VSP 3

Plan Coverage Booklet

MESSA®

www.messa.org

The Connecticut General benefits for which you are insured are set forth in the pages of this booklet. Consult these pages for a further description of the terms and conditions of this coverage. If your plan requires contributions from you, such coverage will not become effective unless you so elect and are making such contributions. Application must be made and signed by the individual before any coverage can become effective.

MESSA reserves the right to modify the coverage provided under the Vision Care Insurance Plan at any time.

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Schedule of Benefits

PLAN EFFECTIVE DATE: September 1, 2002

EMPLOYEES ELIGIBLE: All employees of a participating Employer

DEPENDENTS ELIGIBLE: All dependents as defined

VISION CARE BENEFITS FOR YOU AND YOUR DEPENDENTS:

VSP PANEL PROVIDER

Benefits for examinations, lenses or frames which are Covered Charges and obtained from a VSP Panel Provider are provided in accordance with an agreement between Vision Service Plan (VSP) and the panel provider. Under this agreement a provider accepts the VSP payment as payment in full for incurred Covered Charges, after satisfaction of the applicable deductibles. See the "Note" below for reimbursement for frames and cosmetic contact lenses.

Note: The total maximum benefit payable for each insured person in each plan year for frames is $65.00.

The total maximum benefit payable for each insured person in each plan year for all cosmetic contact lenses and examinations is $115.00.

NON-PANEL PROVIDER

Benefits for examinations, lenses or frames which are Covered Charges and obtained from a Non-Panel Provider are subject to the following maximum amount of reimbursement.

Vision Examination:	**Maximum Amount Performed by an:**	
	Optometrist	**Ophthalmologist**
	$35.00	$45.00

Spectacle Lenses (Pair):	**Clear**	**Color Tints/Color Coats**	**Polarized**
Single Vision	$38.00	$42.00	$56.00
Bifocal	60.00	70.00	90.00
Trifocal	72.00	84.00	110.00
Lenticular	108.00	118.00	138.00

Frames:	$55.00
Contact Lenses (Pair - including the exam):	
Necessary	$200.00
Cosmetic (Elective)	115.00

When Your Insurance Begins

BECOMING ELIGIBLE

If you were insured on the day before the Plan Effective Date, you will be eligible on the Plan Effective Date. Otherwise, you will be eligible on the date of your employment or on the day following completion of the eligibility waiting period as determined by your Employer, whichever is later. The Plan Effective Date is shown in the Schedule of Benefits.

You will become insured on the date you become eligible, including if you are not in Active Service on that date due to your health status.

BECOMING INSURED

If you are not required to contribute toward the cost of your insurance, you will become insured on the day you become eligible.

If you are required to pay any portion of the cost of your insurance, you will become insured on the latest of:

a. the day you become eligible, if you enroll for your insurance on or before the day you become eligible.

b. the day you enroll for your insurance, if you enroll on or before the thirty-first (31st) day following the day you become eligible.

c. the first day of the month following the date your application is approved by the Company, if you enroll for your insurance more than thirty-one (31) days following the day you become eligible.

If you were eligible, but were not insured under the replaced plan for a coverage, you will be treated as if you had enrolled for that coverage under this plan more than thirty-one days after the date you became eligible.

When Your Dependents' Insurance Begins

DEPENDENT

This term means:

- your spouse. Your spouse must not be legally separated from you;
- your unmarried children (including stepchildren, adopted children, and children for whom you are legal guardian; however, foster children are not included) until the end of the calendar year of their 19th birthday;
- your unmarried children beyond the end of the calendar year of their 19th birthday to the end of the calendar year of their 25th birthday who are dependent on you for a majority of their support (dependency for tax purposes, as defined by the IRS, is not required);
- your unmarried children beyond the end of the calendar year of their 25th birthday (if covered under this plan at the end of the calendar year of their 25th birthday and continuously thereafter) who are mentally retarded or physically handicapped, dependent upon you for a majority of their support, and are also incapable of self-sustaining employment by reason of their mental retardation or physical handicap. Under no circumstances will mental illness be considered a cause of incapacity nor will it be

considered as a basis for continued coverage. Please contact MESSA Group Services to obtain the appropriate form to continue coverage;

- your unmarried children beyond the end of the calendar year of their 25th birthday (if covered under this plan at the end of the calendar year of their 25th birthday and continuously thereafter), who are full-time students and dependent on you for a majority of their support;
- your sponsored dependents who are members of your family, either by blood or marriage, who qualify as your dependents under the Internal Revenue Code, were declared as dependents on your federal tax return for the preceding tax year, and are 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.

BECOMING ELIGIBLE

Each person who is your dependent on the day you become eligible for insurance is eligible on that day. Each other person is eligible on the day that person becomes your dependent.

BECOMING INSURED

If any one of your dependents is eligible under this plan for coverage as an employee, that person is not eligible for that coverage as a dependent. If both you and your spouse are insured under this plan as employees, your children may only be enrolled as dependents of you or your spouse.

If you are not required to contribute toward the cost of Dependents' insurance, each eligible dependent will be insured beginning with the later of these dates:

a. the day on which your insurance begins.
b. the date he/she becomes an eligible dependent.

If you are required to contribute toward the cost of Dependents' insurance, and your dependents are enrolled:

a before their date of eligibility, they will be insured on the date they become eligible.
b. within thirty-one days of their date of eligibility, they will be insured on the day of enrollment.
c. more than thirty-one days following the day they become eligible, they will not be insured until the first day of the month following the day MESSA approves the application. Each dependent may be asked to have a physical exam at your expense.

If you have eligible dependents, but they were not insured under the replaced plan for a coverage, they will be treated as if they had been enrolled for that coverage under this plan more than thirty-one days after the date they became eligible.

Your dependents will not be insured before the day your insurance begins.

Vision Care Benefits

WHAT IS COVERED

Benefits are payable for Covered Expenses incurred while the person is insured for these benefits. These charges must be made by a doctor, optometrist or optician.

WHAT ARE COVERED EXPENSES

1. Charges for a vision examination but not for more than one performed on an insured person during a plan year.
2. Charges for corrective spectacle lenses and frames but not more than one pair of such lenses and one frame per insured person during a plan year.
3. Charges for corrective contact lenses but not more than one pair of such lenses per insured person during a plan year.

Note: For each plan year, charges for contact lenses and the examination are in lieu of all other Covered Charges during the plan year for each insured person.

HOW MUCH

VSP Panel Provider

By obtaining examinations, lenses or frames from a VSP Panel Provider, an insured person will pay no more than the deductible, if any, specified in the Schedule of Benefits for each service or material that is a Covered Charge, except, if an insured person selects a service or material which exceeds the plan allowance for any Covered Charge, the insured person will have to pay the provider the excess costs directly. The insured person must also pay the provider for services and materials that are not Covered Charges.

Non-Panel Provider

If an insured person receives an examination by, or purchases lenses or frames from a Non-Panel Provider, the insured person must pay the provider the full cost of the service or material. You will then be reimbursed for Covered Charges up to the maximum amount for the service or material as shown in the Schedule of Benefits (page 2).

NOT COVERED

No payment shall be made for:

1. Non-corrective lenses.
2. Vision therapy or subnormal vision aids.
3. Medical or surgical treatment of the eyes.
4. Replacement of lost or broken lenses or frames if benefits applicable to the replacement were previously provided during the plan year.
5. Charges with respect to which benefits are provided under any Workers' Compensation or similar law.
6. Vision examination, lenses or frames which would have been furnished without cost in the absence of this insurance or for which an insured person has no legal obligation to pay.
7. The extra cost of progressive lenses.
8. The cost of frames that exceeds the plan allowance.
9. Charges by a VSP Panel Provider for cosmetic (elective) contact lenses, including the

examination, that exceed the plan allowance.

10. Charges by a Non-Panel Provider for vision examinations, lenses and frames to the extent that such charges exceed the maximum amount shown in the Schedule of Benefits.

IMPORTANT: See "General Information" for other conditions that may affect this coverage.

General Information

DEFINITIONS

The Company - This term means Connecticut General Life Insurance Company, one of its affiliated companies, or their designee.

Doctor - This term means:

a. a physician legally licensed to practice medicine and surgery.
b. any other legally licensed practitioner of the healing arts who renders services within the scope of his or her license. For health insurance expenses, such services will include those covered under the Group Policy for which benefits must be provided by law when rendered by that practitioner.

This term does not include a resident doctor, an intern, or a person in training.

VSP Panel Providers - This term means ophthalmologists and optometrists who have entered into an agreement with Vision Service Plan, a non-profit corporation, to provide vision examinations, corrective lenses and frames.

Non-Panel Providers - This term means ophthalmologists and optometrists who have not entered into an agreement with Vision Service Plan, and opticians.

Vision Examination - This term means a complete analysis of the eyes and related structures to determine the presence of visual problems or other abnormalities and includes the prescribing of corrective lenses, when needed.

Necessary Contact Lenses - This term means contact lenses furnished because visual acuity is not correctable to 20/70 in the better eye with spectacle lenses, but can be corrected to 20/70 or better by the use of contact lenses.

Cosmetic (Elective) Contact Lenses - This term means contact lenses not included in the definition of Necessary Contact Lenses.

HOW TO USE THE PLAN

You may choose one of the three following options to obtain vision care:

OPTION I - If You Choose To See A VSP Panel Doctor

1. Select a doctor from the list of VSP Panel Doctors in your geographic area and make an appointment for an examination.
2. The Panel Doctor will contact VSP to confirm your eligibility for benefits prior to your appointment date.
3. The VSP Panel Doctor will collect any applicable deductible and take care of all paperwork for payment. VSP will pay the doctor for the services you received according to VSP's agreement with the doctor.

OPTION II - If You Choose To See An Optometrist, Ophthalmologist, Or Dispensing Optician Who Is Not A VSP Panel Provider

1. Make an appointment and receive the necessary services from the provider. Pay the provider the full fee and obtain an itemized receipt which must contain the following information:
    a. Patient's name
    b. Date services began
    c. The services and materials you received
    d. The type of lenses you received (single vision, bifocal, trifocal, etc.)
2. Enter the member's social security number and employer name on the receipt. If the patient is a dependent, write the patient's birth date, relationship to the member, and the member's name. Mail the receipt to:

    VISION SERVICE PLAN
    P.O. Box 997105
    Sacramento, CA 95899-7105
3. You will then be reimbursed directly for the expense of services and materials received subject to the maximum amounts shown in the Schedule of Benefits.

OPTION III - If You Choose To See A Non-Panel Doctor For An Examination And Have A VSP Panel Doctor Fill Your Prescription

1. After receiving an examination from the doctor, pay the doctor the exam fee. Obtain a receipt for the exam and the prescription for your lenses. The receipt must contain all the information described in Option II, except for the references to materials and lenses.
2. The Panel Doctor will contact VSP to confirm your eligibility for benefits prior to your appointment date.
3. Take your prescription from your examination to the VSP Panel Doctor on your first visit.
4. The VSP Panel Doctor will fit you with your new glasses or contacts, collect any applicable deductible and take care of any paperwork for payment for materials and lenses.
5. Submit your receipt for your examination as you would under Option II.
6. You will be reimbursed for your exam up to the maximum amount shown in the Schedule of Benefits and the VSP Panel Doctor will be paid by the VSP for dispensing your glasses or contacts.

YOUR RIGHT TO FILE AN INTERNAL GRIEVANCE AND TO REQUEST AN INDEPENDENT EXTERNAL REVIEW

Michigan Public Act 350, as amended by Public Act 516 of 1996 and Public Act 250 of 2000, provides an internal grievance procedure, including a managerial-level conference, if you believe that we have violated Sections 402 and 403 of Public Act 350.

Public Act 251 of 2000 provides you with the right to request an external review from the Commissioner of Financial and Insurance Services if we have denied, reduced or terminated an admission, availability of care, continued stay or other health care service. Normally, you must exhaust our standard internal grievance procedure before you can request an external review.

INTERNAL GRIEVANCES

Standard Internal Grievance Procedure

Under the standard internal grievance procedure, we must provide you with our final written determination within 35 calendar days of our receipt of your written grievance. However, that time frame may be suspended for any amount of time that you are permitted to take to file your grievance, and for a period of up to 10 days if we have not received information we have requested from a health care provider, for example, your doctor or hospital. The standard internal grievance procedure is as follows:

- You or your authorized representative must send us a written statement explaining why you disagree with our determination on your request for benefits or payments.
- Mail your written grievance to the address found in the top right hand corner of the first page of your Explanation of Benefits statement or to the address contained in the letter we send you to notify you that we have not approved a benefit or service you are requesting.
- We will respond to your grievance in writing. If you agree with our response, it becomes our final determination and the grievance ends.

If you disagree with our response to your grievance, you may then request a managerial-level conference. You must request the conference in writing.

Mail your request to:

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

Our written proposed resolution will be our final determination regarding your grievance.

- If you disagree with our final determination, or if we fail to provide it to you within 35 days of the date we received your original written grievance, you may request an external review from the Michigan Commissioner of Financial and Insurance Services.

In addition to the information found above, you should also know:

- You may authorize in writing another person, including, but not limited to a physician, to act on your behalf at any stage in the standard grievance procedure.
- Although we have 35 days within which to give you our final determination, you have the right to allow us additional time if you wish.
- You may obtain copies of information relating to our denial, reduction or termination of coverage for a health care service for a reasonable copying charge.

Expedited Internal Grievance Procedure

If a physician substantiates verbally or in writing that adhering to the time frame for the standard internal grievance would jeopardize your life or health, or would seriously jeopardize your ability to regain maximum function, you may file a request for an expedited internal grievance. You may file a request for an expedited internal grievance only when you think that we have wrongfully denied, terminated, or reduced coverage for a health care service prior to you having

received that health care service or if you believe we have failed to respond timely to a request for benefits or payment. The procedure is a follows:

- You may submit your expedited internal grievance request by telephone. The required physician's substantiation that your condition qualifies for an expedited grievance can also be submitted by telephone. Call MESSA's Legal and Compliance Department at 800.742.2328.
- 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 Commissioner.

In addition to the information on the preceding page, you should also know:

- You may authorize, in writing, another person, including, but not limited to, a physician, to act on your behalf at any stage in the expedited internal grievance procedure.
- If our decision is communicated to you verbally, we must provide you with written confirmation within two (2) business days.

EXTERNAL REVIEWS

Standard External Review Procedure

Once you have exhausted our standard internal grievance procedure, you or your authorized representative have the right to request an external review from the Commissioner. The standard external review process is as follows:

- Within 60 days of the date you either received our final determination or should have received it, you must send a written request for an external review to the Commissioner.

  Mail your request, including the required forms that we will supply you, to:

  Appeals Section
  Office of Financial & Insurance Regulation
  P.O. Box 30220
  Lansing, MI 48909

- If your request for external review concerns a medical issue, and is otherwise found to be appropriate for external review, the Commissioner will assign an Independent Review Organization, consisting of independent clinical peer reviewers, to conduct the external review. You will have an opportunity to provide additional information to the Commissioner within seven (7) days after you submit your request for an external review. We must provide documents and information considered in making our final determination to the Independent Review Organization within seven (7) business days after we receive notice of your request from the Commissioner.
- The assigned Independent Review Organization will recommend, within 14 days, whether the commissioner should uphold or reverse our determination. The Commissioner must decide within seven (7) business days whether or not to accept the recommendation and will notify you. The Commissioner's decision is the final administrative remedy under the Patient's Right to Independent Review Act.
- If your request for external review is related to non-medical issues, and is otherwise found to be appropriate for external review, the Commissioner's staff will conduct the

external review. The Commissioner's staff will recommend whether the Commissioner should uphold or reverse our determination. The Commissioner will notify you of the decision. The Commissioner's decision is the final administrative remedy under the Patient's Right to Independent Review Act.

Expedited External Review Procedure

If a physician substantiates verbally or in writing that you have a medical condition for which the time frame for completion of an expedited internal grievance seriously jeopardizes your life or health, or would jeopardize your ability to regain maximum function, and, you have filed a request for an expedited internal grievance, you may request an expedited external review, from the Commissioner. You may file a request for an expedited external review only when you think that we have wrongfully denied, terminated, or reduced coverage for a health care service prior to your having received that health care service. The expedited external review process is as follows:

- Within 10 days of your receipt of our denial, termination, or reduction in coverage for health care service, you or your authorized representative may request an expedited external review from the Commissioner.

To do so in writing, mail your request, including the required forms that we will supply to you, to:

Appeals Section
Office of Financial & Insurance Regulation
P.O. Box 30220
Lansing, MI 48909

To do so by telephone, call the following toll free number: 877.999.6442.

- Immediately after receiving your request, the Commissioner will decide if it is appropriate for external review and assign an Independent Review Organization to conduct the expedited external review. If the Independent Review Organization decides that you do not have to first complete the expedited internal grievance procedure, it will review your request and recommend within 36 hours whether the Commissioner should uphold or reverse our determination.

The Commissioner must decide within 24 hours whether or not to accept the recommendation and will notify you. The Commissioner's decision is the final administrative remedy under the Patient's Right to Independent Review Act.

NON-DUPLICATION OF BENEFITS

If an insured person is entitled to benefits for vision care under this plan and at least one other plan, the amount of benefits provided by this plan for that care may be reduced to the extent that the total payment provided for a calendar year by all plans by which the person is covered will not be more than the total of the allowable expenses that the person incurs in the same year. This will be done as set forth in Order of Payment.

Plan - This term means any plan that provides medical or vision care coverage:

a. by any group insurance, or by any other method of coverage for persons in a group.
b. by any governmental plan, except Medicaid (Title XIX of the Federal Social Security Act as it now is or as it may be changed).

c. required by law.
d. by a "no-fault" motor vehicle plan.

This term does not mean school accident insurance or group hospital indemnity benefits.

Allowable Expenses - This term means any necessary, reasonable and customary item of expense, a part of the cost of which is covered by this Plan, or one of the other plans, except Medicare or a "no-fault" motor vehicle plan.

Medicare - This term means Title XVIII of the Federal Social Security Act, as it now is, or as it may be changed. A person who is eligible for Medicare will be deemed to have all the coverages for which he or she is so eligible.

No-fault Motor Vehicle Plan - This term means a motor vehicle plan which is required by law and provides medical care payments which are made, in whole or in part, without regard to fault.

A person subject to such law who has not complied with the law will be deemed to have received the benefits required by the law.

Order of Payment - When a person is covered under two or more plans, the rules that follow will decide the order in which the plans will pay benefits:

1. A plan which does not have a provision like this Non-Duplication of Benefits will pay before this Plan.
2. A plan which covers a person other than as a dependent will pay before a plan which covers a person as a dependent.
3. A plan which covers a person as a dependent of a person whose date of birth occurs earlier in a calendar year will pay before a plan which covers the person as a dependent of a person whose date of birth occurs later in a calendar year; provided that:
   a. if said dates of birth are the same, the plan which has covered a person for the longest time will pay first.
   b. if any other plan does not have a provision for dates of birth, as set forth above, that plan will determine the order of payment with respect to dependents.

   In this clause, date of birth means day and month of birth. It does not mean year of birth. However, if the person is a dependent child of divorced or separated parents, the order will be as follows:

   a. if the parent with custody has not remarried, his or her plan will pay before the plan of the parent without custody.

   b. if the parent with custody has remarried, his or her plan will pay before the plan of the step-parent or the parent without custody; and the plan of the step-parent will pay before the plan of the parent without custody.

   However, if there is a court decree which sets forth a financial duty for the health care expenses of the child, the plan of the parent with such financial duty will pay first.

4. If these three rules do not decide which plan will pay its benefits first, the plan which has covered the person for the longest time will pay first.

   Exception:

   a. Subject to (b) below:

      If a plan covers a person for whom claim is made as a laid-off employee, or as his or her dependent, the benefits of that plan will be determined after those of a plan that covers such person as an employee who is not laid-off or as his or her dependent.

b. If any other plan does not have a provision like that in (a), this Exception will not apply to that plan.

To administer claims, the Company, without the consent of any person, will have the right:

a. to give or to get any data needed to determine benefits under this provision.

b. to recover any sum paid above that is required by this provision.

c. to pay an organization the sum it paid, but which should have been paid by the Company. Amounts so paid will be deemed benefits paid under this Plan; and to the extent so paid there will be no more liability under this Plan.

RIGHT OF RECOVERY

If an overpayment is made due to any reason, including but not limited to a payment under any Workers' Disability Compensation or Occupational Disease Act or law, clerical error or misstatement of age, the Company shall have the right to recover such overpayment from the insured person, or to deduct such amount of over-payment from future benefits.

If you or your dependents incur expenses on account of bodily injury or sickness caused by negligence or wrong of a third party, and benefits are payable under the Group Policy, you will receive the benefits, provided that, if there is recovery by you or your dependents or a personal representative from the third party or his or her personal representative, whether by judgment, settlement or otherwise, on account of such bodily injury or sickness, you shall reimburse the Company to the extent of the total amount of such benefits paid under the Group Policy, but not in an amount in excess of the proceeds of any such recovery after the deduction of reasonable and necessary expenditures, including attorney fees, incurred in effecting such recovery.

WHEN INSURANCE ENDS

Your insurance ends when any of the following events occurs:

a. you leave school employment.

b. you are no longer eligible.

c. contributions are no longer made for the cost of insurance.

d. your Employer's participation under the Group Policy is terminated.

e. the Group Policy ceases.

A dependent's insurance ends when any of the following events occurs:

a. your insurance ends.

b. that dependent is no longer an eligible dependent.

If you cease active work, ask your Employer if arrangements may be made to continue insurance.

CESSATION OF VISION CARE BENEFITS

No vision care benefits will be paid for any vision examinations performed and lenses and frames ordered on or after the date insurance terminates.

COBRA OPTIONAL CONTINUANCE

If your insurance or that of a dependent ends, you and your dependent may each have the right to continue health insurance under the COBRA Optional Continuance. A notice of each person's

rights under this option will be provided by your Employer. Any person who has questions regarding COBRA Optional Continuance should contact their Employer.

This booklet may also describe Optional Continuance rights which may apply to you or your dependents when coverage ends. Although the requirements under the Optional Continuance and the COBRA Optional Continuance may not be the same, a person may be entitled to continue coverage under both. You can ask your Employer if the other option applies to you or your dependents.

REQUIREMENTS OF FAMILY AND MEDICAL LEAVE ACT OF 1993

Any provisions of the Group Policy that provide for continuation of insurance during a leave of absence and reinstatement of insurance following a return to active service are modified by the following provisions of the federal Family and Medical Leave Act of 1993 where applicable:

A. Continuation of Health Insurance During Leave

Your health insurance will be continued during a leave of absence if:

1. that leave qualifies as a leave of absence under the Family and Medical Leave Act of 1993; and
2. you are an eligible employee under the terms of that Act.

The cost of your health insurance during such leave must be paid, whether entirely by your Employer or in part by you and your Employer.

B. Reinstatement of Cancelled Insurance Following Leave

Upon your return to active service following a leave of absence that qualifies under the Family and Medical Leave Act of 1993, any cancelled insurance will be reinstated as of the date of your return.

You will not be required to satisfy any Service or Benefit Waiting Period or the requirements of any pre-existing condition limitation to the extent that they had been satisfied prior to the start of such leave of absence.

Your Employer will give you detailed information about the Family and Medical Leave Act of 1993.

Notice

Your Employer reserves the right to:

a. modify, amend or change the provisions of the Group Policy(ies) subject to the Company's approval;
b. terminate the Group Policy(ies) on any date on which your Employer must pay premiums to the Company;
c. require, change or discontinue at any time, contributions toward the cost of coverage under this plan; and
d. modify, amend, change or discontinue this plan at any time.

Connecticut General
Life Insurance Company
(Herein called The Company)

hereby certifies that employees of the Participating Employer indicated in the Schedule who are insured under Group Policy Number 57227 issued by The Company to:

MICHIGAN EDUCATION SPECIAL SERVICES ASSOCIATION

(Herein called the Policyholder)

are, subject to the terms and conditions of said policy, insured for the benefits described in the pages of the booklet.

The Company insures the vision care coverage. The Company will determine all benefit payments according to the provisions described in the booklet and the Group Policy.

The insurance is effective only if the person concerned is eligible, becomes insured and remains insured, in accordance with the terms and conditions of the policy. This certificate replaces any other certificate issued to you describing this coverage.

GENERAL PROVISIONS

TIME LIMIT ON CERTAIN DEFENSES. No statement relating to insurability made by any member eligible for coverage under the policy shall be used to deny a claim or in contesting the validity of the insurance with respect to which such statement was made after the insurance has been in force prior to the contest for a period of two (2) years during the lifetime of the person with respect to whom any such statement was made.

Note: For the purposes of the following provisions, information submitted to MESSA shall be considered to have been furnished to The Company as herein specified.

NOTICE OF CLAIM. Written notice of claim must be given to The Company no later than twenty (20) days after the date of the occurrence or commencement of any loss covered by the policy, or as soon thereafter as is reasonably possible. Notice given by or on behalf of you or the beneficiary to The Company at its Home Office in Hartford, Connecticut or to any authorized agent of The Company, with information sufficient to identify you, shall be deemed notice to The Company.

CLAIM FORMS. The Company, upon receipt of a written notice of claim, will furnish to the claimant such forms as are usually furnished by it for filing proofs of loss. If such forms are not furnished within fifteen (15) days after the giving of such notice, the claimant shall be deemed to have complied with the requirements of the policy as to proof of loss upon submitting, within the time fixed in the policy for filing proofs of loss, written proof covering the occurrence, the character and the extent of the loss for which claim is made.

PROOF OF LOSS. Written proof of loss must be furnished to The Company within ninety (90) days after the date of the loss. Failure to furnish such proof within the time required shall not invalidate nor reduce any claim if it was not reasonably possible to give proof within such time, provided such proof is furnished as soon as possible and in no event, except in the absence of your legal capacity, later than one year from the time proof is otherwise required. The Company may require, as part of proof of claim, itemized bills of the physician or other source of services or supplies. The Company also has the right to arrange for audits of bills from any provider of services and supplies.

PAYMENT OF CLAIMS. All benefits will be payable to you. If any benefits of the policy shall be payable to your estate, or to you if you are not competent to give valid release, The Company may pay such benefit up to an amount not exceeding $1,000 to any relative by blood or connection by marriage of you who is deemed by The Company to be equitably entitled thereto. Any payment made by The Company in good faith pursuant to this provision shall fully discharge The Company to the extent of such payments.

PHYSICAL EXAMINATIONS. The Company at its own expense shall have the right and opportunity to examine any person when and as often as it may reasonably require during the pendency of a claim under the policy.

LEGAL ACTIONS. No action at law or in equity shall be brought to recover on the policy prior to the expiration of sixty (60) days after written proof of loss has been furnished in accordance with the requirements of the policy. No such action shall be brought after the expiration of 3 years after the time written proof of loss is required to be furnished.

Connecticut General
Life Insurance Company

The Group Policy provides that MESSA and The Company shall share the responsibility for administering the payment of the vision care benefits described in this booklet.

Notes

Notes

Vision Benefits
Underwritten by
Connecticut General
Life Insurance Company

MESSA®
www.messa.org

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