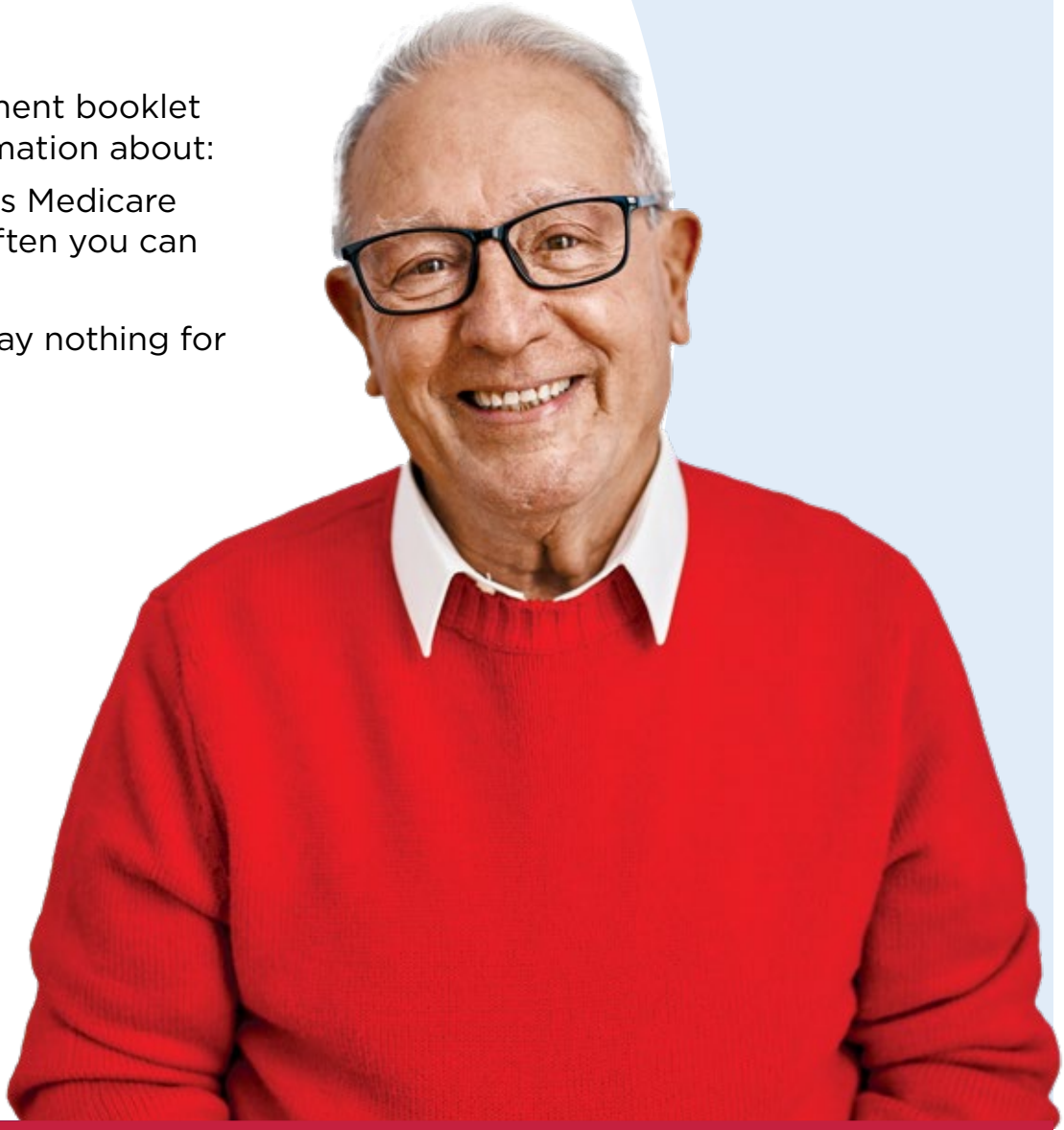
Your Guide to Medicare Preventive Services

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

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

- You may be able to get other preventive services that Original Medicare doesn't cover.
- Your costs may be different.
- Coverage rules (like how often you can get a service) might be different.

For more information about specific costs and coverage information, contact your plan or state Medicaid agency. 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. Visit **Medicare.gov/health-drug-plans/health-plans** for more information about Medicare health plans.

Section 1:

Introduction

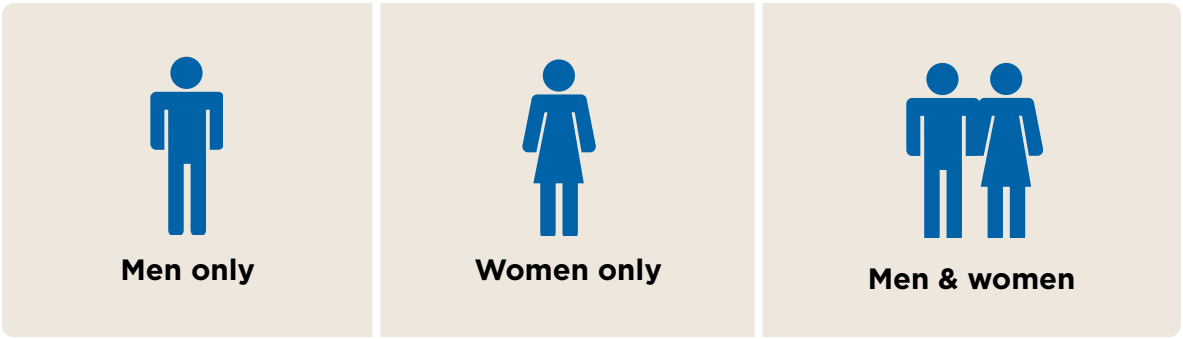
Original Medicare pays for many preventive services to keep you healthy. For example, if you have Part B, you can get a yearly "Wellness" visit and many other covered preventive services, like colorectal cancer screenings and mammograms. Preventive services can help find health problems early, when treatment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

If you get a service that Medicare doesn't cover and you think it should, you can 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**, or call 1-800-MEDICARE (1-800-633-4227). TTY users can call 1-877-486-2048.

Things to know when reading this booklet

Symbols

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



Risk factors

With some services, you'll see 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

Part B deductible

The amount you must pay for Part B-covered services and supplies before Medicare begins to pay its share. The Part B deductible changes each year. Find the current deductible amount at Medicare.gov/basics/costs/medicare-costs.

Assignment

An agreement by your doctor, provider, or supplier to be paid directly by Medicare, to accept the payment amount Medicare approves for the service, and not to bill you for any more than the Medicare deductible and any applicable coinsurance or copayment amounts.

Medicare-approved amount

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

Section 2:

Preventive Services

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

Abdominal aortic aneurysm screening

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.

What are my costs?

You pay nothing if your provider accepts assignment.

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

Am I covered?

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

How often?

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

What are my costs?

You pay nothing if your provider accepts assignment.

Bone mass measurements

Part B covers bone mass measurements to 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?

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

- You're a woman whose provider determines you're estrogen-deficient and at risk for osteoporosis, based on your medical history and other findings.
- Your X-rays show possible osteoporosis, osteopenia, or vertebral fractures.
- You're taking prednisone or steroid-type drugs or plan to begin this treatment.
- You've been diagnosed with primary hyperparathyroidism.
- You're being monitored to find out if your osteoporosis drug therapy is working.

How often?

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

What are my costs?

You pay nothing if your provider accepts assignment.

Cardiovascular behavioral therapy

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

Am I covered?

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

How often?

Once each year.

What are my costs?

You pay nothing if your primary care practitioner accepts assignment.

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 screenings

Part B covers cardiovascular disease screenings that check your cholesterol, blood fat (lipid), and triglyceride levels. High levels of cholesterol can increase your risk for heart disease and stroke. Go to to "Cardiovascular behavioral therapy" on the previous page for a list of risk factors.

Am I covered?

Yes. All people with Medicare can get cardiovascular disease screenings.

How often?

Once every 5 years.

What are my costs?

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

Cervical & vaginal cancer screenings

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

Am I covered?

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

How often?

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.

What are my costs?

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

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

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 screenings

Medicare covers colorectal cancer screening tests to help 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 blood-based bio-marker screening tests (through age 85), computed tomography (CT) colonography screenings, fecal occult blood tests, flexible sigmoidoscopy screenings, and multi-target stool DNA tests (through age 85)).

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

How often?

- **Blood-based biomarker screening tests for colorectal cancer—**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.

- **Multi-target stool DNA test—**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 initially have a non-invasive stool-based colorectal cancer screening test (fecal occult blood test or multi-target stool DNA test) or a blood-based biomarker screening test and get a positive result, Medicare also 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 written 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, Medicare covers this test 120 months after a previous screening colonoscopy.

What are my costs?

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

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

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

Am I covered?

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

How often?

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

What are my costs?

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

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

COVID-19 vaccines

Part B covers FDA-approved and -authorized COVID-19 vaccines.

Am I covered?

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

What are my costs?

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

Depression screenings

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

Am I covered?

Yes. All people with Medicare can get depression screenings.

How often?

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/or referrals to a mental health care provider.

What are my costs?

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

Diabetes screenings

If you have diabetes, your body doesn't make enough insulin, or has a reduced response to insulin. Diabetes increases your blood sugar levels because your body needs insulin to use sugar properly. A high blood sugar level isn't good for your health.

Am I covered?

Part B covers blood glucose (blood sugar) laboratory test screenings (fasting or non-fasting) 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).

What are my costs?

You pay nothing if your provider accepts assignment.

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 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

Am I covered?

If you've been diagnosed with diabetes and have a written order from your doctor or other provider, Part B covers outpatient diabetes self-management training to help you manage your disease. The program may include tips for eating healthy and being active, monitoring blood glucose (blood sugar), taking prescription drugs, and reducing risks. Some people may also be eligible for medical nutritional therapy services. Go to "Medical nutrition therapy services" on page 16.

Through September 30, 2025, you can get diabetes self-management training at any location in the U.S. through telehealth. Starting October 1, 2025, you must be in an office or medical facility located in a rural area (in the U.S.), to get this training through telehealth.

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 shots

Am I covered?

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

How often?

Usually once each flu season.

What are my costs?

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

Glaucoma screenings

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

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 for glaucoma 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 shots

Am I covered?

Part B covers Hepatitis B shots (vaccines) if you meet at least one of these conditions:

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

What are my costs?

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

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 screenings

Am I covered?

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

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

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

How often?

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

What are my costs?

You pay nothing if your provider accepts assignment.

Am I at risk?

Your risk for HBV increases if:

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

Hepatitis C virus screenings

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?

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

What are my costs?

You pay nothing if your provider accepts assignment.

Human immunodeficiency virus (HIV) screenings

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.

What are my costs?

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

Am I at risk?

Your risk for HIV may increase if you:

- Use or have used 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 injection drug users.
- Have another sexually transmitted disease.
- Have a history of blood transfusions between 1978 and 1985.
- Have new sexual partners.

Lung cancer screenings

Am I covered?

Medicare covers lung cancer screenings with low dose computed tomography (also known as "CT scans") if you meet all 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 each year.

What are my costs?

You pay nothing if your provider accepts assignment.

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

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

Am I covered?

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

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 doctor or other provider accepts assignment.
- Diagnostic mammograms: After you meet the Part B deductible, you pay 20% of the Medicare-approved amount.

Medical nutrition therapy services

Part B may cover medical nutrition therapy services and certain related services if a doctor refers you for them. Only a registered dietitian or nutrition professional who meets certain requirements can provide medical nutrition therapy services. Through September 30, 2025, you can get medical nutrition therapy services at any location in the U.S. through telehealth. Starting October 1, 2025, you must be in an office or medical facility located in a rural area (in the U.S.) to get medical nutrition therapy services from a registered dietitian or other nutrition professional through telehealth.

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?

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

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.

What are my costs?

You pay nothing if you qualify to get these services.

Medicare Diabetes Prevention Program

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

- Training to make realistic, lasting behavior changes around diet and exercise
- Tips for getting more exercise
- Strategies to control your weight
- A specially trained coach to help keep you motivated
- Support from people with similar goals and challenges

You can get these services virtually (through December 31, 2027) or in person from an approved supplier. These suppliers may be traditional health care providers or organizations like community centers or faith-based organizations.

Am I covered?

Part B covers this program if all these conditions apply to you:

- Within 12 months before attending your first core session, you have a hemoglobin A1c test result between 5.7% and 6.4%, a fasting plasma glucose between 110-125mg/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).
- You've never participated in the Medicare Diabetes Prevention Program.

How often?

Once in your lifetime. 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.

What are my costs?

You pay nothing if you qualify for this program. To find a supplier or learn more about the program, visit **Medicare.gov/coverage/medicare-diabetes-prevention-program**.

Obesity behavioral therapy

Obesity behavioral therapy includes an initial screening for body mass index (BMI), and behavioral therapy sessions that include a dietary assessment and counseling to help you lose weight by focusing on diet and exercise. Medicare covers obesity screenings and behavioral counseling if your primary care doctor or other primary care practitioner gives the counseling in a primary care setting (like a doctor's office), where they can coordinate your personalized plan with your other care.

Am I covered?

Medicare covers these services if you have a BMI of 30 or more.

What are my costs?

You pay nothing if your primary care practitioner accepts assignment.

Pneumococcal shots

Part B covers pneumococcal shots (or vaccines) to help protect against different strains of the bacteria that cause pneumonia. Talk with your doctor or other provider to decide which immunizations are right for you.

Am I covered?

Yes. All people with Medicare can get pneumococcal shots.

What are my costs?

You pay nothing if your provider accepts assignment.

Pre-exposure prophylaxis (PrEP) for HIV prevention

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 screening (you may be able to get more screenings if you're at high risk for Hepatitis B virus 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 doctor or other 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.

If your provider accepts assignment, you'll also pay nothing out of pocket for injectable PrEP drugs, HIV and Hepatitis B virus 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'll help you find another pharmacy where you can get PrEP. Call 1-800-MEDICARE (1-800-633-4227). TTY users can call 1-877-486-2048.

Prostate cancer screenings

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

Am I covered?

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

Am I at risk?

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

Sexually transmitted infection screenings & counseling

Part B covers sexually transmitted infection 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 sexually transmitted infection screenings if you're pregnant or at increased risk for sexually transmitted infections. 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?

- Sexually transmitted infection screenings: Once every 12 months, or at certain times during pregnancy.
- Behavioral counseling: Up to 2 sessions each 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).

What are my costs?

You pay nothing if your provider accepts assignment.

Shots or vaccines

Medicare covers:

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

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

Am I covered?

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

What are my costs?

You pay nothing for most shots and vaccines.

"Welcome to Medicare" preventive visit

The "Welcome to Medicare" preventive visit isn't a physical exam.

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

Am I covered?

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

How often?

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

What happens during the visit?

During the visit, your provider will:

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

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

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

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

The yearly "Wellness" visit isn't a physical exam.

Part B covers 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 doctor or other 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.

What happens during the visit?

Your visit may include:

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

Am I covered?

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

How often?

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

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

You can learn more about Medicare's preventive services by visiting Medicare.gov/coverage/preventive-screening-services. You can also call 1-800-MEDICARE (1-800-633-4227). TTY users can call 1-877-486-2048.

CMS Accessible Communications

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

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

1. **Call us:**
   For Medicare: 1-800-MEDICARE (1-800-633-4227) TTY: 1-877-486-2048
   For Marketplace: 1-800-318-2596 TTY: 1-855-889-4325
2. **Email us:** altformatrequest@cms.hhs.gov
3. **Send us a fax:** 1-844-530-3676
4. **Send us a letter:**
   Centers for Medicare & Medicaid Services
   Offices of Hearings and Inquiries (OHI)
   7500 Security Boulevard, Mail Stop DO-01-20
   Baltimore, MD 21244-1850
   Attn: Customer Accessibility Resource Staff (CARS)

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

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

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

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

1. **Online:**
   HHS.gov/civil-rights/filing-a-complaint/complaint-process/index.html
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 Medicare.gov or call 1-800-MEDICARE (1-800-633-4227). TTY users can call 1-877-486-2048.

Esta publicación está disponible en español. Para obtener una copia gratis, visite Medicare.gov 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.

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