



Important Information about Your Rights to Guaranteed Issue of Medicare Supplemental Policies

All Highmark Blue Cross Blue Shield Delaware (Highmark Delaware) Medicare Supplement Programs – Plans A, B, C, D, F, F High Deductible, G, and N – described in the enclosed brochure are available to individuals who enroll during their “Open Enrollment Period.”

The “Open Enrollment Period” is the six-month time period after you are first eligible for and you enroll in Medicare Part B Medical Insurance. You may enroll for Highmark Delaware Medicare Supplement Plans A, B, C, D, F, F High Deductible, G, and N or another company’s insurance to supplement your Medicare coverage (also called Medigap coverage) during this six-month period and be **guaranteed coverage**. Guaranteed coverage means you cannot be refused coverage.

If you are *not* within this “Open Enrollment Period,” you still may be able to obtain certain Medicare Supplement Programs without a pre-existing condition limitation if you:

- a) Have Medicare Part A Hospital Insurance and Medicare Part B Medical Insurance;
- b) Apply for this Medicare Supplement coverage no later than 63 days after either the date on which you were notified that your current or previous coverage would be ending, or the date on which your current or previous coverage actually ends; **and**
- c) You fall within one of the six categories described below.

Under the Balanced Budget Act of 1997, the federal government created the Medicare Advantage Program to increase the health care options for Medicare-eligible individuals beyond basic Medicare and Medicare health maintenance organizations (HMOs). These new options include, but are not limited to, Medicare Preferred Provider Organizations (PPOs), Medicare Point-of-Service (POS) Plans and the Medicare Demonstration Project. This law requires insurance companies (including Highmark Blue Cross Blue Shield Delaware) to offer you certain Medicare supplemental plans on a guaranteed issue basis; that is, they cannot refuse to cover you, when you are ending your enrollment in another plan under specific circumstances, as follows:

1. Your current or previous health care coverage was provided by an employer group, trust fund, or welfare fund and (a) was a benefits plan that supplements Medicare that was terminated by the employer or fund, **or** the benefits plan stopped providing all supplemental Medicare benefits, **or** (b) was primary to Medicare and your coverage was terminated by either you or the employer or fund.
2. You are currently or were previously enrolled in a Medicare Advantage or Medicare SELECT plan, or you are 65 years of age or older and were enrolled in a Program of All-Inclusive Care for the Elderly (PACE), and the plan was terminated or otherwise discontinued by the organization that offered it, or the organization has notified you that it will be terminating in the future, or you moved out of the plan’s service area.

3. You were covered under a Medicare Advantage, Medicare SELECT, or other Medigap insurance plan, or you are 65 years of age or older and were enrolled in a Program of All-Inclusive Care for the Elderly (PACE), and you left the plan because that plan is bankrupt, breached your policy, or your policy was misrepresented to you when you bought it.
4. You canceled your Highmark Delaware Medicare Supplement plan to join, for the first time, a Medicare Advantage plan, a Medicare SELECT plan, or a Program of All-Inclusive Care for the Elderly (PACE). However, now you want to end that coverage and return to a Medicare Supplement plan. You must reapply to Highmark Delaware within 12 months of the date you ended your original Medicare Supplement coverage, and you may apply for the Medicare Supplement plan in which you were originally enrolled or a lower-cost Medicare Supplement plan.
5. You canceled the Medicare Supplement plan you had from another insurance company to join a Medicare Advantage plan, a Medicare SELECT plan, or a Program of All-Inclusive Care for the Elderly (PACE). However, within 12 months of joining this plan, you decide to end this coverage and return to the Medicare supplement plan you had before. You can apply for certain Medicare Supplement plans *only* if the previous Medicare supplement plan you had from another insurance company is no longer available.
6. You joined a Medicare Advantage plan, a Medicare SELECT plan, or a Program of All-Inclusive Care for the Elderly (PACE) when you first became eligible for Medicare (during your "Open Enrollment Period"). However, within 12 months of joining that plan, you decide to end that coverage and enroll in a Medicare Supplement plan.

If one of these categories applies to you, here's what you need to do:

- Complete and return your application for Highmark Blue Cross Blue Shield Delaware Medicare Supplement coverage **no later than 63 days after** the date on which your current or previous coverage ends. **Do not complete the health screening questions.** If your situation is described in paragraph number 2, above, you may choose to substitute the date on which you were *notified* that your coverage would be ending for the actual date of termination.
- Along with your application, be sure to **enclose proof of the date** on which your current or previous coverage actually ends, or on which you were notified that your current or previous coverage would be ending. *Your application cannot be finalized without this documentation.*

If you have questions about these rights or about the Medicare Supplement plans available to you, please call a Member Service Representative at 1-800-633-2563, Monday through Friday, between 8:00 a.m. and 7:00 p.m. Hearing-impaired TTY users, call 1-800-232-5460.

Discrimination is Against the Law

The Plan complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. The Plan does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex. The Plan:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
 - Qualified sign language interpreters
 - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
 - Qualified interpreters
 - Information written in other languages

If you need these services, contact the Civil Rights Coordinator.

If you believe that the Plan has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with: Civil Rights Coordinator, P.O. Box 22492, Pittsburgh, PA 15222, Phone: 1-866-286-8295, TTY: 711, Fax: 412-544-2475, email: CivilRightsCoordinator@highmarkhealth.org. You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, the Civil Rights Coordinator is available to help you. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
1-800-368-1019, 800-537-7697 (TDD)

Complaint forms are available at <http://www.hhs.gov/ocr/office/file/index.html>.

ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Call 1-844-679-6930.

ATENCIÓN: Si usted habla español, servicios de asistencia lingüística, de forma gratuita, están disponibles para usted. Llame al 1-844-679-6930.

请注意：如果您说中文，可向您提供免费语言协助服务。

請致電 1-844-679-6930。

ATTENTION: Si c'est créole que vous connaissez, il y a un certain service de langues qui est gratis et disponible pour vous-même. Composez le 1-844-679-6930.

ધ્યાન આપશો: જો તમે ગુજરાતી ભાષા બોલતા હો, તો તમને ભાષા સહાયતા સેવાઓ, મફતમાં ઉપલબ્ધ છે.
1-844-679-6930 નંબર પર ફોન કરો.

ATTENTION: Si vous parlez français, les services d'assistance linguistique, gratuitement, sont à votre disposition. Appelez au 1-844-679-6930.

알림: 한국어를 사용하시는 분들을 위해 무료 통역이 제공됩니다. 1-844-679-6930 로 전화.

ATTENZIONE: se parla italiano, per lei sono disponibili servizi di assistenza linguistica a titolo gratuito. Chiamare l'1-844-679-6930.

CHÚ Ý: Nếu quý vị nói tiếng Việt, chúng tôi cung cấp dịch vụ hỗ trợ ngôn ngữ miễn phí cho quý vị. Xin gọi số 1-844-679-6930.

ACHTUNG: Wenn Sie Deutsch sprechen, steht Ihnen unsere fremdsprachliche Unterstützung kostenlos zur Verfügung. Rufen Sie 1-844-679-6930.

ATENSYON: Kung nagsasalita ka ng Tagalog, may makukuha kang mga libreng serbisyong tulong sa wika. Tumawag sa 1-844-679-6930.

ધ્યાન દે: यदि आप हिन्दी बोलते हैं, तो आपके लिए नि:शुल्क भाषा सहायता सेवा उपलब्ध है।
1-844-679-6930 પર ફોન કરો.

توجه فرمائیں: اگر آپ اردو بولتے ہیں، زبان معاونت سروس، مفت میں آپ کے لیے دستیاب ہے۔ 1-844-679-6930 پر کال کریں۔

تنبيه: إذا كنت تتحدث اللغة العربية، فهناك خدمات المعاونة في اللغة المجانية متاحة لك. اتصل على الرقم
1-844-679-6930.

గమనిక: మీరు తెలుగు మాట్లాడితే, లాంగ్వేజ్ అసిస్టెన్స్ సర్వీసెస్, ఛార్జ్ లోకుండా, మీకు అందుబాటులో ఉన్నాయి. కాల్ చేయండి 1-844-679-6930.

Aandacht: Indien u Nederlands spreekt, is de taaladviesdienst gratis beschikbaar voor u.
Bel 1-844-679-6930.

ВНИМАНИЕ: Если вы говорите по-русски, вы можете воспользоваться бесплатными услугами языковой поддержки. Звоните 1-844-679-6930.

ATENÇÃO: Se a sua língua é o português, temos atendimento gratuito para você no seu idioma. Ligue para 1-844-679-6930.

UWAGA: Dla osób mówiących po polsku dostępna jest bezpłatna pomoc językowa. Zadzwoń 1-844-679-6930.

注: 日本語が母国語の方は言語アシスタンス・サービスを無料でご利用いただけます。1-844-679-6930 を呼び出します。

توجه: اگر شما به زبان فارسی صحبت می کنید، خدمات کمک زبان رایگان با تماس با شماره 1-844-679-6930 موجود است.

BAA ÁKONÍNÍZIN: Diné k'ehgo yáníłti'go, language assistance services, éí t'áa níik'eh, bee níká a'doowot, éí bee ná'ahóót'i'. Kojj' hodíłnih 1-844-679-6930.