

VSP SIGNATURE PLAN®
COMMERCIAL BUSINESS RATES
 5-99 Enrolled Employees
 For Clients Headquartered in Washington
 Valid Until December 1, 2018



Prepared for Connexion 2018 Rates

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 base rates quoted reflect VSP's standard in-network retail allowances of \$130 for frames and \$130 for elective contact lenses.

MONTHLY RATES

4-Rate Basis	Employee Only	Employee + One	Employee + Children	Employee + Family
PLAN B Copay: \$10/\$20	\$6.47	\$10.35	\$10.56	\$17.03
<i>\$150.00 Elective Contact Lens Allowance</i>	\$0.26	\$0.40	\$0.41	\$0.67
<i>\$150.00 Retail Frame Allowance</i>	\$0.25	\$0.41	\$0.42	\$0.67
Total:	\$6.98	\$11.16	\$11.39	\$18.37

4-Rate Basis	Employee Only	Employee + One	Employee + Children	Employee + Family
PLAN B Copay: \$10/\$25	\$6.19	\$9.91	\$10.12	\$16.31
<i>\$150.00 Elective Contact Lens Allowance</i>	\$0.25	\$0.39	\$0.39	\$0.65
<i>\$150.00 Retail Frame Allowance</i>	\$0.24	\$0.39	\$0.40	\$0.64
Total:	\$6.68	\$10.69	\$10.91	\$17.60

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

VSP SIGNATURE PLAN®
COMMERCIAL BUSINESS RATES
 Voluntary Participation 0-24% Employer Paid
 10-50 Enrolled Employees
 For Clients Headquartered in Washington
 Valid Until December 1, 2018



Prepared for Connexion 2018 Rates

Plan Guidelines

- Individual Experience is not available for Pooled Groups
- 24 month rate guarantee and contract term
- These voluntary pooled rates are based on enrollment of 10-50 employees
- 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
Eye Exam	12 Months	12 Months
Lens	12 Months	12 Months
Frame	12 Months	24 Months

The base rates quoted reflect VSP's standard in-network retail allowances of \$130 for frames and \$130 for elective contact lenses.

MONTHLY RATES

4-Rate Basis	Employee Only	Employee + One	Employee + Children	Employee + Family
PLAN B Copay: \$10/\$20	\$9.19	\$14.70	\$15.01	\$24.20
\$150.00 Elective Contact Lens Allowance	\$0.37	\$0.59	\$0.60	\$0.97
\$150.00 Retail Frame Allowance	\$0.37	\$0.59	\$0.60	\$0.97
Total:	\$9.93	\$15.88	\$16.21	\$26.14

4-Rate Basis	Employee Only	Employee + One	Employee + Children	Employee + Family
PLAN B Copay: \$10/\$25	\$8.83	\$14.12	\$14.41	\$23.24
\$150.00 Elective Contact Lens Allowance	\$0.35	\$0.56	\$0.58	\$0.93
\$150.00 Retail Frame Allowance	\$0.35	\$0.57	\$0.58	\$0.93
Total:	\$9.53	\$15.25	\$15.57	\$25.10

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