UF IFAS Extension UNIVERSITY of FLORIDA

FCS2339

Important Things to Know about Medicare Chapter Three: Medicare Part B--Medical Insurance[1]

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Important Things to Know about Medicare is a series of 10 publications that will cover the most common Medicare concerns. The series will provide general information about Medicare, including the four major plans, supplemental policies, interactions with different types of insurance, and assistance programs. This section explains Medicare Part B. Medicare Part B is medical insurance that helps cover physician services, outpatient care, home health care, durable medical equipment, and, recently, some preventative services (Centers for Medicare and Medicaid Services [CMS] 2013).

When Coverage Begins

If you are automatically enrolled in Medicare Part A and Part B, your coverage will begin when you become eligible. The earliest time you can sign up for Medicare Part A and Part B (excluding sufferers of end-stage renal disease) is during your 7-month **initial enrollment period,** which begins 3 months before you turn 65 and ends 3 months after you turn 65. If you sign up before your 65th birthday, your coverage will usually start the first day of your birthday month. If you sign up in the 3 months after your birthday, your coverage start date may be delayed (CMS 2013).

The **general enrollment period** occurs between January 1 and March 31 each year. If you did not sign up for Medicare Part A or Part B when you first became eligible, you can sign up during the general enrollment period and your coverage will start the following July. If you choose not to sign up for Medicare Part B when you first became eligible, you may be responsible for a **late enrollment penalty**. The late enrollment penalty for Part B is 10% for each full year that you did not have Part B when you were eligible. For example, if you choose not to enroll in Part B for 2 years after you become eligible; your premium will be increased by 20% (CMS 2013).

You may be exempt from the late enrollment penalty if you didn't sign up for Medicare Part A or Part B when you originally became eligible because you were covered under your own health insurance, usually through your employer or that of a spouse or other family member. In this case, you can sign up for Part A or Part B during a **special enrollment period**, which can occur during the 8-month period that begins the month after your employment or your coverage ends. You can also sign up for Part A and Part B any time you are still covered by your original group health plan. COBRA and retiree health plans do not qualify you for the special enrollment period, and you will still be responsible for a late enrollment penalty (CMS 2013).

What It Covers

Because of the Affordable Care Act, Medicare Part B now covers many preventative services free of charge to you. Some of these services and tests may be covered more often than listed if they are used to diagnose a medical condition.

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The prices listed below also refer to doctors who **accept assignment** or are "participating physicians." Your costs may be higher if you see a doctor who is not a participating physician.

Medicare Part B covers

- Physician's services (including office visits, a one-time physical exam for new beneficiaries, and an annual wellness visit)
- Durable medical equipment and supplies (such as wheelchairs and oxygen)
- Outpatient hospital services
- Outpatient mental health services
- Clinical laboratory and diagnostic tests (such as blood tests, x-rays, etc.)
- Outpatient occupational, physical, and speech therapy
- Home health care (care not after a hospital stay and visits after the 100-day Part A limit)
- Certain preventative services (such as mammograms, diabetes screening, flu shots, etc.)
- Blood (after you pay for the first three pints per year)

(AARP 2012)

To see a full list of Part B-covered services and costs, see the CMS Handout **Medicare Part B: Covered Services**, reproduced below (CMS 2013).

Medicare does not cover

- Long-term care
- Some preventative health services
- Hearing aids
- Eyeglasses
- Most dental care
- Services obtained outside the United States

(AARP 2001)

What It Costs You

- As a beneficiary of Medicare Part B, you are responsible for one annual deductible, monthly premiums, and coinsurance or copayments associated with the services above.
- For a frame of reference, in 2012 the annual deductible was $140. In 2012, the standard Part B premium rate was $99.90 per beneficiary per month. However, several factors can change the rate you may actually pay. These include **late enrollment penalties** (discussed above), an **income-related monthly adjustment amount**, and a **"hold-harmless" provision**.
- To better understand how your income level may affect your monthly premium for Part B, see The CMS Handout Medicare Part B Income-Related Monthly Adjustment Amounts and Total Monthly Premium Amounts.
- The "hold-harmless" provision applies to those who deduct their premiums from their social security benefits. In essence, this provision holds that the increase in premium cannot be larger than the increase in the social security cost-of-living adjustment. For 2012, this only applied to individuals whose social security cost-of-living adjustments were less than $3.50 and slightly decreased their monthly premiums (Klees, Wolfe, and Curtis 2011).

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Table 1. Medicare Part B: Covered Services

Abdominal aortic aneurysm screening	Medicare covers a one-time screening abdominal aortic aneurysm ultrasound for people at risk. You must get a referral for it as part of your one-time "Welcome to Medicare" preventive visit. You pay nothing for the screening if the doctor or other qualified health care provider accepts assignment (accepts Medicare).
Alcohol misuse counseling	Medicare covers 1 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. 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 (accepts Medicare).
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. In some cases, Medicare may pay for limited non-emergency ambulance transportation if you have a written order from your doctor stating that ambulance transportation is necessary due to your medical condition. Medicare will only cover ambulance services to the nearest appropriate medical facility able to give you the care you need. You pay 20% of the Medicare-approved amount, and the Part B deductible applies.
Ambulatory surgical centers	Medicare covers the facility fees for approved surgical procedures in an ambulatory surgical center (a 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), 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 facility fees for procedures Medicare doesn't cover in ambulatory surgical centers.
Blood	If the provider 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 every unit of blood you get, and the Part B deductible applies. 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.
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 who meet certain criteria. You pay nothing for this test if the doctor or other qualified health care provider accepts assignment (accepts Medicare).
Breast cancer screening (mammograms)	Medicare covers screening mammograms to check for breast cancer once every 12 months for all women 40 and older with Medicare. Medicare covers 1 baseline mammogram for women between ages 35 and 39. You pay nothing for the test if the doctor or other qualified health care provider accepts assignment (accepts Medicare).
Cardiac rehabilitation	Medicare covers comprehensive programs that include exercise, education, and counseling for patients who meet certain conditions. Medicare also covers intensive cardiac rehabilitation programs that are typically more rigorous or more intense than regular cardiac rehabilitation programs. 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.
Cardiovascular disease (behavioral therapy)	Medicare will cover 1 visit per year with your primary care doctor in a primary care setting (like a doctor's office) to help lower your risk for cardiovascular disease. During this visit, your doctor may discuss aspirin use, check your blood pressure, and give you tips to make sure you're eating well. You pay nothing if the doctor or other qualified health care provider accepts assignment (accepts Medicare).
Cardiovascular screenings	These screenings include blood tests that help detect conditions that may lead to a heart attack or stroke. Medicare covers these screening tests every 5 years to test your cholesterol, lipid, lipoprotein, and triglyceride levels. You pay nothing for the tests, but you generally have to pay 20% of the Medicare-approved amount for the doctor's visit.
Cervical and vaginal cancer screening	Medicare covers Pap tests and pelvic exams to check for cervical and vaginal cancers. As part of the 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. You pay nothing if the doctor or other qualified health care provider accepts assignment (accepts Medicare).
Chemotherapy	Medicare covers chemotherapy in a doctor's office, freestanding clinic, or hospital outpatient setting for people with cancer. For chemotherapy given in a doctor's office or freestanding clinic, you pay 20% of the Medicare-approved amount. If you get chemotherapy in a hospital outpatient setting, you pay a copayment for the treatment.

Chiropractic services (limited)	Medicare covers these services to help correct a subluxation (when 1 or more of the bones of your spine move out of position) using manipulation of the spine. You pay 20% of the Medicare-approved amount, and the Part B deductible applies. **Note:** You pay all costs for any other services or tests ordered by a chiropractor (including X-rays and massage therapy).
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, some costs may be covered by Medicare and some may be covered by your plan.
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 the following tests may be covered: • **Fecal occult blood test:** This test is covered once every 12 months if you're 50 or older. You pay nothing if the doctor or other qualified health care provider accepts assignment (accepts Medicare). • **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. You pay nothing if the doctor or other qualified health care provider accepts assignment (accepts Medicare). • **Colonoscopy:** This test is generally covered once every 120 months (high risk every 24 months) or 48 months after a previous flexible sigmoidoscopy. There is no minimum age. You pay nothing if the doctor or other qualified health care provider accepts assignment (accepts Medicare). **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. • **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 20% of the Medicare-approved amount for the doctor services. In a hospital outpatient setting, you also pay the hospital a copayment.
Defibrillator (implantable automatic)	Medicare covers these devices for some people diagnosed with heart failure. If the surgery takes place in an outpatient setting, you pay 20% of the Medicare-approved amount for the doctor's services. If you get the device as a hospital outpatient, you also pay the hospital a copayment, but no more than the Part A hospital stay deductible. The Part B deductible applies.
Depression screening	Medicare covers 1 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 if the doctor or other qualified health care provider accepts assignment (accepts Medicare), but you generally have to pay 20% of the Medicare-approved amount for the doctor's visit.
Diabetes screenings	Medicare covers these screenings if your doctor determines you're at risk for diabetes. You may be eligible for up to 2 diabetes screenings each year. You pay nothing if the doctor or other qualified health care provider accepts assignment (accepts Medicare).
Diabetes self-management training	Medicare covers a program to help people cope with and manage diabetes. The program may include tips for healthy eating, 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.
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 used with an external insulin pump. You pay 20% of the Medicare-approved amount, and the Part B deductible applies. **Note:** Medicare prescription drug coverage (Part D) may cover insulin, certain medical supplies used to inject insulin (like syringes), and some oral diabetic drugs. If you live in a Durable Medical Equipment (DME) competitive bidding area and get your diabetes supplies by mail, the amount you pay may have changed in January 2013. From January through June 2013, you could get your supplies from any supplier, but after July 2013, you'll need to use a Medicare contract supplier. This national mail order program will help you save money.
Doctor and other health care provider services	Medicare covers medically necessary doctor services (including outpatient and some doctor services you get when you're a hospital inpatient) and covered preventative services. Medicare also covers services provided by physicians' health care providers, like physician assistants, nurse practitioners, social workers, physical therapists, and psychologists. Except for certain preventive services (for which you pay nothing), you pay 20% of the Medicare-approved amount, and the Part B deductible.

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. You pay 20% of the Medicare-approved amount, and the Part B deductible applies. **In all areas of the country, you must get your covered equipment or supplies and replacement or repair services from a Medicare-approved supplier for Medicare to pay.** For more information, visit www.medicare.gov/publications to view the booklet "Medicare Coverage of Durable Medical Equipment and Other Devices." You can also call 1-800-MEDICARE (1-800-633-4227) to find out if a copy can be mailed to you. **DME Competitive Bidding Program: To get certain items in some areas of the country, you must use specific suppliers called "contract suppliers," or Medicare won't pay for the item and you likely will pay full price.** **This program is effective in certain areas in Florida.** If you need durable medical equipment or supplies, visit www.medicare.gov/supplier to find Medicare-approved suppliers. If your ZIP code is in a competitive bidding area, the items included in the program are marked with an orange star. You can also call 1-800-MEDICARE (1-800-633-4227). The program is scheduled to expand to 91 more areas around the country in July 2013.
EKG (electro-cardiogram) screening	Medicare covers a one-time screening EKG if you are referred by your doctor or other health care provider as part of your one-time "Welcome to Medicare" preventive visit. You pay 20% of the Medicare-approved amount. An EKG is also covered as a diagnostic test. If you have the test at a hospital or a hospital owned clinic, you also pay the hospital a copayment.
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. However, your costs may be different if you're admitted to the hospital.
Eyeglasses (limited)	Medicare covers 1 pair of eyeglasses with standard frames (or 1 set of contact lenses) after cataract surgery that implants an intraocular lens. You pay 20% of the Medicare-approved amount, and the Part B deductible applies.
Federally qualified health center services	Medicare covers many outpatient primary care and preventive services you get through certain community-based organizations. Generally, you pay 20% of the charges. You pay nothing for most preventive services.
Flu shots	Medicare generally covers flu shots once per flu season in the fall or winter. You pay nothing for getting the flu shot if the doctor or other qualified health care provider accepts assignment (accepts Medicare) for giving the shot.
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.
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 for the doctor's visit. In a hospital outpatient setting, you also pay the hospital a copayment.
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. 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. **Note:** Medicare doesn't cover hearing aids or exams for fitting hearing aids.
Hepatitis B shots	Medicare covers these shots for people at high or medium risk for Hepatitis B. You pay nothing if the doctor or other qualified health care provider accepts assignment (accepts Medicare).
HIV Screening	Medicare covers HIV screenings for people at increased risk for the virus, anyone who asks for the test, and pregnant women. Medicare covers this test once every 12 months or up to 3 times during a pregnancy. You pay nothing if the doctor or other qualified health care provider accepts assignment (accepts Medicare).
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 for people with a continuing need for occupational therapy. A doctor enrolled in Medicare, or certain health care providers who work with the doctor, must see you face-to-face before the doctor can certify that you need home health services. That doctor must order your care, and a Medicare-certified home health agency must provide it. 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 leaving home is a major effort. You pay nothing for covered home health services.

Kidney dialysis services and supplies	Generally, Medicare covers dialysis treatment 3 times a week if you have end-stage renal disease (ESRD). This includes dialysis drugs, laboratory tests, home dialysis training, and related 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.
Kidney disease education services	Medicare covers up to 6 sessions of kidney disease education services if you have Stage IV 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.
Laboratory services	Medicare covers laboratory services including certain blood tests, urinalysis, and some screening tests. You pay nothing if the doctor or other qualified health care provider accepts assignment (accepts Medicare).
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 if the doctor or other qualified health care provider accepts assignment (accepts Medicare).
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 health care provider's office or hospital outpatient department). These include visits with a psychiatrist or other doctor, a clinical psychologist, a nurse practitioner, a physician assistant, a clinical nurse specialist, or a clinical social worker; as well as certain treatments for substance abuse; and lab tests. Certain limits and conditions apply. What you pay will depend on whether you're being diagnosed and monitored or whether you're getting treatment. • For visits to a doctor or other health care provider to diagnose your condition, you pay 20% of the Medicare-approved amount. • Generally, for outpatient treatment of your condition (like counseling or psychotherapy), you pay 35% of the Medicare-approved amount. This coinsurance amount will decrease to 20% in 2014. The Part B deductible applies for both visits to diagnose or treat your condition. **Note:** Inpatient mental health care is covered under Part A.
Obesity screening and counseling	If you have a body mass index (BMI) of 30 or more, Medicare covers intensive counseling to help you lose weight. This counseling may be covered if you get it in a primary care setting (like a doctor's office), where it can be coordinated with your personalized prevention plan. Talk to your primary care doctor or primary care practitioner to find out more. You pay nothing if the doctor or other qualified health care provider accepts assignment (accepts Medicare).
Occupational therapy	Medicare covers evaluation and treatment to help you perform activities of daily living (like dressing or bathing) after an illness or accident 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.
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, for which there is no copayment. The copayment can't be more than the Part A hospital stay deductible. The Part B deductible applies, except for certain preventive services.
Outpatient medical and surgical services and supplies	Medicare covers approved procedures like X-rays, casts, or stitches. 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. For each service, 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.
Physical therapy	When your doctor or other health care provider certifies your need for these services, Medicare covers evaluation and treatment for injuries and diseases that change your ability to function. 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.
Pneumococcal shot	Medicare covers pneumococcal shots to help prevent pneumococcal infections (like certain types of pneumonia). Most people only need this shot once in their lifetime. Talk with your doctor or other health care provider to see if you should get this shot. You pay nothing if the doctor or other qualified health care provider accepts assignment (accepts Medicare) for giving the shot.

Prescription drugs (limited)	Medicare covers a limited number of drugs like injections you get in a doctor's office, certain oral cancer drugs, drugs used with some types of durable medical equipment (like a nebulizer or external infusion pump), and, under very limited circumstances, certain drugs you get in a hospital outpatient setting. You pay 20% of the Medicare-approved amount for these covered drugs and the Part B deductible applies. 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. 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. Other than the examples above, you pay 100% for most prescription drugs, unless you have Part D or other drug coverage.
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 if the doctor or other qualified health care provider accepts assignment (accepts Medicare). You pay 20% of the Medicare-approved amount, and the Part B deductible applies for the digital rectal exam. In a hospital outpatient setting, you also pay the hospital a copayment.
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 these supplies have been 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 enrolled in Medicare. You pay 20% of the Medicare-approved amount, and the Part B deductible applies. Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Competitive Bidding Program: To get enteral nutrition therapy in some areas of the country, you must use specific suppliers called "contract suppliers," or Medicare won't pay and you'll likely pay full price.
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.
Rural health clinic services	Medicare covers many outpatient primary care and preventive services in rural health clinics. Generally, you pay 20% of the charges, and the Part B deductible applies. However, you pay nothing for most preventive services.
Second surgical opinions	Medicare covers second surgical opinions in some cases for surgery that isn't an emergency. In some cases, Medicare covers third surgical opinions. You pay 20% of the Medicare-approved amount, and the Part B deductible applies.
Sexually transmitted infections screening and counseling	Medicare covers sexually transmitted infection (STI) screenings for chlamydia, gonorrhea, syphilis, and/or Hepatitis B. These screenings are covered for people with Medicare who are pregnant and/or for certain people who are at an 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. 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 are 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 if the doctor or other qualified health care provider accepts assignment (accepts Medicare).
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 these services. 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.
Surgical dressing services	Medicare covers these services for 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. You pay a fixed copayment for these services when you get them in a hospital outpatient setting. You pay nothing if the doctor or other qualified health care provider accepts assignment (accepts Medicare).

Tele-health	Medicare covers limited medical or other health services, like office visits and consultations 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 some rural areas, under certain conditions, and only if you're located at one of the following places: a doctor's office, 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 pay 20% of the Medicare-approved amount, and the Part B deductible applies.
Tests (other than lab tests)	Medicare covers X-rays, MRIs, CT scans, EKGs, and some other diagnostic tests. You pay 20% of the Medicare-approved amount, and the Part B deductible applies. 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 it can't be more than the Part A hospital stay deductible.
Tobacco use cessation counseling	**If you use tobacco and you're diagnosed with an illness caused or complicated by tobacco use, or you take a medicine that's affected by tobacco,** Medicare covers up to 8 face-to-face visits in a 12-month period. 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. **If you haven't been diagnosed with an illness caused or complicated by tobacco use,** Medicare coverage of tobacco cessation counseling is considered a covered preventive service. You pay nothing if the doctor or other qualified health care provider accepts assignment (accepts Medicare).
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 covers bone marrow and cornea transplants under certain conditions. Medicare covers immunosuppressive drugs if the transplant was eligible for Medicare payment, 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 transplant, and you must have Part B at the time you get immunosuppressive drugs. You pay 20% of the Medicare-approved amount, and the Part B deductible applies. If you're thinking about joining a Medicare Advantage Plan 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. **Note:** Medicare drug plans (Part D) may cover immunosuppressive drugs, even if Medicare or an employer or union group health plan didn't pay for the transplant. You pay nothing if the doctor or other qualified health care provider accepts assignment (accepts Medicare).
Travel (health care needed when traveling outside the United States)	Medicare generally doesn't cover health care while you're traveling outside the United States (including Puerto Rico, the US 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 United States. Medicare may pay for inpatient hospital, doctor, or ambulance services you get in a foreign country in these rare cases: • You're in the United States when an emergency occurs and the foreign hospital is closer than the nearest US hospital that can treat your medical condition • 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 US hospital that can treat the emergency • You live in the United States and the foreign hospital is closer to your home than the nearest US hospital that can treat your medical condition, regardless of whether an emergency exists 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.
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. In a hospital outpatient setting, you also pay the hospital a copayment.

"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. You pay nothing if the doctor or other qualified health care provider accepts assignment (accepts Medicare). **Note:** If your doctor or other health care provider performs additional tests or services during the same visit that aren't covered under these preventive benefits, you may have to pay coinsurance, and the Part B deductible may apply.
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 based on your current health and risk factors. This visit is covered once every 12 months. 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. The questions are based on years of medical research and advice from the Centers for Disease Control and Prevention (CDC). **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" visit before your yearly "wellness" visit. You pay nothing if the doctor or other qualified health care provider accepts assignment (accepts Medicare). **Note:** If your doctor or other health care provider performs additional tests or services during the same visit that aren't covered under these preventive benefits, you may have to pay coinsurance, and the Part B deductible may apply.
Adapted from: Centers for Medicare and Medicaid Services. (2013). *Medicare and You: The Official U.S. Government Medicare Handbook* (CMS Product No. 10050-28). Washington, DC: Government Printing Office.	

Table 2. 2012 Part B Income-Related Monthly Adjustment and Total Monthly Premium Amounts

Beneficiaries who file individual tax returns with income	**Beneficiaries who file joint tax returns with income**	**Income-related monthly adjustment amount**	**Total monthly premium amount**
Less than or equal to $85,000	Less than or equal to $170,000	$0.00	$99.90
$85,001 - $107,000	$170,001 - $214,000	$40.00	$139.90
$107,001 - $160,000	$214,001 - $320,000	$99.90	$199.80
$160,001 - $214,000	$320,001 - $428,000	$159.80	$259.70
Greater than $214,000	Greater than $428,000	$219.80	$319.70
Beneficiaries who are married and lived with their spouses at any time during the year, but who file separate tax returns from their spouses		**Income-related monthly adjustment amount**	**Total monthly premium amount**
Less than or equal to $85,000		$0.00	$99.90
$85,001 - $129,000		$159.80	$259.70
Greater than $129,000		$219.80	$319.70

Adapted From: Klees, B. S., C. J. Wolfe, and C. A. Curtis. 2011. Brief Summaries of Medicare and Medicaid. *Office of the Actuary, Centers for Medicare and Medicaid Services*. Retrieved from: http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/MedicareProgramRatesStats/downloads/MedicareMedicaidSummaries2011.pdf.