

Medicare Coverage of Cancer Treatment Services

[Medicare.gov](https://www.Medicare.gov)



Medicare

Table of contents

What Medicare Covers	1
Medicare Part A (Hospital Insurance)	1
Medicare Part B (Medical Insurance)	2
What you pay for services	3
Medicare coverage other than Original Medicare	3
Changing Medicare coverage	4
Appealing coverage and payment decisions	6
For more information	6
Definitions	7
CMS Accessible Communications	9
Nondiscrimination Notice	10

This booklet explains Medicare coverage of medically necessary cancer treatment supplies, services, and prescription drugs. For more information, visit [Medicare.gov](https://www.medicare.gov), or call 1-800-MEDICARE (1-800-633-4227). TTY users can call 1-877-486-2048.



Section 1:

What Medicare Covers

Medicare Part A (Hospital Insurance)

Part A covers:

- Inpatient hospital stays, including cancer treatments you get while you're an inpatient in the hospital. You may be in a hospital and still be considered an outpatient (also called observation status). If you're unsure if you're an inpatient, ask the hospital staff.
- Skilled nursing facility care (following a related 3-day hospital stay).
- Home health care (like rehabilitation services for physical therapy, speech-language pathology therapy, occupational therapy, or skilled nursing care).
- Blood.
- Some costs of clinical research studies while you're an inpatient in the hospital.
- Surgically-implanted breast prostheses after a mastectomy, if the surgery takes place in an inpatient setting.
- Hospice care.

Note: Go to pages 7-8 for definitions of **blue** words

Medicare Part B (Medical Insurance)

Part B covers many medically-necessary cancer-related outpatient services and treatments, but for some services, you must meet certain conditions. You may be in a hospital and still be considered an outpatient (observation status). Part B also covers some preventive services for people who are at risk for cancer.

Part B covers:

- Doctors' visits.
- Many chemotherapy drugs that are administered through your vein in an outpatient clinic or a doctor's office.
- Some oral chemotherapy treatments.
- Radiation treatments in an outpatient clinic.
- Diagnostic tests (like X-rays and CT scans).
- **Durable medical equipment (DME)** (like wheelchairs and walkers).
- Specific dental services you'd get at a dentist's office or other outpatient setting if they're directly related to the success of covered cancer treatments (like dental care you might need to get before chemotherapy).
- Enteral nutrition equipment (feeding pump) as DME that your doctor prescribes for use in your home, and certain nutrients if you can't absorb nutrition through your intestinal tract or you can't take food by mouth.
- Outpatient surgeries.
- Breast prostheses (external breast prostheses, including a post-surgical bra) after a mastectomy. Part B covers surgically implanted breast prostheses after a mastectomy if the surgery takes place in an outpatient setting.
- In some cases, a second opinion for surgery that isn't an emergency, and a third opinion if the first and second opinions are different.
- Mental health services, including services that you usually get outside a hospital (like in a clinic, doctor's office, or therapist's office) and services you get in a hospital's outpatient department.
- Nutritional counseling if you have diabetes or kidney disease.
- Certain preventive and screening services.
- Some costs of clinical research studies while you're an outpatient.

What you pay for services

Copayments, **coinsurance**, or **deductibles** may apply for each service. Your costs may depend on several things, like if your doctor or other health care provider accepts **assignment**, the type of facility, other insurance you may have, and the location where you get your test, item, or service. Talk to your doctor or other health care provider for more specific cost information.

Medicare may have maximum payment amounts on certain types of services and may not cover others. Your provider may recommend you get services more often than Medicare covers. Or, they may recommend services that Medicare doesn't cover. If this happens, you may have to pay some or all of the costs. It's important to ask questions so you understand why your doctor is recommending certain services and if, or how much, Medicare will pay for them.

Visit [Medicare.gov](https://www.medicare.gov), or call 1-800-MEDICARE (1-800-633-4227) to get cost information. TTY users can call 1-877-486-2048.

Medicare doesn't cover:

- Room and board in assisted living facilities.
- Adult day care.
- Long-term nursing home care.
- Medical food or nutritional supplements (except enteral nutrition equipment).
- Services that help you with activities of daily living (like bathing and eating) that don't require skilled care.

Medicare coverage other than Original Medicare

Medicare Advantage Plans (also known as Part C)

Medicare Advantage is a Medicare-approved plan from a private company that offers an alternative to Original Medicare for your health and drug coverage. These "bundled" plans include Part A, Part B, and usually Part D. If you're in a **Medicare Advantage Plan** or another type of Medicare health plan, your plan must give you at least the same coverage as **Original Medicare**, but it may have different rules and costs. Because these services may cost more if the provider doesn't participate in your health plan, ask if your provider accepts your plan when scheduling your appointment. Read your plan materials, or call your plan for more information about your benefits.

Medicare coverage other than Original Medicare (continued)

Medicare drug coverage (Part D) of cancer-related drugs and supplies

Medicare offers prescription drug coverage to everyone with Medicare, but that coverage isn't automatic. To get [Medicare drug coverage](#), you must join a Medicare drug plan (or join a [Medicare Advantage Plan](#) with drug coverage).

Part D covers most prescription medications and some chemotherapy treatments and drugs. If you have [Original Medicare](#) with a **Medicare drug plan**, and Part B doesn't cover a cancer drug, your drug plan may cover it. It's important to check with your plan to make sure your drugs are on the plan's formulary (list of covered drugs) and to check each drug's [tier](#) on the formulary. This affects your out-of-pocket costs. Read your plan materials, or call your plan for more information about your drug coverage. Visit [Medicare.gov/plan-compare](https://www.medicare.gov/plan-compare) to compare plans with Medicare drug coverage.

Part D may cover these cancer drugs:

- Prescription drugs for chemotherapy only if taken by mouth
- Anti-nausea drugs
- Other prescription drugs used in the course of your cancer treatment, like pain medication

Medicare Supplement Insurance (Medigap) Policies

If you have other insurance that supplements [Original Medicare](#), like a Medigap policy or a group health plan, it may pay some of the costs for the services and supplies described in this booklet. Private companies sell Medigap policies, which help pay certain out-of-pocket costs, like [deductibles](#), [coinsurance](#), and [copayments](#). For more information about Medigap, visit [Medicare.gov/health-drug-plans/medigap](https://www.medicare.gov/health-drug-plans/medigap), or contact your insurance company.

Changing Medicare coverage

After getting a cancer diagnosis, speaking with your health care providers, and reviewing your current Medicare coverage, you may want to look at other health coverage options based on your needs. However, it's important to remember that you can only change your coverage at certain times. Each year, you have a chance to make changes to your Medicare health and prescription drug coverage for the following year. It's in your best interest to compare the plans available in your area each year to make sure you have the plan that best meets your needs. Visit [Medicare.gov/plan-compare](https://www.medicare.gov/plan-compare) to compare plans. You can make changes to your Medicare health and drug coverage during these enrollment periods:

Changing Medicare coverage (continued)

Open Enrollment Period (October 15 – December 7 each year, with coverage starting January 1)

- **What can I do?**

- Change from Original Medicare to a [Medicare Advantage Plan](#).
- Change from a Medicare Advantage Plan back to Original Medicare.
- Switch from one Medicare Advantage Plan to another Medicare Advantage Plan.
- Switch from a Medicare Advantage Plan that doesn't offer drug coverage to a Medicare Advantage Plan that offers drug coverage.
- Switch from a Medicare Advantage Plan that offers drug coverage to Medicare Advantage Plan that doesn't offer drug coverage.
- Join a Medicare drug plan.
- Switch from one Medicare drug plan to another Medicare drug plan.
- Drop your [Medicare drug coverage](#) completely.

Medicare Advantage Open Enrollment Period (January 1–March 31 each year, with coverage starting the first day of the month after you ask to join the plan)

- **What can I do?**

- Switch from one [Medicare Advantage Plan](#) (with or without drug coverage), to another Medicare Advantage Plan (with or without drug coverage).
- Drop your Medicare Advantage Plan and return to [Original Medicare](#). If you do this, you'll also be able to join a separate Medicare drug plan.

- **What can't I do?**

- Change from Original Medicare to a Medicare Advantage Plan.
- Join a Medicare drug plan (if you're in Original Medicare).
- Switch from one Medicare drug plan to another (if you're in Original Medicare).

Note: If you joined a Medicare Advantage Plan during your Initial Enrollment Period, you can change to another Medicare Advantage Plan (with or without drug coverage) or go back to Original Medicare (with or without a drug plan) within the first 3 months you have Medicare.

For more information on joining or changing plans, visit [Medicare.gov/basics/get-started-with-medicare/get-more-coverage/joining-a-plan](https://www.medicare.gov/basics/get-started-with-medicare/get-more-coverage/joining-a-plan).

Appealing coverage and payment decisions

You can file an appeal if you disagree with a coverage or payment decision made by Medicare, your Medicare health plan, or your Medicare drug plan. You have the right to file an appeal if Medicare, your Medicare health plan, or your Medicare drug plan denies:

- A request for a health care service, supply, item, or prescription that you think you should be able to get
- A request for payment of a health care service, supply, item, or a prescription drug you already got
- A request to change the amount you must pay for a health care service, supply, item, or prescription drug
- Coverage or payment of all or part of a health care service, supply, item, or prescription drug you think you still need

Medicare health and drug plans also have a transition process if you're new to the plan and taking a drug that isn't on the plan's formulary. The plan must let you get a 30-day temporary supply of the prescription (a 91-day supply if you're a resident of a long-term care facility). This gives you time to work with the doctor who prescribed the drug to find a different drug that's on the plan's formulary. If an acceptable alternative drug isn't available, you or your doctor can request an **exception** from the plan, and you can file an appeal if your request is denied. Visit [Medicare.gov/appeals](https://www.medicare.gov/appeals) for more information on how to file an appeal.

For more information

- Visit [Medicare.gov](https://www.medicare.gov) to:
 - Learn more about what Medicare covers.
 - Find and compare doctors, hospitals, and other providers.
 - Find suppliers of **durable medical equipment (DME)** and medical supplies.
- Call 1-800-MEDICARE (1-800-633-4227). TTY users can call 1-877-486-2048.
- Look at topic-specific publications at [Medicare.gov/publications](https://www.medicare.gov/publications).
- Call your State Health Insurance Assistance Program (SHIP) to get free personalized health insurance counseling. To get the phone number for your state, visit shiphelp.org, or call 1-800-MEDICARE.

This booklet explains Medicare coverage of medically necessary cancer treatment supplies, services, and prescription drugs in **Original Medicare** (Part A and Part B), **Medicare Advantage Plans (Part C)**, and **Medicare drug coverage (Part D)**. For more information, visit [Medicare.gov](https://www.medicare.gov), or call 1-800-MEDICARE.



Section 2:

Definitions

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 not to bill you for any more than the Medicare deductible and coinsurance.

Coinsurance: An amount you may be required to pay as your share of the cost for services after you pay any deductibles. Coinsurance 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.

Deductible: The amount you must pay for health care or prescriptions before Original Medicare, your Medicare Advantage Plan, your Medicare drug plan, or your other insurance begins to pay.

Durable medical equipment (DME): Certain medical equipment, like a walker, wheelchair, or hospital bed, that's ordered by your doctor for use in the home.

Exception: A type of Medicare prescription drug coverage determination. A formulary exception is a drug plan's decision to cover a drug that's not on its drug list or to waive a coverage rule. A tiering exception is a drug plan's decision to charge a lower amount for a drug that's on its non-preferred drug tier. You or your prescriber must request an exception, and your doctor or other prescriber must provide a supporting statement explaining the medical reason for the exception.

Hospice: A special way of caring for people who are terminally ill. Hospice care involves a team-oriented approach that addresses the medical, physical, social, emotional, and spiritual needs of the patient. Hospice also provides support to the patient's family or caregiver.

Medicare Advantage Plan (Part C): 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, with a few exclusions, for example, certain aspects of clinical trials which are covered by Original Medicare even though you're still in the plan. Medicare Advantage Plans include:

- Health Maintenance Organizations
- Preferred Provider Organizations
- Private Fee-for-Service Plans
- Special Needs Plans
- Medicare Medical Savings Account Plans

If you're enrolled in a Medicare Advantage Plan:

- Most Medicare services are covered through the plan
- Most Medicare services aren't paid for by Original Medicare
- Most Medicare Advantage Plans offer prescription drug coverage

Medicare drug coverage (Part D): Part D adds prescription drug coverage to:

- Original Medicare
- Some Medicare Cost Plans
- Some Medicare Private-Fee-for-Service Plans
- Medicare Medical Savings Account Plans

These plans are offered by insurance companies and other private companies approved by Medicare. Medicare Advantage Plans may also offer prescription drug coverage that follows the same rules as Medicare drug plans.

Original Medicare: Original Medicare is a fee-for-service health plan that has two parts: Part A (Hospital Insurance) and 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).

Tiers: Groups of drugs that have a different cost for each group. Generally, a drug in a lower tier will cost you less than a drug in a higher tier.

CMS Accessible Communications

Medicare provides free auxiliary aids and services, including information in accessible formats like braille, large print, data or audio files, relay services and TTY communications. If you request information in an accessible format, you won't be disadvantaged by any additional time necessary to provide it. This means you'll get extra time to take any action if there's a delay in fulfilling your request.

To request Medicare or Marketplace information in an accessible format you can:

1. **Call us:**

For Medicare: 1-800-MEDICARE (1-800-633-4227) TTY: 1-877-486-2048

For Marketplace: 1-800-318-2596 TTY: 1-855-889-4325

2. **Email us:** altformatrequest@cms.hhs.gov

3. **Send us a fax:** 1-844-530-3676

4. **Send us a letter:**

Centers for Medicare & Medicaid Services

Offices of Hearings and Inquiries (OHI)

7500 Security Boulevard, Mail Stop DO-01-20

Baltimore, MD 21244-1850

Attn: Customer Accessibility Resource Staff (CARS)

Your request should include your name, phone number, type of information you need (if known), and the mailing address where we should send the materials. We may contact you for additional information.

Note: If you're enrolled in a Medicare Advantage Plan or Medicare drug plan, contact your plan to request its information in an accessible format. For Medicaid, contact your State Medical Assistance (Medicaid) office.

Nondiscrimination Notice

The Centers for Medicare & Medicaid Services (CMS) doesn't exclude, deny benefits to, or otherwise discriminate against any person on the basis of race, color, national origin, disability, sex, or age in admission to, participation in, or receipt of the services and benefits under any of its programs and activities, whether carried out by CMS directly or through a contractor or any other entity with which CMS arranges to carry out its programs and activities.

You can contact CMS in any of the ways included in this notice if you have any concerns about getting information in a format that you can use.

You may also file a complaint if you think you've been subjected to discrimination in a CMS program or activity, including experiencing issues with getting information in an accessible format from any Medicare Advantage Plan, Medicare drug plan, state or local Medicaid office, or Marketplace Qualified Health Plans. There are 3 ways to file a complaint with the U.S. Department of Health & Human Services, Office for Civil Rights:

1. **Online:**

[HHS.gov/civil-rights/filing-a-complaint/complaint-process/index.html](https://www.hhs.gov/civil-rights/filing-a-complaint/complaint-process/index.html)

2. **By phone:**

Call 1-800-368-1019.

TTY users can call 1-800-537-7697.

3. **In writing:** Send information about your complaint to:

Office for Civil Rights
U.S. Department of Health & Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201

Notes

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Notes

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U.S. Department of Health and Human Services
Centers for Medicare & Medicaid Services
7500 Security Blvd.
Baltimore, MD 21244-1850

Official Business
Penalty for Private Use, \$300

Need a copy of this booklet in Spanish?

To get a free copy of this booklet in Spanish, visit [Medicare.gov](https://www.Medicare.gov) or call 1-800-MEDICARE (1-800-633-4227). TTY users can call 1-877-486-2048.

Esta publicación está disponible en Español. Para obtener una copia gratis, visite [Medicare.gov](https://www.Medicare.gov) o llame al 1-800-MEDICARE.



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The information in this booklet describes the Medicare Program at the time this booklet was printed. Changes may occur after printing. Visit **Medicare.gov**, or call 1-800-MEDICARE (1-800-633-4227) to get the most current information. TTY users can call 1-877-486-2048.

“Medicare Coverage of Cancer Treatment Services” isn’t a legal document. Official Medicare Program legal guidance is contained in the relevant statutes, regulations, and rulings.

You have the right to get Medicare information in an accessible format, like large print, braille, or audio. You also have the right to file a complaint if you feel you’ve been discriminated against. Visit **Medicare.gov/about-us/accessibility-nondiscrimination-notice**, or call 1-800-MEDICARE (1-800-633-4227) for more information. TTY users can call 1-877-486-2048.

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