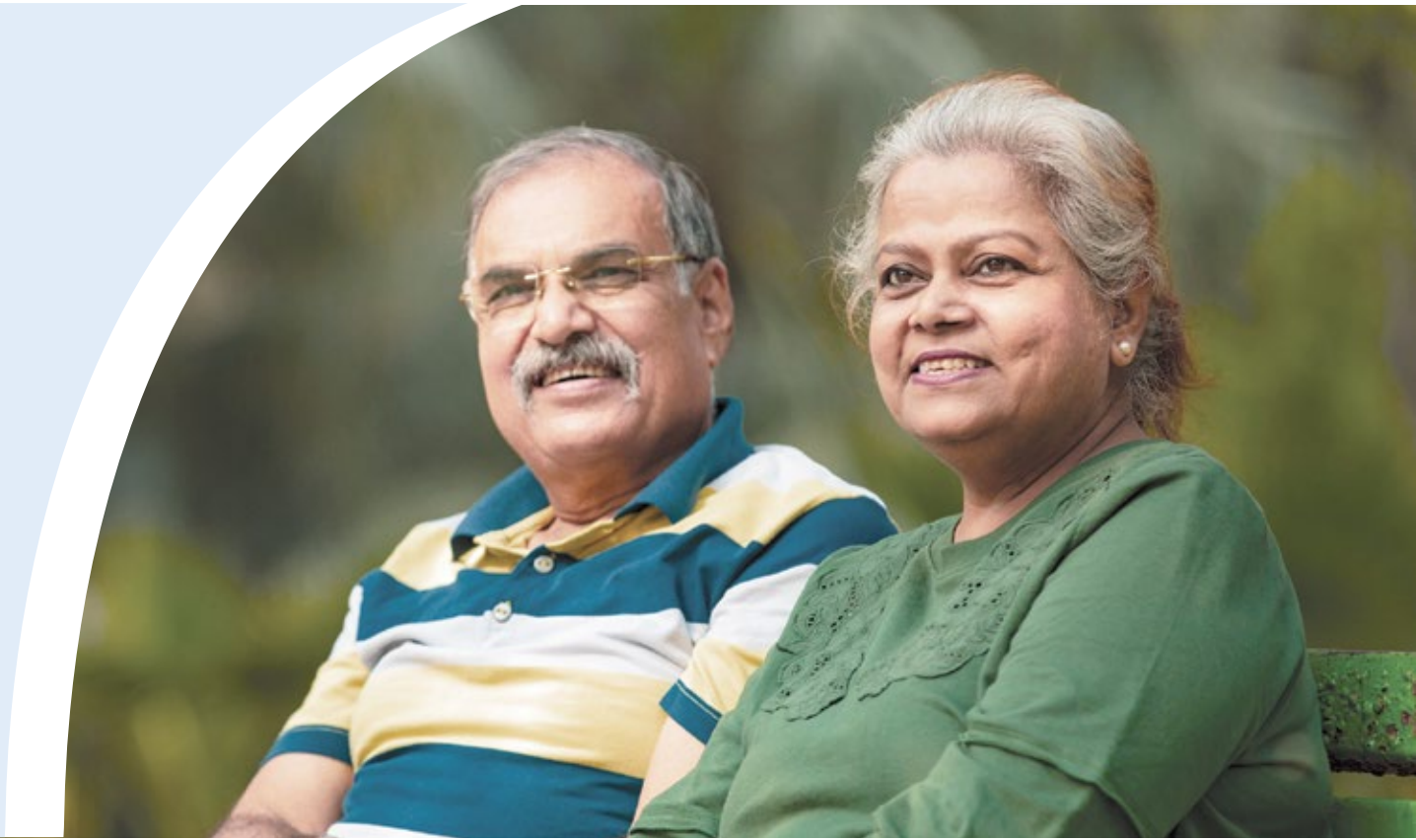
The Part B deductible changes each year. Find the current deductible amount at [Medicare.gov/basics/costs/medicare-costs](https://www.Medicare.gov/basics/costs/medicare-costs).

Assignment

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

Medicare-approved amount

The Medicare-approved amount is the payment amount that Original Medicare sets for a covered service or item. This amount may be less than the actual amount a doctor or other provider charges. When your provider accepts assignment, Medicare pays its share of this amount and you pay your share, including the Medicare deductible and coinsurance.



Section 2:

Preventive Services

This is an alphabetical list of all Medicare-covered preventive services.



Abdominal aortic aneurysm screening

Am I covered?

Medicare covers an abdominal aortic aneurysm screening ultrasound if you're at risk.

How often does Medicare cover it?

Once in your lifetime if you get a referral from your doctor or other provider.

What are my costs if I have Original Medicare?

You pay nothing if your provider accepts assignment.

Am I at risk for abdominal aortic aneurysms?

You're considered at risk if any of these are true:

- You have a family history of abdominal aortic aneurysms.
- You're a man 65-75 and have smoked at least 100 cigarettes in your lifetime.



Alcohol misuse screening and counseling

Am I covered?

Medicare covers an alcohol misuse screening if you're an adult (including a pregnant person) who uses alcohol, but doesn't meet the medical criteria for alcohol dependency.

How often does Medicare cover it?

Medicare covers one alcohol misuse screening per year. If your primary care doctor or other provider determines you're misusing alcohol, you can get up to 4 brief, face-to-face counseling sessions per year (if you're competent and alert during counseling). You must get the counseling in a primary care setting (like a doctor's office).

What are my costs if I have Original Medicare?

You pay nothing if your provider accepts assignment.



Bone mass measurements

Medicare covers bone mass measurements to see if you're at risk for broken bones. Your results will help you and your doctor or other provider choose the best way to keep your bones strong.

Am I covered?

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

- You're a woman whose 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 plan to begin this treatment.
- You've been diagnosed with primary hyperparathyroidism.
- You're taking an osteoporosis drug.

How often does Medicare cover it?

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

What are my costs if I have Original Medicare?

You pay nothing if your provider accepts assignment.



Cardiovascular behavioral therapy

Cardiovascular behavioral therapy helps lower your risk for cardiovascular disease. Medicare covers a cardiovascular behavioral therapy visit with your primary care doctor or other primary care practitioner in a primary care setting (like a doctor's office). During this visit, your primary care practitioner may discuss aspirin use, check your blood pressure, and give you tips on diet and exercise.

Am I covered?

Yes. All people with Medicare can get cardiovascular behavioral therapy.

How often does Medicare cover it?

Once each year.

What are my costs if I have Original Medicare?

You pay nothing if your primary care practitioner accepts assignment.

Am I at risk for cardiovascular disease?

Your risk for cardiovascular disease may increase if:

- You have high blood pressure.
- You have unhealthy cholesterol levels.
- You have diabetes.
- You're overweight.
- You use tobacco and/or drink alcohol.
- You don't get enough physical activity.
- You have an unhealthy diet.
- You have a family history of heart disease.
- You have a history of preeclampsia (a sudden rise in blood pressure and too much protein in the urine during pregnancy).
- You're a woman 55 or older, or a man 45 or older.



Cardiovascular disease screenings

Medicare covers cardiovascular disease screenings that check your cholesterol, blood fat (lipid), and triglyceride levels. High levels of cholesterol can increase your risk for heart disease and stroke.

Am I covered?

Yes. All people with Medicare can get cardiovascular disease screenings when a doctor or other provider orders them.

How often does Medicare cover it?

Once every 5 years.

What are my costs if I have Original Medicare?

You pay nothing if your provider accepts assignment.

Am I at risk for cardiovascular disease?

Refer to “Cardiovascular behavioral therapy” on page 5 for a list of risk factors.



Cervical and vaginal cancer screenings

Medicare covers Pap tests and pelvic exams to check for cervical and vaginal cancers. As part of the pelvic exam, Medicare also covers a clinical breast exam to check for breast cancer.

Am I covered?

If you're a woman, Medicare covers cervical and vaginal cancer screenings.

How often does Medicare cover it?

Medicare covers these screening tests once every 24 months in most cases. If you're at high risk for cervical or vaginal cancer, or if you're of child-bearing age and had an abnormal Pap test in the past 36 months, Medicare covers these screening tests once every 12 months.

Medicare also covers Human Papillomavirus (HPV) tests (as part of Pap tests) once every 5 years if you're 30-65 and don't have HPV symptoms.

What are my costs if I have Original Medicare?

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

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

Cervical and vaginal cancer screenings (continued)

Am I at risk for cervical cancer?

Your risk for cervical cancer increases if:

- You have a history of sexually transmitted disease (including HIV infection).
- You began having sex before 16.
- You've had 5 or more sexual partners.
- You haven't had a Pap smear within the last 7 years.
- You've only had 1 or 2 normal Pap smears within the last 7 years.
- Your mother took DES (Diethylstilbestrol), a hormonal drug, when she was pregnant with you.



Colorectal cancer screenings

Medicare covers colorectal cancer screening tests to help find precancerous polyps (growths in the colon) or detect cancer early, when treatment works best.

Am I covered?

If you're 45 or older, Medicare covers most colorectal cancer screenings (including fecal occult blood tests (screening), flexible sigmoidoscopy screenings, barium enemas (screening), multi-target stool DNA tests (through age 85), and blood-based bio-marker screening tests for colorectal cancer (through age 85)).

There's no minimum age for getting a Medicare-covered screening colonoscopy.

How often does Medicare cover it?

- **Screening colonoscopy**—Once every 120 months (or once every 24 months if you're at high risk), or 48 months after a previous flexible sigmoidoscopy. If you initially have a non-invasive stool-based screening test (fecal occult blood tests or multi-target stool DNA test) and get a positive result, Medicare also covers a follow-up colonoscopy as a screening test.
- **Screening fecal occult blood test**—Once every 12 months, if you get a written referral from your doctor, physician assistant, nurse provider, or clinical nurse specialist.
- **Screening flexible sigmoidoscopy**—Once every 48 months for most people. If you aren't at high risk for colorectal cancer, Medicare covers this test 120 months after a previous screening colonoscopy.
- **Screening barium enema**—Once every 48 months (or once every 24 months if you're at high risk) when used instead of a flexible sigmoidoscopy or screening colonoscopy.

Colorectal cancer screenings (continued)

- **Multi-target stool DNA test**—Once every 3 years if you meet **all** of these conditions:
 - You’re between 45–85.
 - You show no signs or symptoms of colorectal disease including, but not limited to, lower gastrointestinal pain, blood in stool, positive guaiac fecal occult blood test, or fecal immunochemical test.
 - You’re at average risk for developing colorectal cancer, meaning:
 - You have no personal history of adenomatous polyps, colorectal cancer, or inflammatory bowel disease (including Crohn’s Disease and ulcerative colitis).
 - You have no family history of colorectal cancers or adenomatous polyps, familial adenomatous polyposis, or hereditary nonpolyposis colorectal cancer.
- **Blood-based biomarker screening tests for colorectal cancer**—Once every 3 years if you meet **all** of these conditions:
 - You’re between 45–85.
 - You show no signs or symptoms of colorectal disease including, but not limited to, lower gastrointestinal pain, blood in stool, positive guaiac fecal occult blood test, or fecal immunochemical test.
 - You’re at average risk for developing colorectal cancer, meaning:
 - You have no personal history of adenomatous polyps, colorectal cancer, or inflammatory bowel disease (including Crohn’s Disease and ulcerative colitis).
 - You have no family history of colorectal cancers or adenomatous polyps, familial adenomatous polyposis, or hereditary nonpolyposis colorectal cancer.

What are my costs if I have Original Medicare?

You pay nothing for the fecal occult blood test, blood-based biomarker test, flexible sigmoidoscopy, screening colonoscopy, or multi-target stool DNA test if your doctor or other provider accepts assignment.

Note: If your provider finds and removes a polyp or other tissue during your colonoscopy or flexible sigmoidoscopy, 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.

For barium enemas, you pay 20% of the Medicare-approved amount for your provider’s services. The Part B deductible doesn’t apply. In a hospital outpatient setting, you also pay the hospital a copayment.

Colorectal cancer screenings (continued)

Am I at risk for colorectal cancer?

Risk for colorectal cancer increases with age. It's important to continue with screenings, even if you were screened before you had Medicare. Your risk for colorectal cancer increases if:

- You've had colorectal cancer before.
- You have a history of polyps.
- You have a close relative who had colorectal polyps or colorectal cancer.
- You have inflammatory bowel disease (like ulcerative colitis or Crohn's disease).



Counseling to prevent tobacco use and tobacco-caused disease

According to the U.S. Surgeon General, people who quit smoking and stop using other forms of tobacco can significantly lower their risk of developing certain diseases. This is true even in older adults who've smoked for years.

Am I covered?

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

How often does Medicare cover it?

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

What are my costs if I have Original Medicare?

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

Ask your provider about Medicare-covered tobacco cessation programs near you, or visit [NIH.gov](https://www.nih.gov) for more information about stopping tobacco use.



COVID-19 vaccines

Medicare covers FDA-approved and FDA-authorized COVID-19 vaccines.

Am I covered?

Yes. All people with Medicare can get COVID-19 vaccines.

What are my costs if I have Original Medicare?

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



Depression screenings

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](https://www.988lifeline.org). Call 911 if you're in an immediate medical crisis.

Am I covered?

Yes. All people with Medicare can get depression screenings.

How often does Medicare cover it?

Medicare covers one depression screening per year. You must get the screening in a primary care setting (like a doctor's office) where you can get follow-up treatment and referrals.

What are my costs if I have Original Medicare?

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



Diabetes screenings and self-management training

Diabetes is a medical condition in which your body doesn't make enough insulin, or has a reduced response to insulin. Diabetes causes your blood sugar to be too high because your body needs insulin to use sugar properly. A high blood sugar level isn't good for your health.

Diabetes screenings

Am I covered?

Medicare covers blood glucose (blood sugar) laboratory test screenings (including the Hemoglobin A1C test, and other tests with or without a carbohydrate challenge) if your doctor or other provider determines you're at risk for developing diabetes.

How often does Medicare cover it?

You can get up to 2 diabetes screenings per year (within 12 months of your most recent screening).

What are my costs if I have Original Medicare?

You pay nothing if your provider accepts assignment.

Diabetes screenings and self-management training (continued)

Am I at risk for diabetes?

You're considered at risk if you have high blood pressure, a history of abnormal cholesterol and triglyceride levels, obesity, or a history of high blood sugar (glucose). Medicare also covers these tests if 2 or more of these 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 you've had a baby weighing more than 9 pounds.

Diabetes self-management training

Am I covered?

If you've been diagnosed with diabetes and have a written order from your provider, Medicare covers outpatient diabetes self-management training to help you cope with and 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.

How often does Medicare cover it?

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 initial training.

What are my costs if I have Original Medicare?

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



Flu shots

Am I covered?

Yes. All people with Medicare can get the seasonal flu shot.

How often does Medicare cover it?

Once each flu season.

What are my costs if I have Original Medicare?

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



Glaucoma screenings

Glaucoma is an eye disease caused by high pressure in the eye. It can develop gradually without warning and often without symptoms. The best way for people at high risk for glaucoma to protect themselves is to have regular eye exams.

Am I covered?

Medicare covers these screenings if you're at high risk for developing glaucoma.

How often does Medicare cover it?

Once every 12 months.

What are my costs if I have Original Medicare?

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.

Am I at risk for glaucoma?

Your risk for glaucoma increases if:

- 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.



Hepatitis B Shots

Am I covered?

Medicare covers Hepatitis B shots if you're at medium or high risk for Hepatitis B.

What are my costs if I have Original Medicare?

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

Am I at risk for Hepatitis B?

Your Hepatitis B risk increases if one or more of these conditions applies to you:

- You have hemophilia and you get factors VII or IX.
- You have End-Stage Renal Disease (ESRD) (permanent kidney failure requiring dialysis or a kidney transplant).
- You have diabetes.
- You live with someone who has Hepatitis B.
- You're a health care worker and have frequent contact with blood or bodily fluids.

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



Hepatitis B Virus (HBV) infection screenings

Am I covered?

Medicare covers HBV infection screenings if you meet one of these conditions:

- You're at high risk for HBV infection.
- You're pregnant.

Medicare only covers this screening if your Medicare-enrolled doctor or other provider orders it.

How often does Medicare cover it?

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

What are my costs if I have Original Medicare?

You pay nothing if your provider accepts assignment.

Am I at risk for HBV?

Your risk for HBV increases if:

- You were born in a country or region with a high prevalence of HBV infection.
- You were born in the U.S., not vaccinated as an infant, and your parents were born in regions with a very high prevalence of HBV infection.
- You're HIV-positive.
- You're a man who has sex with men.
- You're an injection drug user.
- You have household contacts or sexual partners with HBV infection.



Hepatitis C screening tests

Am I covered?

Medicare covers a Hepatitis C screening if your primary care doctor or other 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 does Medicare cover it?

Once, if you were born between 1945-1965 and aren't considered high risk. If you're at high risk, Medicare covers yearly screenings.

What are my costs if I have Original Medicare?

You pay nothing if your provider accepts assignment.



HIV (Human Immunodeficiency Virus) screenings

Am I covered?

Medicare covers HIV screenings if you meet one of these conditions:

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

How often does Medicare cover it?

Once every 12 months, if you meet one of the conditions above. If you're pregnant, you can get a screening up to 3 times during your pregnancy.

What are my costs if I have Original Medicare?

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

Am I at risk for HIV?

Your risk for HIV may increase if:

- You're a past or present injection drug user.
- You exchange sex for money or drugs, or have sex partners who do.
- You have past or present sex partners who are HIV-infected, bisexual, or injection drug users.
- You have another sexually transmitted disease.
- You have a history of blood transfusions between 1978 and 1985.
- You have new sexual partners.



Lung cancer screenings

Am I covered?

Medicare covers lung cancer screenings with low dose computed tomography (also known as “CT scans”) if you meet **all** of these conditions:

- You’re 50–77.
- You don’t have signs or symptoms of lung cancer (you’re asymptomatic).
- 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’re either a current smoker, or you quit smoking within the last 15 years.
- You get an order from your doctor or other provider.

How often does Medicare cover it?

Once each year.

What are my costs if I have Original Medicare?

You pay nothing if your provider accepts assignment.

Am I at risk for lung cancer?

Your risk for lung cancer may increase if:

- You currently smoke tobacco products or smoked them in the past.
- You’ve been exposed to secondhand smoke.
- You’ve been exposed to radon, asbestos, or other cancer-causing agents.
- You have a family history of lung cancer.



Mammograms (Breast cancer screenings)

Medicare covers screening mammograms to check for breast cancer before you or a doctor may be able to find it. Every woman is at risk, and this risk increases with age. Breast cancer can usually be treated when found early.

Am I covered?

If you’re a woman 40 or older, Medicare covers an annual screening mammogram. Medicare also covers diagnostic mammograms and, if you’re a woman between 35–39, one baseline mammogram.

Mammograms (Breast Cancer screenings) (continued)

How often does Medicare cover it?

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

What are my costs if I have Original Medicare?

- Screening and baseline mammograms: You pay nothing for the test if your doctor or other provider accepts assignment.
- Diagnostic mammograms: After you meet the Part B deductible, you pay 20% of the Medicare-approved amount.



Medical nutrition therapy services

Medicare may cover medical nutrition therapy services and certain related services if a doctor refers you for them. Only a registered dietitian or nutrition professional who meets certain requirements can provide medical nutrition therapy. Services may include:

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

Am I covered?

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

What are my costs if I have Original Medicare?

You pay nothing for nutrition therapy services if you qualify for them.



Medicare Diabetes Prevention Program

The Medicare Diabetes Prevention Program is a health behavior change program to help you prevent type 2 diabetes. In this program, 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.

Am I covered?

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

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

How often does Medicare cover it?

The program begins with weekly core sessions offered in a group setting over a 6-month period. Once you complete the core sessions, you'll get 6 monthly follow-up sessions to help you maintain healthy habits.

What are my costs if I have Original Medicare?

You pay nothing for this program if you qualify for it.



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. Medicare covers obesity screenings and behavioral counseling if your primary care doctor or other primary care practitioner gives the counseling in a primary care setting (like a doctor's office), where they can coordinate your personalized plan with your other care.

Am I covered?

Medicare covers obesity screenings and behavioral counseling if you have a BMI of 30 or more.

What are my costs if I have Original Medicare?

You pay nothing if your primary care practitioner accepts assignment.



Pneumococcal shots

Medicare covers pneumococcal shots (or vaccines) to help protect against different types of pneumonia. Talk with your doctor or other provider to decide which immunizations are right for you.

Am I covered?

Yes. All people with Medicare can get pneumococcal shots.

What are my costs if I have Original Medicare?

You pay nothing if your provider accepts assignment.



Prostate cancer screenings

Your doctor or other provider may find prostate cancer by testing the amount of prostate specific antigen (PSA) in your blood. Your provider can also find prostate cancer during a digital rectal exam.

Am I covered?

Medicare covers digital rectal exams and PSA blood tests if you're over 50 (starting the day after your 50th birthday).

How often does Medicare cover it?

- Digital rectal exam—Once every 12 months.
- PSA blood test—Once every 12 months.

What are my costs if I have Original Medicare?

- **Digital rectal exams:** After you meet the Part B deductible, you pay 20% of the Medicare-approved amount for a yearly digital rectal exam and for your provider's services related to the exam. In a hospital outpatient setting, you also pay a separate hospital visit copayment.
- **PSA blood tests:** You pay nothing for a yearly PSA blood test. If you get the test from a provider that doesn't accept assignment, you may have to pay an additional fee for your provider's services, but not for the test itself.

Am I at risk for prostate cancer?

Talk to your provider to find out if you're at risk for prostate cancer.



Sexually transmitted infection screenings & counseling

Medicare covers sexually transmitted infection screenings for chlamydia, gonorrhea, syphilis, and/or Hepatitis B.

Am I covered?

Medicare covers these screenings and counseling if you're pregnant or at increased risk for sexually transmitted infections. Your primary care provider must order the screening or refer you for behavioral counseling.

How often does Medicare cover it?

Medicare covers sexually transmitted infection screenings once every 12 months or at certain times during pregnancy. Medicare also covers up to 2 behavioral counseling sessions each year. 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).

What are my costs if I have Original Medicare?

You pay nothing if your provider accepts assignment.



Shots or vaccines

Medicare covers:

- COVID-19 vaccines: Go to page 9.
- Flu shots: Go to page 11.
- Hepatitis B shots: Go to page 12.
- Pneumococcal shots: Go to page 18.
- Some other vaccines (like tetanus) when they're related directly to the treatment of an injury or illness. These aren't considered preventive services.

Medicare drug coverage (Part D) covers all vaccines that that the Advisory Committee on Immunization Practices (ACIP) recommends, including the vaccines for Respiratory Syncytial Virus (RSV), shingles, whooping cough, and more. Your Part D plan won't charge you a copayment or apply a deductible for vaccines the ACIP recommends. Contact your Medicare drug plan for details and talk to your provider about which ones are right for you.

Am I covered?

Yes. All people with Medicare can get COVID-19 vaccines, and flu, Hepatitis B, and pneumococcal shots.

What are my costs if I have Original Medicare?

You pay nothing for most shots and vaccines.



“Welcome to Medicare” preventive visit

The “Welcome to Medicare” preventive visit isn’t a physical exam.

Medicare covers a “Welcome to Medicare” preventive visit. This visit is a great way to get up-to-date on important screenings and shots and to talk with your doctor or other health care provider about your family history and how to stay healthy.

Am I covered?

Yes. All people with Medicare can get a “Welcome to Medicare” preventive visit.

How often does Medicare cover it?

You can get this one-time preventive visit within the first 12 months you have Medicare Part B.

What happens during the visit?

During the visit, your provider will:

- Review your medical and social history related to your health.
- Give you information about preventive services, including certain screenings, shots, or vaccines (like flu, pneumococcal, and other recommended immunizations).
- 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.
- Review your potential risk for substance use disorder (like opioid prescription, alcohol, or tobacco use), and refer you for treatment.
- Give you a written plan (like a checklist) letting you know what screenings, shots, and other preventive services you need.
- Give you referrals for other care as needed.

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

- Review your potential risk factors for 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.

“Welcome to Medicare” preventive visit (continued)

What should I bring to the visit?

When you go to your “Welcome to Medicare” preventive visit, bring:

- Your medical records, including immunization records (if you’re seeing a new provider). Call your old provider to get copies of your medical records.
- Your family health history. Try to learn as much as you can about your family’s health history before your appointment. Any information you can give your provider can help determine if you’re at risk for certain diseases.
- A list of prescription and over-the-counter drugs that you currently take, how often you take them, and why.

What are my costs if I have Original Medicare?

You pay nothing if your provider accepts assignment. The Part B deductible doesn’t apply. However, you may have to pay a coinsurance, and the Part B deductible may apply if your provider performs additional tests or services during the same visit that Medicare doesn’t cover under this preventive benefit. If Medicare doesn’t cover the additional tests or services (like a routine physical exam), you may have to pay the full amount.



Yearly “Wellness” visit

The yearly “Wellness” visit isn’t a physical exam.

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

- A review of your medical and family history.
- A review of your current prescriptions.
- Routine measurements (like height, weight, and blood pressure).
- A cognitive assessment to look for signs of dementia, including Alzheimer’s disease.
- Personalized health advice.
- An evaluation of your risk factors for substance use disorder and a referral for treatment, if needed.
- A screening schedule (like a checklist) for appropriate preventive services.
- Advance care planning.
- An optional “Social Determinants of Health Risk Assessment” to help your provider understand your social needs and their impact on your treatment.

Yearly “Wellness” visit (continued)

Am I covered?

If you’ve had Medicare 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.

How often does Medicare cover it?

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

Your costs if you have Original Medicare

You pay nothing if your provider accepts assignment. The Part B deductible doesn’t apply. However, you may have to pay a coinsurance, and the Part B deductible may apply if your provider performs additional tests or services during the same visit that Medicare doesn’t cover under this preventive benefit. If Medicare doesn’t cover the additional tests or services (like a routine physical exam), you may have to pay the full amount.

For more information about Medicare preventive services

You can learn more about Medicare’s preventive services by visiting [Medicare.gov/coverage/preventive-screening-services](https://www.medicare.gov/coverage/preventive-screening-services). You can also call 1-800-MEDICARE (1-800-633-4227). TTY users can call 1-877-486-2048.

CMS Accessible Communications

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

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

1. Call us:

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

For Marketplace: 1-800-318-2596 TTY: 1-855-889-4325

2. Email us: altformatrequest@cms.hhs.gov

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

4. Send us a letter:

Centers for Medicare & Medicaid Services

Offices of Hearings and Inquiries (OHI)

7500 Security Boulevard, Mail Stop DO-01-20

Baltimore, MD 21244-1850

Attn: Customer Accessibility Resource Staff (CARS)

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 Medical Assistance (Medicaid) office.

Nondiscrimination Notice

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

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

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

1. Online:

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

2. By phone:

Call 1-800-368-1019.

TTY users can call 1-800-537-7697.

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

Office for Civil Rights

U.S. Department of Health & Human Services

200 Independence Avenue, SW

Room 509F, HHH Building

Washington, D.C. 20201

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

Official Business
Penalty for Private Use, \$300

Need a copy of this booklet in Spanish?

To get a free copy of this booklet in Spanish, visit [Medicare.gov](https://www.Medicare.gov) or call 1-800-MEDICARE (1-800-633-4227). TTY users can call 1-877-486-2048.

Esta publicación está disponible en español. Para obtener una copia gratis, visite [Medicare.gov](https://www.Medicare.gov) o llame al 1-800-MEDICARE.



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

“Your Guide To Medicare Preventive Services” 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.