FLORIDA OFFICE OF Insurance Regulation

2026 Medigap Frequently Asked Questions

1. **What are the basic benefits of a Medicare Supplement Policy?**

   For issues on or after June 1, 2010, coverage for Medicare Supplement Plans A, B, C, D, F, G, M, and N includes:

   a.) First 3 Pints of Blood when provided during a covered stay;

   b.) Medicare Part A coinsurance amount for days 61-90 ($434 per day in 2026) of a hospital stay;

   c.) Medicare Part A coinsurance for each lifetime reserve day used between days 91-150 ($868 per day in 2026) for a hospital stay;

   d.) Coverage of up to 365 more days of a hospital stay during lifetime after all Medicare hospital benefits are exhausted, paid at the applicable prospective payment system (PPS) rate or other appropriate standard of payment;

   e.) The coinsurance or co-payment amount for Medicare Part B services after the $283 yearly deductible is met; and

   f.) Coverage of cost sharing for all Part A Medicare eligible hospice care and respite care services.

2. **What additional benefits are available?**

   a.) Medicare Part A Deductible: Plans B, C, D, F, High-Deductible F, G, High-Deductible G, and N coverage includes the deductible for Part A hospitalization ($1,736 per benefit period for 2026). Plan M coverage includes one-half of the deductible for Part A.

   b.) Medicare Part B Deductible: Plans C, F, and High-Deductible F coverage includes the deductible for Part B medical expenses ($283 in 2026).

c.) Medicare Part B Excess Charges: Plans F, High-Deductible F, G, and High-Deductible G coverage includes 100% of the difference between the actual charges and the Medicare-approved amount for Part B services.

d.) Skilled Nursing Facility Care: Plans C, D, F, High-Deductible F, G, High-Deductible G, M and N coverage provides $217 per day for days 21-100 in 2026.

e.) Foreign Travel Emergency: Plans C, D, F, High-Deductible F, G, High-Deductible G, M and N pay emergency medical care during the first 60 days of a trip outside the U.S. The supplement policy will pay 80% of the actual billed charges for covered care after the $250 emergency medical deductible is satisfied subject to a lifetime maximum benefit of $50,000 (in addition to other deductibles under Plan High-Deductible F and High-Deductible G).

For a table comparing the benefits by plan letter, please see final page of this document.

3. Are there plans with more cost-sharing?

a.) Plan K and L include similar services as other plans, but cost-sharing for the basic benefits are at different levels. After the out-of-pocket maximum limits ($8,000 for Plan K and $4,000 for Plan L in 2026) and Part B deductible ($283 in 2026) are met, the policy pays 100% of covered services for the rest of the calendar year.

b.) Plan N includes similar coverage as Plan D, but there is a new co-payment structure of up to $20 for Part B physician office visits and up to $50 for emergency room visits.

c.) Plan F also has an option called High Deductible Plan F. Benefits from High Deductible Plan F will not begin until after out-of-pocket expenses reach $2,950 (in 2026).

d.) Like Plan F, Plan G has an option called High Deductible Plan G, also with a $2,950 deductible (in 2026).

For a table comparing the benefits by plan letter, please see final page of this document.

4. **How does Medicare coordinate with other insurance?**

   Contact the Benefits Coordination & Recovery Center (BCRC) at 1-855-798-2627. TTY users call 1-855-797-2627.

5. **I am on Social Security Disability and under 65 years of age. Do I qualify for a guaranteed issue Medicare Supplement policy?**

   As of October 1, 2009, individuals with Medicare Part B benefits, before age 65, due to disability or End Stage Renal Disease (ESRD) (permanent kidney failure treated with dialysis or a kidney transplant), have guaranteed issue rights for a Medicare Supplement policy for a limited time. This 6-month open enrollment period for Medicare Supplement insurance begins on the date of enrollment in Medicare Part B. In addition, individuals that are covered under Medicare Part B and whose employer-based group health plan is terminating have a 2-month open enrollment period following termination of the group health plan. After the open enrollment period, some companies will issue a policy after medically underwriting a person on disability. The company will review the health history in order to decide if they will underwrite a policy.

   Individuals on disability or with ESRD that exercised his/her open enrollment upon Medicare eligibility will have another open enrollment period once he/she turns age 65. Medicare Supplement rates for individuals with ESRD or on disability are generally higher than for those eligible for Medicare due to age. The individual will be eligible for the lower rate once he/she turns 65 years of age. In order to receive a lower premium, the Medicare beneficiary should verify with the current insurer if he/she must reapply in order to receive a lower premium. They may also choose to apply with a new company.

   If individuals live in a county that has a Medicare Advantage plan, they may obtain coverage through the insurer or HMO during the annual enrollment period. The annual enrollment begins on October 15 and runs until December 7 with a January 1 effective date.

6. **Do I need more than one Medicare Supplement policy?**

   It is illegal for anyone to sell a second Medicare Supplement policy to a person when they know the person already has an existing policy. The only exception to this is if the insured notifies the insurance company, in writing, that they plan to cancel their existing Medicare Supplement policy.

7. **I purchased a Medicare Supplement policy and do not wish to keep it. Can I return it to the company and get a refund?**

   A 30-day free-look period is provided on all Medicare Supplement plans. The free-look provision starts from the day the policy is delivered. A Medicare Supplement policy issued or delivered in Florida must contain a provision which allows the insured to return the policy or certificate within 30 days and receive a full refund. We recommend returning the policy to the company in a manner in which delivery can be verified.

8. **What does guaranteed issue mean relating to a Medicare Supplement policy?**

   If one of the following circumstances apply, an individual is guaranteed coverage under plans A, B, C, F, High-Deductible F, K, and L (if newly eligible under MACRA[1], Plans A, B, D, G, High-Deductible G, K, or L):

   a.) Your Medicare Advantage Plan coverage ends because the plan is leaving the Medicare program or stops giving care in your area. You must apply for other coverage between the date you receive notice your coverage will be ending, and no later than 63 calendar days after your coverage ends;

   b.) Your Medicare Supplement policy terminates because the insurance carrier becomes insolvent;

   c.) You move out of the service area of your Medicare Advantage Plan, Medicare SELECT policy, or PACE program;

   d.) You leave the health plan because it failed to meet its contract obligations to you (Example: the marketing materials were misleading, or quality standards were not met); and

   e.) You dropped your Medicare Supplement policy to join a Medicare managed care plan (HMO), Preferred Provider Organization (PPO), Private Fee-for-Service plan (PFFS), or PACE program and then leave the plan within one year after joining. You must go back to your former Medicare Supplement policy with the same company you had before you switched in order to get a guaranteed issue policy. If the former Medicare Supplement policy is not available, then you can get Plans A, B, C, F, High-Deductible F, K, or L (if newly eligible under MACRA[1], Plans A, B, D, G, High-Deductible G, K, or L) from any company on a guaranteed issue basis. The individual must apply no later than 63 calendar days from the date the coverage ends.

Please note: If you joined a Medicare Advantage Plan (like a Medicare HMO, PPO, or

PFFS plan) or PACE program when you first became eligible for Medicare Part A at age 65 and you leave the plan within one year of joining, you are eligible for any Medicare Supplement policy from any company on a guaranteed issue basis.

9. **Can my Medicare Supplement policy be cancelled by the insurance company?**
   All Medicare Supplement Policies sold in the State of Florida must be "Guaranteed Renewable." Florida law prohibits companies from canceling these policies except for nonpayment of premium or for material misrepresentation, such as incomplete or incorrect information on the original application.

10. **I have been notified by my Medicare Advantage Plan that they are withdrawing from my county. Do I have any other options?**
    If a Medicare Advantage Plan withdraws from a county and there are no other Medicare Advantage Plans accepting new enrollees in the county, or the insured does not want to enroll in another Medicare Advantage Plan, the insured is eligible to obtain a Medicare Supplement policy on a guaranteed issue basis.

    Eligibility is limited to Plans A, B, C, F, High-Deductible F, K, or L (if newly eligible under MACRA1, Plans A, B, D, G, High-Deductible G, K, or L) from any carrier offering the plans in the State of Florida. The term "Guaranteed Issue" means the company:

    1.) Cannot exclude benefits based on a pre-existing condition;
    2.) Cannot deny coverage or impose a waiting period on the policy;
    3.) Cannot discriminate in the price of the policy because of health status, claims experience, receipt of health care, or a medical condition; and
    4.) Individuals have 63 days from the cancellation date of prior policies to apply for a Medicare Supplement policy. You will need to supply the new insurer with a copy of the Medicare Advantage Plan withdrawal notice.

11. **What is a Medicare Advantage PPO plan?**
    Medicare began offering people new Preferred Provider Organization health plans (PPO) in Florida in 2003. Benefits vary depending upon what each individual PPO offers in each market, but some of the common features of the PPOs are:

1.) Networks of preferred providers (hospitals, physicians, and other providers);
2.) Access to providers outside the network;
3.) A balance of monthly premiums and some cost sharing amounts (deductible, co-insurance, or co-payment) paid by the plan enrollees; and
4.) Fees paid to out-of-network providers will be no more than they would get in fee-for-service Medicare;

12. Do I need Medicare Part B?

While employed, individuals may not need to purchase Medicare Part B if they are covered by their employer's group health insurance.

Before purchasing Part B, review what the group plan covers and how it coordinates with what Medicare pays. It is important that a prospective Medicare recipient contact the local Social Security office before their 65th birthday to discuss possible problems if they delay selection of Medicare Part B coverage. Contact the Social Security Administration at 1-800-772-1213 or TTY at 1-800-325-0778 to discuss potential penalties for not enrolling for Part B upon turning age 65. Visit their website at http://www.ssa.gov/.

13. What is a Medicare Select policy?

a.) Medicare Select offers the same plans as standardized plans offered through traditional Medicare Supplement insurance. Consumers who purchase Medicare Select policies are required to agree to use a specific network of health-care providers, facilities, or both for some benefits. This generally means they cannot receive care from a hospital or physician other than one in the network.

b.) In an emergency, coverage will apply to care from a provider outside of the network if it is not reasonable to obtain services through a network provider. In general, Medicare Select policies will deny payment for non-emergency services outside of the network.

c.) In return for using in-network providers, Medicare Select policyholders usually are charged lower premiums than policyholders of traditional Medicare Supplement insurance. Medicare always pays its portion of covered services regardless of whether the providers chosen were in or out-of-network.

14. I have a Medicare Supplement policy and am qualified for Medicaid. What will happen to my Medicare Supplement policy?

The benefits and premiums in a Medicare Supplement policy can be suspended for 24 months during the entitlement to benefits under Medicaid. The insured must request suspension within 90 days of becoming eligible for Medicaid. If the insured is no longer entitled to Medicaid, the policy will be reinstated if requested within 90 days of losing Medicaid eligibility.

a.) Whether or not to keep a Medicare Supplement while entitled to Medicaid is dependent upon several factors including:

1.) If Medicaid only pays the Medicare Supplement premium, individuals may wish to keep the policy;

2.) If Medicaid pays your Medicare premiums, deductibles, and coinsurance individuals may wish to discontinue the policy;

3.) If Medicaid pays all or part of your Medicare Part B premium, individuals may wish to keep the policy; and

4.) If Medicaid pays all of your medical expenses, then individuals should suspend the Medicare Supplemental Policy.

b.) Medicaid Assistance - Medicaid programs pay for some or all of Medicare's premiums, deductibles, and coinsurance for certain people who have a low income and are entitled to Medicare. If you would like to find out if you qualify for assistance, call the Department of Elder Affairs SHINE Program at 1-800-963-5337, or ask the local Department of Children and Families (DCF) office.

15. When I turn 65, what time frame do I have to enroll in a Medicare Supplement policy on a guaranteed issue basis?

Federal law requires companies provide an "open-enrollment period" to accept applications and not discriminate in the pricing of the policy, regardless of the enrollee's medical history, health status, or claims experience.

The open-enrollment period for Medicare Supplement insurance begins the first day of the month when a person turns 65 and is enrolled in Medicare Part B. If a birthday falls on the first day of the month, Medicare Part B coverage and Medicare Supplement insurance open enrollment begins the first day of the previous month.

Persons who are 65 years of age or older who reside in Florida should have an open enrollment period of 2 months following termination of coverage under a group health insurance policy.

Persons receiving Medicare before age 65 may take advantage of open enrollment when they turn 65. Open enrollment can be determined by checking the Medicare card for Part B coverage effective date and adding six months. If the current date is within that six-month period, the open-enrollment period is in effect.

Even if an individual exercised his/her open enrollment right when originally eligible for Medicare by reason of disability or ESRD, he/she is eligible for another open enrollment opportunity upon turning age 65. He/she must reapply with the same company or switch to a new company during the open enrollment period in order to get a guaranteed issue policy at the generally less expensive age 65 premium rate.

Medicare Supplement insurance companies may impose the same pre-existing condition restrictions that they apply to policies sold outside the open-enrollment period.

16. **If I replace my Medicare Supplement policy with one from another carrier, will there be a pre-existing condition on the new policy?**
    If one Medicare Supplement policy is replaced by another, the pre-existing condition exclusion of the second policy must allow credit for the time satisfied under the first policy. The maximum pre-existing time period is 6 months minus credit for prior creditable coverage.

17. **I applied for a Medicare Supplement policy and had no prior coverage. How long can the company exclude pre-existing conditions?**
    The insurer may not exclude benefits based on a pre-existing condition for more than 6 months. A pre-existing condition is defined as a condition for which medical advice was given or treatment recommended by or received from a physician within 6 months before the effective date of coverage.

    An insurance carrier cannot impose a pre-existing condition exclusion if an individual has a continuous period of creditable coverage, as defined in section 627.6562(3)(2), Florida

Statutes of at least 6 months as of the date of application for coverage.

18. **Can the insurance company increase the premiums on my Medicare Supplement policy?**

    Most companies will reserve the right to adjust premiums due to inflation, poor claims experience, or because of benefit adjustments in a policy as Medicare benefits change. For example, when the Medicare Part A deductible increases, a company usually raises its premiums to pay for the increased deductible it covers in its Medicare Supplement policy.

    A company can increase its premiums only if it does so for the entire premium class. It cannot single out and raise premiums based on health or the number of claims filed.

    The Florida Office of Insurance Regulation has to approve any rate increase before it goes into effect.

19. **Is there any type of service available that offers assistance shopping for or selecting a Medicare Supplement policy and company?**

    If you need assistance shopping for or selecting a Medicare Supplement policy, contact the Department of Financial Services (DFS) at 1-877-693-5236 within Florida or 850-413-3089 direct and the Department of Elder Affairs SHINE Program at 1-800-963-5337 for assistance.

    The Florida Office of Insurance Regulation offers a Medicare Supplement Sample Rate Search on its website at https://apps.fldfs.com/MCWS/CWSSearch (If link does not work, try using another internet browser). This site provides sample rates by company and plan. You may also access the 2025 CMS guide to choosing a Medigap policy at https://www.medicare.gov/publications/02110-medigap-guide-health-insurance.pdf for information on benefits.

    If you have questions about benefits or premiums, you may contact the Department of Financial Services Consumer Services at 1-877-693-5236 within Florida or direct at 850-413-3089.

20. If I change my Medicare Supplement plan to another insurance company and buy the same plan, will the benefits change?

The benefits for Medicare Supplement Plans A-N are standardized and cannot vary by company. This means that Plan B issued by one company has the same coverage and benefits as Plan B offered by another company. This applies to all 12 plans sold by insurance companies.

Please note: Group coverage through an employer, an individual policy, Medicare Advantage Plans, Medicare Part B, and Medicaid are not Medicare Supplement plans. For a complete description of each plan's benefits, please refer to the 2025 CMS guide to choosing a Medigap policy at https://www.medicare.gov/publications/02110-medigap-guide-health-insurance.pdf or contact the Department of Financial Services Consumer Services at 1-877-693-5236 within Florida or direct at 850-413-3089.

21. I dropped my Medicare Supplement policy and enrolled in a Medicare Advantage Plan. Can I go back to my Medicare Supplement policy I had prior to enrolling in the Medicare Advantage Plan?

If you dropped your Medicare Supplement policy to join a Medicare managed care plan (HMO), Preferred Provider Organization (PPO), Private Fee-for-Service (PFFS) plan, or PACE program and then leave the plan within one year after joining, you can go back to your former Medicare Supplement policy with the same company you had before you switched. If the former Medicare Supplement policy is not available, then you can get Plans A, B, C, F, High-Deductible F, K, or L (if newly eligible under MACRA[1], Plans A, B, D, G, High-Deductible G, K, or L) from any company on a guaranteed issue basis. You must apply no later than 63 calendar days from the date the coverage ends. If an insured dropped their Medicare Supplement policy and enrolled in a Medicare Advantage Plan, the insured may go back to their Medicare Supplement policy within the established guidelines. For current guidelines call Medicare at 1-800-633-4227. TTY users call 1-877-486-2048.

22. I am going on Medicare in 2026 and was considering purchasing Medigap Plan C or F but I heard they could no longer be sold. Is this true?

Starting in 2020, Medigap Plans C or F are no longer sold to beneficiaries who became “newly eligible” for Medicare on or after January 1, 2020. Newly eligible Medicare

beneficiaries are those who attain age 65 on or after January 1, 2020, or becomes entitled to Medicare part A by reason of disability or ESRD on or after January 1, 2020. Individuals who were enrolled in Medicare before 2020 can still purchase these plans and will be able to keep their plan as long as they pay their premiums.

Footnotes

1. "Newly Eligible" is defined as:
    a. An individual who has attained age 65 on or after January 1, 2020, or
    b. An individual who first became eligible for Medicare due to age, disability, or end-stage renal disease, on or after January 1, 2020

Benefits	Plans Available to All Applicants								Medicare first eligible before 2020 only+	
	A	B	D	G[1]	K	L	M	N	C	F[1]
Medicare Part A coinsurance and hospital coverage (up to an additional 365 days after Medicare benefits are used up)	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Medicare Part B coinsurance or Copayment	✓	✓	✓	✓	50%	75%	✓	✓ copays apply[3]	✓	✓
Blood (first 3 pints)	✓	✓	✓	✓	50%	75%	✓	✓	✓	✓
Part A hospice care coinsurance or copayment	✓	✓	✓	✓	50%	75%	✓	✓	✓	✓
Skilled nursing facility coinsurance			✓	✓	50%	75%	✓	✓	✓	✓
Medicare Part A deductible		✓	✓	✓	50%	75%	50%	✓	✓	✓
Medicare Part B deductible									✓	✓
Medicare Part B excess charges				✓						✓
Foreign travel emergency (up to plan limits)			✓	✓			✓	✓	✓	✓
Out-of-pocket limit in 2026[2]					$8,000[2]	$4,000[2]				

Note: A ✓means 100% of the benefit is paid. **+Only applicants first eligible for Medicare before January 1, 2020, may purchase Plans C, F, and high deductible F.** This chart shows the benefits included in each of the standard Medicare supplement plans. Some plans may not be available. Every company must make Plan A available.

1 - Plans F and G also have a high deductible option which require first paying a plan deductible of $2,950 (in 2026) before the plan begins to pay. Once the plan deductible is met, the plan pays 100% of covered services for the rest of the calendar year. High deductible Plans F and G do not cover the separate Foreign travel emergency deductible. High deductible Plan G does not cover the Medicare Part B deductible. However, high deductible Plans F and G count your payment of the Medicare Part B deductible toward meeting the plan deductible.

2 - Plans K and L pay 100% of covered services for the rest of the calendar year once you meet the out-of-pocket yearly limit.

3 - Plan N pays 100% of the Part B coinsurance, except for a co-payment of up to $20 for some office visits and up to a $50 co-payment for emergency room visits that do not result in an inpatient admission.