Medicare Supplement Insurance

2026 Shopper's Guide

SC DOI

This guide is intended as an educational resource for Medicare Supplement (Medigap) Insurance in South Carolina. Please be aware of the following important considerations:

- *Carrier Information: The insurance companies listed as marketing in South Carolina are subject to change. Carriers may exit or enter the market and plan availability can change at any time. We often rely on data from state and federal regulatory sources, which may have delays reporting.*
- *Information Sources: Some information, particularly regarding federal guidelines and benefits, is sourced from agencies like the Centers for Medicare & Medicaid Services (CMS). While we strive for accuracy, we cannot guarantee that such third-party information is current at the time of your reading & review.*
- *Printed vs. Digital Guides: We diligently update our information using state and federal sources, but changes can occur between our print cycles. For this reason, we encourage you to view our online guide at https://www.doi.sc.gov/639/Medicare-Supplement-Insurance for the latest details, or to call us for a current list of available plans and companies.*

We are committed to providing helpful and reliable information and make every effort to keep our materials updated. However, you should always confirm specific plan details, costs, and eligibility directly with the insurance carrier before making a purchase decision.

Please Note: Any issues regarding Medicare A-C, Medicare Advantage, Medicare Prescription, and Medicare Dental Plans, should be handled by the proper federal regulatory agency, the Centers for Medicare and Medicaid Services (CMS).

What is Medicare?

Medicare is a Health Insurance Program for individuals in the following categories:

People age 65 or older

People under age 65 with certain disabilities

People of all ages with End-Stage Renal Disease (permanent kidney failure requiring dialysis or a transplant)

Medicare is made up of two parts:

Part A (Hospital Insurance) **&** **Part B (Medical Insurance)**

You can select different ways to receive the services covered by Medicare. Generally, when you begin receiving Medicare, you are in Original Medicare. You may consider a Medicare Prescription Drug Plan that will provide for drug coverage. Or, you may want to consider a Medicare Advantage Plan (like an HMO or PPO) that provides all of your Part A, Part B, and often Part D coverage. You make this selection when you are first eligible for Medicare. You should review your health and prescription needs annually and select the plan that most suits your needs in the fall. As long as you have both Part A and Part B, items covered by Part A and Part B are covered whether you have Original Medicare or you belong to a Medicare Advantage Plan (like an HMO or PPO).

Part A (Hospital Insurance)

Helps Pay For: Care in hospitals as an inpatient, critical access hospitals (small facilities that give limited outpatient and inpatient services to people in rural areas), skilled nursing facilities (not custodial or long-term care), hospice and some home health care.

Cost: Most people get Part A automatically when they turn age 65. They don't have to pay a monthly payment (called a premium) for Part A because they or a spouse paid Medicare taxes while they were working.

If you don't automatically receive premium-free Part A, you may be able to purchase it:

- If you (or your spouse) aren't entitled to Social Security because you didn't work or didn't pay enough Medicare taxes while you worked and you are age 65 or older, or
- If you are disabled but no longer get premium-free Part A because you returned to work.

If you have limited income and resources, the State of South Carolina may be able to help you pay for Part A and/or Part B.

Part B (Medical Insurance)

Helps Pay For: Doctors services, outpatient hospital care, and some other medical services that Part A doesn't cover, such as the services of physical and occupational therapists, and some home health care. Part B helps pay for these covered services and supplies when they are medically necessary. Information about your coverage under Medicare Part B can be found in the Your Medicare Coverage database.

Enrolling in Part B is a decision that you will have to make. You can sign up for Part B anytime during a 7-month period that begins 3 months prior to your 65th birthday. Please call or visit the local U.S. Social Security Office to sign up. If you choose to have Part B, the premium is usually taken out of your monthly Social Security, Railroad Retirement Board, or Civil Service Retirement payment.

If you don't get any of the above payments, Medicare sends you a bill for your Part B premium called a "Notice of Medicare Premium Payment Due" (CMS-500). You should get your Medicare premium bill no later than the 10th of the month in which the bill is due.

Medicare Premiums for 2026:

Part A: (Hospital Insurance) Monthly Premium:

- **$0 for most people** (because they or a spouse paid Medicare taxes long enough while working—generally at least 10 years (40 work quarters)). If you get Medicare earlier than 65, you won't pay a Part A premium. This is sometimes called "premium-free Part A."
- **If you don't qualify for premium-free Part A, you might have to buy it.** You'll pay either:
  - **$565** each month if you paid Medicare taxes for less than 30 work quarters
  - **$311** each month if you paid Medicare taxes for 30–39 work quarters

Medicare Part A costs if you have Original Medicare for 2026:

Cost	You Pay
Part A Deductible	**$1,736** for each inpatient hospital benefit period, before Original Medicare starts to pay. There's no limit to the number of benefit periods you can have in a year. This means that you may pay the deductible more than once in a year.
Inpatient Stay	■ Days 1–60: **$0** after you meet your Part A deductible. ■ Days 61-90: A **$434** coinsurance amount each day. ■ After day 90: An **$868** coinsurance amount each day while using your 60 lifetime reserve days. **After you use all your lifetime reserve days, you pay all costs.** **NOTE:** You pay for private-duty nursing, a television or phone in your room (if there's a separate charge for these items), personal care items (razors or slipper socks), or a private room, unless medically necessary.
Mental Health Inpatient Stay	If you're an inpatient at a general or psychiatric hospital, you also pay 20% of the Medicare-approved amount for mental health services received from providers during your stay. **NOTE:** If you're getting services at a psychiatric hospital, remember that Part A only pays for up to 190 days of inpatient psychiatric care during your lifetime.
Skilled Nursing Stay **Facility**	• Days 1–20: $0 for each benefit period • Days 21–100: $217 copayment per day for • Days 101 and beyond: You pay all costs
Home Health Care	• $0 for home health care services • 20% of the Medicare-approved amount for durable medical equipment (DME), like wheelchairs, walkers, hospital beds, and other equipment
Hospice Care	■ $0 for covered hospice care services. ■ A copayment of up to $5 per prescription for outpatient drugs for pain and symptom management. ■ 5% of the Medicare-approved amount for inpatient respite care. ■ Medicare won't pay room and board for your care in a facility, unless the hospice medical team decides you need short-term inpatient care to manage pain and other symptoms. This care must be in a Medicare approved facility, like a hospice facility, hospital, or skilled nursing facility that contracts with the hospice

NOTE: Original Medicare will be billed for your hospice care, even if you're in a Medicare Advantage Plan. When you get hospice care, your Medicare Advantage Plan can still cover services that aren't part of your terminal illness or any conditions related to your terminal illness. For more on hospice care and to find Medicare-approved providers, contact your plan or visit Medicare.gov/care-compare.

Part B: (Medical Insurance) Monthly Premium:

$202.90 is the standard premium most people pay.

* If your modified adjusted gross income as reported on your Internal Revenue Service (IRS) tax return from 2 years ago is above a certain amount, you may pay an Income Related Monthly Adjustment Amount (IRMAA). IRMAA is an extra charge added to your premium.

Medicare Part B costs if you have Original Medicare for 2026

Cost	You Pay
Part B Annual Deductible	**$283 before Original Medicare starts to pay.** You pay this deductible once each year.
General Costs for Services (coinsurance)	Usually, 20% of the cost for each Medicare-covered service or item after you've paid your deductible (and as long as your doctor or health care provider accepts the Medicare-approved amount as full payment—called "accepting assignment") for these: ■ Most doctor services (including most doctor services while you're a hospital inpatient) ■ Outpatient therapy ■ Durable medical equipment (DME)
Clinical Laboratory Services	$0 for covered clinical laboratory services
Home Health Care	■ $0 for covered home health care services ■ 20% of the Medicare-approved amount for DME, like wheelchairs, walkers, hospital beds, and other equipment
Inpatient Hospital Care	20% of the Medicare-approved amount for most doctor services while you're a hospital inpatient
Outpatient Mental Health Care	■ $0 for your yearly depression screening if your doctor or health care provider accepts assignment. ■ 20% of the Medicare-approved amount for visits to your doctor or other health care provider to diagnose or treat your condition. ■ If you get your services in a hospital outpatient clinic or hospital outpatient department, you may have to pay an additional copayment or coinsurance amount to the hospital.
Partial Hospitalization Mental Health Care	After you meet the Part B deductible: ■ 20% of the Medicare-approved amount for each service you get from a doctor or certain other qualified mental health professional ■ Coinsurance for each day of partial hospitalization services you get in a hospital setting or community mental health center
Outpatient Hospital Care	■ Usually 20% of the Medicare-approved amount for the doctor and other health care provider's services. ■ You'll also pay a copayment to the hospital for each service you get in a hospital outpatient setting (except for certain preventive services). In most cases, your copayment won't be more than the Part A hospital stay deductible amount. ■ This additional hospital copayment means you may pay more for an outpatient service you get in a hospital than you'd pay if you got the same service in a doctor's office.

NOTE: All Medicare Advantage Plans must cover these services. If you're in a Medicare Advantage Plan, costs vary by plan and may be either higher or lower than those in Original Medicare. Review the "Evidence of Coverage" from your plan.

If your yearly income in 2024 (for what you pay in 2026) was:

File Individual Tax Return	File Joint Tax Return	File Married & Separate Tax Return	You Pay Each Month (in 2026)
$109.000 or less	$218,000 or less	$109,000 or less	$202.90
Above $109,000 up to $137,000	Above $218,000 up to $274,000	Not applicable	$284.10
Above $137,000 up to $171,000	Above $274,000 up to $342,000	Not applicable	$405.80
Above $171,000 up to $205,000	Above $342,000 up to $410,000	Not applicable	$527.50
Above $205,000 and less than $500,000	Above $410,000 and less than $750,000	Above $109,000 and less than $391,000	$649.20
$500,000 or above	$750,000 or above	$391,000 or above	$689.90

Part D (Medicare Drug Coverage) for 2026:

Part D base beneficiary premium - **$38.99** (used to determine any late enrollment penalty amount).

Deductibles, copayments, and coinsurance - The amount you pay for Part D deductibles, copayments, and/or coinsurance varies by plan. Look for specific Medicare drug coverage costs at Medicare.gov/plan-compare and then call the plans you're interested in to get more details.

*No Medicare drug plan may have a deductible more than $615 in 2026

*If you waited 14 months to join a Medicare drug plan, and you didn't have creditable drug coverage, you'll have to pay a 14% late enrollment penalty in addition to your monthly plan premium.

- The penalty amount comes from the "national base beneficiary premium" ($38.99 in 2026).
- The national base beneficiary premium changes each year, so your penalty amount may also change each year. This monthly penalty is added for as long as you have Medicare drug coverage, even if you switch plans.

(The chart below shows your estimated drug plan monthly premium based on your income as reported on your IRS tax return. If your income is above a certain limit, you'll pay an income-related monthly adjustment amount in addition to your plan premium.)

If your filing status and yearly income in 2024 (for what you pay in 2026) was:

Individual Tax Return	Joint Tax Return	Married & Separate Tax Return	You Pay Each Month (in 2026)
$109,000 or less	$218,000 or less	$109,000 or less	Your Plan Premium
Above $109,000 up to $137,000	Above $218,000 up to $274,000	Not applicable	$14.50 + Your Plan Premium
Above $137,000 up to $171,000	Above $274,000 up to $342,000	Not applicable	$37.50 + Your Plan Premium
Above $171,000 up to $205,000	Above $342,000 up to $410,000	Not applicable	$60.40 + Your Plan Premium
Above $205,000 and less than $500,000	Above $410,000 and less than $750,000	Above $109,000 and less than $391,000	$83.30 + Your Plan Premium
$500,000 or above	$750,000 or above	$391,000 or above	$91.00 + Your Plan Premium

Who is eligible for Medicare?

Generally, you are eligible for Medicare if you or your spouse worked for at least 10 years in Medicare-covered employment and you are 65 years or older and a citizen or permanent resident of the United States. If you are not, you might also qualify for coverage if you have a disability or have End-Stage Renal disease (permanent kidney failure requiring dialysis or transplant). You will be eligible for Medicare when you turn 65 even if you are not eligible for Social Security retirement benefits.

Am I eligible?

Most people can join Medicare when they turn 65. You can also join if you:

·Receive Social Security disability checks for 24 months, or

·Have permanent kidney failure, known as end-stage renal disease (ESRD), or

·Have Lou Gehrig's Disease, known as Amyotrophic Lateral Sclerosis (ALS)

You can get Part A at age 65 without having to pay premiums under the following conditions:

If you already receive retirement benefits from Social Security or the Railroad Retirement Board.
If you are eligible to get Social Security or Railroad Retirement Board benefits but haven't yet filed for them.
If you or your spouse had Medicare-covered government employment.

Before age 65, you can get Part A without having to pay premiums:

If you have received Social Security or Railroad Retirement Board disability benefits for 24 months.
If you have End-Stage Renal disease and meet certain requirements.

You can get your Medicare benefits through Original Medicare or a Medicare Advantage Plan (like an HMO or PPO). If you have Original Medicare, the government pays for Medicare benefits when you get them. Medicare Advantage Plans, sometimes called "Part C" or "MA Plans," are offered by private insurance companies approved by Medicare. Medicare pays these companies to cover your Medicare benefits. If you join a Medicare Advantage Plan, the plan will provide all your Medicare Part A (Hospital Insurance) and Medicare Part B (Medical Insurance) coverage.

General Enrollment

If you didn't sign up for Medicare Part B when you first became eligible, you may be able to sign up during the General Enrollment Period. This period runs from January 1 through March 31 each year. During this time, you can sign up for Medicare part B at your local Social Security office. If you receive benefits from the Railroad Retirement Board, call your local RRB office. Your Medicare Part B coverage will begin on July 1 of the year that you sign up.
The cost of Medicare Part B will go up 10% for each full 12-month period that you could have received Medicare Part B but selected not to do so, except for unusual circumstances. You will have to pay this penalty as long as you receive Medicare Part B.

Medigap or Medicare Supplement Insurance

Medicare supplement insurance (often called Medigap insurance) fills in the gaps between what Medicare pays and what you must pay out-of-pocket for deductibles, coinsurance and copayments. Medigap policies only pay for services that Medicare deems medically necessary, and payments are generally based on the Medicare- approved charge. Some plans offer benefits that Medicare doesn't, such as emergency care while in a foreign country.

You can only buy Medigap if you have Original Medicare. Generally, that means you must sign up for Medicare Part A (Hospital Insurance) and Part B (Medical Insurance) before you can buy a Medigap policy.

All Medigap policies are standardized. This means, policies with the same letter offer the same basic benefits no matter where you live or which insurance company you buy the policy from. All companies that sell Medigap insurance must offer Plan A, but do not have to offer the other standardized plans. If you bought a Medigap policy before standardized plans were first introduced in 1992, you may keep your existing policy. You do not have to switch to one of the standardized plans.

Medigap policies are sold by private insurance companies that are licensed and regulated by the South Carolina Department of Insurance but the benefits, however, are set by the federal government. Medigap policies are automatically renewed each year.

Open Enrollment for Medicare Supplement Insurance

Beginning on the first day of the month, when you are 65 years or older and enrolled in Medicare Part B, you will have a ***six-month*** open enrollment period for purchasing Medicare supplement insurance. During this time, you may not be turned down for Medicare supplement insurance because of your health. The insurer may, however, exclude pre-existing health conditions for up to six months. Because of the limited open enrollment period, it is very important that you understand it and take advantage of it when available.

If you apply for Medigap coverage **after** your open enrollment period**,** there is no guarantee that an insurance company will sell you a Medigap policy if you don't meet the medical underwriting requirements or it may cost more.

Your Medigap Open Enrollment Period is a one-time enrollment. It doesn't repeat every year, like the Medicare Open Enrollment Period.

Medigap Rights and Protections *(Guaranteed Issue Rights), See Appendix, Rights and Protections*

In some situations, you may have the right to purchase a Medigap policy outside of your Medigap open enrollment period. These rights are called "Medigap protections." They are also called guaranteed issue rights because federal law requires insurance companies to make Medigap policies available to you.

In these instances, an insurance company must comply with the following requirements:

-Cannot deny you Medigap coverage or place conditions on a policy

-Must cover you for all pre-existing conditions, and

-Cannot charge you more for a policy because of past or present health problems.

In many cases, these rights also apply when your health care coverage changes in some way, such as when you lose or drop your other health care coverage. Remember, it is best not to wait until your current health coverage has almost ended before you apply for a Medigap policy. You can apply for a Medigap policy early (for example, while you are still in your health care plan) and choose to start your Medigap coverage the day after your health care coverage ends. This will prevent gaps in your health coverage.

In many of these instances, you have the right to purchase Medigap plans A, B, C*, D*, F*, G*, K or L from any insurance company that sells Medigap policies in South Carolina **(If you are under age 65, you may only purchase a policy from a company that sells Medigap policies to persons under 65 and on Medicare).** You can purchase the policy at the best premium price available, with no review of your medical records even if you have health problems.

Medicare Select

Medicare Select is a type of Medigap policy. A Medicare Select policy is basically the same as a standard Medigap policy in nearly all respects because you are purchasing one of the eight standard Medicare supplement plans (A through N). The only difference is that each insurer under Medicare Select generally requires you to use doctors and providers in the plan's network for your routine care. If you use out-of-network providers, you'll have to pay more of the costs though benefits are not usually payable if you do not use preferred providers for non-emergency situations. Medicare, however, will pay its share of approved charges regardless of the provider you select.

Premiums are generally lower under these policies due to the preferred provider arrangements. At any time, you may opt to return to a standard Medicare Supplement (Medigap) policy. If you currently have a Medicare Select plan, you also have the right to switch, at any time, to any regular Medigap policy being sold by the same company. The Medigap policy you select must have equal or less coverage than the Medicare Select policy you currently have.

Medicare with Medigap vs. Medicare Advantage Comparison

Question	Traditional Medicare A & B + Medigap Policy	Medicare Advantage Plan
What health care benefits are covered?	All Medicare A and B benefits, Medigap policy benefits depend on the plan purchased. Refer to each policy for details	All the Medicare A and B benefits and perhaps others, depending on the plan. Some plans may offer other coverage. Refer to the plan for details.
Are outpatient prescription drugs covered?	No	It depends on the plan. See each plan for any drug coverage.
Can I go to any doctor or hospital?	You can go to any doctor, specialist or hospital that accepts Medicare.	You may go to any doctor, specialist or hospital that has a contract with the plan.
Does the policy/plan let doctors or hospitals charge more than Medicare's deductibles, coinsurance, and copayments?	Not for hospitals, but possibly for doctors. Doctors who do not accept Medicare assignments may charge up to 15% more than Medicare's approved amount. (Part B excess charges are covered under plans F* and G.)	Medicare Advantage sets the rates for deductibles, coinsurance, and copayments for the plan. Refer to the plan for details
How are claims paid?	The provider sends the claim to Medicare. Medicare approves the amount of the claim and pays its portion. Medicare or the provider forwards the claim to the Medigap policy which, according to the policy requirements, may or may not pay the remaining balance.	Prior to receiving care, the plan member pays a copayment/ deductible amount. The provider sends the claim to the Medicare Advantage plan. The plan approves the claim amount and pays its share. The member pays any remaining share – such as a deductible, coinsurance or copayment – if the plan allows balance billing. Refer to plan details.

Guaranteed Medigap Coverage- under age of 65

South Carolina currently only has guaranteed issue Medigap policies for individuals under the age of 65 and on Medicare due to disability through the South Carolina Health Insurance Pool (SCHIP).

The plans and costs for all ages, effective January 1, 2026, are as follows:

Plan A- $1,191.09/monthly

Plan C*- $1,510.33/monthly *Only applicants first eligible for Medicare before 2020 may purchase Medicare Supplement Plan C.

Plan D- $1,406.01/monthly

For additional questions you may contact the SCHIP Administrator.
Ph: 803-788-0500, ext. 46401 (Columbia)
Ph: 800-868-2500, ext. 46401 (Outside Columbia)

You will reach a BlueCross BlueShield representative but please know that SCHIP is not a BlueCross BlueShield of SC policy. SCHIP is a state program administered by BlueCross BlueShield of SC.

Please note: You will get a Medigap open enrollment period when you reach age 65 and you will be able to buy any Medigap policy sold in the state.

Medicare Supplement Plan Shopping Tips

- ✓ Shop for benefits and price
  - □ Check the benefits in each of the 8 plans. Every company must use the same letters (A through N) to label its policies.
  - □ **Plan A is always the company's lowest-priced Medigap policy. It contains basic benefits and must be sold by every company.**
  - □ Plans B through N add other benefits to fill different gaps in your Medicare coverage. Options K and L provide a product for those who can afford a higher deductible and are healthy. Few companies sell all policies.
- ✓ Research the insurance company
  - □ Find contact information, consumer complaint data, and more using the SCDOI's online company database at www.doi.sc.gov/CoSearch.
  - □ Review financial information and complaint data from all state DOIs through the National Association of Insurance Commissioners' Consumer Information Source at www.naic.org/cis.

Find Health & Drug Plans

Visit the U.S. Government website for those with Medicare, https://www.medicare.gov/ to find and compare Medicare health plans. Additional Medicare information can be obtained by calling 1-800-Medicare (1-800-633-4227), (TTY 1-877-486-2048).

Dos and don'ts of buying Medicare Supplement Plans

Call Medicare

If you have questions about who pays first or if your insurance changes, call: **800-MEDICARE (800-633-4227)**

Ask for a Medicare coordination of benefits contractor.

What to do:

Ask questions of friends and family.
Know what you are buying. Ask for an outline of the coverage.
Choose the benefits you want and need.
Benefits are standardized in Medicare supplement policies.
Compare benefits for different policies before buying. Consider family and medical history.
Check company's consumer complaint history.
Keep proof of prior coverage.
Keep agent's name and contact information for later reference.

What not to do:

Don't feel pressured to buy immediately. There is a six-month open enrollment period.
Don't drop a current insurance policy until you have your new coverage.
Don't buy more than one Medicare Supplement policy.
Never pay cash. Always use a check made out to the insurance company and not the agent.
Don't buy a Medicare Supplement policy if you have a Medicare Advantage Plan. They will not work together.

Basic Benefits

These benefits pay for the patient's share of Medicare's approved amount for physician services (generally 20%) after the annual deductible, the patient's cost for a long hospital stay, and charges for the first three pints of blood not covered by Medicare.

Issue Age or Attained Age Premium

There are two types of premium schedules which insurers generally use. Under an issue age schedule, the insurer charges a premium based on your age when your policy was first issued. Although, your premium will likely increase due to inflation and changes in benefits provided by Medicare (and therefore changes in benefits of the Medicare supplement), the insurer cannot increase your premium simply because you have gotten older.

Under an attained age schedule, the insurer charges a premium based on your age on each premium renewal date. With this type of schedule, your premium is not only likely to increase due to inflation and changes in benefits provided by Medicare but also because you have gotten older.

Medigap Plan Comparison

The chart below shows basic information about the different benefits Medigap policies cover.

✓ = the plan covers 100% of this benefit	% = the plan covers that percentage of this benefit
No = the policy doesn't cover the benefit	N/A = not applicable

Medigap Benefits	A	B	C*	D	F*	G	K	L	M	N***
Part A coinsurance and hospital costs up to an additional 365 days after Medicare bene- fits are used up	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Part B coinsurance or copayment	✓	✓	✓	✓	✓	✓	50%	75%	✓	✓
Blood (first 3 pints)	✓	✓	✓	✓	✓	✓	50%	75%	✓	✓
Part A hospice care coinsurance or copayment	✓	✓	✓	✓	✓	✓	50%	75%	✓	✓
Skilled nursing facility care coinsurance	No	No	✓	✓	✓	✓	50%	75%	✓	✓
Part A deductible	No	✓	✓	✓	✓	✓	50%	75%	50%	✓
Part B deductible	No	No	✓	No	✓	No	No	No	No	No
Part B excess charges	No	No	No	No	✓	✓	No	No	No	No
Foreign travel exchange (up to plan limits)	No	No	80%	80%	80%	80%	No	No	80%	80%
Out-of-pocket limit in 2024**	N/A	N/A	N/A	N/A	N/A	N/A	$7,060	$3.530	N/A	N/A

***NOTE:* Plans C & F** have been discontinued effective January 1, 2020. However, if you were eligible for Medicare before January 1, 2020 but not yet enrolled, you may be able to buy Plan C or Plan F. People eligible for Medicare after January 1, 2020 have the right to buy Plans D and G instead of Plans C and F.

F, G & J Deductible: The high deductible version of Plan F is only available to those who are not new to Medicare before 1/1/2020. High deductible G is available to individuals who are new to Medicare on or after 1/1/2020. People new to Medicare are those who turn 65 on or after January 1, 2020, and those who first become eligible for Medicare benefits due to age, disability or ESRD on or after January 1, 2020.

Plans F and G also offer a high-deductible plan in some states. With this option, you must pay for Medicare-covered costs (coinsurance, copayments, and deductibles) up to the deductible amount of $2,800 in 2024 before your policy pays anything.

Plan G also offers a high deductible plan in some states.

Plan K & Plan L show how much they'll pay for approved services before you meet your out-of-pocket yearly limit and Part B deductible. After you meet these amounts, the plan will pay 100% of your costs for approved services.

Plan N pays 100% of the costs of Part B services, except for copays for some office visits and some emergency room visits.

Make sure you compare plans before enrolling. Factors such as where you live, your gender, whether you smoke or if the policy is for an individual or a group may affect your rates.

An individual Medigap policy is a contract between you and the insurer. It provides the maximum number of consumer protections. These policies are either "guaranteed renewable" or "non-cancelable."

Group Insurance: Group Medigap insurance is a contract between the insurer and a group master policyholder such as AARP or an employer. You receive a certificate rather than a policy. The group negotiates the terms of the insurance and has the option to terminate the policy or change insurance carriers. Some insurance policies will require you to join a group or association.

High-Deductible Option

Insurance companies may offer a high deductible on Plan F. If you choose this option, you must pay an annual deductible before the plan pays anything. If you still have a Plan J (no longer available), the deductible matches the annual deductible for Plan F. For 2024, the deductible for Plans F or J is $2,8000. The monthly premium for Medigap Plan F with a high-deductible option will generally be less than the monthly premium for Plan F without a high-deductible option. However, your out-of-pocket costs for services may be higher if you need to see your doctor or go to the hospital. In addition to the annual deductible that you must pay for the high-deductible option on Plan F, you must pay a deductible for foreign travel emergency ($250 per year for high-deductible Plan F).

F, G & J Deductible: The high-deductible version of Plan F is only available to those who are not new to Medicare before 1/1/2020. High-deductible G is available to individuals who are new to Medicare on or after 1/1/2020. People new to Medicare are those who turn 65 on or after January 1, 2020, and those who first become eligible for Medicare benefits due to age, disability or ESRD on or after January 1, 2020.

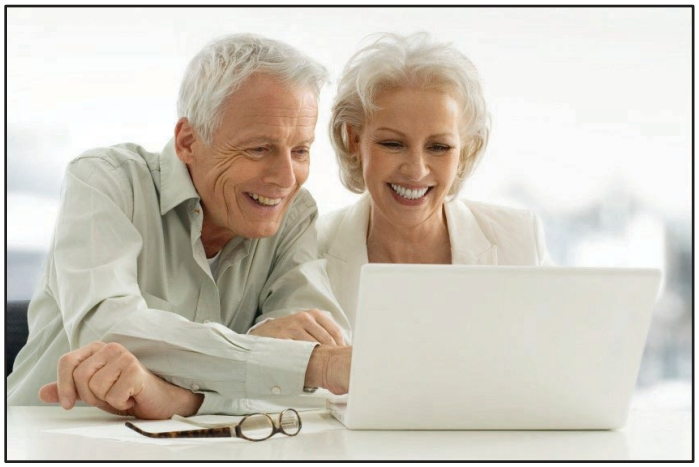
Can I have Medigap and a Medicare Advantage Plan?

If you're in a Medicare Advantage Plan, it's ***illegal*** for anyone to sell you a Medigap policy unless you're switching back to Original Medicare. If you aren't planning to drop your Medicare Advantage Plan, and someone tries to sell you a Medigap policy, report it to your State Insurance Department.

If you have Medigap and join a Medicare Advantage Plan, you may want to drop Medigap. You can't use Medigap to pay your Medicare Advantage Plan copayments, deductibles, and premiums. Important! If you want to cancel your Medigap policy, contact your insurance company. Most Medigap policies don't automatically cancel when joining a Medicare Advantage Plan. If you drop your Medigap policy to join a Medicare Advantage Plan, you may not be able to get the same policy back, or in some cases, any Medigap policy unless you leave your Medicare Advantage Plan during your trial right period.

If you drop a Medigap policy to join a Medicare Advantage Plan for the first time, you'll have a single 12-month period (your trial right period) to get your Medigap policy back if the same insurance company still sells it once you return to Original Medicare. If it isn't available, you can buy certain Medigap policies, depending on state law and whether you're new to Medicare on or after January 1, 2020. You may also have an opportunity to join a Medicare drug plan at this time.

If you joined a Medicare Advantage Plan when you were first eligible for Medicare Part A at 65, you can buy certain Medigap policies sold by an insurance company in your state, if you switch to Original Medicare within the first year of joining the Medicare Advantage Plan. The types of Medigap policies you can buy depend on whether you were new to Medicare on or after January 1, 2020. You may also have an opportunity to join a Medicare drug plan at this time.



Who pays first?

If you have Medicare and other health insurance coverage, each type of coverage is called a "payer." When there is more than one payer, there are "coordination of benefits" rules that decide which one pays first. The primary payer pays what it owes on your bills and then sends them to the second payer. There may be a third payer as well.

Whether Medicare pays first depends on several factors, including those listed in the chart on page 18. This chart does not cover every situation. Make sure to tell your doctor and other health care providers if you have coverage besides Medicare. This will help them send your bills to the correct payer and avoid delays.

Important! If you're still working and have employer coverage through work, contact your employer to find out how your employer's coverage works with Medicare.

Remember:

- The insurance that pays first (primary payer) pays up to the limits of its coverage.
- The insurance that pays second (secondary payer) only pays if there are costs the primary payer didn't cover.
- The secondary payer (which may be Medicare) might not pay all of the uncovered costs.
- If your group health plan or retiree health coverage is the secondary payer, you'll likely need to sign up for Part B before your insurance will pay.

Medicare and Other Insurance: Who Pays First?

If you…	And you are…	Who pays first?	Who pays second?
Are 65 or older, working and covered by a group health plan; or are covered by a group health plan of a working spouse of any age	Enrolled in Medicare and your employer has 20 or more employees Enrolled in Medicare and your employer has fewer than 20 employees, or is part of a multi-employer plan where one employer has 20 or more employees	Group Health Plan Medicare	Medicare Group Health Plan
Have an employer group health plan after you retire and are 65 or older	Enrolled in Medicare	Medicare	Retirement Coverage
Are disabled and covered by a large group health plan from work or by a family member who is working	Enrolled in Medicare and your employer has 100 or more employees Enrolled in Medicare and your employer has fewer than 100 employees and isn't part of a multi-employer plan where any employer has 100 or more employees	Large Group Health Plan Medicare	Medicare Group Health Plan
Are 65 or older or disabled and covered by Medicare and COBRA	Enrolled in Medicare	Medicare	COBRA
Have end-stage renal disease (permanent kidney failure) and plan group health plan coverage – including retirement plan	In your first 30 months of Medicare eligibility or enrollment Past your first 30 months of Medicare eligibility or enrollment	Group health plan Medicare	Medicare Group health plan
Have end-stage renal disease (permanent kidney failure) and COBRA coverage	In your first 30 months of Medicare eligibility or enrollment Past your first 30 months of Medicare eligibility or enrollment	COBRA Medicare	Medicare COBRA
Have been in an accident where no-fault or liability insurance is involved	Enrolled in Medicare	No fault or liability insurance, for services related to accident claims	Medicare
Are covered under workers' compensation because of job-related illness or injury	Enrolled in Medicare	Workers' compensation for claim-related services Medicare, for non-VA - authorized services	Medicare may pay second at any non-VA facility
Are enrolled in TRICARE	Enrolled in Medicare	Medicare, for Medicare-covered services TRICARE, for services from military hospital or other federal provider	TRICARE
Are enrolled in Federal Black Lung Program	Enrolled in Medicare	Federal Black Lung Program, for services related to black lung	Medicare

Appendix

Rights and Protections for Everyone with Medicare

An insurance company cannot refuse to sell you a Medigap policy under the following situations:
Guaranteed Issue Concerns

You are in a Medicare Advantage Plan, and your plan is leaving Medicare or stops giving care in your area, or you move out of the plan's service area.

- You can purchase Medigap Plan A, B, D, G, K or L that is sold by any insurer writing this coverage in SC.
- This option is only available if you switch to Original Medicare rather than joining another Medicare Advantage Plan.
- The earliest you may apply for a Medigap policy is 60 days before the date your health care coverage ends but no later than 63 calendar days after your health care coverage ends. Medigap coverage cannot begin until the Medicare Advantage Plan coverage ends.

You have Original Medicare and an employer group health plan (including retiree or COBRA coverage) or union coverage that pays after Medicare pays and that plan is ending.

- In this situation, you may have additional rights under state law.
  Medigap Plan A, B, D, G, K, or L that is sold by any insurer writing this coverage in SC.
- If you have COBRA coverage, you can either buy a Medigap policy right away or wait until COBRA coverage ends.
- You may apply for a Medigap policy no later than 63 calendar days after the latest of these 3 dates:
  Date the coverage ends, date on the notice you get telling you that coverage is ending (if you get one), date on a claim denial, if this is the only way you know that your coverage ended.

If you have Original Medicare and Medicare Select policy, you will move out of the Medicare Select policy's service area and the following applies:

- You may keep your Medigap policy, or you may want to select another Medigap policy.
- You can purchase Medigap Plan A, B, D, G, K or L that is sold by any insurer writing this coverage in SC.
- You may apply for a Medigap policy as early as 60 calendar days prior to the date your health care coverage will end, but no later than 63 calendar days after your health care coverage ends.

***(Trial Right)* You joined a Medicare Advantage Plan or Programs of All-inclusive Care for the Elderly (PACE) when you were first eligible for Medicare Part A at age 65, and within the first year of joining, you have decided that you want to change and select Original Medicare.**

- Any Medigap policy that is sold by any insurer writing this coverage in SC.
- You may apply for a Medigap policy as early as 60 calendar days before the date your coverage will end but no later than 63 calendar days after your coverage ends.

Note: Your rights and protections may extend for an additional 12 months under certain circumstances.

(Trial Right) **You dropped a Medigap policy to join a Medicare Advantage Plan or switch to a Medicare Select policy for the first time; you have been in the plan less than a year and you want to switch back.**

- The Medigap policy you had before you joined the Medicare Advantage Plan or Medicare Select policy, if the same insurance company you had still offers it.
- If your former Medigap policy isn't available, you can purchase a Medigap Plan A, B, D, G, K, or L thatis sold by an insurer writing this coverage in SC.
- You may purchase a Medigap policy as early as 60 calendar days before the date of your coverage will end, but no later than 63 calendar days after your coverage ends.

Note: Your rights and protections may extend for an additional 12 months under certain circumstances.

Your Medigap insurance company goes bankrupt and you lose your coverage or your Medigap policy coverage otherwise ends through no fault of your own.

- You can purchase Medigap Plan A, B, D, G, K or L that is sold by any insurer writing this coverage inSC.
- You may purchase a Medigap policy no later than 63 calendar days from the date your coverage ends.

You leave a Medicare Advantage Plan or drop a Medigap policy because the company has not followed the rules, or it misled you.

- You may purchase Medigap Plan A, B, D, G, K, or L that is sold by an insurer writing this coverage in SC.
- You may purchase a Medigap policy no later than 63 calendar days from the date your coverageends.

Need more information?

Please review the following guide:

2026 Medicare and You
https://www.medicare.gov/publications/10050-medicare-and-you.pdf

Insurance Terms

Appeal: A complaint you file with your insurance company or Medicare if you disagree with a decision about coverage. You can appeal if you are denied coverage for a treatment, supply or drug prescription, or if the coverage is less than you think it should be. You can also appeal if you are already receiving coverage and the plan stops paying.

Coinsurance: The amount you pay for services after you pay deductibles. In Original Medicare, this is a percentage Perhaps 20%) of the Medicare-approved amount. You have to pay this amount after you pat the Part A and/or Part B deductible. In a prescription drug plan (Part D), the coinsurance will vary.

Copayment: In some Medicare plans, this is the amount you pay for each medical service such as a doctor's visit or prescription. A copayment is usually a set amount, for example $10 or $20. Copayments are also used for some hospital outpatient services.

Creditable prescription drug coverage: Prescription drug coverage (for example, from an employer or union) that is expected to pay, on average, at least as much as Medicare's standard prescription drug coverage. People who have this kind of coverage when they become eligible for Medicare can generally keep that coverage without paying a penalty, if they decide to enroll in Medicare prescription drug coverage later.

Deductible: The amount you pay for healthcare or prescriptions before insurance benefits kick in. So, if you have a $1,000 deductible, you have to pay that much out of your pocket during the year before insurance begins paying. These amounts can change every year.

Formulary: A list of drugs covered by a plan.

Guaranteed issue rights: Rights you have in certain situations when insurance companies are required by law to sell or offer you a Medigap policy. In these situations, an insurance company, cannot deny you a Medigap policy and you cannot be charged more because of a past or present health problem. Coverage of pre-existing conditions starts immediately if you have had at least six months of prior coverage. The pre-existing condition period is offset month for month if you have had less than six months of coverage.

Health Maintenance Organization (HMO) Plan: A type of Medicare Advantage plan. Extra benefits like dental or vision coverage may be offered. In most HMOs, you can only go to network doctors, specialists or hospitals on the plan's list except in an emergency.

Long-Term Care: Assistance with everyday functions, like bathing and dressing, usually provided in a nursing home or at home through a home-health service. Generally, Medicaid pays for long-term are, but Medicare does not.

Medicaid: A joint federal and state program that helps with medical costs for some people with limited income and resources.

Medicare Advantage Plan (Part C): A type of Medicare plan offered by a private company that contracts with Medicare to provide you with all your Medicare Part A and Part B benefits. Also called Part C, Medicare Advantage plans are HMOs, PPOs, private fee-for-service plans, or Medicare medical savings account plans. Some Medicare Advantage plans offer prescription drug coverage.

Medicare-approved amount: In Original Medicare, this is the amount a doctor or supplier that accepts the assignment is paid. It includes what Medicare pays and any deductible, coinsurance or copayment that you pay. It may be less than the actual amount a doctor or supplier charges.

Medicare prescription drug plan (Part D): A stand-alone drug plan offered by insurers and other private companies to those who get benefits through Original Medicare. Medicare Advantage plans may also offer prescription drug coverage and must follow the same rules as Medicare prescription drug plans.

Medigap: Medicare Supplemental insurance sold by private insurance companies to pay deductibles, copayments and coinsurance in Original Medicare coverage. Medigap policies only work with Original Medicare.

Original Medicare: Original Medicare has two parts: Part A (hospital insurance) and Part B (medical insurance. It is a fee-for-service health plan. Medicare pays its share of the Medicare –approved amount, and you pay your share (coinsurance copayments and deductibles).

Network: A group of physicians, hospitals and other health care professionals who provide health care services for Medicare Advantage plans select plans.

Penalty: An amount added to your monthly premium for Medicare Part B, or for a Medicare drug plan (Part D), if you don't join when you're first eligible. You pay this higher amount as long as you have Medicare. There are some exceptions.

Point-of-service plan: A health maintenance organization (HMO) option that lets you use doctors and hospitals outside the plan for an additional cost.

Preferred provider organization (PPO) plan: A type of Medicare health plan available in a local or regional area in which you pay less if you use doctors, hospitals, and providers outside of the network for an additional cost. Extra benefits like dental or vision coverage may be offered. Many Medicare Advantage plans are PPOs.

Premium: Your periodic payment to Medicare, an insurance company, or a healthcare plan for health care or prescription drug coverage. Example: $179 per month.

Preventive services: Care intended to keep you healthy (for example, Pap tests, pelvic exams, flu shots and cancer screenings).

Primary care doctor: Also known as a gatekeeper, the primary care physician is responsible for coordinating your care in a managed care plan. He or she makes sue you get the care you need to keep you healthy. In many Medicare Advantage plans, you must see your primary care doctor before you see a specialist or other health care provider.

Private fee-for-service (PFFS) plan: A type of Medicare Advantage plan in which you may go to any Medicare - approved doctor or hospital that accepts the plan's payment. The insurance plan, rather than Medicare, decides how much it will pay and what you pay for the services you get. Extra benefits like dental or vision coverage may be offered. You may pay more or less for Medicare-covered benefits.

Skilled nursing facility care: This is a level of care that requires the daily involvement of skilled nursing or rehabilitation staff.

Examples include intravenous injections and physical therapy. The need for only custodial care (help with daily living activities such as bathing and dressing) cannot qualify you for Medicare coverage in a skilled nursing facility.

Underwriter: Insurance company employee who figures out how risky it is to insure clients. Underwriters decide what coverage an applicant qualifies for and what rates you should pay, or whether to accept or deny your application.

Additional Resources and Information

U.S. Social Security Administration 1-800-772-1213 TTY: 1-800-325-0778 www.ssa.gov	South Carolina Department on Aging 1301 Gervais Street, Suite 350 Columbia, SC 29201 803-734-9900 or 1-800-868-9095 www.aging.sc.gov
U.S. Railroad Retirement Board 1-877-772-5772 TTY: 1-312-751-4701 www.rrb.gov	SC Department of Consumer Affairs 2221 Devine Street, Suite 200 Columbia, SC 29205 803-734-4200 or 1-800-922-1594 www.consumer.sc.gov
Medicare.gov (U.S. Centers for Medicare & Medicaid Services) 1-800-MEDICARE (800-633-4227) www.medicare.gov www.cms.gov	
For a list of common Medicare Supplement Carrier available in South Carolina please visit www.doi.sc.gov	

The SCDOI is here to help you!

If you have **questions** about insurance, contact the SCDOI's

Office of Consumer Services.

8:30 a.m. - 5:00 p.m. (Mon. - Fri.)

1-800-768-3467

consumers@doi.sc.gov

If you're **having a specific problem** with your insurance company or agent, file a complaint at **doi.sc.gov/complaint**

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