YOUR BENEFITS GUIDE – PREVENTIVE CARE IN 2024

Preventive care is essential to ensuring Medicare beneficiaries live healthier, more productive lives. The following outlines preventive care covered by Medicare in 2024 and you can find more detailed information at https://www.medicare.gov/coverage/preventive-screening-services

- **Abdominal Aortic Aneurysm Screening** – People at risk for abdominal aortic aneurysms may get a referral for a one-time screening ultrasound at their "Welcome to Medicare" physical exam. This test is covered if you have a family history of abdominal aortic aneurysms or if you are a man age 65 to 75 and have smoked at least 100 cigarettes in your lifetime. You pay nothing for this test if you meet Medicare criteria.

- **Bone Mass Measurement** - For those enrolled in Medicare at high risk for losing bone mass. It's covered once every 24 months at no cost (more often if medically necessary) for people who have certain medical conditions or meet one of the following five criteria:

    - A woman whose doctor is treating her for estrogen-deficiency and at risk for osteoporosis based on her medical history or other findings
    - A person with vertebral abnormalities as demonstrated by an X-ray
    - A person getting steroid treatments
    - A person with primary hyperparathyroidism
    - A person taking an osteoporosis drug
    - You pay nothing for these tests if you meet Medicare criteria.

- **Cardiovascular Disease Screenings** - Medicare covers cardiovascular screening tests that check cholesterol, lipid and triglyceride levels every 5 years. Includes:

    - Total Cholesterol Test
    - Cholesterol Test for High Density Lipoproteins; and
    - Triglycerides Test
    - You pay nothing for these tests.

- **Diabetes Screenings** - two screenings per year covered in full for anyone at high risk for diabetes. Risk factors include:

    - High blood pressure (hypertension)
    - History of abnormal cholesterol and triglyceride levels (dyslipidemia)
    - Obesity
    - A history of high blood sugar (glucose)

- **Glaucoma Tests** – covered once every 12 months for those at high risk for glaucoma. Covered annually for:

    - Those with a family history of glaucoma or diabetes
    - African-Americans age 50 and older
    - Hispanic-Americans age 65 and older
    - Other high risk individuals
    - Original Medicare pays 80% for this screening. Your cost share is determined based on the medical plan under which you are enrolled.

- **Screening Mammography** – For women age 40 and older enrolled in Medicare, Medicare covers these annually. Medicare covers one baseline mammogram for women between age 35 and 39. You pay nothing for this annual screening mammogram.
- **Pap Test & Pelvic Examination** - For all women enrolled in Medicare, Medicare covers these screening tests once every 24 months, or once every 12 months for women at high risk, or women of child-bearing age who have had an exam that indicated cancer or other abnormalities in the past three years. You pay nothing for these exams.
- **Colorectal Cancer Screening** – For all those enrolled in Medicare:
    - Fecal-Occult blood test covered at no cost annually for those age 50 or older.
    - Flexible sigmoidoscopy covered at no cost once every four years for most age 50 or older. If not at high risk, Medicare covers this test 120 months after a previous screening colonoscopy.
    - Barium enema can be substituted for sigmoidoscopy or colonoscopy once every 48 months for those age 50 or older or every 24 months for those at high risk of colorectal cancer. Medicare covers this at 80% and your cost share is determined based on the medical plan under which you are enrolled.
    - Screening colonoscopy is covered at no cost for any age enrolled in Medicare at:
        - Average risk – Once every 120 months or 48 months after a previous flexible sigmoidoscopy
        - High-risk for colorectal cancer – Once every 24 months
    - Multi-target stool DNA test (at home test) and Blood-based biomarker test - Medicare covers this at-home test at no cost once every 3 years for people who meet all of these conditions:
        - Those on Medicare between age 50 and age 85
        - Those showing no signs or symptoms of colorectal disease including, but not limited to:
            - Lower gastrointestinal pain
            - Blood in stool
            - Positive guaiac fecal occult blood test
            - Fecal immunochemical test
        - Those at average risk for developing colorectal cancer - no personal history of adenomatous polyps, colorectal cancer or inflammatory bowel disease such as Crohn's Disease and ulcerative colitis.
        - Those without family history of colorectal cancers or adenomatous polyps, familial adenomatous polyposis and hereditary nonpolyposis colorectal cancer.
    - **Screening flexible sigmoidoscopy and a screening colonoscopy can become diagnostic (vs. routine)** if the screening results in the biopsy or removal of a lesion or growth and the biopsy or removal happens during the same visit.
        - When these screenings become diagnostic, Medicare pays 80% of the Medicare approved amount and your cost share is determined based on the medical plan under which you are enrolled.
        - The Part B deductible does not apply.

- **Diabetes Monitoring and Education** - Covered services and supplies for those who must monitor blood sugar:
    - Glucose-monitoring devices**,** lancets & strips
    - Education & training to help control diabetes
    - Foot care for those with peripheral neuropathy
    - Therapeutic shoes and inserts

      Medicare pays for these services and supplies at 80% and your cost share is determined based on the medical plan under which you are enrolled.

- **Medical Nutritional Therapy** – Medicare may cover medical nutrition therapy and certain related services if you have diabetes or kidney disease, or have had a kidney transplant in the last 36 months. You pay nothing for these services.

- **Smoking Cessation Services** – Medicare will cover up to 8 counseling sessions per year for individuals who use tobacco. You pay nothing for these services.

- **Flu Vaccination Annually -** You pay nothing for the flu shot.

- **Pneumococcal Pneumonia Vaccination-** Medicare covers pneumococcal shots to help prevent pneumococcal infections (like certain types of pneumonia). The two shots protect against different strains of the bacteria. Medicare covers the first shot at any time and covers a different second shot if it's given one year (or later) after the first shot. You pay nothing for this vaccination if you meet Medicare criteria.

- **Hepatitis B Shots** – Covered at no cost for those who are at medium or high risk. You pay nothing for this vaccination if you meet Medicare criteria. Your risk for Hepatitis B increases if one of these applies:
    - You have hemophilia.
    - You have End-Stage Renal Disease (ESRD).
    - You have diabetes.
    - You live with someone who has Hepatitis B.
    - You're a health care worker and have frequent contact with blood or bodily fluids.
    - Other factors may also increase your risk for Hepatitis B.

- **COVID-19 Vaccinations -** Covered at no cost to help reduce the risk of illness from Covid-19 by working with the body's natural defenses to safely develop protection (immunity) to the virus.

MEDICARE WELLNESS VISITS VS. ROUTINE PHYSICAL EXAMS

Medicare Covered Wellness Visits
Initial Preventive Physical Exam (IPPE or Welcome to Medicare Visit)
Personal Prevention Plan Services (PPPS) or Annual Wellness Visit

You are entitled to receive the Welcome to Medicare visit (IPPE) within the first 12 months of Medicare Part B coverage and the Annual Wellness Visit (PPPS) each calendar year. Since this is a Medicare covered service, this visit is covered on all of the Anthem plans at no cost.

The Welcome to Medicare Visit and the Annual Wellness Visit include:

- A review of the medical history for you and your family.
- A review of your current providers and prescriptions.
- Height, weight, blood pressure, and other routine measurements (such as BMI).
- A simple vision test.
- Education and counseling about preventive services, including certain screenings, vaccinations, and referrals for other care, if needed.
- Advice to help prevent disease, improve health, and stay well.
- A review of your potential risk for depression and your level of safety.
- Written plan informing which screenings and other preventive services are needed.
- A cognitive assessment to look for signs of dementia, including Alzheimer's disease.

Annual Routine Physical Exam

The Anthem Medicare Preferred plans cover an Annual Routine Physical Examination performed by your primary care physician (PCP). This exam is in addition to the Welcome to Medicare visit and Medicare Annual Wellness Visit. It can be performed at the same time or it can be performed at a different time of the year.

Unlike the Welcome to Medicare Visit and Annual Wellness Visit, the annual routine physical is a comprehensive, extensive physical examination. The purpose of the exam is to screen for disease, promote a healthy lifestyle, and assess a member's potential risk factors for future medical problems.

In addition to the services provided during the wellness visit, a typical annual physical might also include services such as a vital signs check, lung exam, head and neck exam, abdominal exam, neurological exam, and a check of your reflexes. Any blood work or lab tests that may be part of a physical exam are not included under a Medicare Annual Wellness Visit. The lab work included in the Physical would be a complete blood count and a complete metabolic panel. The panel tests your blood plasma and can indicate any issues that exist in your kidneys, liver, blood chemistry, and immune system. This helps detect irregularities in your body that might indicate a larger problem. Your doctor may request a diabetes screen and a thyroid screen. If you have an increased risk of heart attack, heart disease, or stroke, they may also request a lipid panel (cholesterol test). Depending on the results of the exam, further tests may be ordered and cost sharing may apply depending on the test and on which medical plan you are enrolled.