MESSA Vision

Plan Coverage

MESSA®

800.336.0013 • TTY: 888.445.5614

Document version 10/28/19

Table of contents

If you are reading the online version of this booklet, you can click on any topic in this table of contents to review that information. To return to the table of contents, click on the "back" button at the top of the page.

MESSA VSP — Helpful information

The vision benefits available to MESSA members are underwritten by Blue Cross Blue Shield of Michigan (BCBSM). Network administration of the vision program is provided by Vision Service Plan (VSP).

This booklet is designed to help you understand your coverage.

To view your specific VSP benefits, go to **messa.org** to access your member account.

If you prefer to talk with a real person about your specific coverage, call VSP Member Services at 800.877.7195 or visit VSP online at **vsp.com**.

This document is not a contract. It is intended to be a summary description of benefits. Every effort has been made to ensure the accuracy of this information. However, if statements in this description differ from the applicable coverage documents, then the terms and conditions of those documents will prevail.

Eligibility guidelines

Who is eligible for coverage?

The following individuals are eligible to become members of the Michigan Education Special Services Association (MESSA) and may apply for coverage:

- Any member of the Michigan Education Association (MEA) as defined in the MEA bylaws
- Any individual employed by an educational agency that has negotiated MESSA benefits for its members
- Any employee of the State of Michigan or any political subdivision of the State, including but not limited to, counties, townships, cities, villages, school districts, and any authorities created by political subdivisions
- Any other eligible individual as defined in the MESSA bylaws

Applying for coverage

An application is required if you are:

- Enrolling for the first time
- Changing coverage for yourself or your dependents
- Covering dependent children age 19 or older
- Changing employers

We will review your application for coverage to determine if you, your spouse and your dependents are eligible for coverage based upon the terms of your plan.

Your coverage may be rescinded if you, your group or someone applying for coverage on your behalf does either of the following:

- Commits fraud
- Makes an intentional misrepresentation of material fact in completing the application

Eligible dependents

You, your spouse (this does not include the person who marries a member who has coverage as a surviving spouse) and your children are eligible for coverage.

Children are covered through the end of the month or calendar year in which they turn 19 years of age, based on employer guidelines and subject to the following conditions:

- You continue to be covered under this plan
- The children are related to you by birth, marriage, legal adoption or legal guardianship

  NOTE: Your child's spouse and your grandchildren are not covered under this plan.

Disabled, unmarried children may remain on your contract if all of the following apply:

- They are diagnosed as totally and permanently disabled due to a physical or developmental disability.
- They are incapable of self-sustaining employment by reason of their disabilities. (Under no circumstances will mental illness be considered a cause of incapacity. Neither will it be considered as a basis for continued coverage.)

  Please contact MESSA to obtain the appropriate form to continue coverage. Included with those forms will be a required physician's certification.

Your unmarried children beyond the end of the calendar year of their 19th birthday and through the end of the year of their 25th birthday (if covered under this program at the end of the calendar year of their 19th birthday and continuously thereafter), who are full-time students and dependent on you for a majority of their support.

- We will continue coverage when the dependent student takes a leave of absence from school or changes to part-time status due to serious illness or injury. The continuation of coverage will last until the earlier of the following dates occurs:
  - Up to one year after the first day of a medically necessary leave of absence or change in status

Eligible dependents

continued...

- The date on which the student's coverage would otherwise terminate
- To qualify for continued coverage, the student must obtain written certification from his or her attending physician. The certification must verify that the student suffers from a serious illness or injury. It must further state that the leave or change in status is medically necessary. The student must continue to meet all other MESSA eligibility requirements.

Your sponsored dependents who are members of your family, either by blood or marriage. They must qualify as your dependents under the Internal Revenue Code and were declared as dependents on your federal tax return for the preceding tax year. They must be continuing in that status for the current tax year. (Children who are no longer eligible for coverage as dependent children cannot be covered as sponsored dependents.)

You may also request group coverage for yourself or your dependents within 60 days of either of the following events:

- Your Medicaid coverage or your dependents' CHIP coverage (Children's Health Insurance Program) is terminated due to loss of eligibility
- You or your dependent becomes eligible for premium subsidies

It is your responsibility to notify MESSA and your employer:

- Of any change in your employment status
- When you wish to add a spouse and/or dependent(s)
- Of any change to a dependent's eligibility for coverage
- When a spouse and/or dependent is no longer eligible as defined above

When coverage begins

- If you are a new employee and enroll for coverage within 30 days following the date you became eligible (your date of employment or the day following completion of the eligibility waiting period, whichever is later), your coverage will be effective on the date you became eligible. This date is verified by your employer.
- During open enrollment, the effective date of coverage for all new applications and coverage changes will be that date approved by MESSA and verified by your employer.
- If your application is submitted at any other time, your coverage will be effective on the first day of the month following approval of your application by MESSA.
- Each dependent will be eligible for coverage on the later of the date on which your coverage begins or the date he/she becomes an eligible dependent if enrolled within 30 days. If your application for dependent coverage is submitted at any other time, coverage will be effective on the first day of the month following approval of your application by MESSA.
- Each sponsored dependent will be eligible for coverage on the later of the date on which your coverage begins or the first day of January following the date he/she becomes an eligible dependent.

When coverage ends

Your MESSA vision coverage ends on the date specified when the first of the following events occurs:

- **Termination of employment** - Coverage will end on the last day of the month in which you terminate employment.
- **Nonpayment of contributions** - Coverage will end on the last day of the month preceding the month for which the required contribution has not been remitted to MESSA.
- **Termination of employer's participation** - Coverage will end on the last day of any month in which your employer ceases to participate under the MESSA/BCBSM Group Operating Agreement.
- **Rescission** - Coverage may be terminated back to the effective date of your contract if you, your group or someone seeking coverage on your behalf performed an act, practice, or omission that constitutes fraud, or has made an intentional misrepresentation of material fact to MESSA or another party, which results in you or a dependent obtaining or retaining coverage with MESSA or the payment of claims under this or another MESSA plan. You will be provided with 30 days prior notice of the rescission. You will be required to repay MESSA for its payment for any services you received during this period.
- **Member's loss of eligibility** - Coverage will end on the last day of the month in which a member no longer meets the eligibility criteria described earlier in this section.
- **Dependent's loss of eligibility** - Coverage will end on the date a dependent no longer meets the eligibility criteria described earlier in this section.
- **Member's attainment of age 65** - Coverage will end on the first day of the calendar month in which you become age 65, unless you continue employment.
- **Medicare elected as primary** - If you continue active employment beyond age 65 and elect Medicare as your primary coverage, your coverage under the MESSA Vision Program will end on the first day of the month following the date of your election. A spouse age 65 or older who obtains coverage through an active employee may also elect Medicare as his/her primary coverage; however, the spouse's coverage under the MESSA Vision Program will end on the first day of the month following such an election.

  NOTE: If you cease active work, inquire as to what arrangements, if any, may be made to continue coverage. Contact MESSA for additional information.

Continuation of benefits

Consolidated Omnibus Budget Reconciliation Act (COBRA)

COBRA is a federal law that allows you to continue your employer group coverage if you lose it due to a qualifying event; e.g., you are laid off or fired. Your employer must send you a COBRA notice. You have 60 days to choose to continue your coverage. The deadline is 60 days after you lose coverage or 60 days after your employer sends you the notice, whichever is later. If you choose to keep the group coverage you must pay for it. The periods of time you may keep it for are:

- 18 months of coverage for an employee who is terminated, other than for gross misconduct, or whose hours are reduced
- 29 months of coverage for all qualified beneficiaries if one member is determined by the Social Security Administration to be disabled at the time of the qualifying event or within 60 days thereafter
- 36 months of coverage for qualified beneficiaries in case of the death of the employee, divorce, legal separation, loss of dependency status or employee entitlement to Medicare

COBRA coverage can be terminated because:

- The 18, 29 or 36 months of COBRA coverage end
- The required premium is not paid on time
- The employer terminates its group plan
- The qualified beneficiary becomes entitled to Medicare coverage
- The qualified beneficiary obtains coverage under a group plan, unless that new plan has preexisting condition limitations that apply to the qualified beneficiary

Please contact your employer for more details about COBRA.

Individual coverage

When you are no longer eligible for the MESSA Vision Program through your employer, an individual plan is available to you through BCBSM. Your benefits under the individual plan may differ from the benefits covered under the MESSA Vision Program and coverage will be limited to your immediate family.

If you select COBRA coverage, you must exhaust it first to be eligible for individual coverage.

Contact MESSA for additional information on how to apply for this coverage.

Surviving family

Your dependents who are covered under the MESSA Vision Program on the date of your death should contact MESSA for information regarding continuation of coverage.

Save money: Choose in-network providers

MESSA vision plans have different levels of benefits for in-network and out-of-network services. Most eye doctors are in VSP's Signature and Choice network. Staying in-network makes sure you get the most value from your benefits and limits your out-of-pocket costs because in-network providers will accept our approved amount as payment in full (after applicable copayments). In-network doctors also bill VSP directly as a convenience to you. Directories of participating in-network providers are available at **messa.org** and at **vsp.com**.

Out-of-network providers

The amount billed by an out-of-network provider may be more than our approved amount. Members who choose to see an out-of-network provider must pay the provider directly and submit an itemized receipt to VSP for reimbursement. The reimbursement is limited to our approved amount. The member is responsible for the difference between our approved amount and the amount charged by the provider.

Send claims for services of out-of-network providers to:

VSP
P. O. Box 385018
Birmingham, AL 35238-5018

Coverage for vision care services

Eye Exam

We pay for an eye exam by an ophthalmologist or optometrist once per plan year. The exam must include the following:

- History
- Testing of visual acuity
- External exams of the eye
- Binocular measure
- Ophthalmoscopic examinations
- Tonometry (test for glaucoma) when indicated
- Medication for dilating the pupils and desensitizing the eyes for tonometry, if necessary
- Summary of findings

Lenses

We pay for standard lenses when prescribed and dispensed by an ophthalmologist or optometrist once per plan year.

- Lenses may be molded or ground, glass or plastic.
- Lenses must be equal in quality to the first-quality lens series made by American Optical, Bausch & Lomb or Tillyer and Univis.
- The lens blank must meet Z80.1 or Z80.2 standards of the American National Standards Institute.
- The lenses may be colorless or have Pink tints #1 or #2 if therapeutically necessary. The provider may charge you for additional tinting other than for necessary Pink tints #1 or #2.
- The lens blank of a standard lens must not exceed 60 mm in diameter. The provider may charge you for the difference in cost between standard and oversize lenses.
- If only one lens is needed, we pay half the amount we pay per pair.

Coverage for Vision Care Services

continued...

We pay for the following special lenses:

- Myodisc
- Lenticular myodisc
- Lenticular aspheric myodisc
- Aphakic
- Lenticular aphakic
- Lenticular aspheric aphakic
- Polycarbonate lenses for children through 25 years of age

We do not pay for aphakic lenses for aphakia (lack of natural lens). These may be covered by your medical plan.

We pay for prism, slab-off prism and special base curve lenses when medically necessary.

> **NOTE:** We pay for either one pair of eyeglass lenses or a 12-month supply of prescribed contact lenses once per plan year.

Frames

We pay for one pair of standard frames once per plan year. If you select more expensive frames, the provider may charge you the difference between the usual retail charge for standard frames and the more expensive frames.

Contact Lenses

We pay for a 12-month supply of medically necessary or elective contact lenses once per plan year. These lenses may be disposable or extended wear.

Contact lenses are considered medically necessary if:

- They are the only way to correct vision to 20/70 in the better eye, or
- They are the only effective treatment to correct keratoconus, irregular astigmatism or irregular corneal curvature

Contact lenses are considered elective if they are prescribed to improve vision but are not needed for the medically necessary reasons described above.

We do not pay for cosmetic contact lenses that do not improve vision.

We also pay for a contact lens suitability exam to determine whether you can wear contact lenses. The fee for this exam is included in the allowance for the contact lenses. The exam may include:

- Biomicroscopic evaluation
- Lid evaluation
- Ophthalmoscopy
- Tear test
- Pupil evaluation
- Fluorescein evaluation
- Cornea evaluation
- Lens tolerance tests

> **NOTE:** We pay for either one pair of eyeglass lenses or a 12-month supply of prescribed contact lenses once per plan year.

VSP-1 Benefits

MESSA
1475 Kendale Blvd. PO Box 2560
East Lansing, Michigan 48826-2560
517.332.2581 • 800.292.4910

In-network providers

Most eye doctors are in VSP's Signature network. Staying in-network makes sure you get the most value from your benefits and limits your out-of-pocket costs. In-network doctors bill VSP directly as a convenience to you. A directory of Signature network doctors is available at www.messa.org or www.vsp.com. Call VSP member services at 800.877.7195 for assistance.

Out-of-network providers
(Maximum reimbursement to patient)

If you choose to see a doctor who is not in the VSP Signature network, your out-of-pocket costs will likely be higher and you must submit the itemized receipts to VSP for reimbursement. For more information, visit www.vsp.com or call VSP member services at 800.877.7195.

Benefit	In-network provider	Out-of-network provider maximum allowance
Examination ■ Optometrist ■ Ophthalmologist	$10 copayment	$15
Contact lenses (includes examination) ■ Elective lenses to improve vision ■ Medically necessary – *to correct keratoconus, irregular astigmatism, irregular corneal curvature or vision to 20/70 in the better eye*	$65 allowance	$65
Eyeglass frames	$65 allowance	$8
Eyeglass lenses ■ Single vision ■ Bifocal ■ Trifocal ■ Lenticular	$25 copayment	$20 $24 $30 $40
Eyeglass lens enhancements ■ Pink #1 or #2 tint ■ Rimless	MESSA pays 100% of the approved amount	Member must pay the difference between the approved amount and the provider charge
■ Oversize ■ Blended ■ Photochromic ■ Progressive ■ Tinted ● Single vision ● Bifocal ● Trifocal ● Lenticular ■ Polarized ● Single vision ● Bifocal ● Trifocal ● Lenticular	Not covered	Not covered

FS Rev. 10/03/19 Pr. 10/19 - 1PDF

VSP-1 B Benefits

MESSA
1475 Kendale Blvd. PO Box 2560
East Lansing, Michigan 48826-2560
517.332.2581 • 800.292.4910

In-network providers

Most eye doctors are in VSP's Signature network. Staying in-network makes sure you get the most value from your benefits and limits your out-of-pocket costs. In-network doctors bill VSP directly as a convenience to you. A directory of Signature network doctors is available at www.messa.org or www.vsp.com. Call VSP member services at 800.877.7195 for assistance.

Out-of-network providers
(Maximum reimbursement to patient)

If you choose to see a doctor who is not in the VSP Signature network, your out-of-pocket costs will likely be higher and you must submit the itemized receipts to VSP for reimbursement. For more information, visit www.vsp.com or call VSP member services at 800.877.7195.

Benefit	In-network provider	Out-of-network provider maximum allowance
Examination		
■ Optometrist	$10 copayment	$15
■ Ophthalmologist		
Contact lenses (includes examination)		
■ Elective lenses to improve vision	$85 allowance	$65
■ Medically necessary – *to correct keratoconus, irregular astigmatism, irregular corneal curvature or vision to 20/70 in the better eye*		
Eyeglass frames	$130 allowance	$8
Eyeglass lenses		
■ Single vision	$25 copayment	$20
■ Bifocal		$24
■ Trifocal		$30
■ Lenticular		$40
Eyeglass lens enhancements		
■ Pink #1 or #2 tint	MESSA pays 100% of the approved amount	Member must pay the difference between the approved amount and the provider charge
■ Rimless		
■ Oversize ■ Blended ■ Photochromic ■ Progressive ■ Tinted ● Single vision ● Bifocal ● Trifocal ● Lenticular ■ Polarized ● Single vision ● Bifocal ● Trifocal ● Lenticular	Not covered	Not covered

FS Rev. 10/3/19 Pr. 10/19 - 1PDF

VSP-2 Benefits

MESSA
1475 Kendale Blvd. PO Box 2560
East Lansing, Michigan 48826-2560
517.332.2581 • 800.292.4910

In-network providers

Most eye doctors are in VSP's Signature network. Staying in-network makes sure you get the most value from your benefits and limits your out-of-pocket costs. In-network doctors bill VSP directly as a convenience to you. A directory of Signature network doctors is available at www.messa.org or www.vsp.com. Call VSP member services at 800.877.7195 for assistance.

Out-of-network providers
(Maximum reimbursement to patient)

If you choose to see a doctor who is not in the VSP Signature network, your out-of-pocket costs will likely be higher and you must submit the itemized receipts to VSP for reimbursement. For more information, visit www.vsp.com or call VSP member services at 800.877.7195.

Benefit	In-network provider	Out-of-network provider maximum allowance
Examination		
■ Optometrist	$6.50 copayment	$28.50
■ Ophthalmologist		$38.50
Contact lenses (includes examination)		
■ Elective lenses to improve vision	$90 allowance	$90
■ Medically necessary – *to correct keratoconus, irregular astigmatism, irregular corneal curvature or vision to 20/70 in the better eye*	MESSA pays 100% of the approved amount	$175
Eyeglass frames	$65 allowance	$44
Eyeglass lenses		
■ Single vision	$18 copayment	$29
■ Bifocal		$51
■ Trifocal		$63
■ Lenticular		$75
Eyeglass lens enhancements		
■ Rimless	MESSA pays 100% of the approved amount	Member must pay the difference between the approved amount and the provider charge
■ Oversized		
■ Blended		
■ Photochromic		
■ Progressive	Not covered	
■ Tinted	MESSA pays 100% of the approved amount	
• Single vision		$33
• Bifocal		$61
• Trifocal		$75
• Lenticular		$89
■ Polarized		
• Single vision		$47
• Bifocal		$81
• Trifocal		$101
• Lenticular		$119

FS Rev. 10/03/19 Pr. 10/19 - 1PDF

VSP-2 S Benefits

MESSA
1475 Kendale Blvd. PO Box 2560
East Lansing, Michigan 48826-2560
517.332.2581 • 800.292.4910

In-network providers

Most eye doctors are in VSP's Signature network. Staying in-network makes sure you get the most value from your benefits and limits your out-of-pocket costs. In-network doctors bill VSP directly as a convenience to you. A directory of Signature network doctors is available at www.messa.org or www.vsp.com. Call VSP member services at 800.877.7195 for assistance.

Out-of-network providers
(Maximum reimbursement to patient)

If you choose to see a doctor who is not in the VSP Signature network, your out-of-pocket costs will likely be higher and you must submit the itemized receipts to VSP for reimbursement. For more information, visit www.vsp.com or call VSP member services at 800.877.7195.

Benefit	In-network provider	Out-of-network provider maximum allowance
Examination		
■ Optometrist	$6.50 copayment	$28.50
■ Ophthalmologist		$38.50
Contact lenses (includes examination)		
■ Elective lenses to improve vision	$110 allowance	$90
■ Medically necessary – *to correct keratoconus, irregular astigmatism, irregular corneal curvature or vision to 20/70 in the better eye*	MESSA pays 100% of the approved amount	$175
Eyeglass frames	$130 allowance	$44
Eyeglass lenses		
■ Single vision	$18 copayment	$29
■ Bifocal		$51
■ Trifocal		$63
■ Lenticular		$75
Eyeglass lens enhancements		
■ Rimless	MESSA pays 100% of the approved amount	Member must pay the difference between the approved amount and the provider charge
■ Oversized		
■ Blended		
■ Photochromic		
■ Progressive	Not covered	
■ Tinted	MESSA pays 100% of the approved amount	
● Single vision		$33
● Bifocal		$61
● Trifocal		$75
● Lenticular		$89
■ Polarized		
● Single vision		$47
● Bifocal		$81
● Trifocal		$101
● Lenticular		$119

FS Rev. 10/03/19 Pr. 10/19 - 1PDF

VSP-3 Benefits

MESSA
1475 Kendale Blvd. PO Box 2560
East Lansing, Michigan 48826-2560
517.332.2581 • 800.292.4910

In-network providers

Most eye doctors are in VSP's Signature network. Staying in-network makes sure you get the most value from your benefits and limits your out-of-pocket costs. In-network doctors bill VSP directly as a convenience to you. A directory of Signature network doctors is available at www.messa.org or www.vsp.com. Call VSP member services at 800.877.7195 for assistance.

Out-of-network providers
(Maximum reimbursement to patient)

If you choose to see a doctor who is not in the VSP Signature network, your out-of-pocket costs will likely be higher and you must submit the itemized receipts to VSP for reimbursement. For more information, visit www.vsp.com or call VSP member services at 800.877.7195.

Benefit	In-network provider	Out-of-network provider maximum allowance
Examination		
■ Optometrist	No copayment	$35
■ Ophthalmologist		$45
Contact lenses (includes examination)		
■ Elective lenses to improve vision	$115 allowance	$115
■ Medically necessary – *to correct keratoconus, irregular astigmatism, irregular corneal curvature or vision to 20/70 in the better eye*	MESSA pays 100% of the approved amount	$200
Eyeglass frames	$65 allowance	$55
Eyeglass lenses		
■ Single vision	MESSA pays 100% of the approved amount	$38
■ Bifocal		$60
■ Trifocal		$72
■ Lenticular		$108
Eyeglass lens enhancements		
■ Rimless	MESSA pays 100% of the approved amount	Member must pay the difference between the approved amount and the provider charge
■ Oversized		
■ Blended		
■ Photochromic		
■ Progressive	Not covered	
■ Tinted	MESSA pays 100% of the approved amount	
• Single vision		$42
• Bifocal		$70
• Trifocal		$84
• Lenticular		$118
■ Polarized		
• Single vision		$56
• Bifocal		$90
• Trifocal		$110
• Lenticular		$138

FS Rev. 10/03/19 Pr. 10/19 - 1PDF

VSP-3 G Benefits

MESSA
1475 Kendale Blvd. PO Box 2560
East Lansing, Michigan 48826-2560
517.332.2581 • 800.292.4910

In-network providers

Most eye doctors are in VSP's Signature network. Staying in-network makes sure you get the most value from your benefits and limits your out-of-pocket costs. In-network doctors bill VSP directly as a convenience to you. A directory of Signature network doctors is available at www.messa.org or www.vsp.com. Call VSP member services at 800.877.7195 for assistance.

Out-of-network providers
(Maximum reimbursement to patient)

If you choose to see a doctor who is not in the VSP Signature network, your out-of-pocket costs will likely be higher and you must submit the itemized receipts to VSP for reimbursement. For more information, visit www.vsp.com or call VSP member services at 800.877.7195.

Benefit	In-network provider	Out-of-network provider maximum allowance
Examination		
■ Optometrist	No copayment	$35
■ Ophthalmologist		$45
Contact lenses (includes examination)		
■ Elective lenses to improve vision	$135 allowance	$115
■ Medically necessary – *to correct keratoconus, irregular astigmatism, irregular corneal curvature or vision to 20/70 in the better eye*	MESSA pays 100% of the approved amount	$200
Eyeglass frames	$130 allowance	$55
Eyeglass lenses		
■ Single vision	MESSA pays 100% of the approved amount	$38
■ Bifocal		$60
■ Trifocal		$72
■ Lenticular		$108
Eyeglass lens enhancements		
■ Rimless ■ Oversized ■ Blended ■ Photochromic	MESSA pays 100% of the approved amount	Member must pay the difference between the approved amount and the provider charge
■ Progressive	Not covered	
■ Tinted	MESSA pays 100% of the approved amount	
• Single vision		$42
• Bifocal		$70
• Trifocal		$84
• Lenticular		$118
■ Polarized		
• Single vision		$56
• Bifocal		$90
• Trifocal		$110
• Lenticular		$138

FS Rev. 10/03/19 Pr. 10/19 - 1PDF

VSP-3 Plus Benefits

MESSA
1475 Kendale Blvd. PO Box 2560
East Lansing, Michigan 48826-2560
517.332.2581 • 800.292.4910

In-network providers

Most eye doctors are in VSP's Signature network. Staying in-network makes sure you get the most value from your benefits and limits your out-of-pocket costs. In-network doctors bill VSP directly as a convenience to you. A directory of Signature network doctors is available at www.messa.org or www.vsp.com. Call VSP member services at 800.877.7195 for assistance.

Out-of-network providers
(Maximum reimbursement to patient)

If you choose to see a doctor who is not in the VSP Signature network, your out-of-pocket costs will likely be higher and you must submit the itemized receipts to VSP for reimbursement. For more information, visit www.vsp.com or call VSP member services at 800.877.7195.

Benefit	In-network provider	Out-of-network provider maximum allowance
Examination		
■ Optometrist	No copayment	$35
■ Ophthalmologist		$45
Contact lenses (includes examination)		
■ Elective lenses to improve vision (disposable)	$200 allowance	$150
■ Elective lenses to improve vision (non-disposable)		
■ Medically necessary – *to correct keratoconus, irregular astigmatism, irregular corneal curvature or vision to 20/70 in the better eye*	MESSA pays 100% of the approved amount	$200
Eyeglass frames	$80 allowance	$66
Eyeglass lenses		
■ Single vision	MESSA pays 100% of the approved amount	$38
■ Bifocal		$60
■ Trifocal		$72
■ Lenticular		$108
Extra lens features		
■ Pink #1 or #2 tint	MESSA pays 100% of the approved amount	Member must pay the difference between the approved amount and the provider charge.
■ Rimless		
■ Oversize		
■ Blended		
■ Photochromic		
■ Progressive		
■ Tinted		
● Single vision	MESSA pays 100% of the approved amount	$42
● Bifocal		$70
● Trifocal		$84
● Lenticular		$118
■ Polarized		
● Single vision	MESSA pays 100% of the approved amount	$56
● Bifocal		$90
● Trifocal		$110
● Lenticular		$138

FS Rev. 10/03/19 Pr. 10/19 - 1PDF

VSP-3 Plus-200CL Benefits

MESSA
1475 Kendale Blvd. PO Box 2560
East Lansing, Michigan 48826-2560
517.332.2581 • 800.292.4910

In-network providers

Most eye doctors are in VSP's Choice network. Staying in-network makes sure you get the most value from your benefits and limits your out-of-pocket costs. In-network doctors bill VSP directly as a convenience to you. A directory of Choice network doctors is available at www.messa.org or www.vsp.com. Call VSP member services at 800.877.7195 for assistance.

Out-of-network providers
(Maximum reimbursement to patient)

If you choose to see a doctor who is not in the VSP Choice network, your out-of-pocket costs will likely be higher and you must submit the itemized receipts to VSP for reimbursement. For more information, visit www.vsp.com or call VSP member services at 800.877.7195.

Benefit	In-network provider	Out-of-network provider maximum allowance
Examination		
■ Optometrist	No copayment	$35
■ Ophthalmologist		$45
Contact lenses (includes examination)		
■ Elective lenses to improve vision	$200 allowance	$150
■ Medically necessary – *to correct keratoconus, irregular astigmatism, irregular corneal curvature or vision to 20/70 in the better eye*	MESSA pays 100% of the approved amount	$200
Eyeglass frames	$80 allowance	$66
Eyeglass lenses		
■ Single vision	MESSA pays 100% of the approved amount	$38
■ Bifocal		$60
■ Trifocal		$72
■ Lenticular		$108
Extra lens features		
■ Pink #1 or #2 tint	MESSA pays 100% of the approved amount	Member must pay the difference between the approved amount and the provider charge.
■ Rimless		
■ Oversize		
■ Blended		
■ Photochromic		
■ Progressive		
■ Tinted		
• Single vision	MESSA pays 100% of the approved amount	$42
• Bifocal		$70
• Trifocal		$84
• Lenticular		$118
■ Polarized		
• Single vision	MESSA pays 100% of the approved amount	$56
• Bifocal		$90
• Trifocal		$110
• Lenticular		$138

FS Rev. 10/03/19 Pr. 10/19 - 1PDF

VSP-3 Plus P Benefits

MESSA
1475 Kendale Blvd. PO Box 2560
East Lansing, Michigan 48826-2560
517.332.2581 • 800.292.4910

In-network providers

Most eye doctors are in VSP's Signature network. Staying in-network makes sure you get the most value from your benefits and limits your out-of-pocket costs. In-network doctors bill VSP directly as a convenience to you. A directory of Signature network doctors is available at www.messa.org or www.vsp.com. Call VSP member services at 800.877.7195 for assistance.

Out-of-network providers
(Maximum reimbursement to patient)

If you choose to see a doctor who is not in the VSP Signature network, your out-of-pocket costs will likely be higher and you must submit the itemized receipts to VSP for reimbursement. For more information, visit www.vsp.com or call VSP member services at 800.877.7195.

Benefit	In-network provider	Out-of-network provider maximum allowance
Examination		
■ Optometrist	No copayment	$35
■ Ophthalmologist		$45
Contact lenses (includes examination)		
■ Elective lenses to improve vision (disposable)	$250 allowance	$150
■ Elective lenses to improve vision (non-disposable)	MESSA pays 100% of the approved amount	$200
■ Medically necessary – *to correct keratoconus, irregular astigmatism, irregular corneal curvature or vision to 20/70 in the better eye*		
Eyeglass frames	$130 allowance	$66
Eyeglass lenses		
■ Single vision	MESSA pays 100% of the approved amount	$38
■ Bifocal		$60
■ Trifocal		$72
■ Lenticular		$108
Extra lens features		
■ Pink #1 or #2 tint	MESSA pays 100% of the approved amount	Member must pay the difference between the approved amount and the provider charge.
■ Rimless		
■ Oversize		
■ Blended		
■ Photochromic		
■ Progressive		
■ Tinted		
• Single vision	MESSA pays 100% of the approved amount	$42
• Bifocal		$70
• Trifocal		$84
• Lenticular		$118
■ Polarized		
• Single vision	MESSA pays 100% of the approved amount	$56
• Bifocal		$90
• Trifocal		$110
• Lenticular		$138

FS Rev. 10/03/19 Pr. 10/19 - 1PDF

VSP-3 Plus P-250CL Benefits

MESSA
1475 Kendale Blvd. PO Box 2560
East Lansing, Michigan 48826-2560
517.332.2581 • 800.292.4910

In-network providers

Most eye doctors are in VSP's Choice network. Staying in-network makes sure you get the most value from your benefits and limits your out-of-pocket costs. In-network doctors bill VSP directly as a convenience to you. A directory of Choice network doctors is available at www.messa.org or www.vsp.com. Call VSP member services at 800.877.7195 for assistance.

Out-of-network providers
(Maximum reimbursement to patient)

If you choose to see a doctor who is not in the VSP Choice network, your out-of-pocket costs will likely be higher and you must submit the itemized receipts to VSP for reimbursement. For more information, visit www.vsp.com or call VSP member services at 800.877.7195.

Benefit	In-network provider	Out-of-network provider maximum allowance
Examination		
■ Optometrist	No copayment	$35
■ Ophthalmologist		$45
Contact lenses (includes examination)		
■ Elective lenses to improve vision	$250 allowance	$150
■ Medically necessary – *to correct keratoconus, irregular astigmatism, irregular corneal curvature or vision to 20/70 in the better eye*	MESSA pays 100% of the approved amount	$200
Eyeglass frames	$130 allowance	$66
Eyeglass lenses		
■ Single vision	MESSA pays 100% of the approved amount	$38
■ Bifocal		$60
■ Trifocal		$72
■ Lenticular		$108
Extra lens features		
■ Pink #1 or #2 tint	MESSA pays 100% of the approved amount	Member must pay the difference between the approved amount and the provider charge.
■ Rimless		
■ Oversize		
■ Blended		
■ Photochromic		
■ Progressive		
■ Tinted		
● Single vision	MESSA pays 100% of the approved amount	$42
● Bifocal		$70
● Trifocal		$84
● Lenticular		$118
■ Polarized		
● Single vision	MESSA pays 100% of the approved amount	$56
● Bifocal		$90
● Trifocal		$110
● Lenticular		$138

FS Rev. 10/03/19 Pr. 10/19 - 1PDF

Exclusions and limitations

We do not pay for the following:

- Additional charges for:
  - ❍ Progressive/multifocal lenses
  - ❍ Coating/laminating of a lens or lenses
  - ❍ Cosmetic lenses/processes
  - ❍ Two pair of glasses instead of bifocals
  - ❍ Antireflective lenses
- Medical-surgical treatment
- Medications administered during any service except an eye exam
- Services or eyewear ordered before coverage began
- Services not prescribed by an ophthalmologist or optometrist
- Special services, such as orthoptics, vision training, aniseikonic lenses and tonography
- Replacement of broken or lost lenses or frames
- Services received as a result of an eye disease, defect or injury due to an act of war, declared or undeclared
- Services available at no cost to you or for which no charge would be made in the absence of MESSA/ BCBSM coverage
- Charges for lenses or frames ordered while you were eligible for benefits but delivered more than 60 days after coverage ends
- Charges for completing insurance forms
- Aphakic lenses when the patient lacks a natural lens
- Charges for experimental or poor quality services
- Medically unnecessary services, glasses or contact lenses
- Care and services for which you legally do not have to pay or for which you would not have been charged if you did not have coverage under this plan.
- Care and services payable by government-sponsored health care programs, such as Medicare, for which a member is eligible. These services are not payable even if you have not signed up to receive the benefits provided by such programs. However, care and services are payable if federal laws require the government-sponsored program to be secondary to this coverage.
- Care, services, supplies or devices that are personal or convenience items
- The treatment of work-related injuries covered by workers compensation laws or for work-related services you receive through a medical clinic or a similar facility provided or maintained by an employer.
- Experimental treatment (including experimental drugs or devices) or services related to experimental treatment except as approved by the BCBSM or MESSA medical director. In addition, we do not pay for administrative costs related to experimental treatment.

Other general information

This section lists and explains certain general conditions that apply to your contract. These conditions may make a difference in how, where and when benefits are available to you.

Coordination of benefits

We will coordinate the benefits payable under this plan pursuant to the Coordination of Benefits Act, Public Act No. 64 of 1984 (starting at MCLA 550.251). To the extent that the services covered under this plan are also covered and payable under another group plan, we will combine our payment with that of the other plan to pay the maximum amount we would routinely pay for the covered services.

When others are responsible for illness or injuries

If another person or entity, through an act or omission, causes you to suffer an injury or illness, and if we paid benefits for that injury or illness, you must agree to the provisions listed below. In addition, if you are injured and no other person or entity is responsible but you receive (or are entitled to) a recovery from another source, and if we paid benefits for that injury, you must agree to the following provisions:

- All recoveries you or your representatives obtain (whether by lawsuit, settlement, insurance, workers' compensation or benefit program claims, or otherwise), no matter how described or designated, must be used to reimburse us in full for benefits we paid. Our share of any recovery extends only to the amount of benefits we have paid or will pay to you or your representatives. For purposes of this provision, "you" includes your covered dependents, and "your representatives" include, if applicable, your heirs, administrators, legal representatives, parents (if you are a minor), successors, or assignees. This is our right of recovery.
- We are entitled under our right of recovery to be reimbursed for our benefit payments even if you are not "made whole" for all of your damages in the recoveries that you receive. Our right of recovery is not subject to reduction for attorney's fees and costs under the "common fund" or any other doctrine.
- We will not reduce our share of any recovery unless, in the exercise of our discretion, we agree in writing to a reduction (1) because you do not receive the full amount of damages that you claimed or (2) because you had to pay attorneys' fees.
- You must cooperate in doing what is reasonably necessary to assist us with our right of recovery. You must not take any action that may prejudice our right of recovery.
- If you do not seek damages for your illness or injury, you must permit us to initiate recovery on your behalf (including the right to bring suit in your name). This is called subrogation.

If you do seek damages for your illness or injury, you must tell us promptly that you have made a claim against another party for a condition that we have paid or may pay benefits for, you must seek recovery of our benefit payments and liabilities, and you must tell us about any recoveries you obtain, whether in or out of court. We may seek a first priority lien on the proceeds of your claim in order to reimburse ourselves to the full amount of benefits we have paid or will pay.

We may request that you sign a reimbursement agreement and/or assign to us (1) your right to bring an action or (2) your right to the proceeds of a claim for your illness or injury. We may delay processing of your claims until you provide the signed reimbursement agreement and/or assignment, and we may enforce our right of recovery by offsetting future benefits.

- **NOTE:** We will pay the costs of any covered services you receive, up to the approved amount, that are in excess of any recoveries made.

Our rights of recovery and subrogation as described in this Section may be enforced by BCBSM or by any Local Plan that administered the benefits paid in connection with the injury or illness at issue, or by any combination of these entities.

Other general information

continued...

Among the other situations covered by this provision, the circumstances in which we may subrogate or assert a right of recovery shall also include:

- When a third party injures you, for example, through medical malpractice;
- When you are injured on premises owned by a third party; or
- When you are injured and benefits are available to you or your dependent, under any law or under any type of insurance, including, but not limited to:
  - Medical reimbursement coverage
  - Workers' compensation coverage

Contact us if you need more information about subrogation.

Release of information

You agree to permit providers to release information to us. This can include medical records and claims information related to services you may receive or have received.

We agree to keep this information confidential. Consistent with our Notice of Privacy Practices, this information will be used and disclosed only as authorized by law.

Services before coverage begins and after coverage ends

- We will not pay for any services, treatment, care or supplies ordered or provided before the effective date of this plan.
- We will not pay for any services, treatment, care or supplies provided after the date on which coverage under this plan ends, except for eyeglasses and contact lenses ordered before, but received within 60 days after, coverage ends.

Time limit for legal action

Legal action against us may not begin later than two years after we have received a complete claim for services. No action or lawsuit may be started until 30 days after you notify us that our decision under the claim review procedure is unacceptable.

What laws apply

This contract is subject to and interpreted under the laws of the state of Michigan.

Grievance process

MESSA wants you to be satisfied with the services you receive as a member. If you have a question or concern about how we processed your claim or request for benefits, we encourage you to contact our Member Service Center at 800.336.0013 or TTY 888.445.5614.

Eligibility Grievance Process

You or your authorized representative may send us a written statement explaining why you disagree with our decision regarding your eligibility or rescission of your coverage. Your request for review must be submitted within 180 days after receiving a notice of denial.

Mail your written grievance to:

Associate Manager, Legal and Compliance
MESSA
1475 Kendale Boulevard
P.O. Box 2560
East Lansing, MI 48826-2560

We have 60 days to give you our final determination. You have the right to allow us additional time if you wish.

A decision will be made by MESSA after we receive your request for review or the date you provide all information required of you, whichever date is later. The decision will be in writing and will specify the reason for MESSA's decision.

If you disagree with our final decision, or you do not receive our decision within 60 days, you may request an external review. See below for how to request an external review.

Grievance and Appeals Process

We have a formal grievance and appeals process that allows you to dispute an adverse benefit decision or rescission of your coverage.

An adverse benefit decision includes a:

- Denial of a request for benefits
  - A utilization review revealed the benefit should not have been paid
  - We determined the service to be experimental, investigational, or not medically necessary or appropriate
- Reduction in benefits
- Failure to pay for a service, or
- Failure to respond in a timely manner to a request for a determination.

You may file a grievance or appeal about any adverse benefit decision within 180 days after you receive the claim denial. The dollar amount involved does not matter.
If you file a grievance or appeal:

- You will not have to pay any filing charges
- You may submit materials or testimony at any step of the process to help us in our review
- You may authorize another person, including your physician, to act on your behalf at any stage in the standard review process. Your authorization must be in writing. Please call the MESSA Legal and Compliance Department at 800.742.2328 or TTY 888.445.5614 and ask for a Designation of Authorized Representative and Release of Information form. Complete it and send it with your appeal.
- You do not have to pay for copies of information relating to MESSA/BCBSM's decision to deny, reduce or terminate or cancel your coverage.

The grievance and appeals process begins with an internal review by MESSA and BCBSM. Once you have exhausted your internal options, you have the right to a review by the Michigan Department of Insurance and Financial Services.

NOTE: You do not have to exhaust our internal grievance process before requesting an external review in certain circumstances:

- We waive the requirement
- We fail to comply with our internal grievance process
  - Our failure to comply must be for more than minor violations of the internal grievance process. Minor violations are those that do not cause and are not likely to cause you prejudice or harm.

Grievance process

continued...

Standard Internal Grievance Process

Step 1: You or your authorized representative send us a written statement explaining why you disagree with our decision. Your request for review must be submitted within 180 days after receiving a notice of denial.

Mail your written grievance to:

Associate Manager, Legal and Compliance
MESSA
1475 Kendale Boulevard
P.O. Box 2560
East Lansing, MI 48826-2560

- For pre-service appeals, we have 15 days to give you our final determination.
- For post-service appeals, we have 30 days to give you our final determination.

In both cases, you have the right to allow us additional time if you wish.

A decision will be made by MESSA/ BCBSM after MESSA receives your request for review or the date you provide all information required of you, whichever date is later. The decision will be in writing and will specify the reason for BCBSM/MESSA's decision.

Step 2: If you are dissatisfied with this decision, you may request a managerial-level conference by calling the MESSA Legal and Compliance Department at 800.742.2328 or mailing your written request to:

Associate Manager, Legal and Compliance
MESSA
1475 Kendale Boulevard
P.O. Box 2560
East Lansing, MI 48826-2560

During your conference, you can provide us with any other information you want us to consider in reviewing your grievance. You can choose to have the conference in person or over the telephone. If in person, the conference will be held at the MESSA /BCBSM headquarters in Detroit during regular business hours. The written decision we give you after the conference is our final decision.

- For pre-service appeals, we have 15 days to give you our final determination.
- For post-service appeals, we have 30 days to give you our final determination.

In both cases, you have the right to allow us additional time if you wish.

BCBSM and MESSA will complete both steps within 30 days of the date we receive your written grievance under Step 1 for pre-service appeals, and within 60 days for post-service appeals. These time periods do not include the time between your receiving our decision under Step 1 and requesting further review under Step 2.

If you disagree with our final decision, or you do not receive our decision within 30 days after we received your original grievance for a pre-service appeal, or within 60 days for a post-service appeal, you may request an external review. See below for how to request an external review.

Standard External Review Process

Once you have gone through our standard internal review process, you or your authorized representative may request an external review.

Within 120 days of the date you receive or should have received our final decision, send a written request for an external review to the Department listed below. Mail your request and the required forms that we give you to:

Department of Insurance and Financial Services
Office of General Counsel
Health Care Appeals Section
P.O. Box 30220
Lansing, MI 48909-7720

When you file a request for an external review, you will have to authorize the release of medical records that may be required to reach a decision during the external review.

If you ask for an external review about a medical issue and the issue is found to be appropriate for external review,

Grievance process

continued...

the Department will assign an independent review group to conduct the external review. The group will consist of independent clinical peer reviewers. The recommendation of the independent review group will only be binding on you and MESSA/BCBSM if the Department decides to accept the group's recommendation. The Department will make sure that this independent review group does not have a conflict of interest with you, with us, or with any other relevant party.

Review of Medical Issues

The Department will assign an independent review group to review your request if it concerns a medical issue that is appropriate for an external review.

- You can give the Department additional information within seven business days of requesting an external review. We must give the independent review group all of the information we considered when we made a final decision, within seven business days of getting notice of your request from the Department.

The review group will recommend within 14 days whether the Department should uphold or reverse our decision. The Department must decide within seven business days whether to accept the recommendation and then notify you of its decision. The decision is your final administrative remedy under the Patient's Right to Independent Review Act of 2000.

Review of Nonmedical Issues

If your request for an external review is related to nonmedical issues and is appropriate for external review, Department staff will recommend whether our determination should be upheld or reversed.

The Department will notify you of the decision. This is your final administrative remedy under the Patient's Right to Independent Review Act of 2000.

Expedited Internal Review Process

You may file an expedited internal review request if your physician shows (verbally or in writing) that following the timeframes of the standard internal process will seriously jeopardize:

- Your life or health, or
- Your ability to regain maximum function

To submit a request for an expedited internal review, call 800.742.2328, option 4, or TTY 888.445.5614. Your physician must also call this number to confirm that you qualify for an expedited review.

We must provide you with our decision within 72 hours of receiving both your grievance and the physician's substantiation.

If you do not agree with our decision, you may, within 10 days of receiving it, request an expedited external review from the Michigan Department of Insurance and Financial Services.

If you believe your situation is urgent, you may request an urgent review or a simultaneous expedited external review. For more information on how to ask for an urgent review or simultaneous expedited external review, call the MESSA Legal and Compliance Department at 800.742.2328 or TTY 888.445.5614.

Expedited External Review Process

If you have filed a request for an expedited internal grievance, you may concurrently request an expedited external review from the Michigan Department of Insurance and Financial Services. Otherwise, the process is as follows:

- A request for external review form will be sent to you or your representative with our final adverse determination.
- Within 10 days of receiving your denial, complete this form and mail it to:

  Department of Insurance and Financial Services
  Office of General Counsel
  Health Care Appeals Section
  P.O. Box 30220
  Lansing, MI 48909-7720

Grievance process

continued...

When you file a request for an external review, you will have to authorize the release of medical records that may be required to reach a decision during the external review.

- The Department will decide if your request qualifies for an expedited review. If it does, the Department will assign an independent review group to conduct the review. The group will recommend within 36 hours if the Department should uphold or reverse our decision.
- The Department must decide whether to accept the recommendation within 24 hours. You will be told of the Department's decision. This decision is the final administrative decision under the Patient's Right to Independent Review Act of 2000.

Need more information?

At your request and without charge, we will send you details from your vision care plan if our decision was based on your benefits. If our decision was based on medical guidelines, we will provide you with the appropriate protocols and treatment criteria. If we involved a medical expert in making this decision, we will provide that person's credentials.

Other resources to help you

For questions about your rights, this notice, or for assistance, you can contact the MESSA Legal and Compliance Department at 800.742.2328 or TTY 888.445.5614. You can also contact the Director of the Michigan Department of Insurance and Financial Services for assistance.

To contact the Director:

- Call toll-free at 1.877.999.6442; or
- Mail to: Department of Insurance and Financial Services
  P.O. Box 30220
  Lansing, MI 48909-7720

Definitions

Approved amount

The lower of the billed charge or our maximum payment level for the covered service. Copayments and/or deductibles, which may be required of you, are subtracted from the approved amount before we make our payment.

BCBSM

Blue Cross Blue Shield of Michigan

Cancellation

An action that ends a member's coverage dating back to the effective date of the member's contract. This results in the member's contract never having been in effect.

Claim for damages

A lawsuit against, or demand to, another person or organization for compensation for an injury to a person.

COBRA

A federal law that may allow you to temporarily keep your health coverage after:

- Your employment ends,
- You lose coverage as a dependent of the covered employee, or
- Another qualifying event.

If you elect COBRA coverage, you pay 100 percent of the premiums, including the share the employer used to pay for you, plus a small administrative fee.

Contact lenses

Contact lenses prescribed by a physician or optometrist to correct or improve vision. They are fitted directly to the patient's eye. Contact lenses include disposable or extended wear. The frequency of use for disposable lenses can be daily, weekly or monthly and then the lenses are discarded. Extended wear contact lenses are replaced on a planned schedule.

Contract

The insurance plan and related riders, your signed application for coverage and your MESSA/BCBSM ID card.

Copayment

The portion of the approved amount that you must pay for a covered service.

Effective date

The day your coverage begins. This date is established by MESSA and BCBSM.

Exclusions

Situations, conditions or services that are not covered by the member's contract.

Experimental treatment

Treatment that has not been scientifically proven to be as safe and effective for treatment of the patient's conditions as conventional treatment. Sometimes it is referred to as "investigational" or "experimental services."

First priority security interest

The right to be paid before any other person from any money or other valuable consideration recovered by:

- Judgment or settlement of a legal action
- Settlement not due to legal action
- Undisputed payment

This right may be invoked without regard for:

- Whether plaintiff's recovery is partial or complete
- Who holds the recovery
- Where the recovery is held

Frames

Standard frames into which two lenses may be fitted.

In-network provider

An ophthalmologist, optometrist or retailer that has a signed agreement to provide services through this PPO program. In-network providers have agreed to accept our approved amount as payment in full for covered services provided under this PPO program.

Definitions

continued...

Lenses

Glass or plastic lenses prescribed by an ophthalmologist or optometrist to correct or improve vision. They are fitted into frames.

Lien

A first priority security interest in any money or other valuable consideration recovered by judgment, settlement or otherwise up to the amount of benefits, costs and legal fees BCBSM paid as a result of the plaintiff's injuries.

Medically necessary

We pay for contact lenses that are medically necessary. Medical necessity is the determination by ophthalmologists or optometrists, based on criteria and guidelines developed by ophthalmologists and optometrists, that the service is appropriate and necessary for the condition.

> **NOTE**: In the absence of established criteria, medical necessity will be determined by ophthalmologists or optometrists according to accepted standards and practices.

Member

Any person eligible for vision care services under this plan. This means the subscriber and any eligible dependent listed on the application. The member is the "patient" when receiving covered services.

MESSA

Michigan Education Special Services Association

Ophthalmologist

A licensed doctor of medicine or osteopathy who, within the scope of his or her license, performs eye exams and prescribes corrective lenses.

Optometrist

A person licensed to practice optometry in the state the service is provided.

Out-of-network provider

An ophthalmologist, optometrist, optician or retailer that has not signed an agreement to provide services under this PPO program. Out-of-network providers have not agreed to accept the approved amount as full payment for covered services.

Plaintiff

The person who brings the lawsuit or claim for damages. The plaintiff may be the injured party or a representative of the injured party.

Plan year

The vision plan year is July 1 to June 30.

Provider

An ophthalmologist or optometrist who provides services related to vision care.

Subrogation

The assumption by BCBSM of your right, or the right of your dependents or representatives, to make a legal claim against or to receive money or other valuable consideration from another person, insurance company or organization.

VSP

Vision Service Plan©

We, us, our

Used when referring to MESSA, Blue Cross Blue Shield of Michigan and VSP.

You and your

Used when referring to any person covered under a member's contract.