

AN EXAMPLE OF “GUARANTEED ISSUE RIGHTS”

“Guaranteed Issue Rights” is defined by the Center for Medicare Service

- Guaranteed issue rights (also called “Medigap protections”) are rights you have in certain situations when insurance companies are required by law to sell or offer you a Medigap (also called “Medicare Supplement Insurance”) policy even if you have health problems (called “pre-existing conditions,”). In these situations, an insurance company,
 - must sell you a Medigap policy
 - must cover all your pre-existing conditions,
 - can’t charge you more for a Medigap policy because of past or present health problems

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When do you have guaranteed issue rights?

- In most cases, you have a guaranteed issue right when you have other health care coverage that changes in some way, such as when you lose or drop the other health care coverage.²
- A specific definition of other health coverage
 - “You are in the Original Medicare Plan and have an employer group health plan (including retiree or COBRA coverage) that pays after Medicare pays. That coverage is ending.”³
- In the case of Alcatel-Lucent, the Traditional Indemnity plan qualifies as a retiree group health plan that pays after Medicare pays.
 - Since Traditional Indemnity will not be offered to almost all Medicare-eligible retirees in 2008, this is a “one time opportunity” that won’t occur again.

A Real-World Example of How “Guaranteed Issue” Deletes Preexisting Conditions”

- First attachment: a page with “Preexisting Condition Limitation” (no guaranteed issue)
 - “We do not pay for a preexisting condition...”
- Second attachment: See item 4 (as a result of guaranteed issue)
 - “PREEXISTING CONDITION This provision is deleted”

CONCLUSION:

**Guaranteed Issue Rights are Important to the
Health and Well Being of Lucent Retirees**

¹ page 17, 2008 Choosing a Medigap policy, CMS

² page 17, 2008 Choosing a Medigap Policy, CMS

³ page 18, case #2, 2008 Choosing a Medigap Policy, CMS

PREEXISTING CONDITION LIMITATION

Preexisting Conditions: We do not pay for treatment of a Preexisting Condition until an Insured Person's coverage has been in effect for 6 months. Only treatment of the condition made after the 6-month period will be paid for. If an Insured Person obtained coverage under this policy by converting from any CHAMPUS supplement group policy with us, then the time the person was covered under that plan will be counted toward meeting this 6-month waiting period.

If the Medicare supplement insurance provided under this policy replaces Medicare supplement insurance that was provided to an Insured Person under another Medicare supplement insurance policy, then the Preexisting Condition waiting period of 6 months, which is contained in this policy, will be waived either partially or completely as follows:

- 1) An Insured Person will be given credit for each day that the replaced Medicare supplement insurance policy was in effect immediately prior to the replacement; and
- 2) The Preexisting Condition waiting period will be waived only to the extent that benefits contained in this policy are similar to the benefits contained in the Medicare supplement insurance policy that was replaced; and
- 3) To the extent that there are additional or dissimilar benefits contained in this policy, then the 6-month waiting period for Preexisting Conditions will apply before such benefits are available.

EXCLUSIONS

Unless specifically stated otherwise, this policy does not cover or consider for payment any service or supply or any portion of a service or supply that is not a Medicare Eligible Expense, nor will this policy duplicate any benefits paid by Medicare.

PAYMENT OF CLAIMS

1. **Claim forms:** We will give you claim forms when this policy is issued. If more forms are needed, we will provide them upon request.
2. **Claim Submission:** A claim for benefits must be sent to us in writing within 90 days after the date an Insured Person receives covered care. If it is not reasonably possible to submit the claim within this period, the claim must be filed as soon as it is possible. In no event will a claim be paid if it is not received by us within 1 year and 90 days after an Insured Person receives covered care, unless you are legally incapacitated.

If we fail to give you claim forms within 15 days after we receive your notice of a claim, you shall be deemed to have met this claim submission condition upon submitting to us, within the time for filing claims, written proof of the occurrence, nature, and extent of the loss for which your claim is made.

We reserve the right to request any medical records that relate to a claim for benefits. If we ask for such records and do not receive them, benefits will not be paid. The claim will be processed for payment only when the requested records have been received and reviewed.

For prompt payment, please be sure to send us Medicare's "Explanation of Benefits" form with your claim. We will need this form to pay a claim unless:

- a) The claim is for health care covered by this policy but not covered by Medicare, or
 - b) We waive this requirement.
3. **Time of Payment:** We will pay all claims due as soon as we have valid proof of loss. For a continuing Confinement, we will not pay more often than monthly.
 4. **To Whom Paid:** We will pay benefits to you unless the benefits are assigned to someone else. Any benefits unpaid at your death will be paid to your spouse or your estate. We will, however, pay up to \$3,000.00 to any relative we find entitled to payment. Our obligation will be limited by the amount of this payment.

MEDICARE SUPPLEMENT - FLORIDA ENDORSEMENT

PLAN F

This endorsement is issued by USAA Life Insurance Company, San Antonio, Texas, and is made a part of the policy to which it is attached.

The following modifications are made:

1. Page 5. DEFINITIONS. This section is amended as follows:
 - "Preexisting Condition" - this term and definition is deleted.
 - "CHAMPUS" - this term and definition is deleted.
2. Page 5. ELIGIBILITY AND WHEN COVERAGE STARTS. Item 1. under this section is amended to read as follows:
 1. To become an Insured Person, a person must be age 65 or over and must have both Parts A and B of Medicare.
3. Page 6.1. BENEFITS. Item 2.a) Benefits Supplementing Medicare Part B (Medical Insurance) is amended to read as follows:
 - a) We will pay the Medicare Part B Deductible. We will also pay the coinsurance amount for in the case of hospital outpatient department services paid under a prospective payment system, the copayment amount) of Medicare eligible expenses under Part B regardless of hospital confinement. We will not pay this benefit if Medicare has paid the entire Medicare Approved Charge.
4. Page 7. PREEXISTING CONDITION LIMITATION
This provision is deleted.
5. Page 8. CONVERSION PRIVILEGE.
This provision is deleted.
6. Page 8. SUSPENSION OF COVERAGE UPON ELIGIBILITY FOR MEDICAID has changed to SUSPENSION OF COVERAGE PROVISIONS. This section is amended to read as follows:
 1. If an Insured Person becomes entitled to medical assistance under Title XIX of the Social Security Act, you may request that coverage under the policy be suspended. We must be notified within 90 days after the date the person becomes entitled to such assistance. If we receive timely notice, we will suspend the person's benefits and premium under the policy for up to 24 months. We will return to you the premium that applies to the period of Medicaid eligibility.

If the person loses the right to Medicaid while coverage is suspended, we will automatically reinstate the person's coverage. The effective date of the reinstated coverage will be the date the person lost the right to Medicaid. We must be notified 90 days after the date the person loses the right to Medicaid. You must also pay the premium due from the effective date of the reinstated coverage. Preexisting conditions will be covered. The person's premium will be determined as if the person's coverage had not been suspended.
 2. If an Insured Person is entitled to benefits under Section 226 (b) of the Social Security Act and is covered under a group health plan (as defined in Section 1862 (b) (1) (A) (v) of the Social Security Act), you may request that benefits and premiums under the policy be suspended (for the period provided by federal regulation). If suspension occurs and if the person loses coverage under the group health plan, the policy shall be automatically reinstated (effective as of the date of loss of coverage). You must provide notice of loss of coverage within 90 days after the date of such loss and pay the premium attributable to the period, effective as of the date of termination of entitlement.