



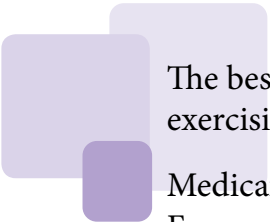
Your Guide to Medicare Preventive Services

CENTERS FOR MEDICARE & MEDICAID SERVICES

This is an official government booklet with important information about:

- What disease prevention is and why it's important
- Which preventive services Medicare covers and how often
- Who can get services
- What you pay – you pay nothing for many services

YOUR GUIDE TO MEDICARE PREVENTIVE SERVICES



The best way to stay healthy is to live a healthy lifestyle and prevent disease by exercising, eating well, keeping a healthy weight, and not smoking.

Medicare can help. 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. 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’s 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

Introduction

Talk to your doctor or health care provider

Talk to your doctor or health care provider to find out which preventive services are right for you and how often you need them. Your doctor or health care 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. Medicare pays for some diagnostic tests. Your doctor or other health care provider may recommend a diagnostic test when a screening test or exam shows an abnormality. In some cases, you may have to pay for these services.

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.

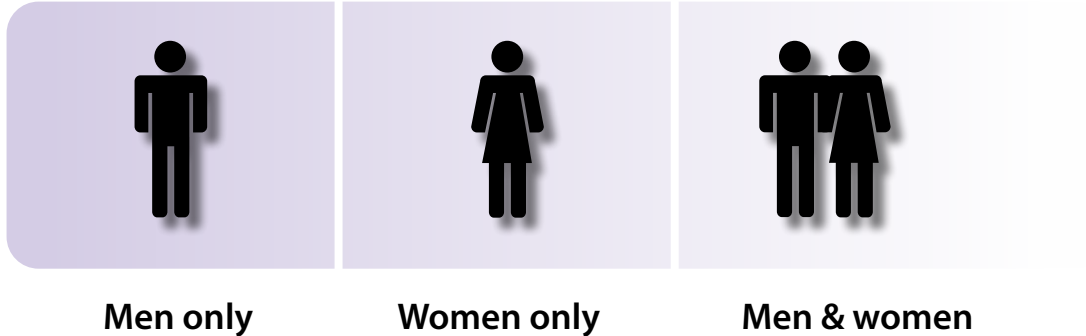
Your costs for preventive services may be different if you're in a Medicare health plan, have other insurance, or see doctors or providers that don't accept assignment. Contact your plan or benefits administrator directly to find out about the costs. For more information about Medicare health plans, visit [Medicare.gov/sign-up-change-plans/different-types-of-medicare-health-plans](https://www.Medicare.gov/sign-up-change-plans/different-types-of-medicare-health-plans).

Remember—
Medicare covers the services listed in this booklet if you have Medicare Part B (Medical Insurance).

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

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 out 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 accept the payment amount Medicare approves for the service, and not to bill you for any more than the Medicare deductible and coinsurance.

Medicare-approved amount

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

SECTION

Preventive Services

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



Abdominal aortic aneurysm screening

Who's covered?

Medicare covers a one-time abdominal aortic aneurysm ultrasound for people at risk.

How often does Medicare cover it?

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

What are my costs if I have Original Medicare?

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

Remember—
Medicare covers the services listed in this booklet if you have Medicare Part B (Medical Insurance).



Alcohol misuse screening and counseling

Who's covered?

Adults with Medicare (including pregnant people) who use alcohol, but don'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 primary care 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). The provider must give you 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 primary care doctor or other primary care provider accepts assignment.



Bone mass measurements

Medicare covers bone mass measurements to see if you're at risk for broken bones due to osteoporosis. Osteoporosis is a disease in which your bones become weak and brittle. In general, the lower your bone density, the higher your risk for a fracture. Bone mass measurement results will help you and your doctor choose the best way to keep your bones strong.

Who's covered?

Certain people with Medicare whose doctors say they're at risk for osteoporosis, and who have one of these medical conditions:

- A woman whose doctor or health care provider says she's estrogen-deficient and at risk for osteoporosis, based on her medical history and other findings
- A person with vertebral abnormalities as demonstrated by an X-ray
- A person getting (or expecting to get) steroid treatments
- A person with hyperparathyroidism
- A person taking an osteoporosis drug

How often does Medicare cover it?

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

What are my costs if I have Original Medicare?

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



Cardiovascular behavioral therapy

Who's covered?

All people with Medicare.

What's covered?

A cardiovascular disease risk reduction visit that includes:

- Encouraging aspirin use when benefits outweigh risks
- Screening for high blood pressure
- Counseling to promote a healthy diet

How often is it covered?

Once each year.

What are my costs if I have Original Medicare?

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

Am I at risk for cardiovascular disease?

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



Cardiovascular disease screenings

Medicare covers cardiovascular disease screenings that check your cholesterol and other blood fat (lipid) levels. High levels of cholesterol can increase your risk for heart disease and stroke. These screenings will tell if you have high cholesterol.

Who's covered?

All people with Medicare when a doctor orders the screening.

What's covered?

Tests for cholesterol, lipid, and triglyceride levels.

How often does Medicare cover it?

Once every 5 years.

What are my costs if I have Original Medicare?

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



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.

Who's covered?

All women with Medicare.

How often does Medicare cover it?

Once every 24 months, or once every 12 months if you're at high risk for cervical or vaginal cancer, or if you're of child-bearing age and had an abnormal Pap test in the past 36 months.

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

What are my costs if I have Original Medicare?

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

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

Am I at high risk for cervical cancer?

Your risk for cervical cancer increases if any of these are true:

- 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 pre-cancerous polyps (growths in the colon), so polyps can be removed before they become cancerous and to help find colorectal cancer at an early stage when treatment works best.

Who's covered?

All people with Medicare 45 and older, but there's no minimum age for having a covered screening colonoscopy.

How often does Medicare cover it?

- **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 after the last flexible sigmoidoscopy or barium enema for most people. If you aren't at high risk, Medicare covers this test, 120 months after a previous screening colonoscopy.
- **Screening colonoscopy**—Once every 120 months (high risk every 24 months), or 48 months after a previous flexible sigmoidoscopy.
- **Screening barium enema**—Once every 48 months (high risk every 24 months) when used instead of sigmoidoscopy or colonoscopy.
- **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.

Colorectal cancer screenings (continued)

- **Blood-based biomarker 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.

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 health care provider accepts assignment.

Note: If your doctor finds and removes a polyp or other tissue during your colonoscopy, you pay 15% of the Medicare-approved amount for your doctor’s services. In a hospital outpatient setting or ambulatory surgical center, you also pay a 15% coinsurance amount.

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

Am I at high 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 any of these are true:

- 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

The U.S. Surgeon General has reported that quitting smoking and stopping other forms of tobacco use lead to significant risk reduction for certain diseases and other health benefits, even in older adults who've smoked for years. Medicare covers smoking and tobacco-use cessation counseling for people who use tobacco.

Who's covered?

People with Medicare who use tobacco.

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 health care provider accepts assignment.

Ask your doctor about Medicare-covered tobacco cessation programs near you, or visit nih.gov for more information about stopping tobacco use.



COVID-19 vaccines

Medicare covers the FDA-approved and FDA-authorized COVID-19 vaccine.

Who's covered?

All people with Medicare.

What are my costs if I have Original Medicare?

You pay nothing for the vaccine for as long as the federal government continues buying and distributing the vaccine. You won't pay a deductible or copayment, and your provider can't charge you an administration fee to give you the shot. When the federal government stops buying and distributing the vaccine, you'll still pay nothing for the vaccine if your doctor or other qualified health care provider accepts assignment.



Depression screenings

Who's covered?

All people with Medicare. 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.

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 accepts assignment.



Diabetes screening 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. Medicare covers a blood screening test to check for diabetes for people at risk. For people with diabetes, Medicare covers educational training to help manage their diabetes.

Diabetes screening (fasting blood glucose test)

Who's covered?

People who are at risk for diabetes and get a referral from a doctor.

How often does Medicare cover it?

Based on the results of your screening tests, you may be eligible for up to 2 diabetes screenings per year.

What are my costs if I have Original Medicare?

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

Diabetes screening and self-management training (continued)

Am I at risk for diabetes?

You're considered at risk if you have high blood pressure, dyslipidemia (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, brothers, or sisters).

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

Who's covered?

This training is for people with diabetes to teach them to manage their condition and prevent complications. You need a written order from a doctor or other health care provider.

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

Medicare covers the seasonal flu shot (or vaccine).

Who's covered?

All people with Medicare.

How often does Medicare cover it?

Once each flu season.

What are my costs if I have Original Medicare?

You pay nothing.



Glaucoma tests

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.

Who's covered?

People with Medicare at high risk for 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 high risk for glaucoma?

Your risk for glaucoma increases if any of these are true:

- 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

Who's 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 health care provider accepts assignment.

Hepatitis B Shots (continued)

Am I at high risk for Hepatitis B?

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

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

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



Hepatitis B Virus (HBV) infection screenings

Who's 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 will only cover this screening if a primary care doctor or provider orders it.

How often does Medicare cover it?

- Yearly only for those with continued high risk who don't get a Hepatitis B vaccination.
- For pregnant women:
 - At the first prenatal visit for each pregnancy.
 - At the time of delivery for those with new or continued risk factors.
 - At the first prenatal visit for future pregnancies, even if you previously got the Hepatitis B shot or had negative HBV screening results.

Hepatitis B Virus (HBV) infection screenings (continued)

Are you at risk?

Your risk for HBV increases if:

- You were born in countries and regions with a high prevalence of HBV infection.
- You were born in the U.S. and 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.

What are my costs if I have Original Medicare?

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



Hepatitis C screening tests

Who's covered?

You're covered if you meet at least **one** of these conditions:

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

How often does Medicare cover it?

Once, 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 primary care doctor or other health care provider orders the screening and accepts assignment.



HIV screenings

Who's covered?

Medicare covers HIV (Human Immunodeficiency Virus) screenings if you meet these conditions:

- You're 15–65, and ask for the screening.
- You're younger than 15 or older than 65, at an increased risk for the virus, and ask for the screening if your doctor or other health care provider accepts assignment.

How often does Medicare cover it?

Once every 12 months, or up to 3 times during a pregnancy.

What are my costs if I have Original Medicare?

You pay nothing.



Lung cancer screening

Who's covered?

Medicare covers lung cancer screenings with Low Dose Computed Tomography if you meet all of these conditions:

- You're 55–77.
- You don't have signs or symptoms of lung cancer (asymptomatic).
- You're either a current smoker or have quit smoking within the last 15 years.

Am I at risk?

Your risk increases if any of the following apply to you:

- Past or present injection drug user
- Men and women who exchange sex for money or drugs, or have sex partners who do
- Individuals whose past or present sex partners were HIV-infected, bisexual, or injection drug users
- Persons who have acquired or request testing for other sexually transmitted infectious diseases
- Persons with a history of blood transfusions between 1978 and 1985
- Persons with new sexual partners

Lung cancer screening (continued)

Who's covered?

Medicare covers lung cancer screenings with low dose computed tomography if you meet all of these updated conditions:

- You're 50–77.
- You don't have signs or symptoms of lung cancer (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 have quit smoking within the last 15 years.
- You get an order from your doctor.

How often does Medicare cover it?

Once each year.

What are my costs if I have Original Medicare?

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



Mammograms (Breast Cancer screenings)

Medicare covers screening mammograms to check for breast cancer before you or a doctor may be able to find it manually. Breast cancer is the most common non-skin cancer in women and the second leading cause of cancer death in women in the U. S. Every woman is at risk, and this risk increases with age. Breast cancer usually can be treated successfully when found early.

Who's covered?

Women 40 and older are eligible for a screening mammogram every 12 months. Medicare also covers one baseline mammogram for women between 35–39.

How often does Medicare cover it?

Once every 12 months.

What are my costs if I have Original Medicare?

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



Medicare Diabetes Prevention Program

Medicare covers a once-per-lifetime proven health behavior change program to help you prevent type 2 diabetes.

Who's covered?

You must have:

- A hemoglobin A1c test result between 5.7 and 6.4%, a fasting plasma glucose of 110-125mg/dL, or a 2-hour plasma glucose of 140-199 mg/dL (oral glucose tolerant test) within 12 months of attending the first core session.
- A body mass index (BMI) of 25 or more (BMI of 23 or more if you're Asian).
- Never been diagnosed with type 1 or type 2 diabetes or End-Stage Renal Disease (ESRD).
- 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. If you started the Medicare Diabetes Prevention Program in 2021 or earlier, you'll get an additional 12 monthly sessions if you meet certain weight loss and attendance goals.

What are my costs if I have Original Medicare?

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



Nutrition therapy services

Medicare may cover medical nutrition therapy services and certain related services. A doctor must refer you for the service(s). Only a Registered Dietitian (or other 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, and follow-up visits to check on your progress in managing your diet

Who's 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 to get them.



Obesity behavioral therapy

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

Who's covered?

All people with Medicare can get obesity screenings. Medicare covers behavioral counseling if you have a body mass index (BMI) of 30 or more.

What are my costs if I have Original Medicare?

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



Pneumococcal shots

Medicare covers pneumococcal shots (or vaccines) to help protect against different types of pneumonia.

Who's covered?

All people with Medicare.

How often does Medicare cover it?

You can get up to 3 doses of the pneumococcal vaccine, depending on certain criteria. Talk with your doctor or other health care provider about this vaccine.

What are my costs if I have Original Medicare?

You pay nothing.



Prostate cancer screenings

Your doctor may find prostate cancer by testing the amount of PSA (Prostate Specific Antigen) in your blood. Your doctor can also find prostate cancer during a digital rectal exam. Medicare covers both of these tests.

Who's covered?

All men with Medicare over age 50 (coverage for these tests begins 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?

After you meet the Part B deductible, you pay 20% of the Medicare-approved amount for the digital rectal exam. You pay nothing for the PSA blood test. If you get the test from a doctor that doesn't accept assignment, you may have to pay an additional fee for your doctor's services, but not for the test itself.

Am I at high risk for prostate cancer?

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



Sexually transmitted infection screenings and counseling

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

Who's covered?

People with Medicare who are pregnant and certain people who are at increased risk for sexually transmitted infections. Your primary care doctor or other 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 Medicare-eligible primary care provider and 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 primary care doctor or other health care provider accepts assignment.



Shots or vaccines

Medicare covers:

- COVID-19 vaccines: See page 11
- Flu shots: See page 13
- Hepatitis B shots: See pages 14–15
- Pneumococcal shots: See page 21
- Some other vaccines when they're related directly to the treatment of an injury or illness. These aren't considered preventive services.

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

Who's covered?

All people with Medicare.

What are my costs if I have Original Medicare?

You pay nothing for most shots and vaccines. If you have Part D, you can get more vaccines at no cost to you. Contact your Medicare drug plan for details.



“Welcome to Medicare” preventive visit

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

Who’s covered?

All people with Medicare.

How often does Medicare cover it?

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

What happens during the visit?

During the visit, your doctor will:

- Review your medical and social history related to your health (like opioid prescription, alcohol or tobacco use, your diet, and your activity level).
- Check your height, weight, and blood pressure.
- Calculate your body mass index (BMI).
- Give you a simple vision test.
- Review your potential risk for depression and your level of safety.
- Offer to talk with you about creating advance directives. Advance directives are legal documents that allow you to put in writing what kind of health care you would want if you were too ill to speak for yourself.
- Review your potential risk for substance use disorder 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.

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 doctor). Call your old doctor 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 doctor 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.

“Welcome to Medicare” preventive visit (continued)

What are my costs if I have Original Medicare?

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



Yearly “Wellness” visit

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

Your provider will ask you to fill out a questionnaire, called a “Health Risk Assessment,” as part of this visit. Answering these questions can help you and your provider develop a personalized prevention plan to help you stay health 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 providers and 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.
- A screening schedule (like a checklist) for appropriate preventive services.
- Advance care planning

Who's 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. Your provider will also perform a cognitive impairment exam.

How often does Medicare cover it?

Once every 12 months.

Yearly “Wellness” visit (continued)

Your costs if you have Original Medicare

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

You don't need to have had a “Welcome to Medicare” preventive visit before getting a yearly “Wellness” visit. If you get the “Welcome to Medicare” preventive visit during your first year with Part B, you'll have to wait 12 months before you can get your first yearly “Wellness” visit.

For more information about Medicare preventive services

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

CMS Accessible Communications

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

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

1. **Call us:** For Medicare: 1-800-MEDICARE (1-800-633-4227) TTY: 1-877-486-2048.
2. **Send us a fax:** 1-844-530-3676.
3. **Send us a letter:**

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

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

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

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 three ways to file a complaint with the U.S. Department of Health and Human Services, Office for Civil Rights:

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

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

**U.S. DEPARTMENT OF HEALTH AND
HUMAN SERVICES**

Centers for Medicare & Medicaid Services

7500 Security Boulevard
Baltimore, Maryland 21244-1850

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