

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





The Bridge Plan

An Individual Major Medical Plan For People Awaiting Medicare Eligibility

Description Of Available Benefits

The Bridge Plan is a temporary major medical expense insurance plan intended for use by persons 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 or \$5,000 per person, per policy period.

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 plan maximum of \$250,000 ages 60-74, \$100,000 maximum ages 75-79, and \$50,000 maximum ages 80-84.

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.**
- Conditionally renewable annually for up to five years. In the event of non-renewal, if hospitalized, benefits shall continue for up to thirty days beyond the period of insurance.
- Benefits paid based on usual, customary and reasonable charges and not on diagnostic related groups. (DRG is what Medicare uses. 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.

This is not intended to be a complete outline of coverage. Actual wording may change without notice.
Underwriters reserve the right to modify terms and benefits at time of underwriting.

The Bridge Plan

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. This coverage is renewable at the option of the Underwriters.
6. 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.
7. 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.

The Bridge Plan

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 temporary 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 on a temporary basis 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 will either 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 one page application along with the two page medical release form.
- Underwriters will accept a faxed copy, a scanned email copy, or the original application for underwriting.

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The Bridge Plan Application Form Page 1 of 2



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.

Please Provide the Following Personal Information

Personal Statistics:

First _____ Middle _____ Last _____

Date of Birth ____/____/____

Height _____ Weight _____ Gender: Male Female

Number & Street _____

City _____ State _____ Zip Code _____

Email _____

Telephone (____) _____ - _____ Fax (____) _____ - _____

Policy Information:

Deductible Options: All Cause Deductible Each Cause Deductible

Deductible Amount: \$1,000 \$1,500 \$2,500 \$5,000

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

Premium Payment Mode: Annual Semi-Annual Quarterly Monthly (Bank Draft Only)

Citizenship: _____

Length of Time Residing in the USA: _____

Requested Effective Date: _____

When do you expect to be eligible for Medicare: _____

Medical Information

Primary Care Physician:

Name _____

Address _____

Date _____ Reason Last Seen _____

Last Physician Seen:

Name _____

Address _____

Date _____ Reason Last Seen _____

Please continue the application on the following page.

Bridge Application 1 of 2 - 02.15.2009

The Bridge Plan Application Form Page 2 of 2

Applicant Name: _____ Date of Birth: _____

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.

Please answer all the questions and provide dates and details in the area below

1. Do you have any physical defect or infirmity?	<input type="checkbox"/> Yes <input type="checkbox"/> No
2. Is your sight or hearing defective?	<input type="checkbox"/> Yes <input type="checkbox"/> No
3. Have you ever suffered from any nervous or mental condition, fainting episode, blackout, headaches or migraines, seizures or paralysis of any kind?	<input type="checkbox"/> Yes <input type="checkbox"/> No
4. Have you ever suffered from high blood pressure, a heart condition, rheumatic fever or diabetes?	<input type="checkbox"/> Yes <input type="checkbox"/> No
5. Have you ever suffered from a "slipped disc" or other spinal disorder, a hernia or any rheumatic or arthritic condition?	<input type="checkbox"/> Yes <input type="checkbox"/> No
6. Have you ever suffered from any respiratory, urinary or allergic condition, or any disorder of the stomach or bowels?	<input type="checkbox"/> Yes <input type="checkbox"/> No
7. Have you ever suffered from any other condition requiring medical investigation or hospital treatment?	<input type="checkbox"/> Yes <input type="checkbox"/> No
8. Have you ever undergone a surgical operation?	<input type="checkbox"/> Yes <input type="checkbox"/> No
9. Have you ever suffered from any other conditions or injuries for which medical advice was sought?	<input type="checkbox"/> Yes <input type="checkbox"/> No
10. Have you any reason to believe that a surgical operation may be necessary in the future?	<input type="checkbox"/> Yes <input type="checkbox"/> No
11. Have you ever been declined or accepted on special terms for life, accident or illness insurance?	<input type="checkbox"/> Yes <input type="checkbox"/> No
12. Do you intend to engage in sports or any other pastimes that expose you to extra personal injury?	<input type="checkbox"/> Yes <input type="checkbox"/> No
13. Are there any additional facts affecting the proposed insurance which should be disclosed to the underwriters?	<input type="checkbox"/> Yes <input type="checkbox"/> No
14. Are you currently taking any medication?	<input type="checkbox"/> Yes <input type="checkbox"/> No
15. Do you have any other medical insurance at this time?	<input type="checkbox"/> Yes <input type="checkbox"/> No
16. If Female: Date and results of last pap testing: _____	
17. If Female: Date and results of last mammogram: _____	

Questions # _____ Dates & Details: _____
 Questions # _____
 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

AUTHORIZATION TO RELEASE HEALTH RELATED INFORMATION
This Authorization complies with the HIPAA Privacy Rule

Name of Proposed Insured (“Applicant”) _____ Date of Birth _____

I specifically authorize the following Healthcare Provider (name of provider) _____ in addition to 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.

The Bridge Plan

The Bridge Plan Premium Rates

All CAUSE DEDUCTIBLE (One deductible for the policy period)				
Payment Mode	Monthly	Quarterly	Semi-Annual	Annual
\$1,000 Deductible				
Age				
60-64	\$366	\$1,212	\$2,339	\$4,251
65-69	\$395	\$1,308	\$2,523	\$4,586
70-74	\$484	\$1,604	\$3,094	\$5,625
75-79	N.A.	N.A.	N.A.	N.A.
80-84	N.A.	N.A.	N.A.	N.A.
\$1,500 Deductible				
Age				
60-64	\$316	\$1,048	\$2,021	\$3,674
65-69	\$344	\$1,140	\$2,200	\$3,999
70-74	\$419	\$1,389	\$2,680	\$4,871
75-79	\$490	\$1,623	\$3,132	\$5,694
80-84	N.A.	N.A.	N.A.	N.A.
\$2,500 Deductible				
Age				
60-64	\$258	\$855	\$1,649	\$2,998
65-69	\$293	\$969	\$1,870	\$3,399
70-74	\$335	\$1,110	\$2,142	\$3,893
75-79	\$408	\$1,351	\$2,607	\$4,739
80-84	\$476	\$1,576	\$3,040	\$5,527
\$5,000 Deductible				
Age				
60-64	\$212	\$699	\$1,348	\$2,450
65-69	\$238	\$784	\$1,513	\$2,750
70-74	\$279	\$919	\$1,774	\$3,225
75-79	\$336	\$1,109	\$2,139	\$3,889
80-84	\$381	\$1,262	\$2,434	\$4,425

For Policy Periods less than 12 months, premiums will be prorated using the annual premium.

Discounts:

- For Part A coverage only = above rates x .60
- For Part B coverage only = above rates x .60
- For a each and every cause deductible multiply the above rates by .87

Please do not send premium with the application.

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