WELLNESS WISDOM

A 2023 Guide to Preventive and Screening Services Covered by Medicare

Preventive care can help you stay healthy and find medical problems early. Medicare offers a number of important preventive services — like yearly "Wellness" visits, screenings, and vaccines.

Medicare covers two types of preventive visits:
1) **"Welcome to Medicare" preventive visit**
2) **Yearly "Wellness" visit**

NEW

Starting on January 1, 2023, Medicare will fully cover all adult vaccines — including boosters — with no out-of-pocket costs, even if you are in the deductible phase of the benefit.

These preventive visits are NOT head-to-toe physicals, but they are a great opportunity to make sure you are up-to-date on important screenings and vaccines, talk with your healthcare provider about your family and medical history, and make a plan to stay as healthy as possible for as long as possible. These visits are recommended for EVERYONE — whether you already have a chronic condition, or you are hoping to prevent one.

"Welcome to Medicare" Preventive Visit

Medicare covers a one-time, initial visit called the "Welcome to Medicare" preventive visit. Everyone who has had Medicare Part B (Medical Insurance) for FEWER than 12 months qualifies for this visit, so be sure to schedule an appointment as soon as your coverage starts. During this visit, your healthcare provider will:

- Review your medical and family history, health conditions, and medications
- Check your height, weight, blood pressure, body mass index, and other routine measurements
- Discuss your risk of depression; and review current opioid prescriptions, the risk of opioid use disorders, and any underlying pain you may be experiencing
- Perform a basic visual acuity screening with an eye chart
- Make sure you are up-to-date with preventive screenings and services, including recommended vaccines that can protect you and your loved ones
- Develop a personalized prevention plan and schedule
- Order further tests or screenings if needed
- You are also eligible at this visit for a once-in-a-lifetime electrocardiogram (ECG/EKG), so ask your provider if it is recommended for you

Yearly "Wellness" Visit

Once you have had Medicare Part B for 12 months, Medicare covers a yearly visit to review your health status and history, and to develop or update your personalized prevention plan. At **each visit your provider will**:

Health Risk Assessment	Ask you to fill out a questionnaire in advance of or during your visit. It asks you about your: • Health status • Behavioral risks • Psychological and social risks • Ability to perform activities of daily living like dressing, eating, and bathing or showering • Hearing • Risk of falls • Home safety • Health care providers and suppliers • Medications and supplements
Medical, Family, and Social History	Ask you about your: • Previous illnesses, surgeries, hospital stays, allergies, injuries, and treatments • History of alcohol, tobacco, opioid, and illicit drug use • Family history of conditions that may be genetic or raise your risk • Diet and exercise
Depression or Mood Disorder Risk	Ask you questions or use a screening tool that can help determine if you are at risk of depression or other mood disorders
Opioid Use Disorder (OUD) Risk	Review current opioid prescriptions, discuss risk factors for OUD, evaluate any pain and treatment plans, and provide information and referrals if needed
Routine Measurements	Measure your height, weight, blood pressure, and body mass index
Cognitive Impairment	Ask you questions or use a screening tool — like the Mini-COG — that can help determine if you have memory loss or other cognitive impairment that may need additional follow-up
Personalized Prevention Plan	Create a written schedule with a checklist of recommended preventive screenings and vaccines based on your health, history, and risk factors
Health Advice, Resources, and Referrals	Make referrals for screenings and other care, and provide you with resources aimed at improving your health and addressing your specific needs
End-of-Life Planning	Offer to give you information about things like planning an advance directive

Preparing for Your Visits

Bring the following items with you when you go to your initial "Welcome to Medicare" or yearly "Wellness" visit:

- ❍ Medical records, including vaccine records
- ❍ A list of prescription drugs, over-the-counter drugs, and supplements that you take regularly
- ❍ A list of healthcare providers and suppliers
- ❍ Family health history — try to learn as much as you can about your family's health history before your appointment
- ❍ Any other information that can help determine if you are at risk for certain diseases

How Much Do the Preventive Services Cost?

- Whether you have Original Medicare or a Medicare Advantage Plan, there is no cost for the one-time "Welcome to Medicare" preventive visit or the yearly "Wellness" visits — when your healthcare provider accepts assignment — meaning they agree to Medicare's payments if you have Original Medicare, or they are in-network if you have a Medicare Advantage Plan. This means you won't have to pay a deductible, copayment, or coinsurance. There must also be at least 12 months between your "Welcome to Medicare" visit and your first Annual Wellness Visit AND between every yearly "Wellness" visit.
- During your preventive visits, your healthcare provider may need to do additional tests/screenings that are subject to cost sharing — meaning you may get billed for some of the costs. Be sure you discuss them with your healthcare provider in advance and are clear on your costs.
- There are many preventive screenings that are provided at no cost. However, when and how often you can get preventive services varies by person and item or service.
- Medicare Advantage Plans often have additional coverage for things like vision and dental benefits, so you may want to shop around to see if there's a Medicare Advantage Plan that best meets your individual care needs.
- If you need financial help for health care costs, there are a number of services and organizations that may be able to help.

All adult vaccines are covered with no out-of-pocket costs

Recommended Immunizations for Adults Ages 65+

Disease	Immunizations for Ages 65+
Influenza (Flu)	• 1 dose every year of an enhanced influenza vaccine — either a high-dose or adjuvanted — if available *If an enhanced vaccine is not available, any age appropriate flu vaccine is better than no vaccine*
Pneumococcal (Pneumonia)	• 1 dose PCV15 followed by PPSV23 or 1 dose PCV20 *People who have previously received PCV13 should consult with their healthcare professional to see if any additional doses are needed*
SARS-CoV-2 (COVID-19)	• Initial vaccine series and booster for everyone ages 5+ *To see if you qualify for another booster or for any new vaccines as they become available, go to* www.cdc.gov/coronavirus/2019-ncov/vaccines/booster-shot.html
Tetanus	• 1 dose of Tdap if you haven't had one as an adult
Diphtheria	• 1 Td or Tdap booster every 10 years
Pertussis (Whooping cough)	
Varicella zoster (Shingles)	• 2 doses RZV vaccine 2 – 6 months apart if haven't yet received this vaccine *Previous shingles infection or vaccination with previous live vaccine are not relevant*

People with certain risk factors due to heath, job, or lifestyle that are not listed here, may need additional vaccines including varicella (chicken pox), hepatitis A, hepatitis B, meningococcal (meningitis), and Hib (haemophilus influenza type b) vaccines. Talk to your healthcare professional to see if you need any of these vaccines.

If you are traveling outside of the U.S., you may need additional vaccines. Ask your healthcare professional about which vaccines you need at least 6 weeks before you travel.

Glossary

Accept Assignment	An agreement by your doctor, provider, or supplier to be paid directly by Medicare, to accept the payment amount Medicare approves for the service, and to not bill you for any more than the Medicare deductible and coinsurance. All participating providers accept assignment. Non-participating providers may accept assignment on a case-by-case basis.
Advance Directive	A written document stating how you want medical decisions to be made if you lose the ability to make them for yourself. It may include a living will and a durable power of attorney for healthcare.
Coinsurance	An amount you may be required to pay as your share of the cost for services after you pay any deductibles. Coinsurances is usually a percentage (for example, 20%).
Copayment	An amount you may be required to pay as your share of the cost for a medical service or supply, like a doctor's visit, hospital outpatient visit, or prescription drug. A copayment is usually a set amount, rather than a percentage. For example, you might pay $10 or $20 for a doctor's visit or prescription drug.
Cost Sharing	An amount that you pay out-of-pocket for services — including deductibles, coinsurance, and copayments. It doesn't include premiums, the cost of out-of-network services, or the cost of non-covered services.
Deductible	The amount you must pay for health care or prescriptions before Original Medicare, your prescription drug plan, or your other insurance you may have begins to pay.
Medicare Advantage	A type of Medicare health plan offered by a private company that contracts with Medicare. Medicare Advantage Plans provide all of your Part A and Part B benefits, excluding hospice. Medicare Advantage Plans include: • Health Maintenance Organizations • Preferred Provider Organizations • Private Fee-for-Service Plans • Special Needs Plans • Medicare Medical Savings Accounts Plans If you're enrolled in a Medicare Advantage Plan: • Most Medicare services are covered through the plan • Medicare services aren't paid for by Original Medicare Most Medicare Advantage Plans offer prescription drug coverage, and many offer vision and dental.
Medigap Plans	Medicare Supplement Insurance sold by private companies, that helps fill "gaps" in Original Medicare.

Original Medicare	A fee-for-service health plan that has two parts: • Part A (Hospital Insurance) • Part B (Medical Insurance) After you pay a deductible, Medicare pays its share of the Medicare-approved amount, and you pay your share (coinsurance and deductibles).
Part A (Hospital Insurance)	Coverage for inpatient hospital stays, skilled nursing facility care, hospice care, and some home health care. All Original Medicare and Medicare Advantage Plans include this coverage (excluding hospice for Medicare Advantage).
Part B (Medical Insurance)	Coverage for certain healthcare provider services, outpatient care, medical supplies, and preventive services (like the Annual Wellness Visit). All Original Medicare and Medicare Advantage Plans include this coverage.
Part C	Also called Medicare Advantage
Part D (Prescription Drug Insurance)	Prescription drug coverage that can be added to Original Medicare — costs vary from plan to plan.
Participating provider	Healthcare providers that accept Medicare and always accept assignment — meaning they will accept Medicare's approved amount for a service as full payment.
Premium	The periodic payment to Medicare, an insurance company, or healthcare plan for health or prescription drug coverage. Medicare premiums vary from plan to plan. Premiums may be paid annually, monthly, or at different intervals.

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