



THE BRIDGE PLAN

“BRIDGING THE GAP TO MEDICARE ELIGIBILITY”

National Marketing

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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, out-patient laboratory services, x-rays & advanced imaging and ambulance services are covered if prescribed as medically necessary.

Policy Period

The Bridge Plan is a temporary plan and has a maximum policy period of 364 days. At the end of the 364 days, you may apply for a new term of insurance.

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:

www.doctorsearchnow.com 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	Gold	Silver	Bronze
	\$1,000,000 Maximum Benefit \$1,000 Deductible	\$500,000 Maximum Benefit \$2,500 Deductible	\$250,000 Maximum Benefit \$5,000 Deductible	\$100,000 Maximum Benefit \$10,000 Deductible
60	\$436	\$313	\$207	\$135
61	\$438	\$323	\$219	\$145
62	\$441	\$333	\$231	\$155
63	\$443	\$342	\$244	\$166
64	\$445	\$352	\$256	\$176
65	\$448	\$362	\$269	\$186
66	\$450	\$372	\$281	\$196
67	\$452	\$381	\$293	\$207
68	\$454	\$391	\$306	\$217
69	\$457	\$401	\$318	\$227
70	-	\$411	\$330	\$238
71	-	\$421	\$343	\$249
72	-	\$431	\$355	\$259
73	-	\$441	\$367	\$269
74	-	\$450	\$380	\$279
75	-	\$460	\$392	\$290
76	-	\$470	\$405	\$300
77	-	\$480	\$417	\$310
78	-	\$489	\$429	\$320
79	-	\$499	\$442	\$331
80	-	-	-	\$340
81	-	-	-	\$351
82	-	-	-	\$361
83	-	-	-	\$371
84	-	-	-	\$381
85	-	-	-	\$392
86	-	-	-	\$402
87	-	-	-	\$412
88	-	-	-	\$423
89	-	-	-	\$433
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 typically 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 not be eligible for Medicare. **If you have been a legal resident of the USA for five 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.

Applicant's Name: First _____ Middle _____ Last _____

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

Residence Address: _____

City _____ State _____ Zip Code _____

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

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

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

Last healthcare provider seen: a. Date and reason last seen: _____
 b. Results of last visit: _____

If "Yes" is answered, please provide full details in the area provided below 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. Have you ever been evaluated or treated for any injury, condition or disorder involving the following? Yes No

a. Eyes/Ears	<input type="checkbox"/> Yes <input type="checkbox"/> No	o. Back/spine/neck	<input type="checkbox"/> Yes <input type="checkbox"/> No
b. Gout	<input type="checkbox"/> Yes <input type="checkbox"/> No	p. Throat/Thyroid/Glands	<input type="checkbox"/> Yes <input type="checkbox"/> No
c. Skin	<input type="checkbox"/> Yes <input type="checkbox"/> No	q. Bones/Bone Density	<input type="checkbox"/> Yes <input type="checkbox"/> No
d. Hernia	<input type="checkbox"/> Yes <input type="checkbox"/> No	r. Arthritis/Joints (Hips Knees, Shoulders)	<input type="checkbox"/> Yes <input type="checkbox"/> No
e. Diabetes	<input type="checkbox"/> Yes <input type="checkbox"/> No	s. Fainting/Dizziness/Unconsciousness	<input type="checkbox"/> Yes <input type="checkbox"/> No
f. HIV/AIDS	<input type="checkbox"/> Yes <input type="checkbox"/> No	t. Fatigue/Tiredness/Paralysis/Weakness	<input type="checkbox"/> Yes <input type="checkbox"/> No
g. Sleep apnea	<input type="checkbox"/> Yes <input type="checkbox"/> No	u. Nervous System/Alzheimer's/Dementia	<input type="checkbox"/> Yes <input type="checkbox"/> No
h. Gallbladder	<input type="checkbox"/> Yes <input type="checkbox"/> No	v. Mental/Emotional/Psychiatric	<input type="checkbox"/> Yes <input type="checkbox"/> No
i. Concussions	<input type="checkbox"/> Yes <input type="checkbox"/> No	w. Respiratory System/Asthma	<input type="checkbox"/> Yes <input type="checkbox"/> No
j. Chronic Pain	<input type="checkbox"/> Yes <input type="checkbox"/> No	x. Circulatory system	<input type="checkbox"/> Yes <input type="checkbox"/> No
k. Lymph nodes	<input type="checkbox"/> Yes <input type="checkbox"/> No	y. Reproductive system	<input type="checkbox"/> Yes <input type="checkbox"/> No
l. Cancer/Growth	<input type="checkbox"/> Yes <input type="checkbox"/> No	z. Gastrointestinal System	<input type="checkbox"/> Yes <input type="checkbox"/> No
m. High blood pressure	<input type="checkbox"/> Yes <input type="checkbox"/> No	aa. Urinary system/Prostate	<input type="checkbox"/> Yes <input type="checkbox"/> No
n. Heart/Chest Pain/Stroke	<input type="checkbox"/> Yes <input type="checkbox"/> No	ab. Any other condition not listed above	<input type="checkbox"/> Yes <input type="checkbox"/> No
5. Has your weight changed in the past year? Yes No
6. Have you ever undergone a surgical operation? Yes No
7. Have you taken any medicines in the past 12 months? Yes No
8. 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
9. Other than the medical conditions noted on this application, I am in good health. Yes No
10. Do you need any assistance to perform activities of daily living (feeding, bathing, dressing)? Yes No

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

DECLARATION

I declare that the above statements are true and complete. I am in good health and ordinarily enjoy good health. 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 this is a temporary insurance policy designed to cover the insured person for medical expenses incurred during the policy period and a new period of insurance is only available at the option of the underwriter and is subject to a new pre-existing condition exclusion. I understand the terms and conditions of this product. 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



PAYMENT AUTHORIZATION FORM

Petersen International Underwriters
23929 Valencia Boulevard, Second Floor, Valencia, CA 91355
Phone (800) 345-8816 • Fax (661) 254-0604 • payment@piu.org

Pre-Authorized Monthly \$ _____

Insured's Name		
Account Billing Address		
City	State	Zip
Email		Phone

Option 1) Credit Card -



Card #

Expiration Date: /

Security Code:

Name on Card:



Visa, Mastercard and Discover Members
Your CVV Number is a 3-digit number located after your account number in the signature strip on the back of your card.



American Express Members
Your CVV Number is a 4-digit number located above your account number to the left or right on the front of your card.

Option 2) Electronic Check - (Must be a U.S. Bank Account)

Select Account Type:

Checking **Routing #**
(9-digits)

Saving **Account #**

Name on Account

Please Include a Copy of a Voided Check

I understand that this authorization will remain in effect until Petersen International Underwriters receives a written request from me to cancel my automatic withdrawal at least 3 days prior to the next scheduled withdrawal or until Petersen International Underwriters elects to cancel this agreement. I understand that if two or more deductions are not honored, Petersen International Underwriters has the right to discontinue my enrollment in the Electronic Funds Transfer Payment Plan. I hereby authorize Petersen International Underwriters to debit my account for the correct installment premium on the due dates of the installments. I understand that my coverage is not in effect until all requirements have been submitted and approved by Petersen International Underwriters. I acknowledge that the origination of EFT transactions to my account must comply with the provision of U.S. law.

Signature: _____ Date: _____

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.

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 Sickesses due to War or any Act of War whether declared or undeclared.
15. Injuries or Sickesses due to Terrorism or any Act of Terrorism whether declared or undeclared.
16. Injuries or Sickesses 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 Sickesses 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.” If you don’t have minimum essential coverage for any month in 2018, you may have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

[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.



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