# THE ORIGINAL MEDICARE PLAN

**The following charts talk about what the Original Medicare Plan covers.**
**The Original Medicare Plan doesn't cover everything (like most prescriptions drugs).**

| | Service or Supply | What is covered and when? | What do YOU pay in 2018 | Part A or B |
|---|---|---|---|---|
| A | **Abdominal Aortic Aneurysm Screening** | Medicare covers a one-time screening abdominal aortic aneurysm ultrasound for people at risk. You must get a referral from your doctor or other practitioner.<br><br>Note: If you have a family history of abdominal aortic aneurysms, or you're a man 65- 75 and you have smoked at least 100 cigarettes in your lifetime, you're considered at risk. | You pay nothing for the screening if the doctor or other qualified health care provider accepts assignment. | B |
| | **Advance Care Planning** | Medicare covers voluntary Advance Care Planning as part of the Yearly "Wellness" visit. This is planning for care you would want to get if you become unable to speak for yourself. You can talk about an advance directive with your health care professional, and he or she can help you fill out the forms, if you want to. An advance directive is a legal document that records your wishes about medical treatment at a future time, if you're not able to make decisions about your care.<br><br>Note: Medicare may also cover this service as part of your medical treatment. | You pay nothing if the doctor or other qualified health care provider accepts assignment.<br><br>When Advance Care Planning isn't part of your Annual "Wellness" visit, the Part B deductible and coinsurance apply. | B |
| | **Alcohol misuse screening and counseling** | Medicare covers one alcohol misuse screening per year for adults with Medicare (including pregnant women) who use alcohol, but don't meet the medical criteria for alcohol dependency. 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). | You pay nothing if the qualified primary care doctor or other primary care practitioner accepts assignment. | B |

# THE ORIGINAL MEDICARE PLAN

| Service or Supply | What is covered and when? | What do YOU pay in 2018 | Part A or B |
|---|---|---|---|
| **Ambulance Services** | **Medicare covers ground ambulance transportation when you need to be transported to a hospital, critical access hospital, or skilled nursing facility for medically necessary services, and transportation in any other vehicle could endanger your health. Medicare may pay for emergency ambulance transportation in an airplane or helicopter to a hospital if you need immediate and rapid ambulance transportation that ground transportation can't provide.**<br><br>**In some cases, Medicare may pay for limited, medically necessary, non-emergency ambulance transportation if you have a written order from your doctor stating that ambulance transportation is medically necessary. An example may be a medically necessary ambulance transport to a renal dialysis facility for an End-Stage Renal Disease (ESRD) patient.**<br><br>**Medicare will only cover ambulance services to the nearest appropriate medical facility that's able to give you the care you need.** | **You pay 20% of the Medicare-approved amount, and the Part B deductible applies.** | **B** |
| **Ambulatory Surgical Centers** | **Medicare covers the facility service fees related to approved surgical procedures provided in an ambulatory surgical center (facility where surgical procedures are performed, and the patient is expected to be released within 24 hours).** | **Except for certain preventive services (for which you pay nothing if the doctor or other health care provider accepts assignment), you pay 20% of the Medicare-approved amount to both the ambulatory surgical center and the doctor who treats you, and the Part B deductible applies. You pay all of the facility service fees for procedures Medicare doesn't cover in ambulatory surgical centers.** | **B** |

# THE ORIGINAL MEDICARE PLAN

| | Service or Supply | What is covered and when? | What do YOU pay in 2018 | Part A or B |
|---|---|---|---|---|
| B | **Blood** | **If the hospital gets blood from a blood bank at no charge, you won't have to pay for it or replace it. However, you'll pay a copayment for the blood processing and handling services for each unit of blood you get and the Part B Deductible applies.** | **However, you'll pay a copayment for the blood processing and handling services for each unit of blood you get and the Part B Deductible applies.**<br><br>**If the provider has to buy blood for you, you must either pay the provider costs for the first 3 units of blood you get in a calendar year or have the blood donated by you or someone else.** | **A & B** |
| | **Bone Mass Measurement (Bone Density)** | **This test helps to see if you're at risk for broken bones. It's covered once every 24 months (more often if medically necessary) for people who have certain medical conditions or meet certain criteria.** | **You pay nothing for this test if the doctor or other qualified health care provider accepts assignment.** | **B** |
| | **Breast Cancer Screening (Mammograms)** | **Medicare covers screening mammograms to check for breast cancer once every 12 months for all women with Medicare who are 40 and older. Medicare covers one baseline mammogram for women between 35–39.**<br><br>**Note: Part B also covers diagnostic mammograms more frequently than once a year when medically necessary.** | **You pay nothing for the test if the doctor or other qualified health care provider accepts assignment.**<br><br>**You pay 20% of the Medicare-approved amount for diagnostic mammograms, and the Part B deductible applies.** | **B** |

# THE ORIGINAL MEDICARE PLAN

| | Service or Supply | What is covered and when? | What do YOU pay in 2018 | Part A or B |
|---|---|---|---|---|
| C | **Cardiac Rehabilitation** | Medicare covers comprehensive programs that include exercise, education, and counseling for patients who meet at least one of these conditions:<br><br>■ A heart attack in the last 12 months<br>■ Coronary artery bypass surgery<br>■ Current stable angina pectoris (chest pain)<br>■ A heart valve repair or replacement<br>■ A coronary angioplasty (a medical procedure used to open a blocked artery) or coronary stenting (a procedure used to keep an artery open)<br>■ A heart or heart-lung transplant<br>■ Stable, chronic heart failure (for regular cardiac rehabilitation only)<br><br>Medicare also covers intensive cardiac rehabilitation programs that are typically more rigorous or more intense than regular cardiac rehabilitation programs. Services are covered in a doctor's office or hospital outpatient setting. | You pay 20% of the Medicare-approved amount if you get the services in a doctor's office. In a hospital outpatient setting, you also pay the hospital a copayment. The Part B deductible applies. | B |
| | **Cardiovascular Disease (behavioral therapy)** | Medicare will cover one visit per year with a primary care doctor in a primary care setting (like a doctor's office) to help lower your risk for cardiovascular disease. During this visit, the doctor may discuss aspirin use (if appropriate), check your blood pressure, and give you tips to make sure you eat well. | You pay nothing if the doctor or other qualified health care provider accepts assignment. | B |
| | **Cardiovascular Disease Screenings** | These screenings include blood tests that help detect conditions that may lead to a heart attack or stroke. Medicare covers these screening tests once every 5 years to test your cholesterol, lipid, lipoprotein, and triglyceride levels. | You pay nothing for the tests if the doctor or other qualified health care provider accepts assignment. | B |
| | **Cervical and Vaginal Cancer Screening** | 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. Medicare covers these screening tests once every 24 months. Medicare covers these screening tests once every 12 months if you're at high risk for cervical or vaginal cancer, or if you're of child-bearing age and had an abnormal Pap test in the past 36 months.<br><br>Part B also covers Human Papillomavirus (HPV) tests (when received with a Pap test) once every 5 years if you're age 30– 65 without HPV symptoms. | You pay nothing for the lab Pap test or for the lab HPV with Pap test if your doctor or other qualified health care provider accepts assignment. You also pay nothing for the Pap test specimen collection and pelvic and breast exams if the doctor or other qualified health care provider accepts assignment. | B |

# THE ORIGINAL MEDICARE PLAN

| Service or Supply | What is covered and when? | What do YOU pay in 2018 | Part A or B |
|---|---|---|---|
| **Chemotherapy** | **Medicare covers chemotherapy in a doctor's office, freestanding clinic, or hospital outpatient setting for people with cancer.** | **You pay a copayment for chemotherapy in a hospital outpatient setting.<br>For chemotherapy given in a doctor's office or freestanding clinic, you pay 20% of the Medicare-approved amount, and the Part B Deductible applies.<br><br>For chemotherapy in a hospital inpatient setting covered under Part A, see Hospital care (inpatient care)** | **A or B** |
| **Chiropractic Services (limited coverage)** | **Medicare covers manipulation of the spine if medically necessary to correct a subluxation (when one or more of the bones of your spine move out of position) when provided by a chiropractor or other qualified provider.** | **You pay 20% of the Medicare-approved amount, and the Part B deductible applies.<br><br>Note: You pay all costs for any other services or tests ordered by a chiropractor (including X-rays and massage therapy).** | **B** |
| **Chronic Care Management Services** | **If you have 2 or more chronic conditions (like arthritis, asthma, diabetes, hypertension, heart disease, osteoporosis and other conditions) that are expected to last at least a year, Medicare may pay for a health care provider's help to manage those conditions. This includes a comprehensive care plan that lists your health problems and goals, other health care providers, medications, community services you have and need, and other information about your health. It also explains the care you need and how your care will be coordinated. Your health care provider will ask you to sign an agreement to provide this service. If you agree, he or she will prepare the care plan, help you with medication management, provide 24/7 access for urgent care needs, give you support when you go from one health care setting to another, review your medicines and how you take them, and help you with other chronic care needs.** | **There's a monthly fee, and the Part B deductible and coinsurance apply.** | **B** |

# THE ORIGINAL MEDICARE PLAN

| Service or Supply | What is covered and when? | What do YOU pay in 2018 | Part A or B |
|---|---|---|---|
| **Clinical Research Studies** | **Clinical research studies test how well different types of medical care work and if they're safe. Medicare covers some costs, like office visits and tests, in qualifying clinical research studies.** | **You may pay 20% of the Medicare-approved amount, and the Part B deductible may apply. Note: If you're in a Medicare Advantage Plan (like an HMO or PPO), some costs may be covered by Original Medicare and some may be covered by your Medicare Advantage Plan** | **B** |

# THE ORIGINAL MEDICARE PLAN

| Service or Supply | What is covered and when? | What do YOU pay in 2018 | Part A or B |
|---|---|---|---|
| **Colorectal Cancer Screenings** | **Medicare covers these screenings to help find precancerous growths or find cancer early, when treatment is most effective. One or more of these tests may be covered:**<br><br>**■ Multi-target stool DNA test—This lab test is generally covered once every 3 years if you meet all of these conditions:**<br>**—Are between ages 50–85.**<br>**—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.**<br>**—At average risk for developing colorectal cancer, meaning:**<br>**• Have no personal history of adenomatous polyps, colorectal cancer, inflammatory bowel disease, including Crohn's Disease and ulcerative colitis.**<br>**• Have no family history of colorectal cancer or adenomatous polyps, familial adenomatous polyposis, or hereditary nonpolyposis colorectal cancer.**<br>**.**<br>**■ Screening fecal occult blood test—This test is covered once every 12 months if you're 50 or older.**<br><br>**Screening flexible sigmoidoscopy—This test is generally covered once every 48 months if you're 50 or older, or 120 months after a previous screening colonoscopy for those not at high risk.**<br><br>**■ Screening colonoscopy—This test is generally covered once every 120 months (high risk every 24 months) or 48 months after a previous flexible sigmoidoscopy. There's no minimum age.**<br><br>**■ Screening barium enema—This test is generally covered once every 48 months if you're 50 or older (high risk every 24 months) when used instead of a sigmoidoscopy or colonoscopy.** | **You pay nothing for the test if the doctor or other qualified health care provider accepts assignment**<br><br>**Colonoscopy 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. The Part B deductible doesn't apply.**<br><br>**Screening Barium Enema Note: You pay 20% of the Medicare-approved amount for the doctor services. In a hospital outpatient setting, you also pay the hospital a copayment.** | **B** |

# THE ORIGINAL MEDICARE PLAN

| | Service or Supply | What is covered and when? | What do YOU pay in 2018 | Part A or B |
|---|---|---|---|---|
| | **Continuous Positive Airway Pressure (CPAP) Therapy** | **Medicare covers a 3-month trial of CPAP therapy if you've been diagnosed with obstructive sleep apnea. Medicare may cover it longer if you meet in person with your doctor, and your doctor documents in your medical record that the CPAP therapy is helping you.**<br><br>**Medicare pays the supplier to rent the machine for 13 months if you've been using it without interruption. After you've rented the machine for 13 months, you own it.**<br><br>**Note: If you had a CPAP machine before you got Medicare, Medicare may cover rental or a replacement CPAP machine and/or CPAP accessories if you meet certain requirements.**<br><br>**If you live in certain areas of the country, you may have to use specific suppliers for Medicare to pay for a CPAP machine and/or accessories.** | **You pay 20% of the Medicare-approved amount for rental of the machine and purchase of related supplies (like masks and tubing), and the Part B deductible applies.** | **B** |
| **D** | **Defibrillator (Implantable Automatic)** | **Medicare covers these devices for some people diagnosed with heart failure.**<br><br>**Part A covers surgeries to implant defibrillators in a hospital inpatient setting.** | **If the surgery takes place in an outpatient setting, you pay 20% of the Medicare-approved amount for the doctor's services.**<br><br>**If you get the device as a hospital outpatient, you also pay the hospital a copayment. In most cases, the copayment amount can't be more than the Part A hospital stay deductible. The Part B deductible applies.**<br><br>**Part A covers surgeries to implant defibrillators in a hospital inpatient setting. (See Hospital Care)** | **B or A** |
| | **Depression Screening** | **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.** | **You pay nothing for this screening if the doctor or other qualified health care provider accepts assignment.** | **B** |

# THE ORIGINAL MEDICARE PLAN

| Service or Supply | What is covered and when? | What do YOU pay in 2018 | Part A or B |
|---|---|---|---|
| **Diabetes Screenings** | Medicare covers these screenings if your doctor determines you're at risk for diabetes or diagnosed with pre-diabetes. You may be eligible for up to 2 diabetes screenings each year. | You pay nothing for the test if your doctor or other qualified health care provider accepts assignment. | B |
| **Diabetes Self-Management Training** | Medicare covers diabetes outpatient self-management training to teach you to cope with and manage your diabetes. The program may include tips for eating healthy, being active, monitoring blood sugar, taking medication, and reducing risks. You must have diabetes and a written order from your doctor or other health care provider. | You pay 20% of the Medicare-approved amount, and the Part B deductible applies. | B |
| **Diabetes Supplies** | Medicare covers blood sugar testing monitors, blood sugar test strips, lancet devices and lancets, blood sugar control solutions, and therapeutic shoes (in some cases). Medicare only covers insulin if it's medically necessary to use with an external insulin pump to administer the insulin.<br><br>Note: Medicare prescription drug coverage (Part D) may cover insulin, certain medical supplies used to inject insulin (like syringes), and some oral diabetic drugs. Check with your plan for more information.<br><br>You may need to use specific suppliers for some types of diabetic testing supplies. Visit Medicare.gov/supplier directory to find a list of suppliers in your area. | You pay 20% of the Medicare-approved amount, and the Part B deductible applies. | B |
| **Doctor and Other Health Care Provider Services** | Medicare covers medically necessary doctor services (including outpatient services and some doctor services you get when you're a hospital inpatient) and covered preventive services. Medicare also covers services provided by other health care providers, like physician assistants, nurse practitioners, social workers, physical therapists, and psychologists. | Except for certain preventive services (for which you may pay nothing), you pay 20% of the Medicare-approved amount, and the Part B deductible applies. | B |

# THE ORIGINAL MEDICARE PLAN

| Service or Supply | What is covered and when? | What do YOU pay in 2018 | Part A or B |
|---|---|---|---|
| **Durable Medical Equipment (DME)** | **Medicare covers items like oxygen equipment and supplies, wheelchairs, walkers, and hospital beds ordered by a doctor or other health care provider enrolled in Medicare for use in the home. Some items must be rented.**<br><br>**Make sure your doctors and DME suppliers are enrolled in Medicare. Doctors and suppliers have to meet strict standards to enroll and stay enrolled in Medicare. If your doctors or suppliers aren't enrolled, Medicare won't pay the claims they submit. It's also important to ask your suppliers if they participate in Medicare before you get DME. If suppliers are participating suppliers, they must accept assignment (that is, they're limited to charging you only coinsurance and the Part B deductible on the Medicare-approved amount). If suppliers are enrolled in Medicare but aren't "contract suppliers," they may choose not to accept assignment. If suppliers don't accept assignment, there's no limit on the amount they can charge you. To find suppliers who accept assignment, visit Medicare.gov/supplierdirectory or call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048. You can also call 1-800-MEDICARE if you're having problems with your DME supplier, or you need to file a complaint.**<br><br>**<u>Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Competitive Bidding Program:</u>**<br><br>**If you have Original Medicare and live in a Competitive Bidding Area (CBA) and use equipment or supplies included under the program (or get the items while visiting a CBA), you generally must use Medicare contract suppliers if you want Medicare to help pay for the item.**<br><br>**Visit Medicare.gov/supplierdirectory to determine if you live in a CBA and to find Medicare-approved suppliers in your area. If your ZIP code is in a CBA, the items included in the program are marked with an orange star. You can also call 1-800-MEDICARE.** | **You pay 20% of the Medicare-approved amount, and the Part B deductible applies** | **B** |

# THE ORIGINAL MEDICARE PLAN

| | Service or Supply | What is covered and when? | What do YOU pay in 2018 | Part A or B |
|---|---|---|---|---|
| E | **EKG or ECG (Electrocardiogram) Screening** | **Medicare covers a one-time screening EKG/ECG if referred by your doctor or other health care provider as part of your one-time "Welcome to Medicare" preventive visit.**<br><br>**An EKG/ECG is also covered as a diagnostic test.** | **You pay 20% of the Medicare-approved amount and the Part B Deductible applies.**<br><br>**If you have the test at a hospital or a hospital owned clinic, you also pay the hospital a copayment.** | **B** |
| | **Emergency Department Services** | **These services are covered when you have an injury, a sudden illness, or an illness that quickly gets much worse.** | **You pay a specified copayment for the hospital emergency department visit, and you pay 20% of the Medicare-approved amount for the doctor's or other health care provider's services. The Part B deductible applies.**<br><br>**However, your costs may be different if you're admitted to the hospital as an inpatient.** | **B** |
| | **Eyeglasses (after cataract surgery)** | **Medicare covers one pair of eyeglasses with standard frames (or one set of contact lenses) after cataract surgery that implants an intraocular lens.**<br><br>**Note: Medicare will only pay for contact lenses or eyeglasses from a supplier enrolled in Medicare, no matter who submits the claim (you or your provider).** | **You pay 20% of the Medicare-approved amount, and the Part B deductible applies.** | **B** |

# THE ORIGINAL MEDICARE PLAN

| | Service or Supply | What is covered and when? | What do YOU pay in 2018 | Part A or B |
|---|---|---|---|---|
| F | Federally- Qualified Health Center (FQHC)Services | FQHCs provide many outpatient primary care and preventive health services.<br><br>To find a FQHC near you, visit findahealthcenter.hrsa.gov. | There's no deductible, and generally, you're responsible for paying 20% of your charges or 20% of the Medicare approved amount. You pay nothing for most preventive services. All FQHCs offer a sliding fee schedule to persons with incomes below 200% of the<br><br>Federal poverty level. | B |
| | Flu Shots | Medicare generally covers one flu shot per flu season. | You pay nothing for the flu shot if the doctor or other qualified health care provider accepts assignment for giving the shot. | B |
| | Foot Exams and Treatment | Medicare covers foot exams and treatment if you have diabetes-related nerve damage and/or meet certain conditions. | You pay 20% of the Medicare-approved amount, and the Part B deductible applies. In a hospital outpatient setting, you also pay the hospital a copayment. | B |
| G | Glaucoma Tests | These tests are covered once every 12 months for people at high risk for the eye disease glaucoma. You're at high risk if you have diabetes, a family history of glaucoma, are African-American and 50 or older, or are Hispanic and 65 or older. An eye doctor who is legally allowed by the state must do the tests. | You pay 20% of the Medicare-approved amount, and the Part B deductible applies. In a hospital outpatient setting, you also pay the hospital a copayment. | B |
| H | Hearing and Balance Exams | Medicare covers these exams if your doctor or other health care provider orders them to see if you need medical treatment.<br><br>Note: Original Medicare doesn't cover hearing aids or exams for fitting hearing aids. | You pay 20% of the Medicare-approved amount, and the Part B deductible applies. In a hospital outpatient setting, you also pay the hospital a copayment. | B |

# THE ORIGINAL MEDICARE PLAN

| Service or Supply | What is covered and when? | What do YOU pay in 2018 | Part A or B |
|---|---|---|---|
| **Hepatitis B Shots** | Medicare covers these shots for people at medium or high risk for Hepatitis B. Some risk factors include hemophilia, End-Stage Renal Disease (ESRD), diabetes, 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. Check with your doctor to see if you're at medium or high risk for Hepatitis B. | You pay nothing for the shot if the doctor or other qualified health care provider accepts assignment. | B |
| **Hepatitis C Screening Test** | Medicare covers one Hepatitis C screening test if you meet one of these conditions:<br><br>You're at high risk because you have a current or past history of illicit injection drug use.<br>You had a blood transfusion before 1992.<br>You were born between 1945–1965.<br><br>Medicare also covers yearly repeat screenings for certain people at high risk.<br>Medicare will only cover Hepatitis C screening tests if they're ordered by a primary care doctor or other primary care provider. | You pay nothing for the screening test if the doctor or other qualified health care provider accepts assignment | B |
| **HIV Screening** | Medicare covers HIV (Human Immunodeficiency Virus) screenings once every 12 months for:<br>People between the ages of 15–65.<br>People younger than 15 and older than 65, who are at increased risk.<br><br>Note: Medicare also covers this test up to 3 times during a pregnancy. | You pay nothing for the HIV screening if the doctor or other qualified health care provider accepts assignment. | B |
| **Home Health Services** | Medicare covers medically necessary part-time or intermittent skilled nursing care, and/or physical therapy, speech-language pathology services, and/or services if you have a continuing need for occupational therapy. A doctor, or certain health care professionals who work with a doctor, must see you face-to-face before a doctor can certify that you need home health services. A doctor must order your care, and a Medicare-certified home health agency must provide it.<br><br>Home health services may also include medical social services, part-time or intermittent home health aide services, durable medical equipment, and medical supplies for use at home. You must be homebound, which means both of these are true:<br>1. You have trouble leaving your home without help (like using a cane, wheelchair, walker, or crutches; special transportation; or help from another person) because of an illness or injury.<br>2. Leaving your home isn't recommended because of your condition, and you're normally unable to leave your home because it's a major effort. | You pay nothing for covered home health services.<br><br>You pay 20% of the Medicare-approved amount, and the Part B Deductible applies for Medicare-covered medical equipment. | A & B |

# THE ORIGINAL MEDICARE PLAN

| Service or Supply | What is covered and when? | What do YOU pay in 2018 | Part A or B |
|---|---|---|---|
| **Hospice Care** | To qualify for hospice care, a hospice doctor and your doctor (if you have one) must certify that you're terminally ill, meaning you have a life expectancy of 6 months or less. If you're already getting hospice care, a hospice doctor or nurse practitioner will need to see you about 6 months after your hospice care started to certify that you're still terminally ill.<br>Coverage includes:<br>■ All items and services needed for pain relief and symptom management<br>■ Medical, nursing, and social services<br>■ Drugs<br>■ Certain durable medical equipment<br>■ Aide and homemaker s<br>■ Other covered services, as well as services Medicare usually doesn't cover, like spiritual and grief counseling<br><br>A Medicare-approved hospice usually gives hospice care in your home or other facility where you live, like a nursing home.<br><br>Hospice care doesn't pay for your stay in a facility (room and board) unless the hospice medical team determines that you need short-term inpatient stays for pain and symptom management that can't be addressed at home. These stays must be in a Medicare-approved facility, like a hospice facility, hospital, or skilled nursing facility that contracts with the hospice. Medicare also covers inpatient respite care, which is care you get in a Medicare-approved facility so that your usual caregiver (family member or friend) can rest. You can stay up to 5 days each time you get respite care. Medicare will pay for covered services for health problems that aren't related to your terminal illness or related conditions. You can continue to get hospice care as long as the hospice medical director or hospice doctor recertifies that you're terminally ill. | You pay nothing for hospice care.<br>You pay a copayment of up to $5 per prescription for outpatient prescription drugs for pain and symptom management In the rare case your drug isn't covered by the hospice benefit, your hospice provider should contact your Medicare drug plan to see if it's covered under Part D<br>You pay 5% of the Medicare-approved amount for inpatient respite care. | A |

# THE ORIGINAL MEDICARE PLAN

| Service or Supply | What is covered and when? | What do YOU pay in 2018 | Part A or B |
|---|---|---|---|
| **Hospital Care (Inpatient Care)** | **Medicare covers semi-private rooms, meals, general nursing, and drugs as part of your inpatient treatment, and other hospital services and supplies. This includes care you get in acute care hospitals, critical access hospitals, inpatient rehabilitation facilities, long-term care hospitals, inpatient care as part of a qualifying clinical research study, and inpatient mental health care given in a psychiatric hospital or other hospital. This doesn't include private-duty nursing, a television or phone in your room (if there's a separate charge for these items), or personal care items, like razors or slipper socks. It also doesn't include a private room, unless medically necessary.**<br><br>**■ Inpatient psychiatric care in a freestanding psychiatric hospital is limited to 190 days in a lifetime.**<br><br>**.** | **If you have Part B, it generally covers 80% of the Medicare-approved amount for doctor's services you get while you're in a hospital.**<br><br>**You pay a deductible and no coinsurance for days 1– 60 of each benefit period.**<br>**■ You pay coinsurance for days 61– 90 of each benefit period.**<br>**■ You pay coinsurance per "lifetime reserve day" after day 90 of each benefit period (up to 60 days over your lifetime).**<br>**■ You pay all costs for each day after you use all the lifetime reserve days.**<br><br>**Inpatient psychiatric care in a freestanding psychiatric hospital is limited to 190 days in a lifetime.** | **A** |

# THE ORIGINAL MEDICARE PLAN

| | Service or Supply | What is covered and when? | What do YOU pay in 2018 | Part A or B |
|---|---|---|---|---|
| K | Kidney Dialysis Services and Supplies | Generally, Medicare covers 3 dialysis treatments per week if you have End-Stage Renal Disease (ESRD). This includes all ESRD-related drugs and biologicals, laboratory tests, home dialysis training, support services, equipment, and supplies. The dialysis facility is responsible for coordinating your dialysis services (at home or in a facility). | You pay 20% of the Medicare-approved amount and the Part B deductible applies. | B |
| | Kidney Disease Education Services | Medicare covers up to 6 sessions of kidney disease education services if you have Stage IV chronic kidney disease, and your doctor or other health care provider refers you for the service. | You pay 20% of the Medicare-approved amount, and the Part B deductible applies. | B |
| L | Laboratory Services | Medicare covers laboratory services including certain blood tests, urinalysis, certain tests on tissue specimens, and some screening tests. | You generally pay nothing for these services. | B |
| | Lung Cancer Screening | Medicare covers a lung cancer screening with Low Dose Computed Tomography (LDCT) once per year if you meet all of these conditions:<br>■ You're 55–77.<br>■ You're asymptomatic (you don't have signs or symptoms of lung cancer).<br>■ You're either a current smoker or have quit smoking within the last 15 years.<br>■ You have a tobacco smoking history of at least 30 "pack years" (an average of one pack a day for 30 years).<br>■ You get a written order from a physician or qualified non-physician practitioner.<br><br>Note: 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. | You generally pay nothing for this service if the primary care doctor or other qualified primary care practitioner accepts assignment. | B |
| M | Medical Nutrition Therapy Services | Medicare may cover medical nutrition therapy and certain related services if you have diabetes or kidney disease, or you have had a kidney transplant in the last 36 months, and your doctor or other health care provider refers you for the service. | You pay nothing for these services if the doctor or other health care provider accepts assignment. | B |

# THE ORIGINAL MEDICARE PLAN

| Service or Supply | What is covered and when? | What do YOU pay in 2018 | Part A or B |
|---|---|---|---|
| **Mental Health Care (outpatient)** | **Medicare covers mental health care services to help with conditions like depression or anxiety. Coverage includes services generally provided in an outpatient setting (like a doctor's or other healthcare provider's office or hospital outpatient department or community mental health center), including visits with a psychiatrist or other doctor, clinical psychologist, nurse practitioner, physician assistant, clinical nurse specialist, or clinical social worker. Laboratory tests are also covered. Certain limits and conditions apply.**<br><br>**Note: Inpatient mental health care is covered under Part A. See Hospital Care (Inpatient Care)** | **Generally, you pay 20% of the Medicare-approved amount and the Part B deductible applies for mental health care services.** | **B** |
| **O**<br>**Obesity screening and counseling** | **If you have a body mass index (BMI) of 30 or more, Medicare covers face-to-face individual behavioral therapy sessions to help you lose weight. This counseling may be covered if you get it in a primary care setting (like a doctor's offce), where it can be coordinated with your other care and a personalized prevention plan.** | **You pay nothing for this service if the primary care doctor or other qualified primary care practitioner accepts assignment.** | **B** |
| **Occupational Therapy** | **Medicare covers evaluation and treatment to help you perform activities of daily living (like dressing or bathing) when your doctor or other health care provider certifies you need it. There may be a limit on the amount Medicare will pay for these services in a single year and there may be certain exceptions to these limits.** | **You pay 20% of the Medicare-approved amount, and the Part B deductible applies.** | **B** |

# THE ORIGINAL MEDICARE PLAN

| Service or Supply | What is covered and when? | What do YOU pay in 2018 | Part A or B |
|---|---|---|---|
| **Outpatient Hospital Services** | **Medicare covers many diagnostic and treatment services in participating hospital outpatient departments.** | **Generally, you pay 20% of the Medicare approved amount for the doctor's or other health care provider's services. You may pay more for services you get in a hospital outpatient setting than you'll pay for the same care in a doctor's office. In addition to the amount you pay the doctor, you'll usually pay the hospital a copayment for each service you get in a hospital outpatient setting, except for certain preventive services that don't have a copayment. In most cases the copayment can't be more than the Part A hospital stay deductible for each service. The Part B deductible applies, except for certain preventive services If you get hospital outpatient services in a critical access hospital, your copayment may be higher and may exceed the Part A hospital stay.** | **B** |

# THE ORIGINAL MEDICARE PLAN

| Service or Supply | What is covered and when? | What do YOU pay in 2018 | Part A or B |
|---|---|---|---|
| **Outpatient Medical and Surgical Services and Supplies** | **Medicare covers approved procedures like X-rays, casts, stitches or outpatient surgeries.** | **You pay 20% of the Medicare-approved amount for the doctor's or other health care provider's services. You generally pay the hospital a copayment for each service you get in a hospital outpatient setting. In most cases, for each service provided, the copayment can't be more than the Part A hospital stay deductible. The Part B deductible applies, and you pay all charges for items or services that Medicare doesn't cover.** | **B** |
| **P** **Physical Therapy** | **Medicare covers evaluation and treatment for injuries and diseases that change your ability to function when your doctor or other health care provider certifies your need for it. There may be a limit on the amount Medicare will pay for these services in a single year and there may be certain exceptions to these limits.** | **You pay 20% of the Medicare-approved amount, and the Part B deductible applies.** | **B** |
| **Pneumococcal Shot** | **Medicare covers a pneumococcal shot to help prevent pneumococcal infections (like certain types of pneumonia). Medicare also covers a different second shot if it's given one year (or later) after the first shot. Talk with your doctor or other health care provider to see if you need one or both of the pneumococcal shots.** | **You pay nothing for getting the shot if the doctor or other qualified health care provider accepts assignment for giving the shot.** | **B** |

# THE ORIGINAL MEDICARE PLAN

| Service or Supply | What is covered and when? | What do YOU pay in 2018 | Part A or B |
|---|---|---|---|
| **Prescription Drugs (limited)** | Medicare covers a limited number of drugs like injections you get in a doctor's office, certain oral anti-cancer drugs, drugs used with some types of durable medical equipment (like a nebulizer or external infusion pump), immunosuppressant drugs and under very limited circumstances, certain drugs you get in a hospital outpatient setting.<br><br>If the covered drugs you get in a hospital outpatient setting are part of your outpatient services, you pay the copayment for the services. However, other types of drugs in a hospital outpatient setting (sometimes called "self-administered drugs" or drugs you would normally take on your own), aren't covered by Part B. What you pay depends on whether you have Part D or other prescription drug coverage, whether your drug plan covers the drug, and whether the hospital's pharmacy is in your drug plan's network.<br><br>Contact your prescription drug plan to find out what you pay for drugs you get in a hospital outpatient setting that aren't covered under Part B. | You pay 20% of the Medicare-approved amount for these covered drugs, and the Part B deductible applies.<br><br>Other than the examples listed, you pay 100% for most prescription drugs, unless you have Part D or other drug coverage. | B |
| **Prostate Cancer Screenings** | Medicare covers a Prostate Specific Antigen (PSA) test and a digital rectal exam once every 12 months for men over 50 (beginning the day after your 50th birthday). | You pay nothing for the PSA test.<br><br>For the digital rectal exam you pay 20% of the Medicare-approved amount, and the Part B deductible applies.<br><br>In a hospital outpatient setting, you also pay the hospital a copayment. | B |
| **Prosthetic/ Orthotic Items** | Medicare covers arm, leg, back, and neck braces; artificial eyes; artificial limbs (and their replacement parts); some types of breast prostheses (after mastectomy); and prosthetic devices needed to replace an internal body part or function (including ostomy supplies, and parenteral and enteral nutrition therapy) when ordered by a doctor or other health care provider enrolled in Medicare. For Medicare to cover your prosthetic or orthotic, you must go to a supplier that's enrolled in Medicare.<br><br>DMEPOS Competitive Bidding Program: To get enteral nutrition therapy in some areas of the country, you generally must use specific suppliers called "contract suppliers," or Medicare won't pay and you'll likely pay full price. | You pay 20% of the Medicare-approved amount, and the Part B deductible applies. | B |

# THE ORIGINAL MEDICARE PLAN

| | Service or Supply | What is covered and when? | What do YOU pay in 2018 | Part A or B |
|---|---|---|---|---|
| | **Pulmonary Rehabilitation** | **Medicare covers a comprehensive pulmonary rehabilitation program if you have moderate to very severe chronic obstructive pulmonary disease (COPD) and have a referral from the doctor treating this chronic respiratory disease.** | **You pay 20% of the Medicare-approved amount if you get the service in a doctor's office. You also pay the hospital a copayment per session if you get the service in a hospital outpatient setting. The Part B deductible applies.** | **B** |
| **R** | **Religious Non-Medical Health Care Institution (inpatient care)** | **In these facilities, religious beliefs prohibit conventional and unconventional medical care. If you qualify for hospital or skilled nursing facility care, Medicare will only cover the inpatient, non-religious, non-medical items and services. Examples are room and board, or any items and services that don't require a doctor's order or prescription, like unmedicated wound dressings or use of a simple walker.** | **Items not covered by Medicare** | **A** |
| | **Rural Health Clinic (RHC)Services** | **Rural health clinics (RHCs) furnish many outpatient primary care and preventive health services. RHCs are located in non-urban areas that are in medically underserved or shortage areas.** | **Generally, you're responsible for paying 20% of the charges, and the Part B deductible applies. You pay nothing for most preventive services.** | **B** |
| **S** | **Second Surgical Opinions** | **Medicare covers second surgical opinions for surgery that isn't an emergency.**<br>**In some cases, Medicare covers third surgical opinions.** | **You pay 20% of the Medicare-approved amount, and the Part B deductible applies.** | **B** |

# THE ORIGINAL MEDICARE PLAN

| Service or Supply | What is covered and when? | What do YOU pay in 2018 | Part A or B |
|---|---|---|---|
| **Sexually transmitted infection (STI) screening and counseling** | **Medicare covers STI screenings for chlamydia, gonorrhea, syphilis, and Hepatitis B. These screenings are covered for people who are pregnant or at increased risk for an STI when the tests are ordered by a primary care doctor or other primary care practitioner. Medicare covers these tests once every 12 months or at certain times during pregnancy.**<br><br>**Medicare also covers up to 2 individual 20–30 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.** | **You pay nothing for these services if the primary care doctor or other qualified primary care practitioner accepts assignment.** | **B** |
| **Shots** | **Part B covers Flu shots, Hepatitis B shots, Pneumococcal shots**<br><br>**<u>Note about the shingles shot:</u>**<br>**The shingles shot isn't covered by Part A or Part B. Generally, Medicare prescription drug plans (Part D) cover the shingles shot, as well as all commercially available vaccines needed to prevent illness. Contact your Medicare drug plan for more information about coverage.** | | **B** |
| **Skilled nursing facility care** | **Medicare covers semi-private rooms, meals, skilled nursing and rehabilitative services, and other medically necessary services and supplies after a 3-day minimum, medically necessary, inpatient hospital stay for a related illness or injury. An inpatient hospital stay begins the day you're formally admitted with a doctor's order and doesn't include the day you're discharged. You may get coverage of skilled nursing care or skilled therapy care if it's necessary to help improve or maintain your condition.**<br><br>**To qualify for care in a skilled nursing facility, your doctor must certify that you need daily skilled care like intravenous injections or physical therapy.**<br><br>**Note: Medicare doesn't cover long-term care or custodial care.** | **You pay nothing for the first 20 days of each benefit period.**<br><br>**You pay $167.50 per day for days 21–100 of each benefit period.**<br><br>**You pay all costs for each day after day 100 in a benefit period.** | **A** |

# THE ORIGINAL MEDICARE PLAN

| Service or Supply | What is covered and when? | What do YOU pay in 2018 | Part A or B |
|---|---|---|---|
| **Smoking and tobacco-use cessation (counseling to stop smoking or using tobacco products)** | **Medicare covers up to 8 face-to-face visits in a 12-month period. All people with Medicare who use tobacco are covered.** | **You pay nothing for the counseling sessions if the doctor or other qualified health care provider accepts assignment.** | **B** |
| **Speech-Language Pathology Services** | **Medicare covers evaluation and treatment given to regain and strengthen speech and language skills, including cognitive and swallowing skills, when your doctor or other health care provider certifies you need it. There may be a limit on the amount Medicare will pay for these services in a single year, and there may be certain exceptions to these limits.** | **You pay 20% of the Medicare-approved amount, and the Part B deductible applies.** | **B** |
| **Surgical Dressing Services** | **Medicare covers medically necessary treatment of a surgical or surgically-treated wound.** | **You pay 20% of the Medicare-approved amount for the doctor's or other health care provider's services.**<br><br>**You pay a fixed copayment for these services when you get them in a hospital outpatient setting.**<br><br>**The Part B deductible applies.**<br><br>**You pay nothing for the supplies.** | **B** |
| **T** **Telehealth** | **Medicare covers services like office visits, psychotherapy, consultations, and certain other medical or health services provided using an interactive, two-way telecommunications system (like real-time audio and video) by an eligible provider who isn't at your location. These services are available in rural areas, under certain conditions, but only if you're located at: a doctor's office, hospital, critical access hospital, Rural Health Clinic, Federally Qualified Health Center, hospital-based dialysis facility, skilled nursing facility, or community mental health center.** | **For most of these services, you'll pay the same amount that you would if you got the services in person.** | **B** |

# THE ORIGINAL MEDICARE PLAN

| Service or Supply | What is covered and when? | What do YOU pay in 2018 | Part A or B |
|---|---|---|---|
| **Tests (other than lab tests)** | **Medicare covers:**<br>• **X-rays,**<br>• **MRIs,**<br>• **CT scans,**<br>• **EKG/ECGs,**<br>**and some other diagnostic tests.** | **You pay 20% of the Medicare-approved amount, and the Part B deductible applies.**<br><br>**If you get the test at a hospital as an outpatient, you also pay the hospital a copayment that may be more than 20% of the Medicare-approved amount, but in most cases this amount can't be more than the Part A hospital stay deductible. See Laboratory Services for other Part B covered tests.** | **B** |
| **Transitional Care Management Services** | **Medicare may cover this service if you're returning to your community after a stay at certain facilities, like a hospital or skilled nursing facility. The health care provider who's managing your transition back into the community will work to coordinate and manage your care for the first 30 days after you return home. He or she will work with you and your family and caregiver(s), as appropriate, and with your other health care providers. You'll also be able to get an in-person office visit within 2 weeks of your return home. The health care provider may also review information on the care you received in the facility, provide information to help you transition back to living at home, work with other care providers, help you with referrals or arrangements for follow-up care or community resources, assist you with scheduling, and help you manage your medications.** | **The Part B deductible and coinsurance apply.** | **B** |

# THE ORIGINAL MEDICARE PLAN

| Service or Supply | What is covered and when? | What do YOU pay in 2018 | Part A or B |
|---|---|---|---|
| **Transplants and Immunosuppressive Drugs** | **Medicare covers doctor services for heart, lung, kidney, pancreas, intestine, and liver transplants under certain conditions and only in a Medicare-certified facility. Medicare also covers bone marrow and cornea transplants under certain conditions.**<br><br>**Note: The transplant surgery may be covered as a hospital inpatient service under Part A.**<br><br>**Medicare covers immunosuppressive drugs if the transplant was covered by Medicare or an employer or union group health plan was required to pay before Medicare paid for the transplant. You must have Part A at the time of the covered transplant, and you must have Part B at the time you get immunosuppressive drugs.**<br><br>**If you're thinking about joining a Medicare Advantage Plan (like an HMO or PPO) and are on a transplant waiting list or believe you need a transplant, check with the plan before you join to make sure your doctors, other health care providers, and hospitals are in the plan's network. Also, check the plan's coverage rules for prior authorization.**<br><br>**Note: Medicare drug plans (Part D) may cover immunosuppressive drugs if they aren't covered by Original Medicare.** | **You pay 20% of the Medicare-approved amount for the drugs, and the Part B deductible applies.** | **B** |
| **Travel (health care needed when traveling outside the U.S.)** | **Medicare generally doesn't cover health care while you're traveling outside the U.S. (The "U.S." includes the 50 states, the District of Columbia, Puerto Rico, the U.S. Virgin Islands, Guam, the Northern Mariana Islands, and American Samoa). There are some exceptions including some cases where Medicare may pay for services that you get while on board a ship within the territorial waters adjoining the land areas of the U.S. Medicare may pay for inpatient hospital, doctor, or ambulance services you get in a foreign country in the following rare cases:**<br>**1. You're in the U.S. when an emergency occurs and the foreign hospital is closer than the nearest U.S. hospital that can treat your medical condition.**<br>**2. You're traveling through Canada without unreasonable delay by the most direct route between Alaska and another state when a medical emergency occurs and the Canadian hospital is closer than the nearest U.S. hospital that can treat the emergency.**<br>**3. You live in the U.S. and the foreign hospital is closer to your home than the nearest U.S. hospital that can treat your medical condition, regardless of whether an emergency exists.**<br><br>**Medicare may cover medically-necessary ambulance transportation to a foreign hospital only with admission for medically-necessary covered inpatient hospital services.** | **You pay 20% of the Medicare-approved amount, and the Part B deductible applies.** | **B** |

# THE ORIGINAL MEDICARE PLAN

| | Service or Supply | What is covered and when? | What do YOU pay in 2018 | Part A or B |
|---|---|---|---|---|
| U | **Urgently-Needed Care** | Medicare covers urgently-needed care to treat a sudden illness or injury that isn't a medical emergency. | You pay 20% of the Medicare-approved amount for the doctor's or other health care provider's services and the Part B deductible applies.<br><br>In a hospital outpatient setting, you also pay the hospital a copayment. | B |
| W | **"Welcome to Medicare" Preventive Visit** | During the first 12 months that you have Part B, you can get a "Welcome to Medicare" preventive visit. This visit includes a review of your medical and social history related to your health and education and counseling about preventive services, including certain screenings, shots, and referrals for other care if needed. When you make your appointment, let your doctor's office know that you would like to schedule your "Welcome to Medicare" preventive visit.<br><br>If your doctor or other health care provider performs additional tests or services during the same visit that aren't covered under this preventive benefit, you may have to pay coinsurance, and the Part B deductible may apply. | You pay nothing for the "Welcome to Medicare" preventive visit if the doctor or other qualified health care provider accepts assignment.<br><br>You may have to pay coinsurance, and the Part B deductible may apply. | B |
| Y | **Yearly "Wellness" Visit** | If you've had Part B for longer than 12 months, you can get a yearly "Wellness" visit to develop or update a personalized plan to prevent disease or disability based on your current health and risk factors. This visit is covered once every 12 months.<br><br>Your provider will ask you to fill out a short questionnaire, called a Health Risk Assessment, as part of this visit. Answering these questions can help you and your provider develop a personalized prevention plan to help you stay healthy and get the most out of your visit. When you make your appointment, let your doctor's office know that you would like to schedule your yearly "Wellness" visit.<br><br>Note: Your first yearly "Wellness" visit can't take place within 12 months of your enrollment in Part B or your "Welcome to Medicare" visit. However, you don't need to have a "Welcome to Medicare" preventive visit to qualify for a yearly "Wellness" visit. | You pay nothing for the yearly "Wellness" visit if the doctor or other qualified health care provider accepts assignment.<br><br>If your doctor or other health care provider performs additional tests or services during the same visit that aren't covered under these preventive benefit, you may have to pay coinsurance, and the Part B deductible may apply. | B |

# THE ORIGINAL MEDICARE PLAN

## What's NOT Covered by Part A and Part B?

**Medicare doesn't cover everything. If you need certain services that aren't covered under Medicare Part A or Part B, you'll have to pay for them yourself unless:**

- **You have other coverage (including Medicaid) to cover the costs.**
- **You're in a Medicare Advantage Plan that covers these services.**

**Some of the items and services that Original Medicare doesn't cover include:**

- **Most dental care.**
- **Eye examinations related to prescribing glasses.**
- **Dentures.**
- **Cosmetic surgery.**
- **Acupuncture.**
- **Hearing aids and exams for fitting them.**
- **Long-term care.**
- **Concierge care (also called concierge medicine, retainer-based medicine, boutique medicine, platinum practice, or direct care).**