# 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 2014 | 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 for it as part of your one-time "Welcome to Medicare" preventive visit.<br><br>Note: If you have a family history of abdominal aortic aneurysms, or you're a man 65 to 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 |
| | **Alcohol misuse 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 |
| | **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 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 |

# THE ORIGINAL MEDICARE PLAN

| Service or Supply | What is covered and when? | What do YOU pay in 2014 | Part A or B |
|---|---|---|---|
| **Ambulatory Surgical Centers** | Medicare covers the facility services fees related to approved surgical procedures 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), 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 for all of the facility service 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 will pay a copayment for the blood processing and handling services for every 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 health care provider accepts assignment. | B |

B

# THE ORIGINAL MEDICARE PLAN

| Service or Supply | What is covered and when? | What do YOU pay in 2014 | Part A or 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. | You pay nothing for the test if the doctor or other qualified health care provider accepts assignment. | B |
| **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. 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're eating 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, but you generally have to pay 20% of the Medicare-approved amount for the doctor's visit and the Part B deductible may apply. | B |
| **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. | B |

# THE ORIGINAL MEDICARE PLAN

| Service or Supply | What is covered and when? | What do YOU pay in 2014 | Part A or B |
|---|---|---|---|
| **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.<br>For chemotherapy in a hospital inpatient setting covered under Part A, see Hospital care (inpatient)** | **A or B** |
| **Chiropractic Services (limited coverage)** | **Medicare covers these services to help correct a subluxation (when one 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.<br><br>Note: You pay all costs for any other services or tests ordered by a chiropractor (including X-rays and massage therapy).** | **B** |

# THE ORIGINAL MEDICARE PLAN

| Service or Supply | What is covered and when? | What do YOU pay in 2014 | 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.**<br><br>**Note: If you're in a Medicare Advantage Plan (like an HMO or PPO), some costs may be covered by Medicare and some may be covered by your plan.** | **B** |

# THE ORIGINAL MEDICARE PLAN

| Service or Supply | What is covered and when? | What do YOU pay in 2014 | 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 the following tests may be covered.** | **You pay nothing for the test if the doctor or other qualified health care provider accepts assignment.** | **B** |
| | **Fecal Occult Blood Test—This test is covered once every 12 months if you're 50 or older.** | **You pay nothing for this test if the doctor or other qualified health care provider accepts assignment.** | |
| | **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 for this test if the doctor or other qualified health care provider accepts assignment.** | |
| | **Colonoscopy—This test is generally covered once every 120 months (high risk every 24 months) or 48 months after a previous flexible sigmoidoscopy. No minimum age** | **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.** | |

# THE ORIGINAL MEDICARE PLAN

| | Service or Supply | What is covered and when? | What do YOU pay in 2014 | Part A or B |
|---|---|---|---|---|
| D | **Defibrillator (Implantable Automatic)** | Medicare covers these devices for some people diagnosed with heart failure.<br><br>Surgeries to implant defibrillators in a hospital inpatient setting are covered under Part A. See Hospital Care (Inpatient) | 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. Surgeries to implant defibrillators in a hospital inpatient setting are covered under Part A. | 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 test if the doctor or other qualified health care provider accepts assignment. If you get the depression screening and another service, you may need to pay 20% of the Medicare-approved amount for the other service and the Part B deductible may apply. | B |
| | **Diabetes Screenings** | Medicare covers these screenings if your doctor determines you're at risk for diabetes.<br>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 |

# THE ORIGINAL MEDICARE PLAN

| Service or Supply | What is covered and when? | What do YOU pay in 2014 | Part A or 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>If you get your diabetic testing supplies by mail, you'll need to use a national mail-order program Medicare contract supplier for Medicare to pay. You can also get your supplies at a store, but you should check if your payment will be more. Visit Medicare.gov/supplier to find a contract supplier. | 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 |
| **Durable Medical Equipment (DME) (like walkers)** | 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>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. | 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 2014 | Part A or B |
|---|---|---|---|---|
| | **Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Competitive Bidding Program** | To get certain items in some areas of the country, you generally must use specific suppliers called "contract suppliers," or Medicare won't pay for the item and you likely will pay full price. Visit Medicare.gov/supplier to find Medicare-approved suppliers in your area. 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). | | B |
| E | **EKG (Electrocardiogram) Screening** | Medicare covers a one-time screening EKG 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 is also covered as a diagnostic test. | You pay 20% of the Medicare-approved amount.<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. | B |
| | **Eyeglasses (limited)** | 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. | 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 2014 | Part A or B |
|---|---|---|---|---|
| F | **Federally- Qualified Health Center Services** | **Medicare covers many outpatient primary care and preventive services you get through certain community health centers.**<br><br>**To find a Medicare participating, federally-qualified health center near you, visit hrsa.gov.** | **Generally, you're responsible for paying a federally-qualified health center 20% of its reasonable costs, but these health centers must offer you a discounted rate if your income is under a certain amount (this amount changes, so check with the health center).**<br><br>**The Part B deductible doesn't apply.**<br>**You pay nothing for most preventive services.** | **B** |
| | **Flu Shots** | **Medicare generally covers one flu shot per flu season.** | **You pay nothing for getting the flu shot if the doctor or other 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** |

# THE ORIGINAL MEDICARE PLAN

| | Service or Supply | What is covered and when? | What do YOU pay in 2014 | Part A or 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 |
| | 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 | You pay nothing for the shot if the doctor or other qualified health care provider accepts assignment. | B |
| | HIV Screening | Medicare covers HIV (Human Immunodeficiency Virus) screenings once per year for people at increased risk for HIV, including anyone who asks for the test.<br><br>Medicare also covers HIV screenings for pregnant women 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 |

# THE ORIGINAL MEDICARE PLAN

| Service or Supply | What is covered and when? | What do YOU pay in 2014 | Part A or 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 for people with a continuing need for occupational therapy. A doctor, or certain health care providers 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're normally unable to leave home and doing so requires a considerable and taxing effort.<br>2. Because of an illness or injury, leaving home isn't medically advisable or isn't possible without the aid of supportive devices, use of special transportation, or the assistance of another person. | You pay nothing for covered home health services.<br><br>You pay 20% of the Medicare-approved amount, and the Part B deductible applies | A & B |
| **Hospice** | To qualify for hospice care, a hospice doctor and your doctor must certify that you're terminally ill and expected to live 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 you enter hospice to certify that you're still terminally ill. 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>Other covered services, as well as services Medicare usually doesn't cover, like spiritual and grief counseling<br>A Medicare-approved hospice usually gives hospice care in your home or other facility where you live, like a nursing home.<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.<br>Medicare also covers inpatient respite care which is care you get in a Medicare-approved facility so that your usual caregiver can rest.<br>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. 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><br>You pay a copayment of up to $5 per prescription for outpatient prescription drugs for pain and symptom management.<br><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 2014 | Part A or B |
|---|---|---|---|---|
| | **Hospital Care (Inpatient)** | 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 mental health care. 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. If you have Part B, it covers the doctor's services you get while you're in a hospital.<br><br>Note: Staying overnight in a hospital doesn't always mean you're an inpatient. You only become an inpatient when a hospital formally admits you as an inpatient, after a doctor orders it. You're still an outpatient if you've not been formally admitted as an inpatient, even if you're getting emergency department services, observation services, outpatient surgery, lab tests, or X-rays. You or a family member should always ask if you're an inpatient or an outpatient each day during your stay, since it affects what you pay and whether you'll qualify for Part A coverage in a skilled nursing facility. | You pay a deductible and no copayment for days 1–60 each benefit period.<br><br>You pay a copayment for days 61–90 each benefit period.<br><br>You pay a copayment per "lifetime reserve day" after day 90 each benefit period (up to 60 days over your lifetime).<br><br>You pay all costs for each day after the lifetime reserve days.<br><br>Inpatient mental health care in a psychiatric hospital is limited to 190 days in a lifetime. | A |
| 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, and some screening tests. | You generally pay nothing for these services. | 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 2014 | 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), including visits with a psychiatrist or other doctor, clinical psychologist, nurse practitioner, physician assistant, clinical nurse specialist, or clinical social worker. Lab 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) | Generally, you pay 20% of the Medicare-approved amount and the Part B deductible applies for:<br><br>Visits to a doctor or other health care provider to diagnose your condition or monitor or change your prescriptions<br><br>Outpatient treatment of your condition (like counseling or psychotherapy) | B |
| **Obesity screening and counseling** | If you have a body mass index (BMI) of 30 or more, Medicare may cover up to 22 face-to-face intensive counseling sessions over a 12-month period to help you lose weight. This counseling is covered when provided in a primary care setting (like a doctor's office). Talk to your primary care doctor or primary care practitioner to find out more. | 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) 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. | B |

# THE ORIGINAL MEDICARE PLAN

| Service or Supply | What is covered and when? | What do YOU pay in 2014 | 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** | **B** |

# THE ORIGINAL MEDICARE PLAN

| Service or Supply | What is covered and when? | What do YOU pay in 2014 | Part A or B |
|---|---|---|---|
| **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. 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 |
| **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 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 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 2014 | 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), 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>You pay 20% of the Medicare-approved amount, and the Part B deductible applies for the digital rectal exam.<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 2014 | 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 nonmedical 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. An example is 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. | | A |
| | **Rural Health Clinic Services** | Medicare covers many outpatient primary care and preventive services in rural health clinics | Generally, you pay 20% of the Medicare-approved amount and the Part B deductible applies. However, you pay nothing for most preventive services. | B |
| S | **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. | B |

# THE ORIGINAL MEDICARE PLAN

| Service or Supply | What is covered and when? | What do YOU pay in 2014 | Part A or B |
|---|---|---|---|
| **Sexually transmitted infections screening and counseling** | Medicare covers sexually transmitted infection (STI) screenings for chlamydia, gonorrhea, syphilis, and Hepatitis B. These screenings are covered for people with Medicare who are pregnant and for certain people who are 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. 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 offce). 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 |
| **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. 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. 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 a coinsurance 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 |
| **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 |

# THE ORIGINAL MEDICARE PLAN

| Service or Supply | What is covered and when? | What do YOU pay in 2014 | Part A or B |
|---|---|---|---|
| **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 for the supplies. The Part B deductible applies. | B |
| **Telehealth** | 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 these: 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. | B |
| **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. See Laboratory Services for other Part B covered tests. | B |

# THE ORIGINAL MEDICARE PLAN

| Service or Supply | What is covered and when? | What do YOU pay in 2014 | Part A or B |
|---|---|---|---|
| **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.<br><br>If you haven't been diagnosed with an illness caused or complicated by tobacco use, Medicare coverage of tobacco use cessation counseling is considered a covered preventive service. 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.<br><br>You pay nothing for the counseling sessions if the doctor or other health care provider accepts assignment. | 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 covers bone marrow and cornea transplants under certain conditions.<br>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.<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, even if Medicare or an employer or union group health plan didn't pay for the transplant. You pay nothing for these services if the doctor or health care provider accepts assignment. | 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 2014 | Part A or B |
|---|---|---|---|---|
| | **Travel (health care needed when traveling outside the United States)** | 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 |
| 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. 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 pay nothing for the "Welcome to Medicare" preventive visit if the doctor or other qualified health care provider accepts assignment. You may have to pay coinsurance, and the Part B deductible may apply. | B |

# THE ORIGINAL MEDICARE PLAN

| | Service or Supply | What is covered and when? | What do YOU pay in 2014 | Part A or 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 based on your current health and risk factors. This visit is covered once every 12 months.**<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. The questions are based on years of medical research and advice from the Centers for Disease Control and Prevention (CDC).**<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" visit before your yearly "Wellness" visit.** | **You pay nothing for the yearly "Wellness" preventive 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 benefits, 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 Medicare doesn't cover, you will have to pay for them yourself unless:**

- **You have other insurance (or Medicaid) to cover the costs.**
- **You're in a Medicare health plan that covers these services.**

**Even if Medicare covers a service or item, you generally have to pay deductibles, coinsurance, and copayments.**

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

- **Acupuncture.**
- **Cosmetic surgery.**
- **Dentures.**
- **Hearing aids and exams for fitting them.**
- **Long-term care (also called custodial care).**
- **Routine dental or eye care.**

**If you have Original Medicare, visit www.medicare.gov/coverage or call 1-800-MEDICARE (1-800-633-4227) to find out if Medicare covers a service you need, TTY users should call 1-877-486-2048. If you're in a Medicare health plan, contact your plan.**

**If you have a question or complaint about the quality of a Medicare-covered service, call your local Quality Improvement Organization (QIO). Visit www.medicare.gov/contacts to get your QIO's phone number. You can also call 1-800-MEDICARE.**

**Note: To get Medicare-covered Part A and/or Part B services, you must be a U.S. citizen or be lawfully present in the U.S.**