

**VSP SIGNATURE PLAN®**  
**COMMERCIAL BUSINESS RATES**  
 2-99 Enrolled Employees  
 For Clients Headquartered in Washington  
 Valid Until December 1, 2021



**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
<b>Eye Exam</b>	12 Months	12 Months	12 Months
<b>Lens</b>	12 Months	12 Months	24 Months
<b>Frame</b>	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
<b>Copay: \$0</b>	\$16.12	\$25.79	\$26.33	\$42.45
<b>Copay: \$5</b>	\$14.63	\$23.41	\$23.90	\$38.53
<b>Copay: \$10</b>	\$12.60	\$20.16	\$20.58	\$33.18
<b>Copay: \$20</b>	\$10.09	\$16.15	\$16.48	\$26.58
<b>Copay: \$25</b>	\$8.79	\$14.07	\$14.36	\$23.15
<b>Copay: \$0/\$20</b>	\$10.84	\$17.34	\$17.70	\$28.54
<b>Copay: \$10/\$10</b>	\$9.05	\$14.49	\$14.79	\$23.84
<b>Copay: \$10/\$20</b>	\$8.35	\$13.36	\$13.64	\$21.99
<b>Copay: \$10/\$25</b>	\$8.00	\$12.80	\$13.07	\$21.07
<b>Copay: \$10/\$30</b>	\$7.56	\$12.10	\$12.35	\$19.91
<b>Copay: \$20/\$20</b>	\$7.54	\$12.06	\$12.31	\$19.85

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

*Our proposal is based on the scope of the obligations that VSP agrees to undertake. VSP will comply with state and/or federal rules and regulations as they pertain to pre-paid vision plans with a defined benefit*

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**MONTHLY RATES**

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

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