

# VSP-3 Plus Benefits

## Panel Providers

When you see a MESSA VSP participating panel provider for services which are covered charges (exam, lenses and frame allowance or exam and contact lenses), the provider bills VSP directly for the covered charges. If the cost of the frames or contact lenses exceeds the maximum benefit allowance specified in the chart below, the member will have to pay the provider directly for excess costs. A directory of MESSA VSP panel providers is available on the Web at [www.messa.org](http://www.messa.org) > Members > Provider Search > Find an Eye Doctor.

## Non-Panel Providers (Maximum Reimbursement to Patient)

Non-panel providers are providers who do not participate with MESSA's VSP plan. Benefits for examinations, lenses or frames which are obtained from a non-panel (non-participating) provider are subject to a maximum reimbursement. Members and dependents who choose to see a non-panel provider must pay the provider and submit an itemized receipt to VSP for reimbursement. The member is responsible for the difference. The reimbursement will be limited to the maximum amount for each covered charge as indicated in the chart below.

Features	VSP-3 Plus Panel Provider	VSP-3 Plus Non-Panel Provider
<b>Exam Deductible</b>		
<ul style="list-style-type: none"> <li>■ Optometrist</li> <li>■ Ophthalmologist</li> </ul>	No Deductible	\$35 max \$45 max
<b>Contact Lens Allowance (includes exam)</b>		
<ul style="list-style-type: none"> <li>■ Cosmetic (Elective)</li> <li>■ Disposable</li> </ul>	Covered in Full \$200	\$150 max
<b>Frame Allowance</b>	<b>\$80</b>	<b>\$66 max</b>
<b>Lenses</b>		
<ul style="list-style-type: none"> <li>■ Single Vision</li> <li>■ Bifocal</li> <li>■ Trifocal</li> <li>■ Lenticular</li> </ul>	Covered	\$ 38 max \$ 60 max \$ 72 max \$108 max
<b>Extra Lens Features</b>		
<ul style="list-style-type: none"> <li>■ Pink #1 or #2 tint</li> <li>■ Rimless</li> <li>■ Oversize</li> <li>■ Blended</li> <li>■ Progressive</li> </ul>	Covered	**
<b>Tinted</b>		
<ul style="list-style-type: none"> <li>● Tinted Single Vision</li> <li>● Tinted Bifocal</li> <li>● Tinted Trifocal</li> <li>● Tinted Lenticular</li> </ul>	Covered	\$ 42 max \$ 70 max \$ 84 max \$118 max
<b>Polarized</b>		
<ul style="list-style-type: none"> <li>● Polarized Single Vision</li> <li>● Polarized Bifocal</li> <li>● Polarized Trifocal</li> <li>● Polarized Lenticular</li> </ul>	Covered	\$ 56 max \$ 90 max \$110 max \$138 max

**\*\*Non-panel provider materials including lens features are subject to and limited by the lens and frame maximum reimbursement. The patient is responsible for paying the cost of materials and services above the maximum reimbursement amount.**