



Your Guide to Medicare's Preventive Services

C E N T E R S F O R M E D I C A R E & M E D I C A I D S E R V I C E S

This is the official government booklet with important information about:

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

YOUR GUIDE TO MEDICARE'S PREVENTIVE SERVICES



Now's the time to get the most out of your Medicare. The best way to stay healthy is to live a healthy lifestyle. You can live a healthy lifestyle and prevent disease by exercising, eating well, keeping a healthy weight, and not smoking.

Medicare can help. Medicare pays for many preventive services to keep you healthy. Preventive services can find health problems early, when treatment works best, and can keep you from getting certain diseases. 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.

The Affordable Care Act makes many improvements to Medicare. If you have Original Medicare, you can get a yearly “Wellness” visit and many other covered preventive services.

Whether it's online, in person, or on the phone, Medicare is committed to helping people get the information they need to make smart choices about their Medicare benefits.

MyMedicare.gov

Register at [MyMedicare.gov](https://www.mymedicare.gov) to get direct access to your preventive health information—24 hours a day, every day. You can track your preventive services, get a 2-year calendar of the Medicare-covered tests and screenings you're eligible for, and print a personalized “on-the-go” report to take to your next doctor's appointment.

How can this booklet help me?

This booklet covers preventive services, and services that help keep certain illnesses from getting worse. The services listed in this booklet are covered if you have Medicare Part B (Medical Insurance). However, the amount you pay for these services varies depending on whether you have Original Medicare or a Medicare Advantage Plan (like an HMO or PPO). If you get your health care coverage through a Medicare Advantage Plan, call your plan for more information.

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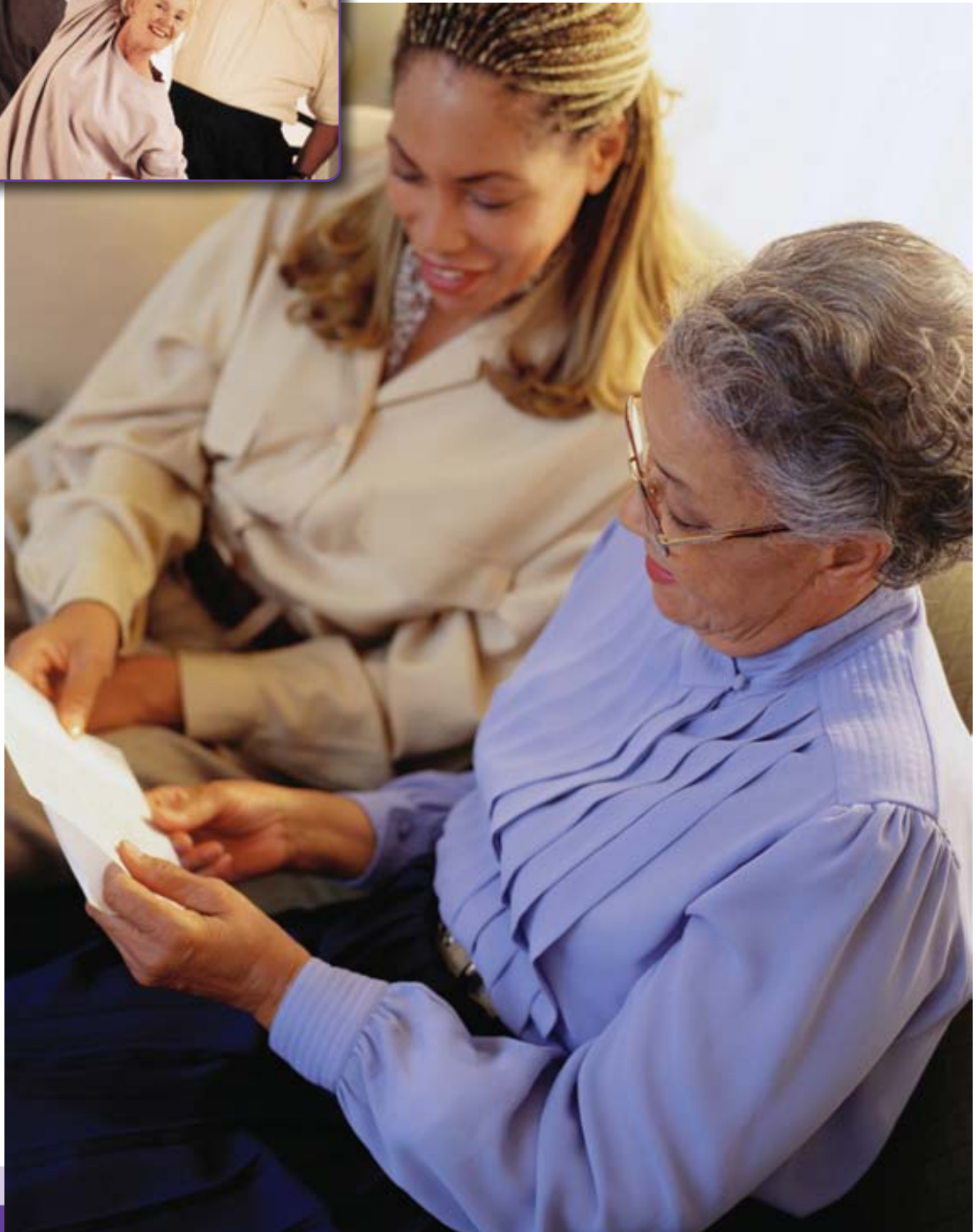
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SECTION

Introduction



What can I do to help prevent illness?

You can stay healthy, live longer, and delay or prevent many diseases by:

Exercising—Do any physical activity you enjoy for 20–30 minutes, 5 or 6 days a week. Talk to your doctor about the right exercise program for you.

Eating well—Eat a healthy diet of different foods, like fruits, vegetables, protein (like meat, fish, or beans), and whole grains (like brown rice). You should also limit the amount of saturated fat you eat.

Keeping a healthy weight—Watch your portions, and try to balance the number of calories you eat with the number you burn by exercising.

Not smoking—If you smoke, talk with your doctor about getting help to quit.

Getting preventive services—Delay or lessen the effects of diseases by getting preventive services (like screening tests) to find disease early, and shots to keep you from getting dangerous illnesses.

Remember—The services listed in this booklet are covered if you have Medicare Part B (Medical Insurance).

Talk to your doctor or health care provider

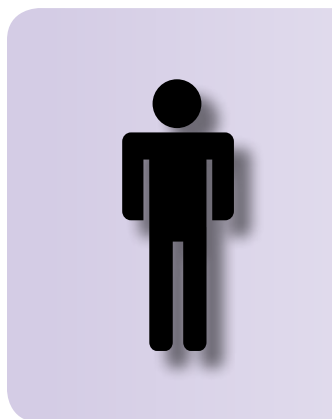
Your doctor or health care provider may do exams or tests that Medicare doesn't cover. Your doctor or health care provider also may recommend that you have tests more or less often than Medicare covers them. Medicare pays for some diagnostic tests. A diagnostic test may be recommended when a screening test or exam shows an abnormality. In some cases, you may have to pay for these services.

Talk to your doctor or health care provider to find out which preventive services are right for you and how often you need them. If a service you get isn't covered and you think it should be, you may appeal this decision. To file an appeal, follow the instructions on your "Medicare Summary Notice" (MSN). The MSN is an easy-to-read statement that clearly lists your health insurance claims information. For more information on filing an appeal, visit [Medicare.gov/appeals](https://www.medicare.gov/appeals), or call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

Things to know when reading this booklet

Symbols

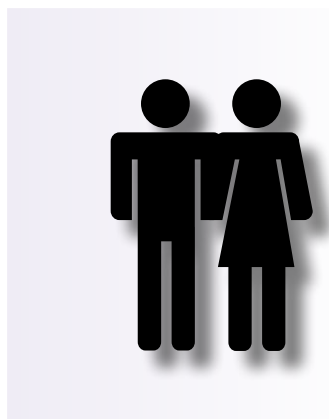
You'll see one of these symbols next to each preventive service. It tells you for whom Medicare covers the service or test.



Men only



Women only



Men & women

Things to know when reading this booklet (continued)

Risk factors

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

Part B deductible

The Part B (Medical Insurance) deductible in 2015 is \$147. This amount may change yearly.

Medicare-approved amount

In Original Medicare, this is the amount a doctor or supplier can be paid, including what Medicare pays, and any deductible, coinsurance, or copayment that you pay. It may be less than the actual amount a doctor or supplier charges. Doctors and suppliers who accept assignment accept the Medicare-approved amount as payment in full. If you get your services from a doctor or supplier who doesn't accept assignment, you might pay more.

Assignment

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

Drug coverage

Medicare Part D covers prescription drugs that may help you treat a disease or condition found by preventive screening tests, like high cholesterol. You can review and compare the cost, coverage, and customer service of Medicare drug plans by visiting Medicare.gov/find-a-plan. Generally, you can join a Medicare drug plan between October 15–December 7. Your coverage will begin on January 1 of the following year. You can get personalized help by visiting Medicare.gov, or by calling 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

Section 1: Introduction

Notes

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SECTION

Preventive Services



Abdominal aortic aneurysm screening

Who's covered?

Medicare covers a one-time abdominal aortic aneurysm ultrasound for people at risk. You're considered at risk if you have a family history of abdominal aortic aneurysms, or you're a man 65–75 and have smoked at least 100 cigarettes in your lifetime.

How often is it covered?

Medicare covers this screening once in your lifetime if you get a referral from your doctor.

Your costs if you have Original Medicare

You pay nothing for this screening if the doctor or other qualified health care provider accepts assignment.

Remember—The services listed in this booklet are covered if you have Medicare Part B (Medical Insurance).



Alcohol misuse screening and counseling

Who's covered?

Adults with Medicare (including pregnant women) who use alcohol, but don't meet the medical criteria for alcohol dependency.

How often is it covered?

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

Your costs if you have Original Medicare

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



Bone mass measurements

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

Who's covered?

Bone mass measurements are covered for certain people with Medicare whose doctors say they're at risk for osteoporosis, and who have one of these medical conditions:

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

How often is it covered?

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

Your costs if you have Original Medicare

You pay nothing for this test if the doctor accepts assignment.



Breast cancer screening (mammograms)

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

Who's covered?

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

How often is it covered?

Once every 12 months.

Your costs if you have Original Medicare

You pay nothing for the test if the doctor accepts assignment.

Am I at high risk for breast cancer?

Your risk of developing breast cancer increases if any of these are true:

- You had breast cancer in the past.
- You have a family history of breast cancer (like a mother, sister, daughter, or 2 or more close relatives who've had breast cancer).
- You had your first baby after age 30.
- You've never had a baby.



Cardiovascular disease (behavioral therapy)

Who's covered?

All people with Medicare.

What's covered?

A cardiovascular disease risk reduction visit that includes:

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

How often is it covered?

Once each year.

Your costs if you have Original Medicare

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



Cardiovascular disease screening

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

Who's covered?

All people with Medicare when the screening is ordered by a doctor.

What's covered?

Tests for cholesterol, lipid, and triglyceride levels.

How often is it covered?

Once every 5 years.

Your costs if you have Original Medicare

You pay nothing for this screening.



Cervical and vaginal cancer screening

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

Who's covered?

All women with Medicare.

How often is it covered?

Medicare covers these screening tests once every 24 months, or once every 12 months for women at high risk, and for women of child-bearing age who've had an exam that indicated cancer or other abnormalities in the past 3 years.

Your costs if you have Original Medicare

You pay nothing for the Pap test. You pay nothing for the pelvic exam (including a clinical breast exam) if the doctor accepts assignment.

Am I at high risk for cervical cancer?

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

- You've had an abnormal Pap test.
- You've had cervical or vaginal cancer in the past.
- You have a history of sexually transmitted disease (including HIV infection).
- You began having sex before age 16.
- You've had 5 or more sexual partners.
- Your mother took DES (Diethylstilbestrol), a hormonal drug, when she was pregnant with you.



Colorectal cancer screening

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

Who's covered?

All people with Medicare 50 and older, but there's no minimum age for having a covered screening colonoscopy.

Colorectal cancer screening (continued)

How often is it covered?

- **Screening fecal occult blood test**—Once every 12 months for people 50 or older.
- **Screening flexible sigmoidoscopy**—Once every 48 months after the last flexible sigmoidoscopy or barium enema, or 120 months after a previous screening colonoscopy.
- **Screening colonoscopy**—Once every 120 months (high risk every 24 months), or 48 months after a previous flexible sigmoidoscopy.
- **Screening barium enema**—Once every 48 months (high risk every 24 months) when used instead of sigmoidoscopy or colonoscopy.
- **Multi-target stool DNA test (like Cologuard™)**—Once every 3 years for people who meet all of these conditions:
 - They're between 50–85.
 - They show no signs or symptoms of colorectal disease including, but not limited to, lower gastrointestinal pain, blood in stool, positive guaiac fecal occult blood test, or fecal immunochemical test.
 - They're at average risk for developing colorectal cancer, meaning they have no personal history of adenomatous polyps, colorectal cancer, or inflammatory bowel disease, including Crohn's Disease and ulcerative colitis.
 - They have no family history of colorectal cancers or adenomatous polyps, familial adenomatous polyposis, or hereditary nonpolyposis colorectal cancer.

Your costs if you have Original Medicare

You pay nothing for the fecal occult blood test, if you get a written referral from your doctor, physician assistant, nurse practitioner, or clinical nurse specialist. You pay nothing for the flexible sigmoidoscopy or screening colonoscopy if your doctor accepts assignment.

Note: If a polyp or other tissue is found and removed during the colonoscopy, you may have to pay 20% of the Medicare-approved amount for the doctor's services and a copayment in a hospital outpatient setting.

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

Colorectal cancer screening (continued)

Am I at high risk for colorectal cancer?

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

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



Depression screening

Medicare covers depression screenings.

Who's covered?

All people with Medicare.

How often is it covered?

Medicare covers one depression screening per year. The screening must be done in a primary care setting (like a doctor's office) that can provide follow-up treatment and referrals.

Your costs if you have Original Medicare

You pay nothing for this test if your doctor or other qualified health care provider accepts assignment.



Diabetes screening and self-management training

Diabetes is a medical condition in which your body doesn't make enough insulin, or has a reduced response to insulin. Diabetes causes your blood sugar to be too high because insulin is needed to use sugar properly. A high blood sugar level isn't good for your health. Medicare covers a blood screening test to check for diabetes for people at risk. For people with diabetes, Medicare covers educational training to help manage their diabetes.

Diabetes screening and self-management training (continued)

Diabetes screening (fasting blood glucose test)

Who's covered?

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

How often is it covered?

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

Your costs if you have Original Medicare

You pay nothing for this screening.

Am I at risk for diabetes?

You're considered at risk if you have high blood pressure, dyslipidemia (history of abnormal cholesterol and triglyceride levels), obesity, or a history of high blood sugar (glucose). Medicare also covers these tests if 2 or more of these apply to you:

- Are you 65 or older?
- Are you overweight?
- Do you have a family history of diabetes (parents, brothers, or sisters)?
- Do you have a history of gestational diabetes (diabetes during pregnancy), or have you had a baby weighing more than 9 pounds?

Diabetes self-management training

Who's covered?

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

Your costs if you have Original Medicare.

You pay 20% of the Medicare-approved amount after the yearly Part B deductible.



Flu shot – See “Shots” on page 22.



Glaucoma tests

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

Who's covered?

People with Medicare whose doctor says they're at high risk for glaucoma.

How often is it covered?

Once every 12 months.

Your costs if you have Original Medicare

You pay 20% of the Medicare-approved amount after the yearly Part B deductible.

Am I at high risk for glaucoma?

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

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



Hepatitis C screening test

Who's covered?

People with Medicare who meet at least **one** of these conditions:

- Those at high risk because they have a current or past history of illicit injection drug use.
- Those at high risk because they've had a blood transfusion before 1992.
- Those born between 1945 and 1965.

How often is it covered?

Medicare covers a one-time Hepatitis C screening test. Medicare also covers repeat screening annually for certain people at high risk.

Your costs if you have Original Medicare

You pay nothing for the screening test if the doctor or other qualified health care provider accepts assignment. Medicare will only cover Hepatitis C screening tests if they're ordered by a primary care doctor or practitioner.



HIV screening

Medicare covers voluntary HIV (Human Immunodeficiency Virus) screenings for people at increased risk for the infection, including anyone who asks for the test and pregnant women.

How often is it covered?

Medicare covers this test once every 12 months, or up to 3 times during a pregnancy.

Your costs if you have Original Medicare

You pay nothing for this test.



Lung cancer screening

Who's covered?

Medicare covers lung cancer screening with Low Dose Computed Tomography (LDCT) for people with Medicare who meet all of these:

- Are age 55-77
- Are either a current smoker or have quit smoking within the last 15 years
- Have a tobacco smoking history of at least 30 “pack years” (an average of one pack a day for 30 years)
- Get a written order from their physician or qualified non-physician practitioner.
 - Before your first lung cancer screening, you'll need to schedule an appointment with your doctor to discuss the benefits and risks of lung cancer screening. You and your doctor can decide whether lung cancer screening is right for you.
- The service is furnished by an appropriate radiology imaging center and a reading radiologist that meet Medicare standards.

How often is it covered?

Once every 12 months.

Your costs if you have Original Medicare

You pay nothing for this service if the primary care doctor or other qualified primary care practitioner meets the appropriate standards and accepts assignment.



Medical nutrition therapy

Medicare may cover medical nutrition therapy if you have diabetes or kidney disease, and your doctor refers you for this service. These services can be given by a registered dietitian or Medicare-approved nutrition professional, and include a nutritional assessment and counseling to help you manage your diabetes or kidney disease.

Who's covered?

Certain people who have any of these:

- Diabetes
- Renal disease (people who have kidney disease, but aren't on dialysis)
- Have had a kidney transplant within the last 3 years

Your doctor needs to refer you for this service.

How often is it covered?

Medicare covers 3 hours of one-on-one counseling services the first year, and 2 hours each year after that. If your condition, treatment, or diagnosis changes, you may be able to get more hours of treatment with a doctor's referral. A doctor must prescribe these services and renew your referral yearly if continuing treatment is needed into another calendar year.

Your costs if you have Original Medicare

You pay nothing for these services if the doctor accepts assignment.

For more information about diabetes and medical nutrition therapy

Visit [Medicare.gov/publications](https://www.medicare.gov/publications) to view the booklet "Medicare Coverage of Diabetes Supplies & Services." You can also call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.



Obesity screening and counseling

Medicare covers intensive behavioral therapy for people with obesity, defined as a body mass index (BMI) of 30 or more.

Who's covered?

All people with Medicare may be screened for obesity. Counseling is covered for anyone found to have a body mass index of 30 or more.

How often is it covered?

This counseling may be covered if you get it in a primary care setting (like a doctor's office). Talk to your primary care doctor or primary care practitioner to find out more.

Medicare covers 15-minute face-to-face individual behavioral therapy sessions and 30-minute face-to-face group behavioral counseling sessions to help you lose weight.

Your costs if you have Original Medicare

You pay nothing for this service if your primary care doctor or other qualified primary care practitioner accepts assignment.



Pneumococcal shot – See “Shots” on page 22.



Prostate cancer screening

Prostate cancer may be found by testing the amount of PSA (Prostate Specific Antigen) in your blood. Another way prostate cancer may be found is when your doctor performs a digital rectal exam. Medicare covers both of these tests.

Who's covered?

All men with Medicare over 50 (coverage for this test begins the day after your 50th birthday).

How often is it covered?

- Digital rectal examination—Once every 12 months.
- PSA test—Once every 12 months.

Your costs if you have Original Medicare

Generally, you pay 20% of the Medicare-approved amount for the digital rectal exam after the yearly Part B deductible. You pay nothing for the PSA test.

Am I at high risk for prostate cancer?

Talk to your doctor or practitioner about whether you're at risk for prostate cancer.



Sexually transmitted infections screening and counseling

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

Who's covered?

People with Medicare who are pregnant and/or certain people who are at increased risk for an STI when the screening tests are ordered and counseling is provided by a primary care doctor or other primary care practitioner.

How often is it covered?

Medicare covers these tests once every 12 months or at certain times during pregnancy. Medicare also covers up to 2 individual 20 to 30 minute, face-to-face, high-intensity behavioral counseling sessions each year for sexually active adults at increased risk for STIs. Medicare will only cover these counseling sessions if they're provided by a primary care doctor or other primary care practitioner and take place in a primary care setting (like a doctor's office). Counseling conducted in an inpatient setting, like a skilled nursing facility, won't be covered as a preventive service.

Your costs if you have Original Medicare

You pay nothing for these services if your primary care doctor or other qualified primary care practitioner accepts assignment.



Shots (flu, pneumococcal, and Hepatitis B)

Medicare covers flu, pneumococcal, and Hepatitis B shots. Flu, pneumococcal infections, and Hepatitis B can be life threatening to an older person. All people 65 and older should get flu and pneumococcal shots. People with Medicare who are under 65 should also get a flu shot. This is especially important for those who have chronic illness, including heart disease, lung disease, diabetes, or End-Stage Renal Disease (ESRD) (permanent kidney failure requiring dialysis or a kidney transplant). People at medium to high risk for Hepatitis B should get Hepatitis B shots.

Flu shot

Who's covered?

All people with Medicare.

How often is it covered?

Once a flu season.

Your costs if you have Original Medicare

You pay nothing if your doctor or health care provider accepts assignment for giving the shot.

Pneumococcal shot

Who's covered?

All people with Medicare.

How often is it covered?

Most people only need one shot once in their lifetime. A different, second shot, is covered 11 months after you get the first shot. Talk with your doctor or other health care provider to see if you need these shots.

Your costs if you have Original Medicare

You pay nothing if your doctor or health care provider accepts assignment for giving the shot.



Shots (flu, pneumococcal, and Hepatitis B) (continued)

Hepatitis B shots

Who's covered?

Certain people with Medicare whose doctor says they're at medium or high risk for Hepatitis B.

How often is it covered?

Three shots are needed for complete protection. Check with your doctor about when to get these shots if you qualify to get them.

Your costs if you have Original Medicare

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

Am I at medium or high risk for Hepatitis B?

These are some of the factors that put you at medium or high risk for Hepatitis B:

- Hemophilia.
- ESRD (End-Stage Renal Disease).
- Diabetes.
- Certain other conditions that increase your risk for infection, like if you live with someone who has Hepatitis B, or if you're a health care worker and have frequent contact with blood or body fluids.

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



Tobacco use cessation counseling

The U.S. Surgeon General has reported that quitting smoking and stopping other forms of tobacco use lead to significant risk reduction for certain diseases and other health benefits, even in older adults who've smoked for years. Any person who uses tobacco can get counseling from a qualified doctor or other Medicare-recognized practitioner who can help them stop using tobacco.

Who's covered?

People with Medicare who use tobacco.

How often is it covered?

Medicare will cover up to 8 face-to-face visits during a 12-month period. These visits must be provided by a qualified doctor or other Medicare-recognized practitioner.

Your costs if you have Original Medicare

You pay nothing for the counseling sessions.

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



“Welcome to Medicare” preventive visit

Medicare covers a one-time preventive visit within the first 12 months that you have Medicare Part B (Medical Insurance). This visit is called the “Welcome to Medicare” preventive visit. The visit is a great way to get up-to-date on important screenings and shots and to talk with your doctor about your family history and how to stay healthy.

What happens during the visit?

During the visit, your doctor will:

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

Depending on your general health and medical history, your doctor will give you advice on education, and counseling to help you prevent disease, improve your health, and stay well. Your doctor will also give you a written plan (like a checklist) letting you know what screenings, shots, and other preventive services you need.

What should I bring to the visit?

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

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

Who’s covered, and how often is it covered?

This visit is only covered one time, and you must have the visit within the first 12 months you’re enrolled in Part B.

Your costs if you have Original Medicare

You pay nothing if your doctor accepts assignment.



Yearly “Wellness” visit

If you’ve had Medicare Part B (Medical Insurance) for longer than 12 months, you can get a yearly “Wellness” visit to develop or update a personalized prevention plan based on your current health and risk factors. This includes:

- Health risk assessment (Your doctor or health professional will ask you to answer some questions before or during your visit, which is called a health risk assessment. Your responses to the questions will help you and your health professional get the most from your yearly “Wellness” visit.)
- Review of medical and family history.
- Develop or update a list of current providers and prescriptions.
- Height, weight, blood pressure, and other routine measurements.
- Detection of any cognitive impairment.
- Personalized health advice.
- A list of risk factors and treatment options for you.
- A screening schedule (like a checklist) for appropriate preventive services.

How often is it covered?

Once every 12 months.

Your costs if you have Original Medicare

You pay nothing for this visit if your doctor accepts assignment.

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

Preventive services checklist

Keep track of the preventive services you need by using the chart below. You can also visit [MyMedicare.gov](https://www.mymedicare.gov) to track your preventive services, get a 2-year calendar of the Medicare-covered tests and screenings you're eligible for, and print a personalized "on-the-go" report to take to your next doctor's appointment.

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Section 2: Preventive Services

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For more information about Medicare preventive services

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

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

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

**U.S. DEPARTMENT OF HEALTH AND
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