The Bridge Plan

"Bridging The Gap To Medicare Eligibility"

FOR

U.S. Citizens Or U.S. Residents
Awaiting
Medicare Eligibility

OR

U.S. Citizens Or U.S. Residents
Without Medicare
Part A Or Part B

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The Bridge Plan

An Individual Major Medical Plan For People Awaiting Medicare Eligibility

Description of Available Benefits

The Bridge Plan is a major medical expense insurance plan intended for persons age 60-95 who are awaiting acceptance as a participant in the U.S. Medicare System. Foreign Nationals are eligible to participate in U.S. Medicare five years after becoming a U.S. Resident. Certain U.S. citizens not covered by both parts of Medicare A and B may also apply for coverage under this plan. The Bridge Plan pays medically necessary expenses incurred. The expenses eligible for payment under this plan are subject to the deductible, coinsurance and limitations as outlined in the policy.

The Bridge Plan pays like this…

Deductible

A choice of $1,000, $1,500, $2,500, $5,000, or $10,000 per policy year.

Coinsurance

The plan pays 80% of the eligible expenses that exceed the deductible amount, up to the next $10,000.

Thereafter

After the deductible and coinsurance amounts are satisfied, 100% of eligible expenses are paid on the basis of usual, customary and reasonable charges, up to the lifetime maximum benefit of:

- $250,000 ages 60-74
- $100,000 ages 75-79
- $50,000 ages 80-89
- $25,000 ages 90-95

Additional Information

1. The deductible and coinsurance are on a per policy period basis.
2. The maximum benefit, limitations and pre-existing conditions begin from the inception date of the first policy.
3. The plan may include coverage for Part A, Part B or both.

Covered Expenses

Part A: These benefits include Hospitalization, Hospice Facilities, Skilled Nursing Facilities, and Home Health care services, based on medical necessity.

Part B: These benefits include the costs of Physicians and Surgeons on either an in-patient or out-patient basis, supplies, therapy and ambulance services, based on medical necessity.

Plan Highlights

- **Any Doctor and Any Hospital.**
- This coverage is renewable at the option of the Underwriters.
- Benefits paid based on usual, customary and reasonable charges and not on diagnostic related groups. (DRG is what Medicare uses as it has a much lower fee schedule.)

Pre-Existing Conditions

- A pre-existing condition means any condition which originated and which would have caused an ordinarily prudent person to seek medical diagnosis or treatment or was treated or diagnosed prior to the coverage effective date. A pre-existing condition shall not be covered until a period of 24 months, treatment free, has elapsed after inception of the first policy. The Bridge Plan, like Medicare, pays a large part of health care expenses, but it does not pay all of them. There are limits as to the amounts payable.

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Description of Available Benefits

Part A: Hospitalization

Hospitalization Benefits

Covered expenses include semi-private room and board charges, general nursing, miscellaneous hospital services and supplies, drugs, x-rays, laboratory tests and operating rooms.

Hospice Facilities Benefits

Such costs are covered, including medically necessary out-patient treatment. A physician must certify the need of such care.

Skilled Nursing Facility Benefits

Such costs are covered following a necessary hospital confinement of three days or longer and begins within thirty days following the hospital confinement.

Home Health Care Services Benefits

Skilled care at home is covered if such care is deemed to be medically necessary.

Part B: Physicians and Surgeons

Physicians and Surgeons Benefits

The costs of physicians and surgeons are covered on either an in-patient or out-patient basis. Supplies, therapy and ambulance services are covered if prescribed as medically necessary.

Conditions:

1. Benefits are paid directly to you to reimburse you for eligible medical expenses which have been paid by you, unless we agree to pay the provider directly. Unless and until we agree, this is a reimbursement plan.
2. The policy is issued on the basis of information given in the Application. A copy of the Application becomes a part of the policy of Insurance.
3. Material misstatement or concealment of health information made by or on behalf of you may render the insurance null and void.
4. Notice of claim is to be given at the earliest possible date.
5. Benefits shall be paid for all eligible expenses which are necessarily incurred due to an illness manifesting itself or an accidental bodily injury occurring during the period of insurance.
6. These benefits are available only if there is no other source of funding available through any government insurance or private programs.

Limitations and Exclusions

Expenses which have limitations include:

- Alzheimer's disease is limited to a lifetime maximum benefit of $25,000.
- Cardiac and/or Cancer related conditions are limited to a maximum benefit of $25,000 the first 180 days after inception of the first Policy. After 180 days, benefits will be paid as any other condition.
- Cataract surgery and procedures are limited to a maximum benefit of $2,000.

Expenses which are not covered include: Any expense which you are not legally obligated to pay; services which are not medically necessary or are not furnished by and under supervision of a Physician; any type of expense for which payment was made by Medicare or any other private or public program; expenses incurred in excess of usual, customary, and reasonable charges in your home area; outpatient drugs; self-inflicted injuries while sane; treatment of alcoholism, drug addiction, allergies, and nervous or mental disorders; rest cures, quarantine or isolation; cosmetic and plastic surgery unless necessitated by an accidental injury; dental exam, dental x-rays and general dental care except as the result of an accidental injury; eye glasses; hearing aids; general or routine exams; coverage outside the boundaries of the United States; injuries due to war or any act of war, whether declared or undeclared; or while committing a criminal or felonious act; or expenses for or resulting from subjective pain. Injuries sustained from participation in hazardous sport (mountaineering, hang gliding, scuba diving, etc.); This policy will automatically cease upon eligibility of the insured into the United States Medicare System. It is your responsibility to enroll in Medicare when you are first eligible.

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Who Needs The Bridge Plan

Senior age people desire coverage under the Social Security Medicare program. There are some people who, either by residency status or other reasons, may not be currently eligible for Medicare. All permanent residents and citizens of the United States are eligible for Medicare at some point in time. There are three conditions for which The Bridge Plan plan is used as a substitute.

Medicare Restriction #1:

Medicare will accept people who have been a permanent resident of the United States for at least five years. This does not require citizenship or any payment into Social Security prior to eligibility. The only requirement is that they must pay a premium to have both Part A and Part B.

Petersen's Solution #1:

The Bridge Plan is available to persons who have become permanent residents of the United States and who are within the five year waiting period for Medicare eligibility.

Medicare Restriction #2:

Some people may be eligible for Medicare due to age and qualifications, but have failed to enroll. Enrollment is not automatic. Social Security does not remind people to enroll. If they miss their enrollment period they must wait to enroll at a later date. This may be as much as 18 months later!

Petersen's Solution #2:

The Bridge Plan will cover them with benefits similar to Medicare until the next enrollment opportunity.

Medicare Restriction #3:

Some people, for various reasons, have only Part A or Part B. They may be able to get the additional part through Medicare, but at a later date.

Petersen's Solution #3:

The Bridge Plan may be sold with both Part A and Part B, just Part A, or just Part B.

Underwriting Guidelines

Medical Underwriting:

- Please allow approximately 3-4 weeks for Underwriters to process the applications.
- Underwriters may order medical records from your primary care physician or they will schedule a medical exam including a blood test, a urine test, and a resting EKG at the expense of Underwriters.

Application Submission

- Please submit the two page application along with the medical release form.
- Underwriters will accept a faxed copy, a scanned email copy, or the original application for underwriting.
- **Please do NOT send premium with the application.**

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Frequently Asked Questions

Question #1: If I have a claim under the first policy will the condition be considered a pre existing condition on the renewal?

Answer #1: The condition will be considered a pre-existing condition on the renewal of the policy.

Question #2: If I have a chronic pre existing condition such as diabetes necessitating regular treatment, will the policy provide coverage for medical expenses related to diabetes?

Answer #2: The policy will not provide coverage for expenses related to diabetes or any chronic conditions. The policy wording has an exclusion which requires 24 months, treatment free, before being covered.

Question #3: I had a heart attack 5 years ago, will this still be considered a pre existing condition?

Answer #3: Due to the cardiac event underwriters will most likely place a permanent exclusion for the entire cardiovascular system including heart attack and stroke.

Question #4: How will my premiums be determined on the renewals?

Answer #4: Premiums will adjust each renewal year by age and any other underwriting ratings at that time.

Question #5: Will my prescription medications be covered under this plan?

Answer #5: Prescriptions will be covered during a hospitalization only. Maintenance medication is typically covered by a Medicare supplement under Medicare Part D and is not covered under the Bridge Plan.

Question #6: Do I need to pay the premium when I apply for the coverage?

Answer #6: No, the premium is not due until the coverage has been approved by underwriters. If the payment is set up to be automated on a monthly basis the payment will be drafted the day of the month the coverage became effective.

Question #7: Is there a list of doctors that I am restricted to?

Answer #7: No, with the Bridge Plan you can see any doctor and go to any hospital. The policy does not require that the insured go to a specific network of doctors and hospitals.

Monthly Premium Rates

Age	$1,000 Deductible	$1,500 Deductible	$2,500 Deductible	$5,000 Deductible	$10,000 Deductible
60	$366	$316	$258	$212	$204
61	$372	$322	$265	$217	$207
62	$378	$328	$272	$222	$210
63	$384	$334	$279	$227	$213
64	$390	$340	$286	$232	$216
65	$395	$344	$293	$238	$221
66	$413	$359	$301	$246	$227
67	$431	$374	$309	$254	$233
68	$449	$389	$317	$262	$239
69	$467	$404	$325	$270	$245
70	$484	$419	$335	$279	$252
71	$502	$433	$349	$290	$260
72	$520	$447	$363	$301	$268
73	$538	$461	$377	$312	$276
74	$556	$475	$391	$323	$284
75	-	$490	$408	$336	$296
76	-	$504	$421	$345	$304
77	-	$518	$434	$354	$312
78	-	$532	$447	$363	$320
79	-	$546	$460	$372	$328
80	-	-	$476	$381	$336
81	-	-	$489	$424	$368
82	-	-	$502	$467	$400
83	-	-	$540	$510	$432
84	-	-	$578	$553	$464
85	-	-	-	$598	$500
86	-	-	-	$641	$534
87	-	-	-	$684	$568
88	-	-	-	$727	$602
89	-	-	-	$770	$636
90	-	-	-	-	$673
91	-	-	-	-	$707
92	-	-	-	-	$741
93	-	-	-	-	$775
94	-	-	-	-	$809
95	-	-	-	-	$843

Additional Calculations:

- For Part A coverage only = above rates x .60
- For Part B coverage only = above rates x .60

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To be eligible for the Bridge Plan coverage, you must not be eligible for Medicare. **If you have been a legal resident of the USA for 5 years you are eligible to purchase Medicare and you should not complete this application.** Benefits are subject to all terms, limitations and conditions outlined in your certificate. Please read your certificate carefully once you receive it.

Producer #:_____

Please Provide the Following Personal Information

Applicant's Name: First _____ Middle _____ Last_____

Date of Birth: _____ / _____ / _____ Height: _____ Weight: _____ Sex: ❑Male ❑Female

Residence Address: _____

City _____ State _____ Zip Code _____

E-mail: _____ Telephone (_____) _____ - _____ Fax (_____) _____ - _____

Citizenship: _____ Length of Time Residing in the USA: _____

Requested Start Date: _____ Date you expect to be eligible for Medicare?_____

Deductible Amount: ❑ 1,000 ❑ 1,500 ❑ 2,500 ❑ 5,000 ❑ 10,000

Coverage Type: ❑ Bridge Part A & B ❑ Bridge Part B ❑ Bridge Part A

Payment Mode: ❑ In Full (11 Months) ❑ Monthly (EFT/CC)

Medical Information

Primary care physician:

a. Name & address: _____
b. Date and reason last seen: _____
c. Results of last visit: _____

All healthcare providers seen in the last three years (if more space is needed, please attach a separate piece of paper):

a. Name & address: _____
b. Date and reason last seen: _____
c. Results of last visit: _____

If "Yes" is answered for any of the following questions please provide full details in the space below. If there is not sufficient space, please attach your answers on a separate sheet.

1. Have you had an medical insurance in the past year? ❑ Yes ❑ No
2. Do you intend to engage in sports or any other pastimes that expose you to extra personal injury? ❑ Yes ❑ No
3. Have you ever been declined or accepted on special terms for life, accident or illness insurance? ❑ Yes ❑ No
4. Have you ever had any abnormal tests or blood work that have required additional evaluation or treatment? ❑ Yes ❑ No
5. Have you ever been recommended to have any procedure(s), exam(s), treatment(s), and/or test(s) that have not been completed? ❑ Yes ❑ No
6. Date of last colonoscopy:_____ Results:_____
7. If Female: Date of last pap testing:_____ Results:_____
8. If Female: Date of last mammogram:_____ Results:_____

Questions # _____ Dates & Details: _____
Questions # _____ _____
Questions # _____ _____
Questions # _____ _____

Please continue the application on the following page.

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For any questions that you answer "YES," please provide details of the medical condition including treatment, dates, diagnosis, prognosis, and present course of treatment in the area provided below or if additional space is needed please use a separate sheet and submit the it along with the application. Please attach these responses to this application. Underwriters may request additional medical information.

9. Have you ever been evaluated or treated for any injury, condition or disorder involving the following?

a.	Eyes	❑ Yes ❑ No	aa.	Gall bladder	❑ Yes ❑ No
b.	Ears	❑ Yes ❑ No	ab.	Convulsions	❑ Yes ❑ No
c.	Nose	❑ Yes ❑ No	ac.	Concussions	❑ Yes ❑ No
d.	Cyst	❑ Yes ❑ No	ad.	Blood vessels	❑ Yes ❑ No
e.	Gout	❑ Yes ❑ No	ae.	Lymph nodes	❑ Yes ❑ No
f.	Knees	❑ Yes ❑ No	af.	Intestinal tract	❑ Yes ❑ No
g.	Back/spine/neck	❑ Yes ❑ No	ag.	Urinary system	❑ Yes ❑ No
h.	Skin	❑ Yes ❑ No	ah.	Arthritis/joints/rheumatism	❑ Yes ❑ No
i.	Liver	❑ Yes ❑ No	ai.	Nervous system	❑ Yes ❑ No
j.	Heart	❑ Yes ❑ No	aj.	Growth/tumor/cancer	❑ Yes ❑ No
k.	Blood	❑ Yes ❑ No	ak.	Unconsciousness	❑ Yes ❑ No
l.	Bones	❑ Yes ❑ No	al.	Circulatory system	❑ Yes ❑ No
m.	Throat	❑ Yes ❑ No	am.	Fainting/dizziness	❑ Yes ❑ No
n.	Hernia	❑ Yes ❑ No	an.	Paralysis/weakness	❑ Yes ❑ No
o.	Fatigue/Tiredness	❑ Yes ❑ No	ao.	High blood pressure	❑ Yes ❑ No
p.	Bladder	❑ Yes ❑ No	ap.	Disorder of the brain/Alzheimer's	❑ Yes ❑ No
q.	Muscles	❑ Yes ❑ No	aq.	Mental/Emotional/Psychiatric	❑ Yes ❑ No
r.	Kidneys	❑ Yes ❑ No	ar.	Lungs	❑ Yes ❑ No
s.	Glands	❑ Yes ❑ No	as.	Asthma	❑ Yes ❑ No
t.	Thyroid	❑ Yes ❑ No	at.	Allergies	❑ Yes ❑ No
u.	Pancreas	❑ Yes ❑ No	au.	Tuberculosis	❑ Yes ❑ No
v.	Diabetes	❑ Yes ❑ No	av.	Respiratory system	❑ Yes ❑ No
w.	Chest pain	❑ Yes ❑ No	aw.	Reproductive system	❑ Yes ❑ No
x.	Headaches	❑ Yes ❑ No	ax.	Digestive system/stomach	❑ Yes ❑ No
y.	HIV/AIDS	❑ Yes ❑ No			
z.	Sleep apnea	❑ Yes ❑ No			

10. Are you currently taking any medication? ❑ Yes ❑ No
11. Has your weight changed in the past year? ❑ Yes ❑ No
12. Have you ever undergone a surgical operation? ❑ Yes ❑ No
13. Have you taken any other medicines in the past 12 months? ❑ Yes ❑ No
14. Have you any reason to believe that a surgical operation may be necessary in the future? ❑ Yes ❑ No
15. Have you ever suffered from any other conditions or injuries for which medical advice was sought? ❑ Yes ❑ No
16. Other than the medical conditions noted above, I am in good health. ❑ Yes ❑ No
17. Do you need any assistance to perform activities of daily living (feeding, bathing, dressing)? ❑ Yes ❑ No

Questions # _____ Dates & Details: _____
Questions # _____ _____
Questions # _____ _____
Questions # _____ _____
Questions # _____ _____
Questions # _____ _____
Questions # _____ _____
Questions # _____ _____

DECLARATION

Declaration: I declare that the above statements are true and complete, and that, apart from the matters declared above, I am in good health and ordinarily enjoy health. I agree to the Underwriters obtaining medical information from any doctor who has attended me and authorize such doctors to give information. I agree that this proposal shall form the basis of the contract should the insurance be effected and any misstatements above may be grounds for rescission.
I understand that pre-existing conditions are not covered until I have been treatment free for 24 months after inception.

Proposed Insured_____ Signature _____ Date_____
Please Print

PETERSEN INTERNATIONAL UNDERWRITERS
23929 Valencia Boulevard, Second Floor, Valencia, California 91355
(661) 254-0006 (800) 345-8816 Facsimile (661) 254-0604
Website: http://www.piu.org E-Mail: piu@piu.org

AUTHORIZATION TO RELEASE HEALTH RELATED INFORMATION

This Authorization complies with the HIPAA Privacy Rule

Name of Proposed Insured ("Applicant") _____Date of Birth_____

I authorize all Healthcare Providers that have been involved in my care, diagnosis or treatment including, but not limited to Physicians, Medical Practitioners, Hospitals, Clinics, Medically related facilities, Rehabilitation facilities, Laboratories, Pharmacy, Insurance or Reinsurance Company, Consumer Reporting Agency, to disclose my medical records to Petersen International Underwriter, or its assigned authorized agents/representative including, but not limited to: Secure Image Solutions, for the purpose of insurance underwriting or claims administration.

For purposes of this authorization, medical records shall include all health information pertaining to any medical history or physical condition and treatment received including, but not be limited to patient histories, progress notes, test results, X-ray/laboratory and other reports, psychiatric evaluations, drug and/or Alcohol Treatment, information and/or HIV Tests/ Test Results, and any other pertinent medical information.

I understand and agree that Petersen International Underwriters may disclose my medical records and the information contained in those records to third parties such as insurance companies or insurance underwriters, attorneys, or to representatives of such third parties (including reinsurers and information agencies) for the purpose as stated in the above. I also understand that when my medical records are disclosed pursuant to this Authorization, my medical records and the information contained in those records may be subject to re-disclosure by the recipient and may no longer be protected by Federal Privacy Laws.

I understand that I may refuse to sign this authorization and that such refusal to sign will not be a condition to affect the ability of the Applicant to obtain treatment. I understand that I may revoke this Authorization, except to the extent that any health care provider or Petersen International Underwriters, has acted in reliance upon this Authorization. My revocation of this Authorization must be in writing to:

Petersen International Underwriters
23929 Valencia Boulevard, Suite 215
Valencia, California 91355

A copy of this signed Authorization is valid as the original. I have the right to a copy of this Authorization. This Authorization will expire 2 years after the date the Authorization.

_____ _____
Signature of Proposed Insured/Patient Date

_____ _____
*Signature of Legal Representative (if other than Proposed Insured/Patient) Date

_____
Printed Name and Relationship

*If the individual whose information is being disclosed is a minor, a parent or legal guardian must sign.