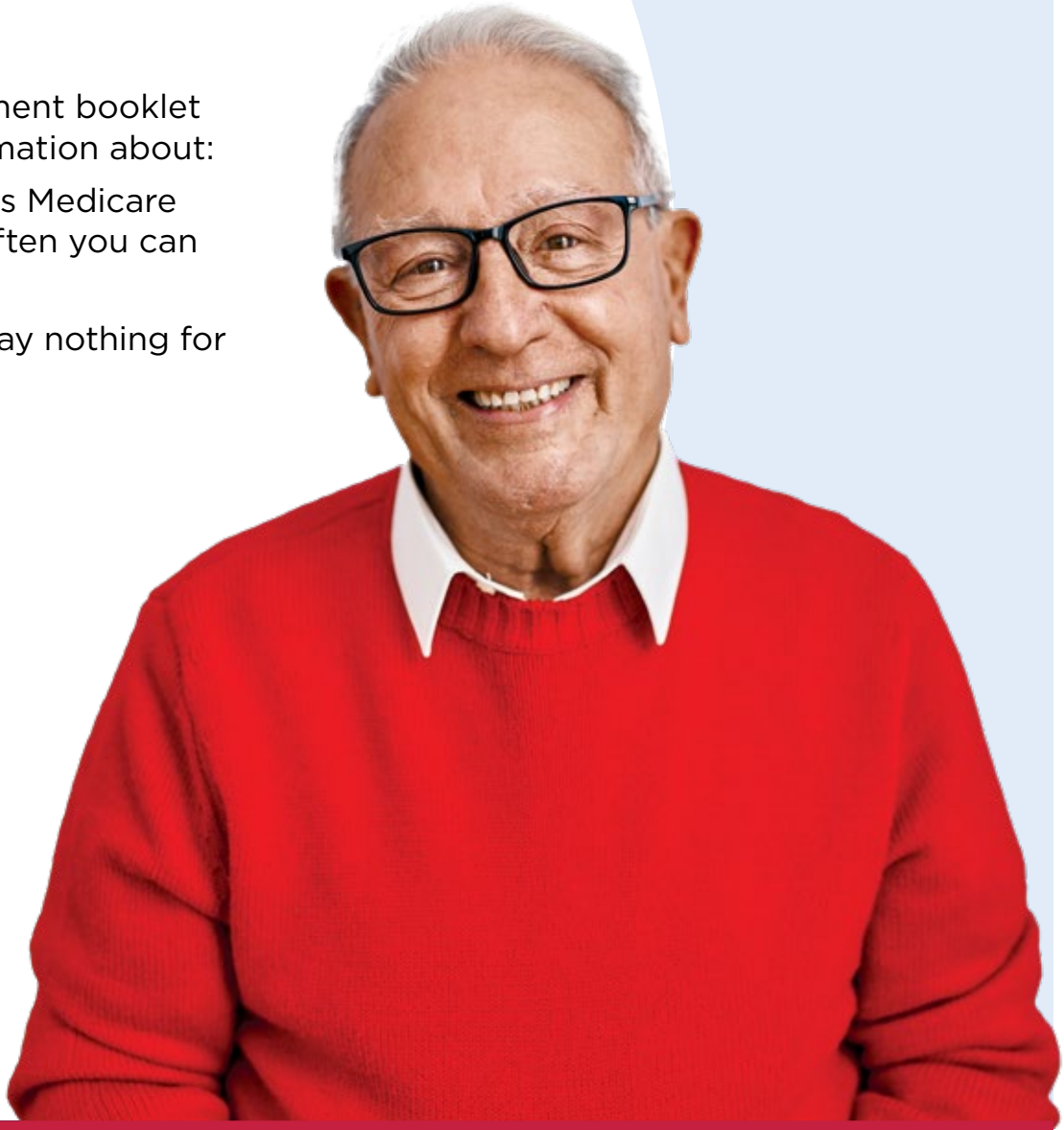
Your Guide to Medicare Preventive Services

This official government booklet has important information about:

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

Medicare.gov



Medicare

About this booklet

Original Medicare includes Part A (Hospital Insurance) and Part B (Medical Insurance). This booklet explains the preventive services Original Medicare covers, including exams, screenings, vaccines, and counseling to help you stay healthy. These services can help find health problems early, when treatment works best.

Talk with your doctor or other provider about which services are right for you and how often you need them. Your provider may recommend services that Medicare doesn't cover or suggest a different schedule. If you get a service that Medicare doesn't cover and you think it should, you can appeal this decision. To file an appeal, follow the instructions on your "Medicare Summary Notice" (MSN). For more information about filing an appeal, visit **Medicare.gov/appeals**, or call 1-800-MEDICARE (1-800-633-4227). TTY users can call 1-877-486-2048.

If you have a Medicare Advantage Plan, another Medicare health plan, or both Medicare and Medicaid, your coverage, costs, and rules might be different. Check with your plan or state Medicaid office for more details about the preventive services they offer. You can usually find your plan's contact information on your plan membership card. Visit **Medicaid.gov/about-us/where-can-people-get-help-medicaid-chip** to get the phone number for your state's Medicaid office.

Section 1:

Introduction

Original Medicare covers many preventive and screening services that can help you stay healthy, find health problems early, determine the most effective treatments, and prevent certain diseases.

What you'll pay for preventive services

If you have Medicare Part B, you'll pay nothing for many preventive services if you get them from a doctor or other qualified health care provider who accepts assignment.
If your doctor or other provider accepts assignment:

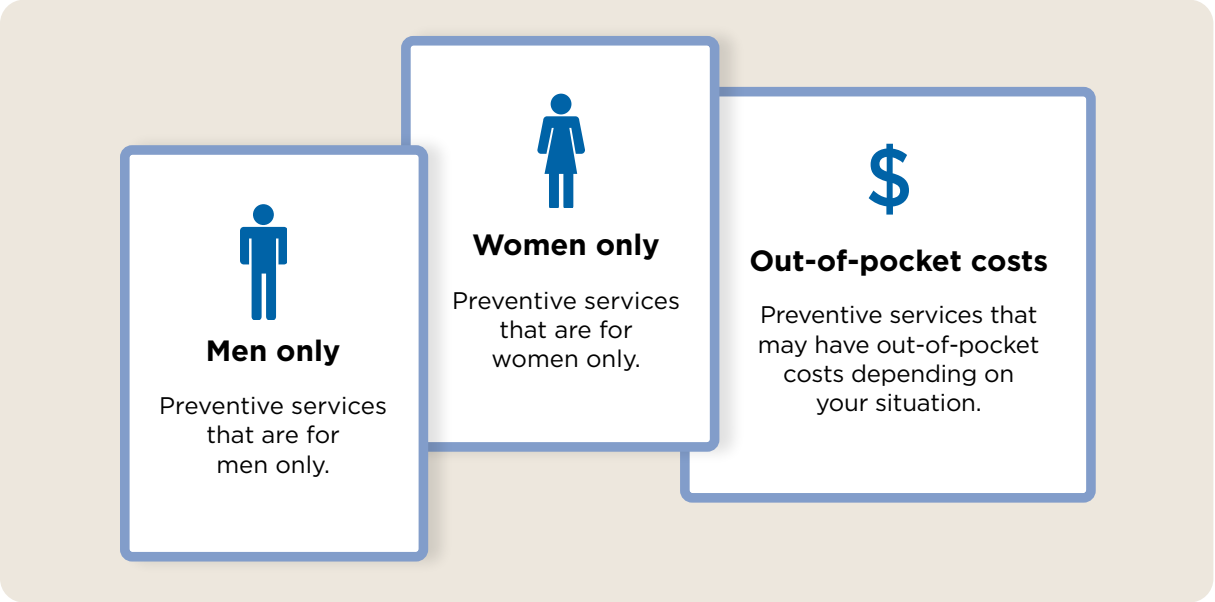
- Your out-of-pocket costs may be less.
- They agree to charge you only the Medicare deductible and coinsurance amount and usually wait for Medicare to pay its share before asking you to pay your share.
- They have to submit your claim directly to Medicare and can't charge you for submitting the claim.

Depending on the service, the amount you pay may be higher if the provider doesn't accept assignment. Providers who don't accept assignment can charge you 15% over the Medicare-approved payment amount for most Part B-covered services. This is called the "limiting charge." The limiting charge only applies to certain services.

Things to know when reading this booklet

Symbols

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



Risk factors

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

Helpful terms to understand

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

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

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

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

Part B deductible: The amount you must pay for Part B-covered services and supplies before Medicare begins to pay its share. You pay the Part B deductible once a year, and the amount changes each year. Visit Medicare.gov/basics/costs/medicare-costs to get the current Part B deductible amount.

Section 2:

Preventive Services

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

Abdominal aortic aneurysm screening

What is it?

Abdominal aortic aneurysm screenings check for aneurysms (bulges in blood vessels) in the abdominal area.

Am I covered?

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

How often?

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

Am I at risk?

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

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

Alcohol misuse screenings & counseling

What is it?

Alcohol misuse screening tests include questions about your alcohol use. Your primary care doctor or other provider reviews your responses to check for alcohol misuse and alcohol use disorders.

Am I covered?

Part B covers an alcohol misuse screening for adults who use alcohol, but don't meet the medical conditions for alcohol dependency.

How often?

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

Bone mass measurement

What is it?

A bone mass measurement can help find out 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?

Part B covers bone mass measurements 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 being monitored to find out if your osteoporosis drug therapy is working.

How often?

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

Cardiovascular behavioral therapy

What is it?

Cardiovascular behavioral therapy helps lower your risk for cardiovascular disease (conditions that affect the heart and blood vessels). During therapy, your primary care doctor or other primary care practitioner may discuss aspirin use, check your blood pressure, and give you tips on diet and exercise.

Am I covered?

If you have Part B, you can get a cardiovascular behavioral therapy visit with your primary care practitioner in a primary care setting (like their office).

How often?

Once each year.

Am I at risk?

Your risk for cardiovascular disease may increase if you:

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

Cardiovascular disease screening

What is it?

Cardiovascular disease screenings check for problems with your heart and blood vessels to help find out if you're at risk for heart disease.

Am I covered?

If you have Part B, you can get screenings that include blood tests for cholesterol, lipid, and triglyceride levels.

How often?

Once every 5 years.

Am I at risk?

High levels of cholesterol can increase your risk for heart disease and stroke. Go to "Cardiovascular behavioral therapy" above for a list of risk factors.

Cervical & vaginal cancer screening

What is it?

Screenings to check for cancer in the cervix and vagina.

Am I covered?

If you're a woman, Part B covers Pap tests and pelvic exams. As part of the pelvic exam, Medicare also covers a clinical breast exam to check for breast cancer.

How often?

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

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

Am I at risk?

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, during pregnancy.

$ Colorectal cancer screening

What is it?

Colorectal cancer screening helps find precancerous polyps (growths in the colon) or find cancer early, when treatment works best.

Am I covered?

If you're 45 or older, Medicare covers most colorectal cancer screenings, including screening colonoscopies, blood-based bio-marker screening tests, computed tomography (CT) colonography screenings, fecal occult blood test screenings, flexible sigmoidoscopy screenings, and multi-target stool DNA screening tests.

There's no minimum age requirement to get a Medicare-covered screening colonoscopy.

How often?

- **Blood-based biomarker screening tests for colorectal cancer & Multi-target stool DNA screening tests—**Once every 3 years if you meet all these conditions:
  - You're between 45–85.
  - You show no symptoms of colorectal disease (including, but not limited to, lower gastrointestinal pain, blood in stool, 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.

- **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 get a positive result after having a Medicare-covered, non-invasive stool-based colorectal cancer screening test (fecal occult blood test or multi-target stool DNA test) or a blood-based biomarker screening test, Medicare covers a follow-up colonoscopy as a screening test.
- **Screening computed tomography (CT) colonography—**Once every 60 months (or once every 24 months if you're at high risk), or 48 months after a previous flexible sigmoidoscopy or colonoscopy.
- **Screening fecal occult blood test—**Once every 12 months, if you get a referral from your doctor, physician assistant, nurse practitioner, or clinical nurse specialist.
- **Screening flexible sigmoidoscopy—**Once every 48 months for most people. If you aren't at high risk for colorectal cancer but have had a screening colonoscopy, Medicare covers this test 120 months after the previous screening colonoscopy.

What are my costs?

- You pay nothing for colorectal cancer screenings if your doctor or other provider accepts assignment.
- 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. The Part B deductible doesn't apply.

Am I at risk?

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 & tobacco-caused disease

What is it?
Counseling to help you identify triggers (like stress or habits), build coping skills, and break tobacco addiction routines.

Am I covered?
If you use tobacco, Part B covers counseling to help you stop smoking or using tobacco.

How often?
Up to 8 counseling sessions in a 12-month period.

Ask your provider about Medicare-covered programs to help you stop smoking or using tobacco, or visit **smokefree.gov** for more information about stopping tobacco use.

COVID-19 vaccine

What is it?
COVID-19 vaccines help lower your chances of becoming sick from COVID-19 by working with the body's natural defenses to safely develop immunity (protection) against the virus.

Am I covered?
If you have Part B, you can get FDA-approved and FDA-authorized COVID-19 vaccines.

$ Depression screening

What is it?
Depression screenings include questions about your mood and how it impacts your daily life. Your primary care doctor or other provider reviews your responses to find out if you have depression.

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**.

Am I covered?

If you have Part B, you can get depression screenings.

How often?

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

What are my costs?

You pay nothing for a depression screening. If you need follow-up treatments or go to a mental health care provider, you may have to pay a copayment or coninsurance.

Diabetes screening

What is it?

Diabetes screenings are blood tests that check if you have or are at risk for diabetes. These screenings may be fasting or non-fasting glucose tests, A1C tests, or other Medicare-approved glucose tests.

Am I covered?

Part B covers diabetes screenings if your doctor or other provider determines you're at risk for developing diabetes.

How often?

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

Am I at risk?

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. You may also be at risk if 2 or more of these conditions apply to you:

- You're 65 or older.
- You're overweight.
- You have a family history of diabetes (parents or siblings).
- You have a history of gestational diabetes (diabetes during pregnancy), or delivery of a baby weighing more than 9 pounds.

$ Diabetes self-management training

What is it?

Diabetes self-management training teaches you skills to manage diabetes. The program may include tips for eating healthy and being active, monitoring blood glucose (blood sugar), taking prescription drugs, and reducing risks.

Am I covered?

If you've been diagnosed with diabetes and have an order from your doctor or other provider, Part B covers outpatient diabetes self-management training to help you manage your disease. Some people may also be eligible for medical nutritional therapy services. Go to "Medical nutrition therapy services" on page 15.

Visit adces.org/program-finder to find certified diabetes self-management training programs near you.

How often?

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

What are my costs?

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

Flu vaccine

What is it?

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

Am I covered?

If you have Part B, you can get the seasonal flu vaccine.

How often?

Usually one vaccine each flu season.

$ Glaucoma screening

What is it?

Glaucoma is an eye disease caused by high pressure in the eye. It can develop gradually without warning and often without symptoms. Glaucoma screenings painlessly check your vision and optic nerve health to look for signs of glaucoma.

Am I covered?

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

How often?

Once every 12 months.

What are my costs?

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

Am I at risk?

You're considered high risk if at least one of these conditions applies to you:

- You have diabetes.
- You have a family history of glaucoma.
- You're African American and 50 or older.
- You're Hispanic and 65 or older.

Hepatitis B vaccine

What is it?

Hepatitis B vaccines help protect against the hepatitis B virus (HBV).

Am I covered?

Part B covers hepatitis B vaccines if you meet at least one of these conditions:

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

Am I at risk?

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

- You have hemophilia (a genetic bleeding disorder that keeps your blood from clotting properly) 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.

Hepatitis B virus (HBV) infection screening

What is it?

Screenings to find out if you're infected with HBV.

Am I covered?

Medicare covers HBV infection screenings if your doctor or other provider orders one, and you meet one of these conditions:

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

How often?

- Once a year if you're at continued high risk and don't get a hepatitis B vaccine.
- If you're pregnant, at the following times, even if you previously got the hepatitis B vaccine or had negative HBV screening results:
  - First prenatal visit
  - Time of delivery if you have new or continued risk factors

Am I at risk?

Your risk for HBV increases if:

- You were born in a country or region where HBV infections are more common.
- You were born in the U.S., not vaccinated as an infant, and your parents were born in regions where HBV infections are more common.
- You're HIV-positive.
- You're a man who has sex with men.
- You use illicit injection drugs.
- You have household contacts or sexual partners with HBV infection.

Hepatitis C virus screening

What is it?

Screenings to find out if you're infected with the hepatitis C virus.

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?

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

Human immunodeficiency virus (HIV) screening

What is it?

Screenings to find out if you've been infected with HIV.

Am I covered?

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

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

How often?

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

Am I at risk?

Your risk for HIV may increase if you:

- Use or have used illicit injection drugs.
- Exchange sex for money or drugs, or have sex partners who do.
- Have past or present sex partners who are HIV-infected, bisexual, or illicit injection drug users.
- Have another sexually transmitted disease.
- Have a history of blood transfusions between 1978 and 1985.
- Have new sexual partners.

Lung cancer screening

What is it?

Screenings that check for early signs of lung cancer.

Am I covered?

Part B covers lung cancer screenings with low dose computed tomography (also known as "CT scans") if you meet all these conditions:

- You're between 50–77.
- You don't have signs or symptoms of lung cancer (you're asymptomatic).
- You 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?

Once a year.

Am I at risk?

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

What is it?

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

Am I covered?

Part B covers:

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

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

How often?

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

What are my costs?

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

Medical nutrition therapy services

What is it?

Medical nutrition therapy uses nutrition education to manage, treat, or prevent chronic diseases and conditions.

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?

Part B covers medical nutrition therapy services if you have diabetes or kidney disease, or if you've had a kidney transplant in the last 36 months. A doctor must refer you for the services and you must get them from a registered dietitian or nutrition professional who meets certain requirements. If you get dialysis in a dialysis facility, Medicare also covers medical nutrition therapy as part of your overall dialysis care.

If you have diabetes, you may also qualify to get diabetes self-management training, which offers similar services to the ones you can get through medical nutrition therapy. You must meet certain requirements to get both diabetes self-management training and medical nutrition therapy services.

How often?

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

Medicare Diabetes Prevention Program

What is it?

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?

Part B covers this program if you're at risk for developing type 2 diabetes and meet all these requirements:

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

Through December 31, 2029, you can participate in person or virtually through distance learning (you attend live sessions online), or a combination of both. You can also participate online at any time (non-live sessions). You can get these services from an approved Medicare Diabetes Prevention Program supplier. These suppliers may be traditional health care providers or organizations like community centers or faith-based organizations.

Visit **Medicare.gov/coverage/medicare-diabetes-prevention-program** to find a program near you or online.

How often?

There's no limit to the number of times you can participate. The program begins with 16 weekly core sessions offered in a group setting over a six-month period. Once you complete the core sessions, you'll get 6 monthly follow-up sessions to help you maintain healthy habits.

Obesity behavioral therapy

What is it?

Obesity behavioral therapy is a type of weight loss treatment. It 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.

Am I covered?

Part B covers obesity screenings and behavioral counseling if:

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

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

Pneumococcal vaccine

What is it?

Pneumococcal vaccines help protect against different strains of the bacteria that cause pneumonia. Talk with your doctor or other provider to decide which vaccines are right for you.

Am I covered?

If you have Part B, you can get pneumococcal vaccines.

Pre-exposure prophylaxis (PrEP) for HIV prevention

What is it?

PrEP uses antiretroviral medication to lower your risk of getting HIV (human immunodeficiency virus).

Am I covered?

Part B covers FDA-approved oral or injectable PrEP medication and related services if you don't have HIV, but your doctor or other provider determines you're at an increased risk for HIV.

How often?

If you qualify, you can get:

- Up to 8 individual counseling sessions (including HIV risk assessment, HIV risk reduction, and medication adherence) every 12 months.
- Up to 8 HIV screenings every 12 months.
- A one-time hepatitis B virus (HBV) screening (you may be able to get more screenings if you're at high risk for HBV or you're pregnant).

What are my costs?

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

If your provider accepts assignment, you'll also pay nothing out of pocket for injectable PrEP drugs, HIV and HBV screenings, and counseling sessions.

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

$ Prostate cancer screening

What is it?

Prostate cancer screenings check for cancer in the prostate, a gland in the male reproductive system. 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?

Part B covers digital rectal exams and PSA blood tests for men over 50 (starting the day after your 50th birthday).

How often?

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

What are my costs?

- **Digital rectal exams:** After you meet the Part B deductible, you pay 20% of the Medicare-approved amount for the digital rectal exam and for your 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?

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

Sexually transmitted infection (STI) screenings & counseling

What is it?

Confidential medical tests and discussions with a doctor or other provider to find, prevent, and treat infections spread through sexual contact.

Part B covers STI screenings for chlamydia, gonorrhea, syphilis, and/or hepatitis B. Medicare also covers behavioral counseling sessions to lower your risk of getting a sexually transmitted disease.

Am I covered?

Medicare covers STI screenings if you're pregnant or at increased risk for an STI. Medicare also covers face-to-face, high-intensity behavioral counseling sessions if you're a sexually active adult at increased risk for these infections. Your primary care doctor or other provider must order the screening or refer you for behavioral counseling.

How often?

- **STI screenings:** Once every 12 months, or at certain times during pregnancy.
- **Behavioral counseling:** Up to 2 sessions a year. Each session can be 20–30 minutes long. You must get the 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).

Vaccines (or shots)

What is it?

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

Medicare Part B covers preventive vaccines for:

- COVID-19: Go to page 8.
- Flu: Go to page 10.
- Hepatitis B: Go to page 11.
- Pneumococcal disease: Go to page 17.

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

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

- Respiratory Syncytial Virus (RSV)
- Shingles
- Tdap
- Traveling (like yellow fever and chikungunya), measles, and more

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

Am I covered?

If you have Part B, you can get COVID-19, flu, hepatitis B, and pneumococcal vaccines.

$ "Welcome to Medicare" preventive visit

What is it?

The "Welcome to Medicare" visit is a one-time preventive check-up to review your medical history, get up-to-date on important screenings and vaccines, and talk with your doctor or other provider about ways to stay healthy. **The "Welcome to Medicare" preventive visit isn't a comprehensive physical exam**.

Am I covered?

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

How often?

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 or vaccines (like flu, pneumococcal, and other recommended vaccines).
- 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 factors for substance use disorder (like alcohol and tobacco use), and refer you for treatment, if needed.
- Give you a written plan (like a checklist) letting you know what screenings, vaccines, 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.

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?

- You pay nothing if your provider accepts assignment. The Part B deductible doesn't apply. However, you may have to pay coinsurance, and the Part B deductible may apply if your provider performs additional tests or services during your visit that Medicare doesn't cover under this preventive 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

What is it?

The yearly "Wellness" visit is a check-up to develop or update your personalized plan to help prevent disease and disability, based on your current health and risk factors. **The yearly "Wellness" visit is a conversation-based visit with your doctor or other provider to create a prevention plan. It isn't a routine physical exam**. If you have specific concerns about your health, you should schedule a separate appointment to discuss those so your "Wellness" visit stays focused on prevention.

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

Am I covered?

If you've had Part B for longer than 12 months, you can get a yearly "Wellness" visit.

What happens during the visit?

During this visit, your provider will:

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

How often?

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

What are my costs?

You pay nothing if your provider accepts assignment. The Part B deductible doesn't apply. However, you may have to pay coinsurance, and the Part B deductible may apply if your provider performs additional tests or services during your visit that Medicare doesn't cover under this preventive 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

Visit Medicare.gov/coverage/preventive-screening-services, or call 1-800-MEDICARE (1-800-633-4227). TTY users can call 1-877-486-2048.

You can also log into (or create) your secure Medicare account at Medicare.gov to get a list of preventive services Original Medicare covers. You can also use your account to: review your Medicare claims, print a copy of your official Medicare card, pay your Medicare premiums if you get a bill from Medicare, and more.

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 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.

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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
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 and 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 es.Medicare.gov or call 1-800-MEDICARE (1-800-633-4227). TTY users can call 1-877-486-2048.

Esta publicación está disponible en español. Para obtener una copia gratis, visite es.Medicare.gov o llame al 1-800-MEDICARE.

Medicare

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

"Your 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.

CMS Product No. 10110 • May 2026