

Transamerica Premier Life Application Packet

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 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 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-washington.com>

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
 SEE OUTLINES OF COVERAGE SECTIONS FOR DETAILS ABOUT ALL PLANS**

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	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 Deductible	Part B Excess (100%)					
				Part B Excess (100%)	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	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.

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.

- This outline of coverage does not give all the details of Medicare coverage. Contact your local Social Security Office or consult *Medicare and You* for details.

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.

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.

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.

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 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.

Review the application carefully before you sign it. Be certain that all information has been properly recorded.

**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* Semi-private room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but \$1,340	\$0	\$1,340 (Part A Deductible)
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	All approved amounts	\$0	\$0
21 st through 100 th day	All but \$167.50 a day	\$0	Up to \$167.50 a day
101 st day and after	\$0	\$0	All costs
BLOOD First 3 pints Additional amounts			
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 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) \$0
Remainder of Medicare Approved Amounts	Generally 80%	Generally 20%	Deductible) \$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 AND 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 F Pays	You Pay	Plan G Pays	You Pay
HOSPITALIZATION* Semi-private room and board, general nursing and miscellaneous services and supplies First 60 days	All but \$1,340	\$1,340 (Part A Deductible)	\$0	\$1,340 (Part A Deductible)	\$0
61 st through 90 th day	All but \$335 a day	\$335 a day	\$0	\$335 a day	\$0
91 st day and after: While using 60 lifetime reserve days	All but \$670 a day	\$670 a day	\$0	\$670 a day	\$0
Once lifetime reserve days are used: Additional 365 days	\$0	100% of Medicare Eligible Expenses	\$0**	100% of Medicare Eligible Expenses	\$0**
Beyond the additional 365 days	\$0	\$0	All costs	\$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	All approved amounts	\$0	\$0	\$0	\$0
21 st through 100 th day	All but \$167.50 a day	Up to \$167.50 a day	\$0	Up to \$167.50 a day	\$0
101 st day and after	\$0	\$0	All costs	\$0	All costs
BLOOD First 3 pints	\$0	3 pints	\$0	3 pints	\$0
Additional amounts	100%	\$0	\$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	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 AND 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 F Pays	You Pay	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	\$183 (Part B Deductible)	\$0	\$0	\$183 (Part B Deductible)
Remainder of Medicare Approved Amounts	Generally 80%	Generally 20%	\$0	Generally 20%	\$0
Part B Excess Charges (above Medicare Approved Amounts)	\$0	100%	\$0	100%	\$0
BLOOD First 3 pints	\$0	All costs	\$0	All costs	\$0
Next \$183 of Medicare Approved Amounts*	\$0	\$183 (Part B Deductible)	\$0	\$0	\$183 (Part B Deductible)
Remainder of Medicare Approved Amounts	80%	20%	\$0	20%	\$0
CLINICAL LABORATORY SERVICES --- TESTS FOR DIAGNOSTIC SERVICES	100%	\$0	\$0	\$0	\$0

PARTS A & B

HOME HEALTH CARE ---MEDICARE APPROVED SERVICES Medically necessary skilled care services and medical supplies	100%	\$0	\$0	\$0	\$0
Durable medical equipment First \$183 of Medicare Approved Amounts*	\$0	\$183 (Part B Deductible)	\$0	\$0	\$183 (Part B Deductible)
Remainder of Medicare Approved Amounts	80%	20%	\$0	20%	\$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	\$250	\$0	\$250
	\$0	80% to a lifetime Maximum Benefit of \$50,000	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* Semi-private 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 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.			
First 20 days	All approved amounts	\$0	\$0
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	\$0	\$0	\$183 (Part B Deductible)
First \$183 of Medicare Approved Amounts*	Generally 80%	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.	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.
Remainder of Medicare Approved Amounts		\$0	All costs
Part B Excess Charges (above Medicare Approved Amounts)	\$0		
BLOOD			
First 3 pints		All costs	\$0
Next \$183 of Medicare Approved Amounts*		\$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

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	\$0	\$250
Remainder of charges	\$0	80% to a lifetime Maximum Benefit of \$50,000	20% and amounts over the \$50,000 lifetime Maximum Benefit