The Bridge Plan

"Bridging the Gap to Medicare Eligibility"

Petersen®
International Underwriters

THE BRIDGE PLAN

The Bridge Plan is a major medical insurance plan intended for persons aged 60-95 who are awaiting acceptance as a participant in the U.S. Medicare System. All permanent residents of the United States are eligible for Medicare at some point in time. Foreign nationals are usually eligible to purchase Medicare Parts A & B five years after becoming U.S. residents. While awaiting enrollment in Medicare, they may apply for coverage through The Bridge Plan. The Bridge Plan is set up to be as simple as possible - No co-pay & No coinsurance.

1 **All eligible expenses are applied toward the deductible.**

2 **Once the deductible has been fulfilled, the policy will cover 100% up to the policy maximum.**

Part A: Hospitalization

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

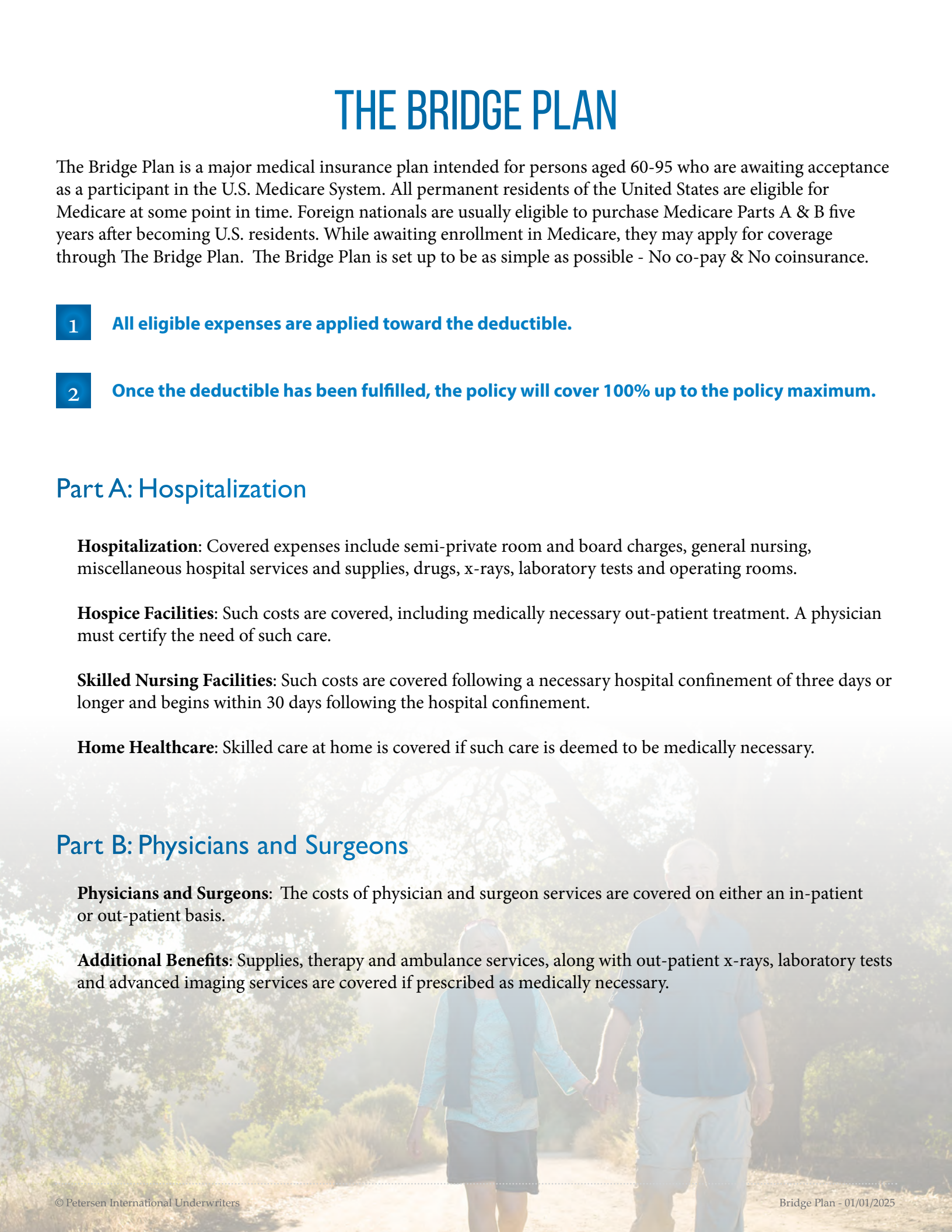
Skilled Nursing Facilities: Such costs are covered following a necessary hospital confinement of three days or longer and begins within 30 days following the hospital confinement.

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

Part B: Physicians and Surgeons

Physicians and Surgeons: The costs of physician and surgeon services are covered on either an in-patient or out-patient basis.

Additional Benefits: Supplies, therapy and ambulance services, along with out-patient x-rays, laboratory tests and advanced imaging services are covered if prescribed as medically necessary.



Policy Period

The Bridge Plan is a temporary plan and has a maximum policy period of 3 months. At the end of 3 months you may apply for a new term of insurance for 1 month only. *Individual state restrictions apply which may restrict policy term lengths and the ability to reapply for new coverage.*

Free Look Period

This plan allows you to cancel coverage and receive a full refund up to 10 days from when the certificate of insurance was received.

Additional Information

- The insured may be treated by any doctor or at any hospital.
- Benefits paid are based on usual, customary and reasonable charges.
- The deductible is on a per policy period basis.
- The plan may include coverage for Part A, Part B or both.

In-Network Coverage

The First Health Network has providers in all 50 states. The network has more than 5,000 hospitals, over 90,000 ancillary facilities, and over 1 million health care professional service locations in the network. To locate a provider please use the following information:

http://provider.piu.org
or
800-226-5116

You may receive diagnosis and treatment of your Sickness or Injury from a Provider within the PPO Network, at your option. To find a Provider within the PPO Network please review the information on Your identification card. By utilizing the PPO network, you may receive discounts and savings for any incurred eligible expenses. Utilizing the PPO network is not required, and it does not guarantee that benefits will be payable or that the Provider will bill us directly. You have the option to see any provider whether they are in-network or out-of-network.

Out-of-Network Coverage

We allow the insured to see any provider even if they are outside of the PPO Network. PPO Network discounts do not apply for treatment received out of network and expenses will be reimbursed up to UCR.

Monthly Premium Rates

Age	Platinum $1,000,000 Maximum Benefit $1,000 Deductible	Gold $500,000 Maximum Benefit $2,500 Deductible	Silver $250,000 Maximum Benefit $5,000 Deductible	Bronze $100,000 Maximum Benefit $10,000 Deductible
60	$886	$596	$394	$298
61	$890	$616	$417	$317
62	$896	$635	$440	$336
63	$901	$652	$465	$357
64	$905	$671	$488	$376
65	$911	$690	$513	$395
66	$915	$709	$536	$414
67	$919	$726	$558	$435
68	$923	$745	$583	$454
69	$929	$764	$606	$473
70	-	$783	$629	$494
71	-	$802	$654	$515
72	-	$821	$677	$534
73	-	$840	$699	$553
74	-	$858	$724	$572
75	-	$877	$747	$593
76	-	$896	$772	$612
77	-	$915	$795	$631
78	-	$932	$818	$650
79	-	$951	$842	$671
80	-	-	-	$821
81	-	-	-	$847
82	-	-	-	$871
83	-	-	-	$896
84	-	-	-	$920
85	-	-	-	$946
86	-	-	-	$970
87	-	-	-	$995
88	-	-	-	$1,021
89	-	-	-	$1,045
90+	Contact Our Office For Options.			

Additional Calculations:

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

WHO NEEDS THE BRIDGE PLAN

Medicare Restriction #1: Medicare will usually accept people who have been a permanent resident of the United States for at least five years. This does not require citizenship or any pre-payment into Social Security prior to eligibility. The only requirement is that they must pay a monthly premium to have both Part A and Part B. **Solution:** 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 a person misses the enrollment period, that person must wait to enroll at a later date. This process may take as long as 18 months! **Solution:** The Bridge Plan will cover that person 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 acquire the additional part through Medicare, but at a later date. **Solution:** The Bridge Plan may be sold with both Part A and Part B, just Part A, or just Part B.

FAQ's

Question #1: If I have a claim under the first policy, will the condition be considered a pre-existing condition on the renewal? **Answer:** The condition will be considered a pre-existing condition on any new term of insurance.

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:** Each policy has an exclusion for pre-existing conditions which has a 12 month look back. Since the condition will always require medication and regular care, it will fall into the pre-existing condition definition.

Question #3: I had a heart attack five years ago, will this still be considered a pre-existing condition? **Answer:** 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:** Premiums will adjust every new term of insurance by age and any other underwriting ratings at that time. Premiums typi cally follow the chart from the current brochure.

Question #5: Will my prescription medications be covered under this plan? **Answer:** Prescriptions will be covered during a hospitalization. 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:** 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.

The Bridge Plan Application Form

Producer Number:_____

To be eligible for the Bridge Plan coverage, you must attest to the following statements:

❑ I attest that I am not eligible for Medicare or Affordable Care Act (ACA) compliant insurance.

❑ I attest that I have tried, but was unable to obtain short-term medical insurance.

Reason why: _____

Applicant's Name: First _____ M.I. _____ Last_____

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

Residence Address: _____

City _____ State_____ Zip Code_____

Email Address: _____ Telephone (_____) _____ - _____

Requested Start Date: _____ Date eligible for Medicare or ACA Coverage: _____

Plan Type: ❑ **Platinum** *($1,000,000 Max. & $1,000 Deductible)* ❑ **Gold** *($500,000 Max. & $2,500 Deductible)*

❑ **Silver** *($250,000 Max. & $5,000 Deductible)* ❑ **Bronze** *($100,000 Max. & $10,000 Deductible)*

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

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Primary Care Physician:

a. Name: _____

b. Address: _____

c. Date and reason last seen: _____

d. Results of last visit: _____

If "Yes" is answered, please provide full details in the area provided or attach a separate page if needed

1. Do you intend to engage in sports or any other pastimes that expose you to extra personal injury? ❑ Yes ❑ No
2. Have you ever been declined or accepted on special terms for life, accident or illness insurance? ❑ Yes ❑ No
3. Have you ever had any abnormal tests or blood work that have required additional evaluation or treatment? ❑ Yes ❑ No
4. Has your weight changed in the past year? ❑ Yes ❑ No
5. Have you ever undergone a surgical operation? ❑ Yes ❑ No
6. Have you taken any medicines in the past 12 months? ❑ Yes ❑ No
7. 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
8. Do you need any assistance to perform activities of daily living (feeding, bathing, dressing)? ❑ Yes ❑ No
9. Date and results of last colonoscopy: _____
10. Date and results of last pap (female): _____
11. Date and results of last mammogram (female): _____
12. Date and results of last PSA (male): _____

Question # _____ Dates & Details: _____

Question # _____ _____

Question # _____ _____

Question # _____ _____

PLEASE INITIAL THE FOLLOWING

I have read or had read to me and understand each of the questions and statements on this entire application and no one has prevented me from spending as much time as I felt was necessary to understand this application. _____

Last Healthcare Provider Seen:

a. Name: _____

b. Address: _____

c. Date and reason last seen: _____

d. Results of last visit: _____

If "Yes" is answered, please provide full details in the area provided or attach a separate page if needed

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

a.	Eyes/Ears	❑ Yes ❑ No	o.	Back/spine/neck	❑ Yes ❑ No
b.	Gout	❑ Yes ❑ No	p.	Throat/Thyroid/Glands	❑ Yes ❑ No
c.	Skin	❑ Yes ❑ No	q.	Bones/Bone Density	❑ Yes ❑ No
d.	Hernia	❑ Yes ❑ No	r.	Arthritis/Joints (Hips Knees, Shoulders)	❑ Yes ❑ No
e.	Diabetes	❑ Yes ❑ No	s.	Fainting/Dizziness/Unconsciousness	❑ Yes ❑ No
f.	HIV/AIDS	❑ Yes ❑ No	t.	Fatigue/Tiredness/Paralysis/Weakness	❑ Yes ❑ No
g.	Sleep apnea	❑ Yes ❑ No	u.	Nervous System/Alzheimer's/Dementia	❑ Yes ❑ No
h.	Gallbladder	❑ Yes ❑ No	v.	Mental/Emotional/Psychiatric	❑ Yes ❑ No
i.	Concussions	❑ Yes ❑ No	w.	Respiratory System/Asthma	❑ Yes ❑ No
j.	Chronic Pain	❑ Yes ❑ No	x.	Circulatory system	❑ Yes ❑ No
k.	Lymph nodes	❑ Yes ❑ No	y.	Reproductive system	❑ Yes ❑ No
l.	Cancer/Growth	❑ Yes ❑ No	z.	Gastrointestinal System	❑ Yes ❑ No
m.	High blood pressure	❑ Yes ❑ No	aa.	Urinary system/Prostate	❑ Yes ❑ No
n.	Heart/Chest Pain/Stroke	❑ Yes ❑ No	ab.	Any other condition not listed above	❑ Yes ❑ No

Question#	Details of Conditions/Treatment	Date & Duration	Details and Degree of Recovery

14. To the best of your knowledge and belief, are you in good health and free from any mental or physical impairment, except as described in this application? ❑ Yes ❑ No - If No, please provide details: _____

_____

_____

IT IS UNDERSTOOD AND AGREED: 1) That all answers to the questions on this application, to the best of my knowledge and belief, are complete and true, 2) That all answers on this application shall form the basis of the issuance of any coverage hereunder, 3) That in the event that You, the Loss Payee, the Owner or any person on Your behalf commits fraud, a misstatement or concealment either in the application or by any other statement, this Certificate may become void and no benefits will be payable, 4) That except as amended by the answers to the above questions, any answer shown on any prior application for this coverage signed and dated by me are expressly reaffirmed, 5) I have read or had read to me and understand each of the questions and statements on this entire application, 6) No one has prevented me from spending as much time as I felt was necessary to understand this application, 7) I understand the terms and conditions of this product, and 8) I also understand that since this is a temporary policy it is exempt from the Patient Protection and Affordable Care Act (PPACA) so pre-existing conditions are not covered by this policy.

Proposed Insured_____ Signature _____ Date_____

Please Print

Authorization to Release Personal Information

In Compliance with HIPAA & Financial Privacy Regulation

I, the proposed insured, 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, or Consumer Reporting Agency, to disclose my medical records to Petersen International Underwriters, or its assigned authorized agent/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, 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. Additionally, it is understood that disclosure of medical conditions as they relate to my insurability may be disclosed to persons with a direct insurable interest. Medical or financial information, as it affects my insurability or any claim, may also be discussed with my insurance agent or broker. 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 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.

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 that I have signed this Authorization.

Proposed Insured Name	Date of Birth
Legal Representative*	Relationship
Email	

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

Signature of Proposed Insured _____ Date _____

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

PETERSEN® INTERNATIONAL UNDERWRITERS

23929 Valencia Boulevard • Second Floor • Valencia, CA 91355
800.345.8816 toll-free • 661-254-0604 fax
www.piu.org • piu@piu.org

Limitations

- Alzheimer's disease is limited to a lifetime maximum benefit of $25,000.
- Cataract surgery and procedures are limited to a maximum benefit of $2,000.
- Cardiac and/or Cancer related conditions are limited to a maximum benefit of $25,000.00 the first 180 days after inception of the first Certificate. After 180 days of continuous coverage, benefits will be paid as for any other condition.

Conditions

1. 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.
2. Material misstatement or concealment of health information made by or on behalf of you may render the insurance null and void.
3. Notice of claim is to be given at the earliest possible date.
4. 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.
5. These benefits are available only if there is no other source of funding available through any government insurance or private programs.

Pre-Existing Conditions

Pre-existing Condition means a condition caused or contributed to by a Sickness or Injury for which medical advice, diagnosis, care or treatment, including the use of prescription medication, including but not limited to ongoing conditions(s), was recommended by or received from a licensed health care practitioner, and/or any symptom(s) and/or any condition(s) which would have caused a reasonably prudent person to seek medical attention during the twelve (12) months immediately preceding the effective date of the insurance described in this Certificate, whether disclosed or not on your application.

Complications Due To Hypertension Benefit

Health complications resulting from Medically-Controlled Hypertension will not be considered a Pre-existing Condition.

Termination of Benefits

The insurance described in this Certificate will terminate upon the Expiry Date of this Certificate, or your eligibility for the United States Medicare System, whichever occurs first. It is your responsibility to enroll in Medicare when you are first eligible.

Exclusions

1. Any expense which You are not legally obligated to pay.
2. Services which are not Medically Necessary or are not furnished by and under supervision of a Physician.
3. Expenses for services and supplies for which You are entitled to benefits, services or reimbursement through the Veterans' Administration, Workers' Compensation insurance, any private health plan or from any other source except Medicaid.
4. Expenses in excess of UCR.
5. Self-inflicted injuries while sane or insane.
6. Treatment for alcoholism, drug addiction, allergies, and/or Mental or Nervous Disorders.
7. Rest cures, quarantine or isolation.
8. Cosmetic surgery unless necessitated by an accidental Injury.
9. Dental exams, dental x-rays and general dental care except as a result of an accidental Injury.
10. Eye glasses or eye examinations.
11. Hearing aids or hearing examinations.
12. General or routine examinations.
13. Injuries sustained from participation in Hazardous Sports or Activities.
14. Injuries or Sicknesses due to War or any Act of War whether declared or undeclared.
15. Injuries or Sicknesses due to Terrorism or any Act of Terrorism whether declared or undeclared.
16. Injuries or Sicknesses due to an Act of Terrorism involving the use or release of any nuclear weapon or device or chemical or biological agent, regardless of any contributory cause(s).
17. Injuries or Sicknesses sustained while committing a criminal or felonious act.
18. Expenses incurred for or resulting from pain which is not supported by medical diagnosis.
19. Outpatient drugs.
20. Any elective surgery, including but not limited to complications of previous elective or cosmetic surgeries.
21. Custodial Care.
22. Expenses for supplies and services incurred outside of United States boundaries.
23. Pre-existing conditions.
24. Racing of any kind, all professional or semi-professional sports, and collegiate, sponsored, or interscholastic athletics.

Important Notice Regarding the Patient Protection and Affordable Care Act

This coverage is not required to comply with certain federal market requirements for health insurance, principally those contained in the Affordable Care Act. Be sure to check your policy carefully to make sure you are aware of any exclusions or limitations regarding coverage of preexisting conditions or health benefits (such as hospitalization, emergency services, maternity care, preventive care, prescription drugs, and mental health and substance use disorder services). Your policy might also have lifetime and/or annual dollar limits on health benefits. If this coverage expires or you lose eligibility for this coverage, you might have to wait until an open enrollment period to get other health insurance coverage. Also, this coverage is not "minimum essential coverage."

This plan is not compliant with the Affordable Care Act

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.

PETERSEN®
INTERNATIONAL UNDERWRITERS

CA License #: 0591207

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