VSP SIGNATURE PLAN®
COMMERCIAL BUSINESS RATES

2-99 Enrolled Employees
For Clients Headquartered in Washington
Valid Until December 1, 2020

Prepared for Total Benefit Solution

Plan Guidelines

- Individual Experience is not available for Pooled Groups
- 24 month rate guarantee and contract term
- These rates assume a minimum employer contribution of 75% toward employees and dependents or 100% participation of employees and dependents enrolled in the medical or dental plan
- Rates are based on our sliding 10% commission scale and the agreement that VSP will receive these amounts over the full plan term
- Platform participation and associated fees are not included
- The first copay applies to the eye examination and the second copay applies to materials
- Rates include all applicable taxes and health assessment fees known as of the date of the proposal

Plan Frequencies

	PLAN C	PLAN B	PLAN A
Eye Exam	12 Months	12 Months	12 Months
Lens	12 Months	12 Months	24 Months
Frame	12 Months	24 Months	24 Months

The difference in the following plans is the intervals when services are available, as shown above. The base rates quoted reflect VSP's standard in-network retail allowances of $130 for frames and $130 for elective contact lenses. The 12/12/12 option includes tinted or photochromic lenses at no extra cost.

MONTHLY RATES

4-Rate Basis PLAN C (12/12/12)	Employee Only	Employee + One	Employee + Children	Employee + Family
Copay: $0	$16.12	$25.79	$26.33	$42.45
Copay: $5	$14.63	$23.41	$23.90	$38.53
Copay: $10	$12.60	$20.16	$20.58	$33.18
Copay: $20	$10.09	$16.15	$16.48	$26.58
Copay: $25	$8.79	$14.07	$14.36	$23.15
Copay: $0/$20	$10.84	$17.34	$17.70	$28.54
Copay: $10/$10	$9.05	$14.49	$14.79	$23.84
Copay: $10/$20	$8.35	$13.36	$13.64	$21.99
Copay: $10/$25	$8.00	$12.80	$13.07	$21.07
Copay: $10/$30	$7.56	$12.10	$12.35	$19.91
Copay: $20/$20	$7.54	$12.06	$12.31	$19.85

4-Rate Basis PLAN B (12/12/24)	Employee Only	Employee + One	Employee + Children	Employee + Family
Copay: $0	$13.16	$21.05	$21.49	$34.65
Copay: $5	$11.85	$18.96	$19.36	$31.21
Copay: $10	$10.21	$16.33	$16.67	$26.88
Copay: $20	$8.15	$13.04	$13.31	$21.47
Copay: $25	$7.08	$11.33	$11.56	$18.64
Copay: $0/$20	$8.75	$14.01	$14.30	$23.05
Copay: $10/$10	$7.29	$11.67	$11.91	$19.20
Copay: $10/$20	$6.73	$10.76	$10.98	$17.71
Copay: $10/$25	$6.44	$10.31	$10.52	$16.96
Copay: $10/$30	$6.09	$9.74	$9.94	$16.03
Copay: $20/$20	$6.09	$9.74	$9.95	$16.04

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MONTHLY RATES

4-Rate Basis PLAN A (12/24/24)	Employee Only	Employee + One	Employee + Children	Employee + Family
Copay: $0	$11.75	$18.80	$19.19	$30.94
Copay: $5	$10.47	$16.75	$17.10	$27.57
Copay: $10	$9.04	$14.46	$14.76	$23.80
Copay: $20	$7.12	$11.39	$11.63	$18.75
Copay: $25	$6.14	$9.83	$10.03	$16.18
Copay: $0/$20	$7.65	$12.23	$12.49	$20.14
Copay: $10/$10	$6.33	$10.12	$10.34	$16.66
Copay: $10/$20	$5.84	$9.34	$9.53	$15.37
Copay: $10/$25	$5.59	$8.95	$9.13	$14.72
Copay: $10/$30	$5.28	$8.45	$8.63	$13.91
Copay: $20/$20	$5.32	$8.51	$8.69	$14.01