FIDELITY SECURITY LIFE INSURANCE COMPANY

3130 Broadway
Kansas City, Missouri 64111-2406
Phone 800-648-8624
A STOCK COMPANY
(Herein Called "the Company")

POLICY NUMBER: VC-19

POLICYHOLDER: Wellesley College

POLICY EFFECTIVE DATE: January 1, 2013

POLICY ANNIVERSARY DATE: January 1 of the following year and each January 1 thereafter

Fidelity Security Life Insurance Company represents that the Insured Person is insured for the benefits described on the following pages, subject to and in accordance with the terms and conditions of the Policy.

The Policy may be amended, changed, cancelled or discontinued without the consent of any Insured Person.

The Certificate explains the plan of insurance. An individual identification card will be issued to the Insured containing the group number, the Insured's effective date, the name of the Network and toll-free customer service number. The Certificate replaces all certificates previously issued to the Insured under the Policy.

All periods of time under the Policy will begin and end at 12:01 A.M. Local Time at the Policyholder's business address.

The Policy is issued by Fidelity Security Life Insurance Company at Kansas City, Missouri on the Policy Effective Date.

FIDELITY SECURITY LIFE INSURANCE COMPANY

President Secretary

*This plan is not intended to provide comprehensive health coverage**.** This health plan, alone, **does not meet Minimum Creditable Coverage standards** and **will not satisfy** the individual mandate that you have health insurance. Please see page 9 for additional information.

There are no pre-existing condition limitations or exclusions under this plan.

GROUP VISION INSURANCE CERTIFICATE

THIS IS A LIMITED BENEFIT CERTIFICATE

Please read the Certificate carefully.

THIS PLAN IS NOT MEDICARE SUPPLEMENT. If you are eligible for Medicare, please review "Choosing a Medigap Policy: A Guide to Health Insurance for People With Medicare," available from the Company.

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DEFINITIONS

Benefit Frequency means the period of time in which a benefit is payable.

The Benefit Frequency begins on the later of the Insured Person's effective date or last date services were provided to the Insured Person. Each new Benefit Frequency begins at the expiration of the previous Benefit Frequency.

Co-payment means the designated amount, if any, shown in the Schedule of Benefits each Insured Person must pay to a Provider before benefits are payable for a covered Vision Examination or Vision Materials per Benefit Frequency.

Comprehensive Eye Examination means a comprehensive ophthalmological service as defined in the Current Procedural Technology (CPT) and the Documentation Guidelines listed under "Eyes-examination items". Comprehensive ophthalmological service describes a general evaluation of the complete visual system. The comprehensive services constitute a single service entity but need not be performed at one session. The service includes history, general medical observation, external and ophthalmoscopic examinations, gross visual fields and basic sensorimotor examination. It often includes, as indicated by examination, biomicroscopy, examination with cycloplegia or mydriasis and tonometry. It always includes initiation of diagnostic and treatment programs.

Dependent means any of the following persons whose coverage under the Policy is in force and has not ended:

1. the Insured's lawful spouse or Domestic Partner;
2. each child from birth to age 26 or for two years after the end of the calendar year in which such persons last qualified as a Dependent, whichever occurs first; or
3. each child who is mentally or physically incapable of earning his or her own living, if due proof of the incapacity is received by the Company within 31 days of the date upon which the coverage would otherwise be terminated.

Child includes stepchild, foster child, legally adopted child, child legally placed in the Insured's home for adoption and child under the Insured's legal guardianship.

Domestic Partner means an adult who is in a committed relationship with the Insured, and the Insured and the Domestic Partner are mutually responsible for one another financially and otherwise. To qualify as a Domestic Partner or Dependent under the Policy, all of the following conditions must be met:

1. the Domestic Partner and the Insured are over the age of 18 and are mentally competent to enter into contracts;
2. the Domestic Partner and the Insured reside in the same household;
3. the Domestic Partner and the Insured have a committed relationship with each other for no less than six months; intend to continue the relationship indefinitely and have no such relationship with any other person;
4. the Domestic Partner and the Insured are not related by blood;
5. the Domestic Partner and the Insured are not married to any third party;
6. the Domestic Partner and the Insured are of the same sex or opposite sex; and
7. the Domestic Partner and the Insured are not claiming Dependent status for the primary purpose of gaining insurance coverage under the Policy.

The term "spouse", wherever used, will include a Domestic Partner.

Insured means an employee of the Policyholder who meets the eligibility requirements as shown in the Policyholder's application, and whose coverage under the Policy is in force and has not ended.

Insured Person means the Insured. Insured Person will also include the Insured's Dependents, if enrolled.

In-Network Provider means a Provider who has signed a Preferred Provider Agreement with the PPO.

Medically Necessary Contact Lenses means:

1. Keratoconus where the Insured Person is not correctable to 20/30 in either or both eyes using standard spectacle lenses, or the Provider attests to the specified level of visual improvement;
2. High Ametropia exceeding -10D or +10D in spherical equivalent in either eye;
3. Anisometropia of 3D in spherical equivalent or more; or
4. vision for an Insured Person can be corrected two lines of improvement on the visual acuity chart when compared to best corrected standard spectacle.

Out-of-Network Provider means a Provider, located within the PPO Service Area, who has not signed a Preferred Provider Agreement with the PPO.

Policy means the Policy issued to the Policyholder.

Policyholder means the Employer named as the Policyholder in the face page of the Policy.

PPO Service Area means the geographical area where the PPO is located. The counties are Bristol, Essex, Middlesex, Norfolk, Plymouth, Suffolk, Berkshire and Worcester.

Preferred Provider Agreement means an agreement between the PPO and a Provider that contains the rates and reimbursement methods for services and supplies provided by such Provider.

Preferred Provider Organization ("PPO") means a network of Providers and retail chain stores within the PPO Service Area that has signed a Preferred Provider Agreement.

Provider means a licensed physician or optometrist who is operating within the scope of his or her license or a dispensing optician.

Vision Examination means any eye or visual examination covered under the Policy and shown in the Schedule of Benefits.

Vision Materials means those materials shown in the Schedule of Benefits.

EFFECTIVE DATES

Effective Date of Insured's Insurance. The Insured's insurance will be effective as follows:

1. if the Policyholder does not require the Insured to contribute toward the premium for this coverage, the Insured's insurance will be effective on the date the Insured became eligible;
2. if the Policyholder requires the Insured to contribute toward the premium for this coverage, the Insured's insurance will be effective on the date the Insured became eligible, provided;
   a. the Insured has given the Company the Insured's enrollment form (if required) on, prior to, or within 30 days of the date the Insured became eligible; and
   b. the Insured has agreed to pay the required premium contributions; and
3. if the Insured fails to meet the requirements of 2 a) and 2 b) within 30 days after becoming eligible, the Insured's coverage will not become effective until the Company has verified that the Insured has met these requirements. The Insured will then be advised of the Insured's effective date.

Effective Date of Dependents' Insurance. Coverage for Dependents becomes effective on the later of:

1. the date Dependent coverage is first included in the Insured's coverage; or
2. the premium due date on or after the date the person first qualifies as the Insured's Dependent. If an enrollment form is required, the Insured must provide such form and agree to pay any premium contribution that may be required prior to coverage becoming effective.

If the Insured and the Insured's spouse are both Insureds, one Insured may request to be a Dependent spouse of the other. A Dependent child may not be covered by more than one Insured.

Newborn Children. A Dependent child born while the Insured's coverage is in force will be covered from the moment of birth for 31 days or greater, if elected by the Policyholder. In order to continue coverage beyond this period, the Insured must provide notice to the Company and agree to pay any premium contribution that may be required within this period.

Adopted Children. If a Dependent child is placed with the Insured for adoption while the Insured's coverage is in force, this child will be covered from the date of placement for 31 days or greater, if elected by the Policyholder. In order to continue coverage beyond this period, the Insured must provide notice to the Company and agree to pay any premium contribution that may be required within this period. If proper notice has been given, coverage will continue unless the placement is disrupted prior to legal adoption and the child is removed from placement.

BENEFITS

Benefits are payable for each Insured Person as shown in the Schedule of Benefits for expenses incurred while this insurance is in force.

Comprehensive Eye Examination. An Insured Person is eligible for one Comprehensive Eye Examination in each Benefit Frequency.

In-Network Provider Benefits. The Insured Person must pay any Co-payment or any cost above the allowance shown in the Schedule of Benefits at the time the covered service is provided. Benefits will be paid to the In-Network Provider who will file a claim with the Company.

Out-of-Network Provider Benefits. The Insured Person must pay the Out-of-Network Provider the full cost at the time the covered service is provided and file a claim with the Company. The Company will reimburse the Insured Person for the Out-of-Network Provider benefits up to the maximum dollar amount shown in the Schedule of Benefits.

Vision Materials. If a Vision Examination results in an Insured Person needing corrective Vision Materials for the Insured Person's visual health and welfare, those Vision Materials prescribed by the Provider will be supplied, subject to certain limitations and exclusions of the Policy, as follows:

- *Lenses* provided one time in each Benefit Frequency.
- *Frames* provided one time in each Benefit Frequency.
- *Contact Lenses* provided one time in each Benefit Frequency in lieu of lenses.

CHOICE OF PROVIDERS

Insured Persons may receive vision care services and Vision Materials from an In-Network Provider or an Out-of-Network Provider. Out-of-Network Provider services and Vision Materials may be secured from an optometrist, ophthalmologist and/or dispensing optician. The Company will reimburse the Insured as shown in the Schedule of Benefits.

If the Insured hasn't requested one sooner, the Insured will be given a PPO Directory when enrolled. The Insured may request a PPO Directory at any time or to locate an In-Network Provider in the Insured's area, the Insured may call the PPO toll-free automated voice response system number located on the back of the Insured's identification card. This service is available 24 hours per day, 7 days per week. The Insured may call and enter the Insured's zip code. The computer will give the Insured a list of the 10 closest In-Network Providers to that zip code including the In-Network Provider's name, telephone number, and the services available at each location.

The Insured may also obtain a PPO Directory via the PPO's website at: www.eyemedvisioncare.com. The procedures are the same as the automated voice response system.

In addition, the PPO has service staff available, Monday through Saturday from 8:00 a.m. – 11:00 p.m. and Sunday 11:00 a.m. – 8:00 p.m. EST to assist callers with their selection of In-Network Providers. The toll-free number is 1-877-226-1115.

A physician profile may be available from the Board of Registration in Medicine for Providers licensed to practice in Massachusetts.

PROCEDURES FOR USING IN-NETWORK PROVIDER BENEFITS

The Insured should have the Insured's identification card available when scheduling an appointment and visiting an In-Network Provider. For information on In-Network Providers in the Insured's area, call the PPO's toll-free number listed in the Insured's identification card.

The Insured presents the Insured's identification card at the time the Insured receives services from an In-Network Provider, pays the Co-payment, if any, and any other charges not covered at the time of the service. No paperwork is required.
If the Insured selects an Out-of-Network Provider, the Insured does not receive PPO preferred pricing. The Insured will make full payment to the Out-of-Network Provider at the time of service and submit a claim for reimbursement.

If the Insured should need emergency care and cannot reach an In-Network Provider, payment for the care related to the emergency will be made at the In-Network Provider level. The Insured also has the option of calling the local pre-hospital emergency medical service system whenever confronted with an emergency care for a vision condition which in the judgment of a prudent layperson would require pre-hospital emergency services. Emergency care benefits are limited to the specific vision care services outlined in the Schedule of Benefits.

LIMITATIONS

Fees charged by a Provider for services other than a covered benefit must be paid in full by the Insured Person to the Provider. Such fees or materials are not covered under the Policy.

Benefit allowances provide no remaining balance for future use within the same Benefit Frequency.

EXCLUSIONS

No benefits will be paid for services or materials connected with or charges arising from:

1. orthoptic or vision training, subnormal vision aids and any associated supplemental testing; Aniseikonic lenses;
2. medical and/or surgical treatment of the eye, eyes or supporting structures;
3. any Vision Examination, or any corrective eyewear required by a Policyholder as a condition of employment; safety eyewear;
4. services provided as a result of any Workers' Compensation law, or similar legislation, or required by any governmental agency or program whether federal, state or subdivisions thereof;
5. plano (non-prescription) lenses;
6. non-prescription sunglasses;
7. two pair of glasses in lieu of bifocals;
8. services or materials provided by any other group benefit plan providing vision care;
9. services rendered after the date an Insured Person ceases to be covered under the Policy, except when Vision Materials ordered before coverage ended are delivered, and the services rendered to the Insured Person are within 31 days from the date of such order; or
10. lost or broken lenses, frames, glasses, or contact lenses will not be replaced except in the next Benefit Frequency when Vision Materials would next become available.

TERMINATION OF INSURANCE

The Policyholder or the Company may terminate or cancel the Policy as shown in the Policy.

For All Insureds. The Insured's insurance will cease on the earliest of the following dates:

1. the date the Policy ends;
2. the end of the last period for which any required premium contribution agreed to in writing has been made. The Company will provide written notification of the termination to the Insured, by mail, to the last known home address, a letter that includes the following information: a) the date the Policy was terminated; b) that the termination was for nonpayment of premiums; and c) that the termination of the insurance of any Insured Person will be without prejudice to any covered service incurred before the date of termination. The Company will honor claims, to the extent covered under the Policy, for any benefit received by the Insured or the Insured's Dependent prior to the notification date;
3. the date the Insured is no longer eligible for insurance; or
4. the date the Insured's employment with the Policyholder ends. The Policyholder may, at the Policyholder's option, continue insurance for individuals whose employment has ended, if the Policyholder:
   a. does so without individual selection between Insureds; and
   b. continues to pay any premium contribution for those individuals.

For Dependents. A Dependent's insurance will cease on the earlier of:

1. the date the Insured's coverage ends;
2. the date in which the Dependent ceases to be an eligible Dependent as defined in the Policyholder's application; or
3. the end of the last period for which any required premium contribution has been made. The Company will provide written notification of the termination to the Insured, by mail, to the last known home address, a letter that includes the following information: a) the date the Policy was terminated; b) that the termination was for nonpayment of premiums; and c) that the termination of the insurance of any Insured Person will be without prejudice to any covered service incurred before the date of termination.

Extension of Benefits. If the Insured terminates employment with the Policyholder, coverage under the Policy will continue for 31 days from the date the Insured terminated employment. If the Insured's coverage terminates due to a plant closing or partial closing, coverage under the Policy will be continued for 90 days after the date of the plant closing or partial closing. This Extension of Benefits provision will not apply if the Insured is eligible for similar benefits under another policy.

A Dependent child will not cease to be a Dependent solely because of age if the child is:

1. not capable of self-sustaining employment due to mental incapacity or physical handicap that began before the age limit was reached; and
2. mainly dependent on the Insured for support.

The Company may ask for proof of the eligible Dependent child's incapacity and dependency two months prior to the date the Dependent child would otherwise cease to be covered.

The Company may require the same proof again, but will not ask for it more than once a year after this coverage has been continued for two years. This continued coverage will end:

1. on the date the Policy ends;
2. on the date the incapacity or dependency ends;
3. on the end of the last period for which any required premium contribution for the Dependent child has been made; or
4. 60 days following the date the Company requests proof and such proof is not provided to the Company.

CLAIMS

Notice of Claim. Written notice of claim must be given to the Company within 30 days after the occurrence or commencement of any loss covered by the Policy, or as soon as is reasonably possible. Notice given by or for the Insured Person to the Company at the Company's home office, to the Company's authorized administrator or to any of the Company's authorized agents with sufficient information to identify the Insured Person will be deemed as notice to the Company.

Claim Forms. The Company will furnish claim forms to the Insured Person within 15 days after notice of claim is received. If the Company does not provide the forms within that time, the Insured Person may send written proof of the occurrence, character and extent of loss for which the claim is made within the time stated in the Policy for filing proof of loss.

Proof of Loss. Written proof of loss must be furnished to the Company at the Company's home office within 90 days after the date of the loss. Failure to furnish proof within the time required will not invalidate or reduce any claim if it was not reasonably possible to give proof within that time, if the proof is furnished as soon as reasonably possible. In no event, except in the absence of legal capacity, will proof of loss be accepted later than one year from the time proof is required.

Time Payment of Claims. Any benefit payable under the Policy will be paid immediately, but not more than 30 days, upon receipt of due written proof of loss.

Payment of Claims. All claims will be paid to the Insured, unless assigned. Any benefits payable on or after the Insured's death will be paid to the Insured's estate.

Right of Recovery. If payment for claims exceeds the amount for which the Insured Person is eligible under any benefit provision or rider of the Policy, the Company has the right to recover the excess of such payment from the Provider or the Insured.

Legal Actions. No Insured Person can bring an action at law or in equity to recover on the Policy until more than 60 days after the date written proof of loss has been furnished according to the Policy. No such action may be brought after the expiration of three years after the time written proof of loss is required to be furnished. If the time limit of the Policy is less than allowed by the laws of the state where the Insured Person resides, the limit is extended to meet the minimum time allowed by such law.

GENERAL PROVISIONS

Clerical Error. Clerical errors or delays in keeping records for the Policy will not deny insurance that would otherwise have been granted, nor extend insurance that otherwise would have ceased, and call for a fair adjustment of premium and benefits to correct the error.

Conformity to Law. Any provision of the Policy that is in conflict with the laws of the state in which it is issued is amended to conform with the laws of that state.

Entire Contract. The Policy, including any endorsements and riders, the Certificate, the Policyholder's application, which is attached to the Policy when issued, the Insured's individual enrollment form, if any, and the eligibility file, if any, are the entire contract between the parties. A copy of the Policy may be examined at the Office of the Policyholder during normal business hours. All statements made by the Policyholder or an Insured will, in the absence of fraud, be deemed representations and not warranties, and no such statement shall be used in defense to a claim hereunder unless it is contained in a written instrument signed by the Policyholder, the Insured, the Insured's beneficiary or personal representative, a copy of which has been furnished to the Policyholder, the Insured, the Insured's beneficiary or personal representative.

Amendments and Changes. No agent is authorized to alter or amend the Policy, or to waive any conditions or restrictions herein, or to extend the time for paying any premium. The Policy and the Certificate may be amended at any time by mutual agreement between the Policyholder and the Company without the consent of the Insured, but without prejudice to any loss incurred prior to the effective date of the amendment. No person except an Officer of the Company has authority on behalf of the Company to modify the Policy or to waive or lapse any of the Company's rights or requirements.

Incontestability. After the Policy has been in force for two years, it can only be contested for nonpayment of premiums. No statement made by an Insured Person can be used in a contest after the Insured Person's insurance has been in force for two years during the Insured Person's lifetime. No statement an Insured Person makes can be used in a contest unless it is in writing and signed by the Insured Person.

Insurance Data. The Policyholder must give the Company the names and ages of all individuals initially insured. The names of persons who later become eligible (whether or not the person becomes insured), and the names of those who cease to be eligible must also be given. The eligibility dates and any other necessary data must be given to the Company so that the premium can be determined.

The Company has the right to audit the Policyholder's books and records as the books and records relate to this insurance. The Company may authorize someone else to perform this audit. Any such inspection may be done at any reasonable time.

Workers' Compensation. The Policy is not a Workers' Compensation policy. The Policy does not satisfy any requirement for coverage by Workers' Compensation Insurance.

Massachusetts Health Care Reform Law. As of January 1, 2009, the Massachusetts Health Care Reform Law requires that Massachusetts residents, eighteen (18) years of age and older, must have health coverage that meets the Minimum Creditable Coverage standards set by the Commonwealth Health Insurance Connector, unless waived from the health insurance requirement based on affordability or individual hardship. For more information call the Connector at 1-877-MA-ENROLL or visit the Connector website (www.mahealthconnector.org).

This plan is not intended to provide comprehensive health care coverage and **does not meet Minimum Creditable Coverage standards**, even if it does include services that are not available in the Insured's other health plans.

If you have questions about this notice, you may contact the Division of Insurance by calling (617) 521-7794 or visiting its website at www.mass.gov/doi.

GRIEVANCE PROCEDURE

Note: References to Insured Person includes the Insured Person's authorized representative.

Form and Manner of Request. Grievances may be made by telephone, in person, by mail, or by electronic means. Oral grievances made by the Insured Person will be reduced to writing by PPO. A copy will be sent to the Insured Person within 48 hours of receipt, except where this time limit is waived or extended by mutual written agreement of the Insured Person and PPO.

Any grievance that required the review of medical records will include the signature of the Insured Person on a form provided promptly by PPO. This will authorize the release of medical and treatment information relevant to the grievance to PPO when necessary, in a manner consistent with state and federal law. The Insured Person will have access to any medical information and records relevant to the grievance relating to the Insured Person which is in PPO's possession and under its control. PPO will request the authorization from the Insured Person when necessary for requests reduced to writing by PPO and for any written requests lacking the authorization.

Acknowledgment of Grievances. A written acknowledgment of the receipt of a grievance will be sent to the Insured Person within 15 business days of receipt except where an oral grievance has been reduced to writing by PPO pursuant to the above section, or this time period is waived or extended by mutual written agreement of the Insured Person and PPO.

Time Requirements for Resolution of Grievances. PPO will provide the Insured Person with a written resolution of a grievance within 30 business days of receipt of the oral or written grievance.

When a grievance requires the review of medical records, the 30 business day period will not begin to run until the Insured Person submits a signed authorization for release of medical records and treatment information. In the event that the signed authorization is not provided within 30 business days of the receipt of the grievance, PPO may, in its discretion, issue a resolution of the grievance without review of some or all of the medical records.

The time limits may be waived or extended by mutual written agreement of the Insured Person and PPO.

Review of Grievances. Grievances will be reviewed by an individual or individuals who are knowledgeable about the matters at issue in the grievance.

Grievances of adverse determinations are reviewed with the participation of an individual or individuals who did not participate in any of PPO's prior decisions on the grievance. In at least one level of review of grievances of adverse determinations, these individuals will be actively practicing health care professionals in the same or similar specialty who typically correct the vision problem, perform the exam or provide the materials that is the subject of the grievance.

Form of Written Resolution. A written resolution will include identification of the specific information considered and an explanation of the basis for the decision.

In the case of a grievance that involves an adverse determination the written resolution will include a substantive clinical justification therefor that is consistent with generally accepted principles of professional medical practice, and will at a minimum:

1. identify the specific information upon which the adverse determination was based;
2. discuss the Insured Person's presenting symptoms or condition, diagnosis and treatment interventions and the specific reasons such medical evidence fails to meet the relevant medical review criteria;
3. specify alternative treatment options covered by the Company, if any; and
4. reference and include applicable clinical practice guidelines and review criteria.

Opportunity for Reconsideration. PPO may offer to the Insured Person, the opportunity for reconsideration of PPO's final adverse determination where relevant medical information:

1. was received too late to review within the 30 business day time limit; or
2. was not received but is expected to become available within a reasonable time period following the written resolution.

When an Insured Person chooses to request reconsideration, PPO must agree in writing to a new time period for review, but in no event greater than 30 business days from the agreement to reconsider the grievance. The time period for requesting external review will begin to run on the date of the resolution of the reconsidered grievance.

Expedited Review of Grievances. PPO will provide for an expedited resolution concerning coverage or provision or immediate and urgently needed services, which will include, but not be limited to provisions for the automatic reversal of decisions denying coverage for services pending the outcome of the internal grievance process, within 48 hours of receipt of certification by the physician that, in his or her opinion:

1. the service at issue in a grievance is medically necessary;
2. a denial of coverage for such services would create a substantial risk of serious harm to the patient; and
3. such risk of serious harm is so immediate that the provision of such services should not await the outcome of the normal grievance process.

Failure of PPO to Meet Time Limits. A grievance not properly acted on by PPO within the time limits required by Massachusetts' laws and regulations will be deemed resolved in favor of the Insured Person.

Time limits include any extensions made by mutual written agreement of the Insured Person and PPO.

QUALITY ASSURANCE

The delivery of quality vision care is of prime concern to PPO and to the Policyholders and the Insured Persons which the PPO serves. It is PPO's credo that Insured Persons receive high quality vision care services, spectacles and contact lenses, where these products are available through their respective plans. Ultimately, it is the perceived value and expectations of each of the PPO's Insured Persons or patients that will decide the quality of care delivered. Quality care assures Insured Person satisfaction.

The PPO Quality Assurance Program includes:

- Patient surveys with patient input on vision care services provided.
- Patient grievance procedures with formal and timely grievance management.
- Provider profiling programs to review, evaluate, and identify Provider achievements or deficiencies and to initiate appropriate remediation.
- Oversight Committees consisting of Grievance, Peer Review and Quality Assurance Committees whose functions are to review and make recommendations for remediation or termination of a Provider.
- Product quality assurance standards to insure the delivery of quality ophthalmic products.

Please call 1-877-226-1115 to determine the status or outcome of a utilization review.

SCHEDULE OF BENEFITS

Insured Persons have the right to obtain vision care from the Provider of his or her choice. However, payment of benefits varies depending on the type of Provider chosen. Benefits are payable as shown in the following Schedule of Benefits:

Benefit	In-Network	Out-of-Network	Benefit Frequency
VISION EXAMINATION			
Comprehensive Eye Examination	$15 Co-payment	up to $50	12 months
VISION MATERIALS			
Standard Plastic Lenses			12 months
Single Vision	$0 Co-payment	up to $42	
Bifocal	$0 Co-payment	up to $78	
Trifocal	$0 Co-payment	up to $130	
Lenticular	$0 Co-payment	up to $130	
Frames	$0 Co-payment, up to $130 retail allowance	up to $74	12 months
Contact Lenses ***(only one option available per Benefit Frequency)***			12 months
Conventional	$0 Co-payment, up to $130 allowance	up to $104	
Disposable	$0 Co-payment, up to $130 allowance	up to $104	
Medically Necessary	Paid in full	up to $210	

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AMENDMENT RIDER
For Massachusetts Residents Only

By attachment of this Rider, the Policy/Certificate is amended by the following:

1. Any Dependent child age restriction is replaced with the following:

   Coverage for a Dependent child will continue to the earlier of age 26 or for two years after the loss of dependent status under the Internal Revenue Code. For purposes of this continuation, the date on which a person loses dependent status is December 31st of the last federal tax year for which the individual was claimed as a dependent on the child's parent's federal income tax form.

2. The definition of Dependent is amended to include the following:

   Dependent will include a Dependent child of a Dependent child.

This Rider takes effect on the effective date of the Policy/Certificate to which it is attached. This Rider terminates concurrently with the Policy/Certificate to which it is attached. It is subject to all the definitions, limitations, exclusions and conditions of the Policy/Certificate except as stated.

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President Secretary

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AMENDMENT RIDER
For Massachusetts Residents Only

By attachment of this Rider, the Policy/Certificate is amended by the following:

Voluntary and Involuntary Disenrollment. Under Massachusetts law, the Company is required to report the voluntary and involuntary disenrollment rate amount among the Company's Insureds. The rates are:

Voluntary disenrollment rate: 5% of Insureds
Involuntary disenrollment rate: 0% of Insureds

This Rider takes effect on the effective date of the Policy/Certificate to which it is attached. This Rider terminates concurrently with the Policy/Certificate to which it is attached. It is subject to all the definitions, limitations, exclusions and conditions of the Policy/Certificate except as stated.

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NOTICE OF ADMINISTRATOR'S CAPACITY

PLEASE READ: This notice advises insured persons of the identity and relationship among the administrator, the policyholder and the insurer:

1. Fidelity Security Life Insurance Company (FSL) has, by agreement, arranged for First American Administrators, Inc. to provide administrative services for your insurance plan. As administrator, First American Administrators, Inc., is authorized to process claim payments, and perform other services, according to the terms of its agreement with the insurance company. First American Administrators, Inc. is not the insurance company or the policyholder.

2. The policyholder is the entity to whom the insurance policy has been issued. The policyholder is identified on either the face page or schedule page of the policy or certificate.

3. Fidelity Security Life Insurance Company is liable for the funds to pay your insurance claims.

As First American Administrators, Inc. is authorized to process claims for the insurance company, they will do so promptly. In the event there are delays in claims processing, you will have no greater rights to interest or other remedies against First American Administrators, Inc. than would otherwise be afforded to you by law.

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Massachusetts Bulletin for People with Medicare

Health Insurance Choices for People with Medicare

- Original Medicare (Part A and/or Part B)
- Medicare Supplement Insurance (Medigap)
- Medicare Advantage Plans (Medicare Part C)
- Prescription Drug Coverage (Medicare Part D)
- Employer, Union, Retiree, other group health insurance coverage
- COBRA (employer or union that may allow temporary health coverage after employment ends)
- Veterans Benefits - Health coverage for veterans and people who have served in the U.S. military
- Military Benefits (TRICARE) Health plan for active-duty service members, retirees and their families
- Indian Health Services for American Indians and Alaska Natives

Programs for people with limited income and resources that may help pay for some health care expenses.

- Extra Help pays for some Medicare prescription drug costs
- Medicare Savings Programs help pay Medicare premiums
- Prescription Advantage, a State Pharmacy Assistance Program, helps pay for prescription drugs
- MassHealth (Medicaid)

January 2013

This Bulletin provides basic information for people eligible for Medicare. Contact your plan Benefits Administrator for information about employer, union, retiree or other coverage. Contact your local Veteran's agent for veteran's and TRICARE information and Indian Health Services for American Indian and Alaska Natives.

Medicare

Medicare is a Federal Government health insurance program administered by the Centers for Medicare and Medicaid Services (CMS) for people:

- age 65 or older
- under age 65 with certain disabilities
- People of any age with End-Stage Renal Disease (ESDR) requiring dialysis or kidney transplant

Medicare has **five** parts:

- **Medicare Part A (Hospital Insurance)**
  Helps cover inpatient care in hospitals, skilled nursing facility, hospice, home health care and other services.
- **Medicare Part B (Medical Insurance)**
  Helps cover outpatient medical services including doctors' and other health care provider services, durable medical equipment, home health care, outpatient care, some preventive and other medical services.
- **Medicare Part C (Medicare Advantage Plans)**
  Medicare Advantage Plans (like an HMO or PPO) are health plans run by Medicare-approved private insurance companies, include Medicare Part A and Part B services, and may include optional prescription drug coverage (Part D).
- **Medicare Part D (Medicare Prescription Drug Coverage)**
  Helps cover the cost of outpatient prescription drugs. Medicare Prescription Drug Plans are sold by private insurance companies approved by Medicare.
- **Medicare Preventive Services**
  Medicare helps pay for many services to keep people healthy. Preventive services include exams, lab tests, shots, screenings, monitoring and information to help people take care of their health.

There are (2) ways to get Medicare health insurance coverage:

(1) **Original Medicare** is fee-for-service coverage managed by Medicare.
Original Medicare covers **Part A** and **Part B** services and is the prime payer for Medicare covered services.
Beneficiaries may go to any Medicare participating doctor, hospital or other Medicare provider accepting Medicare patients.

People with Original Medicare may purchase optional Medicare Supplement (Medigap) insurance as secondary payer to cover payment gaps in Original Medicare coverage.
Effective January 1, 2006, Medicare Supplement Insurance Insurers cannot offer prescription drug coverage to new enrollees.
People with Original Medicare may purchase a Medicare prescription drug plan (Medicare Part D) sometimes called "PDP" or stand-alone plan from a Medicare-approved private insurance company.

(2) **Medicare Advantage Plans** are health plans (like HMOs, PPOs, PFFS) sold by private insurance companies that contract with Medicare to provide Medicare Part A and Part B services. Some plans include Medicare Part D (Medicare prescription drug coverage).
Some plans offer additional benefits not covered by Medicare.
There is no need to purchase Medicare Supplement Insurance if a person is enrolled in a Medicare Advantage Plan. To join a Medicare Advantage Plan, the person must be enrolled in Medicare A and B, live in the plan's service area and pay plan premiums, copays and deductibles.

Types of Medicare Advantage Plans sold in Massachusetts

- **Health Maintenance Organization (HMO)**
  The person must be a resident of the plan's service area, and must use Medicare providers in the plan's network.
- **Preferred Provider Organization (HMO/PPO)**
  The person must be a resident of the plan's service area, and may use out-of-network Medicare providers for covered services at higher cost.
- **Point-of Service (HMO/POS)**
  The person must be a resident of the plan's service area, and may use out-of-network Medicare providers for covered services at higher cost.
- **Private Fee-for-Service (PFFS)**
  The person can go to any Medicare provider that agrees to treat patient.
  The Plan determines provider and patient payment for the services.
- **Special Needs Plans (SNP)**
  Provide coordinated Medicare health services for people in institutions or at home.

Medicare Prescription Drug Coverage (Part D)

Medicare prescription drug coverage (Part D) helps pay for outpatient prescription drugs. Each plan can vary in cost and specific drugs covered.
Medicare prescription drug plans are sold by private companies approved by Medicare.

There are (2) ways to get Medicare Prescription Drug Coverage (Part D):

(1) **Medicare Prescription Drug Plans (PDPs)** are offered to individuals who get health coverage from **Original Medicare** or other Medicare cost plan.

(2) **Medicare Advantage Plans** may offer optional Medicare prescription drug coverage to their Medicare health plans.

Medicare Supplement Insurance (Medigap)

Medicare Supplement Insurance (also called Medigap Insurance) is sold by private insurance companies to fill the "gaps" in Original Medicare coverage. Some Medigap insurers may include coverage for services that are not covered by Original Medicare. For example, medical care when traveling outside the U.S.

Two standard Medigap policies are offered to Massachusetts residents:

Medicare Supplement Core and Medicare Supplement 1

Note: *In compliance with Medicare regulations, Medicare Supplement 2, including prescription drug coverage, cannot be sold after December 31, 2005. Existing members may remain enrolled.*

Medicare Supplement Insurance (Medigap) for Massachusetts residents is regulated by federal and state laws including the following:

- Medigap policies must be clearly identified as **"Medicare Supplement Insurance"**
- Policies and text are standard for all insurers, Basic benefits are the same, some may offer additional benefits.
- Medigap insurance is guaranteed renewable and cannot be cancelled unless the beneficiary stops paying the premium or provides false information on the application.
- Medigap insurers cannot refuse to sell a policy, exclude or limit coverage, or require a waiting period before coverage starts due to existing health problems.
- Medigap insurers must offer the same premium (a "community rate") to all policyholders and cannot charge a different premium based on age or health.

The Massachusetts Division of Insurance monitors insurance companies authorized to sell insurance in Massachusetts. For information, contact

Massachusetts Division of Insurance
1-877-563-4467/617-521-7794 (Boston)
www.state.ma.us/doi

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Programs for People with Limited Income and Resources

Extra Help is a Medicare program to help people with limited income and resources pay Medicare prescription drug costs.

For more information or to enroll in **Extra Help**, contact
Social Security 1-800-772-1213 or visit www.socialsecurity.gov

Medicare Savings Programs (MassHealth Buy-In) is a federal/state program for people with limited income and resources to get help to pay Medicare costs.
There are 4 Medicare Savings Programs:

1. Qualified Medicare Beneficiary (QMB) Program
   Helps pay Part A and/or Part B premiums, deductible, coinsurance, copayments
2. Specified Low-Income Medicare Beneficiary (SLMB)
   Helps pay Part B premiums
3. Qualified Individual Program (QI)
   Helps pay Part B premiums
4. Qualified Disabled and Working Individuals Program (QDWI)
   Helps pay Part A premiums

For more information about Medicare Savings Programs, contact
MassHealth Customer Service
1-800-841-2900 (TTY: 1-800-497-4648)

Prescription Advantage/State Pharmacy Assistance Program (SPAP)
A state prescription drug assistance program to help people with limited income pay for prescription drugs. For information contact:
Prescription Advantage Customer Service
1-800-243-4636 press 2 (TTY: 1-800-610-0241)

MassHealth

MassHealth and Commonwealth Care provide a wide range of medical and other benefits. These programs are authorized by state and federal law and help pay medical costs for people with **limited income and resources** and meet other eligibility requirements.

January 2013
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Several MassHealth programs, for Massachusetts residents are briefly described below:

- **MassHealth Standard** provides a full range of health care benefits.

- **MassHealth CommonHealth** for adults and children with disabilities whose income is too high to be eligible for MassHealth Standard.

- **MassHealth Frail Elder Waiver Program** provides coordinated community-based services to frail elders living in the community.

- **MassHealth Personal Care Attendant Services (PCA)** helps people with long-term disabilities live independently at home.

- **Program for All-Inclusive Care for the Elderly (PACE)**
  PACE providers deliver needed medical and support services to people living in the community.

- **MassHealth Senior Care Options (SCO)** is a coordinated health plan that combines Medicare and Medicaid health care services with social support services.

- **MassHealth Long-Term Care (LTC)** covers LTC costs for individuals living in LTC facilities.

For information or questions about eligibility, contact
MassHealth Customer Service 1-800-841-2900 (TTY: 1-800-497-4648)
or visit **www.mass.gov/masshealth**

Helpful Numbers

Massachusetts Executive Office of Elder Affairs
To directly connect with elder services in your area call press or say:
1-800-AGE-INFO (1-800-243-4636)

- to connect to your local elder service agency or caregiver program 1
- to connect to Prescription Advantage - state prescription drug program 2
- to connect to your regional SHINE Program 3
- to report elder abuse, neglect or financial exploitation 4
- all other matters 5

MassHealth **1-800-841-2900**
www.mass.gov/masshealth **TTY: 800-497-4648**
MassHealth provides a wide range of health care services that pay for all or part of the health care cost for people with limited income and resources.

MassHealth Senior Care Options (SCO) **1-888-885-0484**
www.mass.gov/masshealth **TTY: 1-888-821-5225**
A health plan that combines Medicare and Medicaid services with home support services.

MA Division of Insurance **Boston 617-521-7794**
www.state.ma.us/doi **1-877-563-4467**

DOI regulates insurance companies authorized to sell insurance in Massachusetts.

Protective Services **Elder Abuse Hotline 1-800-922-2275**
Protective Services provide services to alleviate abuse of elders.
Elder Abuse Hotline, 24-hours a day, 7 days a week.

Attorney General of Massachusetts **Elder Hotline 1-888-243-5337**
www.ago.state.ma.us
The Attorney General of Massachusetts is the state's chief law enforcement officer.
The Hotline provides information about elder-related issues and programs.

Massachusetts Medicare Advocacy Project **1-800-323-3205**
MAP provides Medicare beneficiaries free legal advice and legal representation for appealing medical decisions.

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Medicare **1-800-MEDICARE**
www.medicare.gov **(1-800-633-4227)**

MCPHS Pharmacy Outreach Program **1-866-633-1617**
www.massmedline.com
MassMedLine provides free prescription drug information and referrals.
MassMedline is a public service of the Massachusetts College of Pharmacy and Health Sciences and the Massachusetts Executive Office of Elder Affairs.

Social Security Administration **1-800-772-1213**
www.ssa.gov
Contact SSA to enroll in Medicare and for information and issues about Social Security and other related programs.

SHINE (Serving Health Information Needs of Elders) **1-800-243-4636**
www.800ageinfo.com
SHINE provides information, counseling and assistance to Medicare beneficiaries and their families on Medicare and other health insurance issues.
SHINE counselors are trained and certified by the Massachusetts Executive Office of Elder Affairs.
The SHINE Program is administered by the Massachusetts Executive Office of Elder Affairs in partnership with elder service agencies, councils on aging and other community-based organizations. SHINE is partially funded by the Centers for Medicare & Medicaid Services (CMS) and the Administration on Aging (AoA).

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Standard Medigap Plans
Available in Massachusetts
in 2013

Comparison of Plans	Core	Supplement 1
Basic Benefits Included In All Plans:		
Hospitalization Part A Co-payments		
Days 61 - 90: $296 per day	X	X
Days 91-150: $592 per day	X	X
365 Additional Lifetime Hospital days - Paid in full	X	X
Part B Coinsurance - Coverage of coinsurance, in most cases, 20% of approved amount	X	X
Parts A and B Blood First 3 pints	X	X
Additional Benefits	**Core**	**Supplement 1**
Part A Deductible for Hospital Days 1 - 60 $1184 per benefit period		X
Skilled Nursing Facility Coinsurance Days 21-100 - $148 per day		X
Part B Annual Deductible - $147		X
Foreign Travel - For Medicare-covered services needed while traveling abroad.		X
Inpatient Days in Mental Health Hospitals In addition to Medicare's coverage of 190 lifetime days and less any days previously covered by plan in same benefit period	60 days per calendar year	120 days per benefit period

Medicare Supplement Plans
Offered in Massachusetts
in 2013

Medigap Carriers Please note that rates may change in 2013	**Medicare Supplement Core**	**Medicare Supplement 1**
Blue Cross & Blue Shield of MA (Medex™) 1-800-678-2265 sales/apps 1-800-258-2226 member services 1-800-522-1254 (TDD) www.bluecrossma.com (continuous open enrollment)	**$96.38**	**$183.73**
Optional Preventive Care Benefits Rider[1]	**$7.67**	**$7.67**
Fallon Health & Life Assurance Company 1-866-330-6380 sales/apps 1-800-868-5200 member services 1-877-608-7677 (TDD) www.fchp.org/medicare-choices (continuous open enrollment)	**$100.25**	**$182.00**
HNE Insurance Company 1-877-443-3314 1-800-439-2370 (TDD/TTY) www.hne.com (continuous open enrollment)	**$97.00**	**$189.00**
HPHC Insurance Company, Inc. 1-800-782-0334 sales/apps 1-877-907-4742 member services 1-888-259-8276 (TDD) www.harvardpilgrim.org (continuous open enrollment)	**$100.50**	**$189.50**

[1] Effective January 1, 2013, an optional innovative hearing and vision coverage benefit rider will be available with Blue Cross and Blue Shield of Massachusetts, Inc.'s Supplement Core and Supplement policies.

Medicare Supplement Plans
Offered in Massachusetts
in 2013

Medigap Carriers Please note that rates may change in 2013	**Medicare Supplement Core**	**Medicare Supplement 1**
Humana Insurance Company 1-800-872-7294 sales/apps 1-800-866-0581 member services 1-800-833-3301 (TDD) www.humana-medicare.com (continuous open enrollment)	**$137.18**	**$214.41**
Humana Insurance Company HEALTHY LIVING (including dental and vision benefits) 1-800-872-7294 sales/applications 1-800-866-0581 member services 1-800-833-3301 (TDD) www.humana-medicare.com (continuous open enrollment)	**$149.28**	**$226.51**
Tufts Insurance Company 1-800-714-3000 sales/apps 1-800-701-9000 member services TDD 1-800-208-9562 (member services) 1-888-899-8977 (sales/apps) www.tuftsmedicarepreferred.org (continuous open enrollment)	**$102.71**	**$199.70**
United HealthCare Insurance Company Only for members of AARP (American Association of Retired Persons) 1-800-523-5800 (continuous open enrollment)	**$122.75**	**$211.50**

In addition to the above-noted Medicare Supplemental plans, Massachusetts residents may enroll in Medicare Advantage Plans as well as Part D Prescription Drug Plans with the Centers for Medicare and Medicaid Services ("CMS"). For further information regarding these plans please visit the following website:

https://www.medicare.gov/find-a-plan/questions/home.aspx

Medicare Advantage Plans
Offered in Massachusetts
in 2013

	Plan Name	Plan Type	Monthly Premium	Drugs	Doctor Choice	Counties
AARP Medicare Complete Provided by Secure Horizons Phone: 1-800-547-5514	Medicare Complete	HMO	$0.00	Yes	Plan Doctors Only (some exceptions)	Middlesex Suffolk
	Medicare Complete Choice	PPO	$20.00	Yes	Any Doctor	Barnstable Berkshire Bristol Dukes Essex Franklin Hampden Hampshire Middlesex Nantucket Norfolk Plymouth Suffolk Worcester
Blue Cross Blue Shield of Massachusetts Phone: 1-800-678-2265 TTY: 1-800-522-1254	Medicare HMO Blue PlusRx	HMO	$183.00	Yes	Plan Doctors Only	Barnstable Bristol Essex Franklin Hampden Hampshire Middlesex Norfolk Plymouth Suffolk Worcester
	Medicare HMO Blue Value Rx	HMO	$28.00	Yes	Plan Doctors Only	Barnstable Bristol Essex Franklin Hampden Hampshire Middlesex Norfolk Plymouth Suffolk Worcester

	Plan Name	Plan Type	Monthly Premium	Drugs	Doctor Choice	Counties
	Medicare PPO Blue PlusRx	PPO	$136.10	Yes	Any Doctor	Barnstable Bristol Essex Franklin Hampden Hampshire Middlesex Norfolk Plymouth Suffolk Worcester
	Medicare PPO Blue ValueRx	PPO	$66.10	Yes	Any Doctor	Barnstable Bristol Essex Franklin Hampden Hampshire Middlesex Norfolk Plymouth Suffolk Worcester
Erickson Advantage Phone: 1-800-989-1389	Erickson Advantage Signature with Drugs	HMO-POS	$176.00	Yes	Plan Doctors Only	Essex Plymouth
	Erickson Advantage Signature without Drugs	HMO-POS	$136.00	No	Plan Doctors Only	Essex Plymouth
	Erickson Advantage Freedom	HMO-POS	$48.00	Yes	Plan Doctors Only	Essex Plymouth
Fallon Community Health Plan Phone: 1-888-377-1980	Fallon Senior Plan Plus Enhanced Rx	HMO	$129.00	Yes	Plan Doctors Only	Bristol Middlesex Norfolk Plymouth
	Fallon Senior Plan Plus Enhanced Rx	HMO	$76.00	Yes	Plan Doctors Only	Hampden Hampshire
	Fallon Senior Plan Plus Enhanced Rx	HMO	$202.00	Yes	Plan Doctors Only	Franklin Worcester
	Fallon Senior Plan Plus Enhanced Rx	HMO	$153.00	Yes	Plan Doctors Only	Suffolk Essex
	Fallon Senior Plan Plus Enhanced Rx	HMO	$178.00	Yes	Plan Doctors Only	Barnstable

	Plan Name	Plan Type	Monthly Premium	Drugs	Doctor Choice	Counties
	Fallon Senior Plan Saver	HMO	$0.00	No	Plan Doctors Only	Bristol Hampden Hampshire Middlesex Norfolk Plymouth
	Fallon Senior Plan Saver	HMO	$28.00	No	Plan Doctors Only	Franklin Worcester
	Fallon Senior Plan Saver	HMO	$0.00	No	Plan Doctors Only	Suffolk Essex
	Fallon Senior Plan Saver	HMO	$38.00	No	Plan Doctors Only	Barnstable
	Fallon Senior Plan Saver Rx	HMO	$58.00	Yes	Plan Doctors Only	Franklin Worcester
	Fallon Senior Plan Saver Enhanced Rx	HMO	$32.00	Yes	Plan Doctors Only	Bristol Middlesex Norfolk Plymouth
	Fallon Senior Plan Saver Enhanced Rx	HMO	$11.00	Yes	Plan Doctors Only	Hampden Hampshire
	Fallon Senior Plan Saver Enhanced Rx	HMO	$69.00	Yes	Plan Doctors Only	Franklin Worcester
	Fallon Senior Plan Saver Enhanced Rx	HMO	$72.00	Yes	Plan Doctors Only	Barnstable
	Fallon Senior Plan Saver Enhanced Rx	HMO	$52.00	Yes	Plan Doctors Only	Suffolk Essex
	Fallon Senior Plan Super Saver Rx	HMO	$0.00	Yes	Plan Doctors Only	Bristol Essex Franklin Hampden Hampshire Middlesex Norfolk Plymouth Suffolk Worcester
	Fallon Senior Plan Super Saver Rx	HMO	$30.00	Yes	Plan Doctors Only	Barnstable
	Fallon Senior Plan Standard	HMO	$96.00	No	Plan Doctors Only	Franklin Worcester
	Fallon Senior Plan Standard Enhanced Rx	HMO	$142.10	Yes	Plan Doctors Only	Franklin Worcester

	Plan Name	Plan Type	Monthly Premium	Drugs	Doctor Choice	Counties
Health New England Phone: 1-877-443-3314 TTY: 1-800-439-2370	HNE Medicare Basic No Rx	HMO	$4.00	No	Plan Doctors Only	Berkshire Franklin Hampden Hampshire
	HNE Medicare Basic Rx	HMO	$58.00	Yes	Plan Doctors Only	Berkshire Franklin Hampden Hampshire
	HNE Medicare Plus Rx	HMO	$92.00	Yes	Plan Doctors Only	Berkshire Franklin Hampden Hampshire
	HNE Medicare Premium No Rx	HMO	$74.00	No	Plan Doctors Only	Berkshire Franklin Hampden Hampshire
	HNE Medicare Premium Rx	HMO	$143.00	Yes	Plan Doctors Only	Berkshire Franklin Hampden Hampshire
	HNE Medicare Freedom (HMO-POS)	HMO	$166.00	Yes	Plan Doctors Only	Berkshire Franklin Hampden Hampshire
Tufts Health Plan Phone: 1-877-218-4835 TTY: 1-888-899-8977	Medicare Preferred HMO Basic	HMO	$20.00	No	Plan Doctors Only	Essex Suffolk Worcester
	Medicare Preferred HMO Basic Rx	HMO	$0.00	Yes	Plan Doctors Only	Hampden Hampshire
	Medicare Preferred HMO Basic Rx	HMO	$24.80	Yes	Plan Doctors Only	Barnstable Bristol Middlesex Norfolk Plymouth
	Medicare Preferred HMO Basic Rx	HMO	$44.80	Yes	Plan Doctors Only	Essex Suffolk
	Medicare Preferred HMO Basic Rx	HMO	$66.10	Yes	Plan Doctors Only	Worcester
	Medicare Preferred HMO Prime	HMO	$112.00	No	Plan Doctors Only	Barnstable Bristol Middlesex Norfolk Plymouth
	Medicare Preferred HMO Prime	HMO	$49.00	No	Plan Doctors Only	Hampden Hampshire

	Plan Name	Plan Type	Monthly Premium	Drugs	Doctor Choice	Counties
	Medicare Preferred HMO Prime	HMO	$136.00	No	Plan Doctors Only	Essex Suffolk
	Medicare Preferred HMO Prime	HMO	$126.00	No	Plan Doctors Only	Worcester
	Medicare Preferred HMO Prime Rx	HMO	$140.10	Yes	Plan Doctors Only	Barnstable Bristol Middlesex Norfolk Plymouth
	Medicare Preferred HMO Prime Rx	HMO	$77.10	Yes	Plan Doctors Only	Hampden Hampshire
	Medicare Preferred HMO Prime Rx	HMO	$164.10	Yes	Plan Doctors Only	Essex Suffolk
	Medicare Preferred HMO Prime Rx	HMO	$172.10	Yes	Plan Doctors Only	Worcester
	Medicare Preferred HMO Prime Rx Plus	HMO	$172.90	Yes	Plan Doctors Only	Barnstable Bristol Middlesex Norfolk Plymouth
	Medicare Preferred HMO Prime Rx Plus	HMO	$109.90	Yes	Plan Doctors Only	Hampden Hampshire
	Medicare Preferred HMO Prime Rx Plus	HMO	$196.90	Yes	Plan Doctors Only	Essex Suffolk
	Medicare Preferred HMO Value	HMO	$82.00	No	Plan Doctors Only	Barnstable Bristol Middlesex Norfolk Plymouth
	Medicare Preferred HMO Value	HMO	$19.00	No	Plan Doctors Only	Hampden Hampshire
	Medicare Preferred HMO Value	HMO	$103.00	No	Plan Doctors Only	Essex Suffolk
	Medicare Preferred HMO Value	HMO	$93.00	No	Plan Doctors Only	Worcester
	Medicare Preferred HMO Value Rx	HMO	$110.10	Yes	Plan Doctors Only	Barnstable Bristol Middlesex Norfolk Plymouth

	Plan Name	Plan Type	Monthly Premium	Drugs	Doctor Choice	Counties
	Medicare Preferred HMO Value Rx	HMO	$47.10	Yes	Plan Doctors Only	Hampden Hampshire
	Medicare Preferred HMO Value Rx	HMO	$131.10	Yes	Plan Doctors Only	Essex Suffolk
	Medicare Preferred HMO Value Rx	HMO	$139.10	Yes	Plan Doctors Only	Worcester
	Medicare Preferred HMO Saver Rx	HMO	$0.00	Yes	Plan Doctors Only	Barnstable Bristol Essex Middlesex Norfolk Plymouth Suffolk Worcester
Universal American Phone: 1-800-996-8867	Today's Options Premier 300	PFFS	$105.00	No	Any Willing Doctor	Berkshire Nantucket
	Today's Options Premier 600	PFFS	$14.00	No	Any Willing Doctor	Dukes
	Today's Options Premier Plus 350A	PFFS	$183.00	Yes	Any Willing Doctor	Berkshire Nantucket
	Today's Options Premier Plus 350A	PFFS	$105.00	Yes	Any Willing Doctor	Dukes
	Today's Options Premier 600	PFFS	$58.00	No	Any Willing Doctor	Berkshire Nantucket
	Today's Options Premier 300	PFFS	$35.00	No	Any Willing Doctor	Dukes
	Today's Options Premier Plus 650G	PFFS	$99.00	Yes	Any Willing Doctor	Berkshire Nantucket
	Today's Options Premier Plus 650B	PFFS	$48.00	Yes	Any Willing Doctor	Dukes

HMO = Health Maintenance Organization A type of plan in which you can only go to doctors, hospitals and other providers that belong to the plan network, except in an emergency.

MSA = Medical Savings Account A plan that has two parts. The first part is a high-deductible Medicare Advantage MSA Health Plan. This health plan won't begin to pay covered costs until you have met the annual deductible, which varies by plan. The second part is a Medical Savings Account into which Medicare deposits money that you may use to pay health care costs.

PPO = Preferred Provider Organization A type of plan in which you pay less if you use doctors, hospitals, and other providers that belong to the plan network. You can use doctors, hospitals, and other providers outside of the network for an additional cost.

PFFS = Private Fee for Service A type of Medicare Health Plan in which you may go to any Medicare-approved doctor or hospital that accepts the plan's payment. The insurance plan, rather than the Medicare Program, decides how much it will pay and how much you will pay for the services you have. Under this type of plan you may pay more or less for Medicare-covered benefits and you may have extra benefits that Original Medicare Plan doesn't cover.

SCO = Senior Care Option A voluntary program that combines health care services with social support services to help low-income seniors maintain their health and stay in their own homes. With SCO, a team of medical professionals works together to provide you with care that is individually tailored to meet your needs. You must be 65 years of age or older and eligible for MassHealth (Medicaid) to join; you may also have Medicare.

SNP = Special Needs Plan A special type of Medicare Advantage Plan that provides all Medicare Part A and Part B health care and services to people who can benefit the most from things like special care for chronic illnesses, care management of multiple diseases, and focused care management. These plans may limit membership to people in certain institutions (like a nursing home), eligible for both Medicare and Medicaid, or with certain chronic or disabling condition.

Medicare Prescription Drug Plans
Offered in Massachusetts in 2013

Company	Prescription Drug Plan	Monthly Premium	Annual Deductible	Customer Service Phone Number
Aetna	• CVS/pharmacy Prescription Drug Plan • Medicare Rx Premier	$31.60 $109.60	$325 $0	Phone: 1-800-832-2640
Blue Cross Blue Shield of Massachusetts	• Blue MedicareRx Value Plus • Blue MedicareRx Premier	$39.20 $100.70	$250 $0	Phone: 1-877-479-2227 TTY: 1-866-236-1069
CIGNA Medicare Rx	• CIGNA Medicare Rx Plan One • CIGNA Medicare Rx Plan Two	$34.00 $76.50	$325 $0	Phone: 1-800-735-1459 TTY: 1-800-322-1451
Envision RxPlus	• Envision Rx Plus Silver • Envision Rx Plus Gold	$33.20 $54.00	$325 $150	Phone: 1-866-250-2005
Express Scripts Medicare	• Express Scripts Medicare Value	$47.80	$325	Phone: 1-866-477-5704 TTY: 1-800-716-3231

Company	Prescription Drug Plan	Monthly Premium	Annual Deductible	Customer Service Phone Number
First Health Part D	• First Health Part D Premier • First Health Part D Premier Plus • First Health Part D Value Plus	$34.90 $92.40 $31.00	$325 $0 $0	Phone: 1-877-815-8163
HealthMarkets Medicare	• Reader's Digest Value Rx	$33.60	$325	Phone: 1-888-625-5531
Health Spring Prescription Drug Plan	• Health Spring Prescription Drug Plan – Reg 2	$37.70	$325	Phone: 1-877-357-1685
Humana Insurance Company	• Humana Walmart – Preferred Rx Plan • Humana Enhanced • Humana Complete	$18.50 $43.10 $114.00	$325 $0 $0	Phone: 1-800-706-0872
SilverScript Insurance Company	• SilverScript Choice • SilverScript Basic • SilverScript Plus	$29.20 $30.50 $102.90	$0 $325 $0	Phone: 1-866-552-6106 TTY: 1-866-552-6288

Company	Prescription Drug Plan	Monthly Premium	Annual Deductible	Customer Service Phone Number
SmartD Rx	• SmartD Rx Saver • SmartD Rx Plus	$32.40 $69.00	$325 $0	Phone: 1-855-976-2781 TTY: 1-888-328-0419
Unicare	• Medicare Rx Rewards Standard	$52.50	$325	Phone: 1-877-541-7382
United American Insurance Company	• Enhanced • Select	$51.20 $33.70	$140 $325	Phone: 1-866-524-4169 TTY: 1-866-524-4170
United HealthCare Insurance Company	• AARP Medicare Rx Saver Plus • AARP Medicare Rx Preferred • AARP Medicare Rx Enhanced	$15.00 $37.70 $90.00	$325 $0 $0	Phone: 1-866-679-3282
WellCare	• WellCare Classic • WellCare Extra	$30.80 $39.00	$0 $0	Phone: 1-888-293-5151 TTY: 1-888-816-5252