private insurance and patients' cash resources; and

(iv) Limits the amounts it collects or seeks to collect from a Medicare Part B beneficiary and others on the beneficiary's behalf to:

(A) Any unmet deductible applied to the charges related to the reasonable costs that the facility incurs in providing the covered services;

(B) Twenty percent of the remainder of those charges;

(C) The charges for noncovered services.

(7) Rural health clinic services that meet the requirements set forth in part 491 of this chapter.

[54 FR 41734, Oct. 11, 1989, as amended at 56 FR 2139, Jan. 22, 1991]

§411.9 Services furnished outside the United States.

(a) *Basic rule.* Except as specified in paragraph (b) of this section, Medicare does not pay for services furnished outside the United States. For purposes of this paragraph (a), the following rules apply:

(1) The United States includes the 50 States, the District of Columbia, Puerto Rico, the Virgin Islands, Guam, American Samoa, The Northern Mariana Islands, and for purposes of services rendered on board ship, the territorial waters adjoining the land areas of the United States.

(2) Services furnished on board ship are considered to have been furnished in United States territorial waters if they were furnished while the ship was in a port of one of the jurisdictions listed in paragraph (a)(1) of this section, or within 6 hours before arrival at, or 6 hours after departure from, such a port.

(3) A hospital that is not physically situated in one of the jurisdictions listed in paragraph (a)(1) of this section is considered to be outside the United States, even if it is owned or operated by the United States Government.

(b) *Exception.* Under the circumstances specified in subpart H of part 424 of this chapter, payment may be made for covered inpatient services furnished in a foreign hospital and, on the basis of an itemized bill, for covered physicians' services and ambulance service furnished in connection with those inpatient services, but only for the period during which the inpatient hospital services are furnished.

§411.10 Services required as a result of war.

Medicare does not pay for services that are required as a result of war, or an act of war, that occurs after the effective date of a beneficiary's current coverage for hospital insurance benefits or supplementary medical insurance benefits.

§411.12 Charges imposed by an immediate relative or member of the beneficiary's household.

(a) *Basic rule.* Medicare does not pay for services usually covered under Medicare if the charges for those services are imposed by—

(1) An immediate relative of the beneficiary; or

(2) A member of the beneficiary's household.

(b) *Definitions.* As used in this section—

Immediate relative means any of the following:

(1) Husband or wife.

(2) Natural or adoptive parent, child, or sibling.

(3) Stepparent, stepchild, stepbrother, or stepsister.

(4) Father-in-law, mother-in-law, son-in-law, daughter-in-law, brother-in-law, or sister-in-law.

(5) Grandparent or grandchild.

(6) Spouse of grandparent or grandchild.

Member of the household means any person sharing a common abode as part of a single family unit, including domestic employees and others who live together as part of a family unit, but not including a mere roomer or boarder.

Professional corporation means a corporation that is completely owned by one or more physicians and is operated for the purpose of conducting the practice of medicine, osteopathy dentistry, podiatry, optometry, or chiropractic, or is owned by other health care professionals as authorized by State law.

(c) *Applicability of the exclusion.* The exclusion applies to the following charges in the specified circumstances:

(1) *Physicians' services.* (i) Charges for physicians' services furnished by an immediate relative of the beneficiary or member of the beneficiary's household, even if the bill or claim is submitted by another individual or by an entity such as a partnership or a professional corporation.

(ii) Charges for services furnished incident to a physician's professional services (for example by the physician's nurse or technician), only if the physician who ordered or supervised the services has an excluded relationship to the beneficiary.

(2) *Services other than physicians' services.* (i) Charges imposed by an individually owned provider or supplier if the owner has an excluded relationship to the beneficiary; and

(ii) Charges imposed by a partnership if any of the partners has an excluded relationship to the beneficiary.

(d) *Exception to the exclusion.* The exclusion does not apply to charges imposed by a corporation other than a professional corporation.

§ 411.15 Particular services excluded from coverage.

The following services are excluded from coverage:

(a) Routine physical checkups such as:

(1) Examinations performed for a purpose other than treatment or diagnosis of a specific illness, symptoms, complaint, or injury, except for screening mammography, colorectal cancer screening tests, screening pelvic examinations, prostate cancer screening tests, or glaucoma screening exams that meet the criteria specified in paragraphs (k)(6) through (k)(10) of this section.

(2) Examinations required by insurance companies, business establishments, government agencies, or other third parties.

(b) *Eyeglasses or contact lenses, except for:*

(1) Post-surgical prosthetic lenses customarily used during convalescence for eye surgery in which the lens of the eye was removed (e.g., cataract surgery);

(2) Prosthetic lenses for patients who lack the lens of the eye because of congenital absence or surgical removal; and

(3) One pair of conventional eyeglasses or conventional contact lenses furnished after each cataract surgery during which an intraocular lens is inserted.

(c) *Eye examinations* for the purpose of prescribing, fitting, or changing eyeglasses or contact lenses for refractive error only and procedures performed in the course of any eye examination to determine the refractive state of the eyes, without regard to the reason for the performance of the refractive procedures. Refractive procedures are excluded even when performed in connection with otherwise covered diagnosis or treatment of illness or injury.

(d) *Hearing aids* or examination for the purpose of prescribing, fitting, or changing hearing aids.

(e) *Immunizations, except for—*

(1) Vaccinations or inoculations directly related to the treatment of an injury or direct exposure such as antirabies treatment, tetanus antitoxin or booster vaccine, botulin antitoxin, antivenom sera, or immune globulin;

(2) Pneumococcal vaccinations that are reasonable and necessary for the prevention of illness;

(3) Hepatitis B vaccinations that are reasonable and necessary for the prevention of illness for those individuals, as defined in §410.63(a) of this chapter, who are at high or intermediate risk of contracting hepatitis B; and

(4) Influenza vaccinations that are reasonable and necessary for the prevention of illness.

(f) *Orthopedic shoes* or other supportive devices for the feet, *except when* shoes are integral parts of leg braces.

(g) *Custodial care, except as necessary* for the palliation or management of terminal illness, as provided in part 418 of this chapter. (Custodial care is any care that does not meet the requirements for coverage as SNF care as set forth in §§409.31 through 409.35 of this chapter.)

(h) *Cosmetic surgery and related services,* except as required for the prompt repair of accidental injury or to improve the functioning of a malformed body member.