

Transamerica Premier Life Plan Outline

Thank you for your interest in the Transamerica Premier Life Medicare Supplement plan!

This application packet provides you with access to a printable copy of the Enrollment Form and the Outline of Coverage in addition to a link to the Choosing a Medigap Policy Guide.

Should you decide to apply by upload/mail/fax/email, the printable application needs to be reviewed and signed by an Agent before it can be submitted to Transamerica Premier Life. You may upload, email, fax or mail it in to CDA Insurance:

- Fax: 1.541.284.2994
- Email: cs@cda-insurance.com
- Secure File Upload: [Click here](#)
- Mail: CDA Insurance LLC
PO Box 26540
Eugene, Oregon 97402

Other Important Information

Download Medicare's [Choosing a Medigap Policy Guide](#) (.pdf)
Download [Policy Outline](#) (.pdf)
Download [Application](#) (.pdf)

Our website: <https://medicare-texas.net>

If you should have any questions on the application, please call us at 1.800.884.2343 or 1.541.434.9613.

**TRANSAMERICA PREMIER LIFE INSURANCE COMPANY
OUTLINE OF MEDICARE SUPPLEMENT COVERAGE – COVER PAGE
BENEFIT PLANS A, F, G AND N**

These charts show the benefits included in each of the standard Medicare supplement plans. Every company must make available Plan “A”. Some plans may not be available in your state. See Outlines of Coverage sections for details about ALL plans.

Basic Benefits:

Hospitalization: Part A coinsurance plus coverage for 365 additional days after Medicare benefits end.

Medical Expenses: Part B coinsurance (generally 20% of Medicare-approved expenses) or copayments for hospital outpatient services.

Blood: Plans K, L and N require insured’s to pay a portion of Part B coinsurance or copayments.

Hospice: First 3 pints of blood each year.

Part A coinsurance.

A	B	C	D	F	F*	G	K	L	M	N
Basic, including 100% Part B Co-insurance	Basic, including 100% Part B Co-insurance	Basic, including 100% Part B Co-insurance	Basic, including 100% Part B Co-insurance	Basic, including 100% Part B Co-insurance	Basic, including 100% Part B Co-insurance	Basic, including 100% Part B Co-insurance	Hospitalization and preventive care paid at 100%; other basic benefits paid at 50%	Hospitalization and preventive care paid at 100%; other basic benefits paid at 75%	Basic, including 100% Part B Co-insurance	Basic, including 100% Part B Co-insurance, except up to \$20 co-payment for office visit, and up to \$50 co-payment for ER
		Skilled Nursing Facility Co-insurance	Skilled Nursing Facility Co-insurance	Skilled Nursing Facility Co-insurance	Skilled Nursing Facility Co-insurance	Skilled Nursing Facility Co-insurance	50% Skilled Nursing Facility Co-insurance	75% Skilled Nursing Facility Co-insurance	Skilled Nursing Facility Co-insurance	Skilled Nursing Facility Co-insurance
	Part A Deductible	Part A Deductible	Part A Deductible	Part A Deductible	Part A Deductible	Part A Deductible	50% Part A Deductible	75% Part A Deductible	50% Part A Deductible	Part A Deductible
		Part B Deductible		Part B Deductible						
				Part B Excess (100%)		Part B Excess (100%)				
		Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency			Foreign Travel Emergency	Foreign Travel Emergency
							Out-of-pocket limit \$5,240; paid at 100% after limit reached	Out-of-pocket limit \$2,620; paid at 100% after limit reached		

*Plan F also has an option called a high deductible Plan F. This high deductible plan pays the same benefits as Plan F after one has paid a calendar year \$2,240 deductible. Benefits from high deductible Plan F will not begin until out-of-pocket expenses exceed \$2,240. Out-of-pocket expenses for this deductible are expenses that would ordinarily be paid by the policy. These expenses include the Medicare deductibles for Part A and Part B, but do not include the plan’s separate foreign travel emergency deductible. Please note: High deductible Plan F is currently not available as part of this program.

Transamerica Premier Life Insurance Company

Administrative Office: 4333 Edgewood Rd. NE Cedar Rapids, Iowa 52499

PREMIUM INFORMATION

- We, Transamerica Premier Life Insurance Company, can only raise your premium if we raise the premium for all policies like yours in this state.
- However, because the premium rate is based upon your attained age, the premium will increase as you age from age 65 through age 95. This annual change will occur on each Policy Renewal Date.
- There will be a one-time enrollment fee of \$25.00 added to the first premium.
- Your policy contains a refund of premium statement that in the event of cancellation or death, upon receipt of timely notification, we will promptly return the unearned portion of any premium paid.

RIGHT TO RETURN POLICY

- If you find that you are not satisfied with your Policy, you may return it to Transamerica Premier Life Insurance Company, 4333 Edgewood Road, Cedar Rapids, Iowa 52499.
- If you send the Policy back to us within 30 days after you receive it, we will treat the Policy as if it had never been issued and return all of your payments.

DISCLOSURES

- Use this outline to compare benefits and premiums among policies.

POLICY REPLACEMENT

- If you are replacing another health insurance Policy, do NOT cancel it until you have actually received your new Policy and are sure you want to keep it.

COMPLETE ANSWERS ARE VERY IMPORTANT

- When you fill out the application for the new Policy, be sure to answer truthfully and completely all questions about your medical and health history. The company may cancel your Policy and refuse to pay any claims if you leave out or falsify important medical information.
- Review the application carefully before you sign it. Be certain that all information has been properly recorded.

READ YOUR POLICY VERY CAREFULLY

- This is only an outline describing your Policy's most important features. The Policy is the insurance contract. You must read the Policy itself to understand all of the rights and duties of both you and Transamerica Premier Life Insurance Company.

NOTICE

- This policy may not fully cover all of your medical costs. Neither Transamerica Premier Life Insurance Company nor its agents are connected with Medicare.

EXCLUSIONS

- Coverage is not provided for any expenses which are not Medicare approved, we will not pay benefits for:
 - (a) expense incurred while this policy is not in force, except as provided in the **EXTENSION OF BENEFITS** section;
 - (b) expense incurred before your policy effective date;
 - (c) that portion of any expense incurred which is paid for by Medicare;
 - (d) any expense that duplicates payments made under any other provision of the policy;
 - (e) services for non-Medicare Eligible Expenses, including, but not limited to, routine exams, take-home drugs and eye refractions;
 - (f) services for which a charge is not normally made in the absence of insurance; or
 - (g) loss or expense that is payable under any other Medicare supplement insurance policy or certificate.
 - (h) expenses which are not determined to be Medicare Eligible Expenses by the Federal Medicare Program or its administrators, except to the extent provided in the policy.

Please also reference **EXTENSION OF BENEFITS** provision on page 6 of your policy.

**PLAN A
MEDICARE (PART A) – HOSPITAL SERVICES – PER BENEFIT PERIOD**

*A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

Services	Medicare Pays	Plan A Pays	You Pay
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies First 60 days 61 st through 90 th day 91 st day and after: While using 60 lifetime reserve days Once lifetime reserve days are used: Additional 365 days Beyond the additional 365 days	All but \$1,340 All but \$335 a day All but \$670 a day \$0 \$0	\$0 \$335 a day \$670 a day 100% of Medicare Eligible Expenses \$0	\$1,340 (Part A Deductible) \$0 \$0 \$0** All costs
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare approved facility within 30 days after leaving the hospital First 20 days 21 st through 100 th day 101 st day and after	All approved amounts All but \$167.50 a day \$0	\$0 \$0 \$0	\$0 Up to \$167.50 a day All costs
BLOOD First 3 pints Additional amounts	\$0 100%	3 pints \$0	\$0 \$0
HOSPICE CARE You must meet Medicare's requirements, including a doctor's certification of terminal illness.	All but very limited copayment/coinsurance for outpatient drugs and inpatient respite care	Medicare copayment/coinsurance	\$0

**NOTICE: When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits." During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

**PLAN A
MEDICARE (PART B) – MEDICAL SERVICES – PER CALENDAR YEAR**

*Once you have been billed \$183 of Medicare Approved amounts for covered services (which are noted with an asterisk), your Medicare Part B Deductible will have been met for the calendar year.

Services	Medicare Pays	Plan A Pays	You Pay
MEDICAL EXPENSES – IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT , such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment First \$183 of Medicare Approved Amounts*	\$0	\$0	\$183 (Part B Deductible)
Remainder of Medicare Approved Amounts	Generally 80%	Generally 20%	\$0
Part B Excess Charges (above Medicare Approved Amounts)	\$0	\$0	All costs
BLOOD			
First 3 pints	\$0	All costs	\$0
Next \$183 of Medicare Approved Amounts*	\$0	\$0	\$183 (Part B Deductible)
Remainder of Medicare Approved Amounts	80%	20%	\$0
CLINICAL LABORATORY SERVICES - TESTS FOR DIAGNOSTIC SERVICES	100%	\$0	\$0

PARTS A & B

HOME HEALTH CARE – MEDICARE APPROVED SERVICES			
Medically necessary skilled care services and medical supplies	100%	\$0	\$0
Durable medical equipment			
First \$183 of Medicare Approved Amounts*	\$0	\$0	\$183 (Part B Deductible)
Remainder of Medicare Approved Amounts	80%	20%	\$0

**PLANS F
MEDICARE (PART A) – HOSPITAL SERVICES – PER BENEFIT PERIOD**

*A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

Services	Medicare Pays	Plan F Pays	You Pay
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies First 60 days	All but \$1,340	\$1,340 (Part A Deductible)	\$0
61 st through 90 th day	All but \$335 a day	\$335 a day	\$0
91 st day and after: While using 60 lifetime reserve days	All but \$670 a day	\$670 a day	\$0
Once lifetime reserve days are used: Additional 365 days	\$0	100% of Medicare Eligible Expenses	\$0**
Beyond the additional 365 days	\$0	\$0	All costs
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare approved facility within 30 days after leaving the hospital First 20 days			
21 st through 100 th day	All approved amounts	\$0	\$0
101 st day and after	All but \$167.50 a day	Up to \$167.50 a day	\$0
	\$0	\$0	All costs
BLOOD First 3 pints Additional amounts	\$0	3 pints	\$0
	100%	\$0	\$0
HOSPICE CARE You must meet Medicare's requirements, including a doctor's certification of terminal illness.	All but very limited copayment/coinsurance for outpatient drugs and inpatient respite care	Medicare copayment/coinsurance	\$0

**NOTICE: When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits." During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

**PLANS F
MEDICARE (PART B) – MEDICAL SERVICES – PER CALENDAR YEAR**

*Once you have been billed \$183 of Medicare Approved Amounts for covered services (which are noted with an asterisk), your Part B Deductible will have been met for the calendar year.

Services	Medicare Pays	Plan F Pays	You Pay
MEDICAL EXPENSES ---IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physician's services, inpatient and outpatient medical and surgical services physical and speech therapy, diagnostic tests, and durable medical equipment First \$183 of Medicare Approved Amounts*	\$0	\$183 (Part B Deductible)	\$0
Remainder of Medicare Approved Amounts	Generally 80%	Generally 20%	\$0
Part B Excess Charges (above Medicare Approved Amounts)	\$0	100%	\$0
BLOOD First 3 pints	\$0	All costs	\$0
Next \$183 of Medicare Approved Amounts*	\$0	\$183 (Part B Deductible)	\$0
Remainder of Medicare Approved Amounts	80%	20%	\$0
CLINICAL LABORATORY SERVICES ---TESTS FOR DIAGNOSTIC SERVICES	100%	\$0	\$0

PARTS A & B

HOME HEALTH CARE ---MEDICARE APPROVED SERVICES Medically necessary skilled care services and medical supplies	100%	\$0	\$0	\$0
Durable medical equipment First \$183 of Medicare Approved Amounts*	\$0	\$183 (Part B Deductible)	\$0	\$183 (Part B Deductible)
Remainder of Medicare Approved Amounts	80%	20%	\$0	20%

OTHER BENEFITS - NOT COVERED BY MEDICARE

FOREIGN TRAVEL ---NOT COVERED BY MEDICARE Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA First \$250 each calendar year Remainder of charges	\$0 \$0	\$250 20% and amounts over the \$50,000 lifetime Maximum Benefit	\$0 80% to a lifetime Maximum Benefit of \$50,000	\$250 20% and amounts over the \$50,000 lifetime Maximum Benefit
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PLANS G
MEDICARE (PART A) – HOSPITAL SERVICES – PER BENEFIT PERIOD

*A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

Services	Medicare Pays	Plan G Pays	You Pay
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies First 60 days	All but \$1,340	\$1,340 (Part A Deductible)	\$0
61 st through 90 th day	All but \$335 a day	\$335 a day	\$0
91 st day and after: While using 60 lifetime reserve days	All but \$670 a day	\$670 a day	\$0
Once lifetime reserve days are used: Additional 365 days	\$0	100% of Medicare Eligible Expenses	\$0**
Beyond the additional 365 days	\$0	\$0	All costs
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare approved facility within 30 days after leaving the hospital First 20 days			
21 st through 100 th day	All approved amounts	\$0	\$0
101 st day and after	All but \$167.50 a day	Up to \$167.50 a day	\$0
BLOOD	\$0	\$0	All costs
First 3 pints	\$0	3 pints	\$0
Additional amounts	100%	\$0	\$0
HOSPICE CARE You must meet Medicare's requirements, including a doctor's certification of terminal illness.	All but very limited copayment/coinsurance for outpatient drugs and inpatient respite care	Medicare copayment/coinsurance	\$0

**NOTICE: When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits." During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

PLANS G

MEDICARE (PART B) – MEDICAL SERVICES – PER CALENDAR YEAR

*Once you have been billed \$183 of Medicare Approved Amounts for covered services (which are noted with an asterisk), your Part B Deductible will have been met for the calendar year.

Services	Medicare Pays	Plan G Pays	You Pay
MEDICAL EXPENSES ---IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physician's services, inpatient and outpatient medical and surgical services physical and speech therapy, diagnostic tests, and durable medical equipment First \$183 of Medicare Approved Amounts*	\$0	\$0	\$183 (Part B Deductible)
Remainder of Medicare Approved Amounts	Generally 80%	Generally 20%	\$0
Part B Excess Charges (above Medicare Approved Amounts)	\$0	100%	\$0
BLOOD First 3 pints	\$0	All costs	\$0
Next \$183 of Medicare Approved Amounts*	\$0	\$0	\$183 (Part B Deductible)
Remainder of Medicare Approved Amounts	80%	20%	\$0
CLINICAL LABORATORY SERVICES ---TESTS FOR DIAGNOSTIC SERVICES	100%	\$0	\$0

PARTS A & B

HOME HEALTH CARE ---MEDICARE APPROVED SERVICES Medically necessary skilled care services and medical supplies	100%	\$0	\$0	\$0
Durable medical equipment First \$183 of Medicare Approved Amounts*	\$0	\$183 (Part B Deductible)	\$0	\$183 (Part B Deductible)
Remainder of Medicare Approved Amounts	80%	20%	\$0	20%

OTHER BENEFITS - NOT COVERED BY MEDICARE

FOREIGN TRAVEL ---NOT COVERED BY MEDICARE Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA First \$250 each calendar year	\$0	\$250	\$0	\$250
Remainder of charges	\$0	20% and amounts over the \$50,000 lifetime Maximum Benefit	80% to a lifetime Maximum Benefit of \$50,000	20% and amounts over the \$50,000 lifetime Maximum Benefit

**PLAN N
MEDICARE (PART A) – HOSPITAL SERVICES – PER BENEFIT PERIOD**

* A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

Services	Medicare Pays	Plan N Pays	You Pay
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies	All but \$1,340	\$1,340 (Part A Deductible)	\$0
First 60 days			
61 st through 90 th days	All but \$335 a day	\$335 a day	\$0
91 st day and after: While using 60 lifetime reserve days	All but \$670 a day	\$670 a day	\$0
Once lifetime reserve days are used: Additional 365 days	\$0	100% of Medicare Eligible Expenses	\$0**
Beyond the additional 365 days	\$0	\$0	All costs
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare approved facility within 30 days after leaving the hospital.	All approved amounts	\$0	\$0
First 20 days			
21 st through 100 th day	All but \$167.50 a day	Up to \$167.50 a day	\$0
101 st day and after	\$0	\$0	All costs
BLOOD			
First 3 pints	\$0	3 pints	\$0
Additional amounts	100%	\$0	\$0
HOSPICE CARE You must meet Medicare's requirements, including a doctor's certification of terminal illness.	All but very limited copayment/coinsurance for outpatient drugs and inpatient respite care	Medicare copayment/coinsurance	\$0

**NOTICE: When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits." During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

**PLAN N
MEDICARE (PART B) – MEDICAL SERVICES – PER CALENDAR YEAR**

*Once you have been billed \$183 of Medicare Approved Amounts for covered services (which are noted with an asterisk), your Part B Deductible will have been met for the calendar year.

Services	Medicare Pays	Plan N Pays	You Pay
MEDICAL EXPENSES---IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT , such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment First \$183 of Medicare Approved Amounts* Remainder of Medicare Approved Amounts	\$0 Generally 80%	\$0 Balance, other than up to \$20 per office visit and up to \$50 per emergency room visit. The copayment of up to \$50 is waived if the insured is admitted to any hospital and the emergency visit is covered as a Medicare Part A expense. \$0	\$183 (Part B Deductible) Up to \$20 per office visit and up to \$50 per emergency room visit. The copayment of up to \$50 is waived if the insured is admitted to any hospital and the emergency visit is covered as a Medicare Part A expense. All costs
Part B Excess Charges (above Medicare Approved Amounts)	\$0	\$0	All costs
BLOOD First 3 pints	\$0	All costs	\$0
Next \$183 of Medicare Approved Amounts*	\$0	\$0	\$183 (Part B Deductible)
Remainder of Medicare Approved Amounts	80%	20%	\$0
CLINICAL LABORATORY SERVICES---TESTS FOR DIAGNOSTIC SERVICES	100%	\$0	\$0

PARTS A & B

HOME HEALTH CARE---MEDICARE APPROVED SERVICES Medically necessary skilled care services and medical supplies	100%	\$0	\$0
Durable medical equipment First \$183 of Medicare Approved Amounts* Remainder of Medicare Approved Amounts	\$0 80%	\$0 20%	\$183 (Part B Deductible) \$0

OTHER BENEFITS – NOT COVERED BY MEDICARE

FOREIGN TRAVEL---NOT COVERED BY MEDICARE Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA First \$250 each calendar year Remainder of charges	\$0 \$0	\$0 80% to a lifetime Maximum Benefit of \$50,000	\$250 20% and amounts over the \$50,000 lifetime Maximum Benefit
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