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

Blood: First 3 pints of blood each year.

Hospice: 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**	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**	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**	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**
						Out-of-pocket limit $4,660; paid at 100% after limit reached	Out-of-pocket limit $2,330; 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 $2,070 deductible. Benefits from high deductible Plan F will not begin until out-of-pocket expenses exceed $2,070. 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.

Monthly Rates by Plan - Kansas

Non-Tobacco Rates									Tobacco Rates							
Plan A		Plan F		Plan G		Plan N		Issue Age	Plan A		Plan F		Plan G		Plan N	
Female	Male	Female	Male	Female	Male	Female	Male		Female	Male	Female	Male	Female	Male	Female	Male
78.24	83.59	131.87	140.90	121.91	130.25	101.88	108.85	**Under 65**	86.06	91.95	145.06	154.99	134.10	143.28	112.07	119.74
78.24	83.59	131.87	140.90	121.91	130.25	101.88	108.85	**65**	86.06	91.95	145.06	154.99	134.10	143.28	112.07	119.74
79.41	84.98	133.85	143.24	123.74	132.41	103.41	110.66	**66**	87.35	93.48	147.24	157.56	136.11	145.65	113.75	121.73
80.57	86.27	135.82	145.42	125.55	134.43	104.92	112.34	**67**	88.63	94.90	149.40	159.96	138.11	147.87	115.41	123.57
83.25	89.29	140.34	150.52	129.74	139.14	108.42	116.28	**68**	91.58	98.22	154.37	165.57	142.71	153.05	119.26	127.91
85.82	91.84	144.67	154.82	133.74	143.12	111.77	119.61	**69**	94.40	101.02	159.14	170.30	147.11	157.43	122.95	131.57
88.29	94.48	148.83	159.26	137.58	147.22	114.98	123.04	**70**	97.12	103.93	163.71	175.19	151.34	161.94	126.48	135.34
90.80	97.83	153.05	164.90	141.49	152.44	118.24	127.40	**71**	99.88	107.61	168.36	181.39	155.64	167.68	130.06	140.14
93.62	101.73	157.81	171.48	145.88	158.52	121.91	132.48	**72**	102.98	111.90	173.59	188.63	160.47	174.37	134.10	145.73
96.61	106.00	162.84	178.67	150.54	165.17	125.81	138.04	**73**	106.27	116.60	179.12	196.54	165.59	181.69	138.39	151.84
99.52	110.36	167.75	186.01	155.07	171.95	129.60	143.71	**74**	109.47	121.40	184.53	204.61	170.58	189.15	142.56	158.08
102.15	114.53	172.20	193.05	159.19	178.46	133.04	149.15	**75**	112.37	125.98	189.42	212.36	175.11	196.31	146.34	164.07
104.42	118.36	176.02	199.52	162.71	184.44	135.99	154.14	**76**	114.86	130.20	193.62	219.47	178.98	202.88	149.59	169.55
106.37	121.81	179.29	205.32	165.74	189.80	138.52	158.62	**77**	117.01	133.99	197.22	225.85	182.31	208.78	152.37	174.48
108.13	124.90	182.26	210.54	168.48	194.62	140.81	162.65	**78**	118.94	137.39	200.49	231.59	185.33	214.08	154.89	178.92
109.89	127.75	185.24	215.33	171.24	199.05	143.11	166.36	**79**	120.88	140.53	203.76	236.86	188.36	218.96	157.42	183.00
111.80	130.44	188.45	219.87	174.21	203.26	145.59	169.86	**80**	122.98	143.48	207.30	241.86	191.63	223.59	160.15	186.85
113.92	133.05	192.02	224.27	177.51	207.32	148.35	173.26	**81**	125.31	146.36	211.22	246.70	195.26	228.05	163.19	190.59
116.22	135.57	195.90	228.52	181.09	211.25	151.34	176.54	**82**	127.84	149.13	215.49	251.37	199.20	232.38	166.47	194.19
118.62	137.98	199.94	232.58	184.83	215.01	154.47	179.68	**83**	130.48	151.78	219.93	255.84	203.31	236.51	169.92	197.65
121.03	140.27	204.01	236.43	188.59	218.56	157.61	182.66	**84**	133.13	154.30	224.41	260.07	207.45	240.42	173.37	200.93
123.40	142.40	207.99	240.04	192.28	221.90	160.69	185.45	**85**	135.74	156.64	228.79	264.04	211.51	244.09	176.76	204.00
125.72	144.46	211.93	243.51	195.91	225.11	163.72	188.12	**86**	138.29	158.91	233.12	267.86	215.50	247.62	180.09	206.93
128.10	146.52	215.93	246.98	199.61	228.31	166.82	190.80	**87**	140.91	161.17	237.52	271.68	219.57	251.14	183.50	209.88
130.55	148.63	220.05	250.53	203.42	231.60	170.01	193.55	**88**	143.61	163.49	242.06	275.58	223.76	254.76	187.01	212.91
132.91	150.73	224.04	254.07	207.11	234.87	173.09	196.29	**89**	146.20	165.80	246.44	279.48	227.82	258.36	190.40	215.92
134.78	152.53	227.18	257.12	210.01	237.69	175.51	198.64	**90**	148.26	167.78	249.90	282.83	231.01	261.46	193.06	218.50
135.37	153.55	228.19	258.83	210.94	239.26	176.29	199.96	**91**	148.91	168.91	251.01	284.71	232.03	263.19	193.92	219.96
136.10	154.89	229.41	261.09	212.07	241.36	177.23	201.71	**92**	149.71	170.38	252.35	287.20	233.28	265.50	194.95	221.88
136.90	156.41	230.76	263.64	213.32	243.72	178.27	203.68	**93**	150.59	172.05	253.84	290.00	234.65	268.09	196.10	224.05
137.79	158.09	232.25	266.48	214.70	246.34	179.43	205.87	**94**	151.57	173.90	255.48	293.13	236.17	270.97	197.37	226.46
138.76	159.96	233.90	269.64	216.23	249.26	180.70	208.31	**95+**	152.64	175.96	257.29	296.60	237.85	274.19	198.77	229.14

For Quarterly, Semi-Annual and Annual Premium Modes, multiply monthly rates by 3, 6 and 12 respectively
For Tier 1 rates multiply by 1.1 and for Tier 2 rates multiply by 1.2
Rates quoted above are per person and based upon individual age. Rates increase every year, as you grow older. Neither Stonebridge Life nor its agents are connected with Medicare. FOR AGENT USE ONLY. NOT FOR PUBLIC DISSEMINATION. Rates effective as of 07/01/12.

25525085-KS

Home Office: Rutland, VT
a Transamerica Company

Stonebridge Life Insurance Company

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

PREMIUM INFORMATION

We, Stonebridge 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.

DISCLOSURES

Use this outline to compare benefits and premiums among policies.

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 Stonebridge Life Insurance Company.

RIGHT TO RETURN POLICY

If you find that you are not satisfied with your Policy, you may return it to Stonebridge 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.

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.

NOTICE

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

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.

You have purchased Medicare supplement Plan_____and the [monthly] premium will be _______ .

____
(Agent's Signature)

____
(Agent's Name)

____
(Date)

MSH10 KS

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	All but $1,156	$0	$1,156 (Part A Deductible)
61st through 90th day	All but $289 a day	$289 a day	$0
91st day and after: While using 60 lifetime reserve days	All but $578 a day	$578 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
21st through 100th day	All but $144.50 a day	$0	Up to $144.50 a day
101st 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 A

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

*Once you have been billed $140 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 $140 of Medicare Approved Amounts*	$0	$0	$140 (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 $140 of Medicare Approved Amounts*	$0	$0	$140 (Part B Deductible)
Remainder of Medicare Approved Amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES - TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

PARTS A & B

Services	Medicare Pays	Plan A Pays	You Pay
HOME HEALTH CARE – MEDICARE APPROVED SERVICES Medically necessary skilled care services and medical supplies	100%	$0	$0
Durable medical equipment First $140 of Medicare Approved Amounts*	$0	$0	$140 (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* Semiprivate room and board, general nursing and miscellaneous services and supplies First 60 days	All but $1,156	$1,156 (Part A Deductible)	$0	$1,156 (Part A Deductible)	$0
61st through 90th day	All but $289 a day	$289 a day	$0	$289 a day	$0
91st day and after: While using 60 lifetime reserve days	All but $578 a day	$578 a day	$0	$578 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
21st through100th day	All but $144.50 a day	Up to $144.50 a day	$0	Up to $144.50 a day	$0
101st 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 $140 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 and medical equipment First $140 of Medicare Approved Amounts*	$0	$140 (Part B Deductible)	$0	$0	$140 (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 $140 of Medicare Approved Amounts*	$0	$140 (Part B Deductible)	$0	$0	$140 (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

Services	Medicare Pays	Plan F Pays	You Pay	Plan G Pays	You Pay
HOME HEALTH CARE—MEDICARE APPROVED SERVICES Medically necessary skilled care services an d medical supplies	100%	$0	$0	$0	$0
Durable medical equipment First $140 of Medicare Approved Amounts*	$0	$140 (Part B Deductible)	$0	$0	$140(Part B Deductible)
Remainder of Medicare Approved Amounts	80%	20%	$0	20%	$0

OTHER BENEFITS - NOT COVERED BY MEDICARE

Services	Medicare Pays	Plan F Pays	You Pay	Plan G Pays	You Pay
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	$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	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 First 60 days	All but $1,156	$1,156 (Part A Deductible)	$0
61st through 90th days	All but $289 a day	$289 a day	$0
91st day and after: While using 60 lifetime reserve days	All but $578 a day	$578 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
21st through 100th day	All but $144.50 a day	Up to $144.50 a day	$0
101st 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 $140 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 $140 of Medicare Approved Amounts*	$0	$0	$140 (Part B Deductible)
Remainder 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.
Part B Excess Charges (above Medicare Approved Amounts)	$0	$0	All costs
BLOOD First 3 pints	$0	All costs	$0
Next $140 of Medicare Approved Amounts*	$0	$0	$140 (Part B Deductible)
Remainder of Medicare Approved Amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES—TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

PARTS A & B

Services	Medicare Pays	Plan N Pays	You Pay
HOME HEALTH CARE—MEDICARE APPROVED SERVICES Medically necessary skilled care services and medical supplies	100%	$0	$0
Durable medical equipment First $140 of Medicare Approved Amounts*	$0	$0	$140 (Part B Deductible)
Remainder of Medicare Approved Amounts	80%	20%	$0

OTHER BENEFITS – NOT COVERED BY MEDICARE

Services	Medicare Pays	Plan N Pays	You Pay
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