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What Does Medicare NOT Cover? A Plain-English Breakdown

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KEY POINTS

- Original Medicare leaves out routine dental and vision care, hearing aids, and long-term custodial care.
- Several exclusions have narrow exceptions, such as glasses after cataract surgery or dental work tied to a heart valve replacement.
- Original Medicare has no yearly limit on out-of-pocket costs, so even covered care can add up.
- If Medicare denies a service it normally covers, you can appeal, and a Solace advocate can handle

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If you are searching "what does original Medicare not cover," you may be holding a bill you did not expect. Original Medicare pays for medically necessary hospital and medical care, which leaves out routine dental work, hearing aids, and the long-term care that can cost the most.

Quick Answer

Original Medicare is Part A (hospital insurance) and Part B (medical insurance).
On their own, they don’t cover:

- Routine dental care is not covered, though Medicare may pay for dental work closely tied to a covered treatment, such as a preoperative dental evaluation before a heart valve replacement or an organ transplant.
- Routine eye exams and eyeglasses are not covered, except for one pair of glasses after cataract surgery.
- Hearing aids and the exams to fit them are not covered, though Part B covers diagnostic hearing and balance exams that your doctor orders.
- Long-term custodial care is not covered, though Medicare pays for limited skilled nursing facility care after a qualifying hospital stay.
- Most outpatient prescription drugs are not covered by Parts A and B, and they come from Part D instead.

- Healthcare outside the United States is covered only in a few narrow situations.
- Cosmetic surgery is not covered, with limited exceptions such as repair after an accidental injury.

Private insurers run Medicare Advantage plans, and many add some of these benefits. The Medicare Advantage section below explains what to check.

Why Original Medicare Has Gaps

Original Medicare pays for medically necessary hospital and medical care. It does not cover routine care, like cleanings and glasses, or the ongoing help many people need as they age. Many of these exclusions are written into federal law, so no appeal or paperwork can unlock them under Original Medicare. Private Medicare Advantage plans can add some of these services as extra benefits, which vary by plan.

Parts A and B together make up Original Medicare. The other two parts are options you add or choose instead.

Part	What it covers
Part A	Inpatient hospital stays, hospice, and skilled nursing facility care after a qualifying hospital stay, along with some home health care
Part B	Doctor visits, outpatient care, and preventive services, plus some

Part	What it covers
	medical equipment
Part C (Medicare Advantage)	Private plans that cover the same Part A and Part B services, along with variable extra benefits
Part D	Outpatient prescription drug coverage

The Biggest Things Medicare Doesn't Cover

Routine dental care

Original Medicare does not cover routine dental care such as cleanings, fillings, tooth extractions, and dentures. It may pay for dental services closely linked to a covered treatment, such as an oral exam and infection treatment before a heart valve replacement or an organ transplant. The same applies to dental care before and during certain cancer treatment, and to dental exams before and during dialysis for end-stage renal disease.

Follow-up dental care after the underlying treatment is not covered. Many Medicare Advantage plans add dental benefits, though the amounts and limits vary by plan.

Routine vision and eyeglasses

Original Medicare does not pay for routine eye exams to update a prescription, or for eyeglasses and contact

lenses. Part B does cover one pair of glasses with standard frames, or one set of contact lenses, after cataract surgery that implants an intraocular lens. It also covers medically necessary eye care, such as a yearly diabetic eye exam if you have diabetes and glaucoma screening if you are at high risk.

Our guides on glasses after cataract surgery and Medicare cataract surgery coverage explain what to ask before the procedure.

Hearing aids and hearing-aid exams

Original Medicare does not cover hearing aids or exams to fit them. Part B does cover diagnostic hearing and balance exams when your doctor orders them to find out whether you need medical treatment, and you pay 20% of the Medicare-approved amount after the Part B deductible. You can also see an audiologist once every 12 months without an order for hearing loss that has developed over many years.

The FDA now allows adults 18 and older with perceived mild to moderate hearing loss to buy over-the-counter hearing aids without a prescription or a fitting visit. Our guide to whether Medicare covers hearing aids has the details.

Long-term (custodial) care

Original Medicare does not cover long-term care, which includes **custodial care**: ongoing help with daily activities such as bathing, dressing, or eating. It does cover care in a **skilled nursing facility** (SNF) when you need daily skilled nursing or therapy. You must first have a qualifying

inpatient hospital stay of at least three days in a row, and time spent in observation does not count.

Days 1 to 20 in a SNF cost you nothing. From day 21 through day 100 you pay a daily coinsurance amount that CMS updates each year, and after day 100 in a benefit period you pay the full cost. If you are in the hospital, ask whether you were admitted as an inpatient. Medicaid may pay for long-term care if you meet your state's income and asset limits. See when Medicare stops paying for nursing home care for more.

Most outpatient prescription drugs

Parts A and B cover few drugs that you pick up at a pharmacy. Medicare drug coverage comes from Part D, either as a standalone plan or inside a Medicare Advantage plan that includes it. Part D has an annual out-of-pocket cap on covered drugs, which CMS set at $2,100 for 2026 and $2,400 for 2027. After you reach it, you pay nothing more for covered Part D drugs for the rest of the year, and your monthly premium does not count toward the cap.

Care outside the United States

Original Medicare generally does not cover healthcare you get outside the United States, with only a few narrow exceptions. If you travel, check your coverage before you go. Some Medigap policies include coverage for emergency care abroad.

Cosmetic surgery and other exclusions

Cosmetic surgery is on Medicare's list of exclusions, with limited exceptions such as repair after an accidental injury. Routine foot care, like cutting toenails or removing corns and calluses, is excluded too, though Part B covers medically necessary treatment for foot injuries and diseases.

Acupuncture is covered only for chronic low back pain. Part B pays for up to 12 treatments in 90 days, plus 8 more if you improve, for a maximum of 20 in 12 months.

What You Still Pay for when Medicare does cover something

Covered care still comes with costs you pay. Part B has an annual deductible, and after you meet it you generally pay 20% of the Medicare-approved amount for doctor visits and outpatient care. Part A has its own deductible, charged per benefit period rather than per year. CMS updates both amounts each year, and Medicare.gov lists the current figures.

Original Medicare has no yearly limit on what you pay out of pocket, unless you add supplemental coverage like a **Medigap** policy or join a Medicare Advantage plan. These cost-sharing amounts are sometimes called Medicare gaps, and they are separate from the services Medicare excludes. Our guides to Medigap and out-of-pocket costs explain the terms.

Does Medicare Advantage cover what Original Medicare doesn't?

Some do, within limits. Medicare Advantage (Part C) plans are sold by private insurers, and many add benefits that Original Medicare leaves out, such as dental, vision, and hearing coverage. Plans also use provider networks, and many require prior authorization, which means your plan must approve certain services before you get them.

Medicare Advantage plans have a yearly limit on what you pay out of pocket for Part A and Part B services. Before you assume a service is covered, check your plan's Evidence of Coverage and the Annual Notice of Change your plan sends each fall. Annual Enrollment runs October 15 to December 7, which is the window to compare plans. Knowing what Medicare doesn't cover helps you decide which extras matter most to you.

How People Fill the Gaps

People usually combine a few options to fill these gaps.

- A Medicare Advantage plan that includes extra benefits, such as dental or hearing coverage
- A standalone dental, vision, or hearing plan bought separately
- A Medigap policy, which helps pay Part A and Part B cost-sharing but generally does not cover dental or vision care, hearing aids, or custodial care
- Part D coverage for prescription drugs

- Long-term care insurance, which people usually buy before they need care
- Medicaid for long-term care, if you meet your state's income and asset limits
- Extra Help and Medicare Savings Programs, for people with limited income and resources

Your State Health Insurance Assistance Program (SHIP) offers free, unbiased Medicare counseling. You can find yours at shiphelp.org.

"Not Covered" vs. "Denied"

Services not covered by Medicare and denials that can be appealed are two different problems. An exclusion cannot be appealed into coverage. A denial for missing paperwork, a billing code error, a missing prior authorization, or a finding that the service was not medically necessary often can be appealed. Our guides on prior authorization denied and appeals and grievances in Medicare Advantage plans explain the next steps for plan denials.

1. Read the denial notice. In Original Medicare, it is your Medicare Summary Notice. In Medicare Advantage, it is the plan's denial notice. Both state the reason and the deadline to appeal.
2. Check whether the service is an exclusion. If it is on Medicare's list of non-covered services, such as routine hearing aids, an appeal will not change the result. Your doctor's office or 1-800-MEDICARE can tell you.
3. Ask your doctor for supporting records. A letter explaining why the service was medically necessary

can make an appeal stronger.

4. File before the deadline. In Original Medicare, you have 120 days from receiving the Medicare Summary Notice to request a redetermination. In Medicare Advantage, you have 65 days from the date on the plan's denial notice.
5. Keep copies of everything you send, and follow up if you do not hear back within the decision timeframe on your notice.

In 2024, more than 80% of appealed Medicare Advantage prior authorization denials were overturned, but only 11.5% of denials were appealed at all.

*Based on a 2026 report by KFF

How Solace Can Help

If you already have Medicare, a Solace advocate can walk you through what your plan covers, sort out a confusing bill, and take on a denial that is worth appealing.

Solace advocates are experienced healthcare professionals with 16 years of healthcare experience on average. They work with you 1-on-1 to navigate healthcare and insurance challenges, and stay with you as long as you need them.

Advocates do not provide medical or legal advice or services. They cannot change what Medicare excludes. Solace is covered by Medicare, Medicare Advantage, and most major insurance plans. Your cost depends on your plan and deductible. Many patients pay very little out of pocket. Learn how Solace advocacy covered by Medicare works.

A healthcare advocate can appeal denied claims and look into coverage on your behalf.

See if you qualify →

Not sure what your Medicare plan covers?

A bill for something you thought Medicare covered is stressful, and the rules behind it take time to sort through.

If you have Medicare, a Solace advocate can read your denial or bill with you and check it against what Medicare covers. Your advocate then makes the calls and follows up for you. Your Solace advocate stays with you as long as you need their help. Solace is covered by Medicare and many Medicare Advantage plans. Your cost depends on your plan and deductible. Many patients pay very little out of pocket.

Once your Medicare coverage is active, check your eligibility to see if a Solace advocate can help you.

Check your eligibility.

Eligibility varies by plan. Advocates do not provide medical or legal advice or services. Must be 18 years or older.

FAQs

What does Medicare not cover?

Original Medicare (Parts A and B) generally doesn't cover routine dental care, routine eye exams and glasses,

hearing aids, long-term custodial care, most outpatient prescription drugs, care outside the U.S., or cosmetic surgery. A few of these have narrow exceptions, such as glasses after cataract surgery. Some Medicare Advantage plans offer extra dental and hearing benefits.

Does Medicare cover dental, vision and hearing?

Original Medicare generally does not cover routine dental care or routine eye exams for glasses, and it does not cover hearing aids. It does cover medically necessary eye care and diagnostic hearing and balance exams that a doctor orders. It also covers dental work that is part of a covered medical procedure. Many Medicare Advantage plans add some of these benefits, but coverage varies by plan.

Does Medicare pay for nursing homes or long-term care?

No, Medicare does not pay for custodial care, which is help with daily activities like bathing, dressing, or eating. It covers limited skilled nursing facility care after a qualifying hospital stay, up to 100 days per benefit period, but not ongoing long-term stays. Medicaid may cover long-term care for people who meet income and asset limits.

Does Medicare cover prescription drugs?

Original Medicare (Parts A and B) covers few outpatient prescription drugs. Most people get drug coverage through a standalone Part D plan or a Medicare Advantage plan that includes it. Part D has an annual out-of-pocket cap on covered drugs, set at $2,400 for 2027.

Does Medicare cover medical care outside the United States?

In most cases, no. Original Medicare generally doesn't pay for healthcare received outside the U.S., with only a few narrow exceptions. People who travel can look at Medigap plans that include foreign travel emergency coverage or a separate travel insurance policy.

Does Medicare Advantage cover what Original Medicare doesn't?

Some Medicare Advantage plans include extra benefits such as dental, vision, hearing, and fitness, but the benefits and dollar limits differ from plan to plan. These plans cover the same Part A and Part B services as Original Medicare. Check the plan's Evidence of Coverage before assuming a specific service is included.

Does Medicare have an out-of-pocket limit?

Original Medicare has no yearly out-of-pocket limit, so you owe deductibles and coinsurance with no cap unless you have supplemental coverage like Medigap. Medicare Advantage plans have a yearly limit on what you pay for Part A and Part B services. That is one reason people pair Original Medicare with a Medigap plan or choose a Medicare Advantage plan.

What can I do if Medicare denies something it should cover?

You can appeal. Start by reading the denial notice, which is a Medicare Summary Notice for Original Medicare or a plan notice for Medicare Advantage, to see why it was denied and the deadline to appeal. That deadline is 120

days for Original Medicare and 65 days for Medicare Advantage. A Solace advocate can handle the follow-up with your plan or provider if you have Medicare coverage.

REFERENCES

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Solace puts an advocate in your corner—someone who's spent years in healthcare, knows the system, and takes on the toughest parts of your care. Don't do this alone.

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Eligibility varies by plan. Advocates do not provide medical or legal advice or services. Must be 18 years or older. Consult a licensed health professional or obtain a valid prescription.

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