# Current

## State of Delaware Current Vision Plan Offerings
## Fully-Insured Vision Proposal Template

**Instructions: Please populate columns F-I with your proposed Plan Design that allows for a match to the existing Low Plan and High Plan designs**

| | Proposed Plan Design - LOW PLAN Summary | | Proposed Plan Design - HIGH PLAN Summary | |
|---|---|---|---|---|
| **Underwritten by:** | Please fill in underlying Insurance Company name | | Please fill in underlying Insurance Company name | |
| **Financial Ratings:**<br>AM Best<br>S&P | Please fill in AM Best rating for underlying Insurance Company<br>Please fill in S&P rating for underlying Insurance Company | | Please fill in AM Best rating for underlying Insurance Company<br>Please fill in S&P rating for underlying Insurance Company | |
| **Comprehensive Initial Eye Examination** | $10 co-pay<br>Dilation as necessary $0<br>Refraction $0 | Up to $30 | $5 co-pay<br>Dilation as necessary $0<br>Refraction $0 | Up to $30 |
| **Materials:** | $25 copayment | No deductible | | |
| **Standard Frames** | $0 copay, plus 80% of balance over $160 | Up to $45 | $0 copay, plus 80% of balance over $210 | |
| **Lenses:** | Standard Plastic | Standard Plastic | Standard Plastic | Standard Plastic |
| Single Vision | $20 copay | Up to $25 | $10 copay | Up to $25 |
| Bifocal | $20 copay | Up to $40 | $10 copay | Up to $40 |
| Trifocal | $20 copay | Up to $55 | $10 copay | Up to $55 |
| Lenticular | $20 copay | Up to $55 | $10 copay | Up to $55 |
| **Contact Lenses:** | | | | |
| Evaluation and Fitting ---<br>Standard Fit (or Covered-In-Full Contacts) | Up to $40; contact lens fit & up to two follow-up visits | N/A | Up to $40; contact lens fit & up to two follow-up visits | N/A |
| Evaluation and Fitting ---<br>Specialty/Premium Fit (or All Other Contacts) | 90% of retail price | N/A | 90% of retail price | N/A |
| Cosmetic (Elective) Lenses ---<br>Conventional (or Covered-In-Full Contact) | $0 copay, plus 85% of balance over $160 | Up to $105 | $0 copay, plus 85% of balance over $210 | Up to $170 |
| Cosmetic (Elective) Lenses ---<br>Disposable (or All Other Contacts) | $0 copay, plus 100% of balance over $160 | Up to $105 | $0 copay, plus 100% of balance over $210 | Up to $170 |
| Medically Necessary Lenses | $0 copay (paid in full by Plan) | Up to $200 | $0 copay (paid in full by Plan) | Up to $200 |
| **Cosmetic Lens Options:** | | | | |
| -Solid Tint | $15 | Not Covered | $0 | Up to $5 |
| -Fashion Gradient Tint | $15 | Not Covered | $0 | Up to $5 |
| -Standard Scratch-Resistant Coating | $0 | Up to $5 | $0 | Up to $5 |
| -Premium Scratch-Resistant Coating | $xx member charge (quote standard) | Not Covered | $xx member charge (quote standard) | Not Covered |
| - Ultra-Violet (UV) Protection (Frontside) | $15 | Up to $5 | $0 | Up to $5 |
| - Ultra-Violet (UV) Protection (Backside) | $15 | Up to $5 | $0 | Up to $5 |
| -Standard Anti-Reflective Coating | $45 | Up to $5 | $0 | Up to $5 |
| -Premium Anti-Reflective Coating (Tier 1) | $57 | Up to $5 | $57 | Up to $5 |
| -Premium Anti-Reflective Coating (Tier 2) | $68 | Up to $5 | $68 | Up to $5 |
| -Premium Anti-Reflective Coating (Tier 3) | $100 | Up to $5 | $100 | Up to $5 |
| -Glass Photogrey (Single Vision) | $xx member charge (quote standard) | Not Covered | | |
| -Glass Photogrey (Multi-Focal) | $xx member charge (quote standard) | Not Covered | | |
| -Plastic Photochromic Tints (Single Vision) | $75 | Not Covered | $75 | Not Covered |
| -Plastic Photochromic Tints (Multifocal) | $75 | Not Covered | $75 | Not Covered |
| -Polarized Lenses | 80% of retail price | Not Covered | 80% of retail price | Not Covered |
| -Plastic Photosensitive Lenses | $xx member charge (quote standard) | Not Covered | | |



*This Document and all its contents are CONFIDENTIAL and PROPRIETARY and cannot be disclosed to any third party without the prior, written consent of Willis Towers Watson Northeast, Inc.*

wtw

## State of Delaware Current Vision Plan Offerings
## Fully-Insured Vision Proposal Template

**Instructions: Please populate columns F-I with your proposed Plan Design that allows for a match to the existing Low Plan and High Plan designs**

| | Proposed Plan Design - LOW PLAN Summary | | Proposed Plan Design - HIGH PLAN Summary | |
|---|---|---|---|---|
| -Progressive Standard Lenses | $85 copay | Up to $40 | $10 copay | |
| -Progressive Premium Lenses | Tier 1 $105 copay<br>Tier 2 $115 copay<br>Tier 3 $130 copay<br>Tier 4 $235 copay | Tier 1 Up to $40<br>Tier 2 Up to $40<br>Tier 3 Up to $40<br>Tier 4 Up to $40 | Tier 1 $95 copay<br>Tier 2 $105 copay<br>Tier 3 $120 copay<br>Tier 4 $225 copay | Tier 1 Up to $40<br>Tier 2 Up to $40<br>Tier 3 Up to $40<br>Tier 4 Up to $40 |
| -Progressive Custom Lenses | $xx member charge (quote standard) | Not Covered | | |
| -Digital Progressive Lenses | $xx member charge (quote standard) | Not Covered | | |
| -Computer / Near Variable Lenses | $xx member charge (quote standard) | Not Covered | | |
| -Blue Blocker Lenses | $xx member charge (quote standard) | Not Covered | | |
| -Transitions Single Vision Standard | $xx member charge (quote standard) | Not Covered | | |
| -Transitions Multi-Focal Standard | $xx member charge (quote standard) | Not Covered | | |
| -Polycarbonate (Single Vision) | Under Age 19<br>$0 member charge<br>Age 19 and over<br>$0 member charge | Under Age 19<br>Up to $5<br>Age 19 and over<br>Up to $5 | Under Age 19<br>$0 member charge<br>Age 19 and over<br>$0 member charge | Under Age 19<br>Up to $5<br>Age 19 and over<br>Up to $5 |
| -Polycarbonate (Bifocal) | Under Age 19<br>$0 member charge<br>Age 19 and over<br>$0 member charge | Under Age 19<br>Up to $5<br>Age 19 and over<br>Up to $5 | Under Age 19<br>$0 member charge<br>Age 19 and over<br>$0 member charge | Under Age 19<br>Up to $5<br>Age 19 and over<br>Up to $6 |
| -Polycarbonate (Trifocal) | Under Age 19<br>$0 member charge<br>Age 19 and over<br>$0 member charge | Under Age 19<br>Up to $5<br>Age 19 and over<br>Up to $5 | Under Age 19<br>$0 member charge<br>Age 19 and over<br>$0 member charge | Under Age 19<br>Up to $5<br>Age 19 and over<br>Up to $7 |
| -Blended Bifocal (Segment) | $xx member charge (quote standard) | Not Covered | | |
| -High Index Plastic | $xx member charge (quote standard) | Not Covered | | |
| -Other | 80% of retail price | Not Covered | 80% of retail price | Not Covered |
| **Frequency Limitations:** | Measured from last date of service | | Measured from last date of service | |
| Eye Examination | Adults and Children | Once every plan year | Adults and Children | Once every plan year |
| Contact Lens Fitting and Follow-Up | Adults and Children | Once every plan year | Adults and Children | Once every plan year |
| Lenses | Adults and Children | Once every plan year | Adults and Children | Once every plan year |
| Contacts | Adults and Children | Once every plan year | Adults and Children | Once every plan year |
| Frames | Adults and Children | Once every plan year | Adults and Children | Once every plan year |
| **Contact Lens Replacement by Mail Program** | | | | |
| **Are contact lenses and associated expenses provided in lieu of all other lens and frame benefits available herein?** | | | | |



*This Document and all its contents are CONFIDENTIAL and PROPRIETARY and cannot be disclosed to any third party without the prior, written consent of Willis Towers Watson Northeast, Inc.*

## State of Delaware Current Vision Plan Offerings
## Fully-Insured Vision Proposal Template

**Instructions: Please populate columns F-I with your proposed Plan Design that allows for a match to the existing Low Plan and High Plan designs**

| | Proposed Plan Design - LOW PLAN Summary | | Proposed Plan Design - HIGH PLAN Summary | |
|---|---|---|---|---|
| **Low Vision**<br>(Professional services, as necessary, for severe visual problems not correctable with regular lenses) | Quote standard benefit and fill in description here, including frequency limits. | Supplemental Testing<br>Quote standard benefit and fill in description here, including frequency limits.<br>Supplemental Aids<br>Quote standard benefit and fill in description here, including frequency limits. | | |
| **Supplemental Primary Eyecare Plan Rider**<br>(designed for the detection, treatment and management of ocular conditions and/or systemic conditions that produce ocular or visual symptoms) | Fill in description of benefit offering or note as "Not Applicable. | | | |
| **Laser Vision Correction** | 85% of retail price or 95% of promotional price Whichever is lesser | Not Covered | 85% of retail price or 95% of promotional price Whichever is lesser | Not Covered |
| **Safety Glasses** | Fill in description of benefit offering or note as "Not Applicable. | Not Covered | | |
| **Hearing Aid Program** | Up to 66% off hearing aids; call 1.877.203.0675 (Amplifon Network) | Not Covered | Up to 66% off hearing aids; call 1.877.203.0675 (Amplifon Network) | Not Covered |
| **Diabetic Eye Care Program** | $0 copay | Copay varies | $0 copay | Copay varies |
| **Retinal Imaging Benefit** | Up to $39 | Not Covered | Up to $39 | Not Covered |
| **Eye Health Management Program** | Fill in description of benefit offering or note as "Not Applicable. | | | |
| **Non-Covered Glasses and/or Supplies at Participating Providers** | Fill in description of benefit offering or note as "Not Applicable. | | | |
| **What is the wholesale allowance for frames?** | Not applicable | | | |
| **What is the equivalent retail allowance for frames?** | $180 Retail Allowance, with xx% discount on overage. | | | |
| **Dependent Child Definition** | To age 26 | | To age 26 | |



*This Document and all its contents are CONFIDENTIAL and PROPRIETARY and cannot be disclosed to any third party without the prior, written consent of Willis Towers Watson Northeast, Inc.*

## State of Delaware Current Vision Plan Offerings
## Fully-Insured Vision Proposal Template

**Instructions: Please populate columns F-I with your proposed Plan Design that allows for a match to the existing Low Plan and High Plan designs**

| | Proposed Plan Design - LOW PLAN Summary | Proposed Plan Design - HIGH PLAN Summary |
|---|---|---|
| **Telemedicine** | Practices participation in our network offering telemedicine will include the notation "Telemedicine Services Available." Services can vary by location, so contact your provider for details on specific telemedicine services provided. Common types of telemedicine services include, but are not limited to: remote visits/consultation, including triaging issues like pink eye, remote treatment options, like online vision therapy, remote monitoring of common conditions like dry eyes, remote review and analysis of digital images, remote follow up care, including prescriptions and virtual frame try-on. | |
| **Contribution** | Contributory (Employees will "buy-up" by paying the premium difference between the Low Plan and High Plan) | |
| **Proposed Monthly Rates:** | | |
| Single | $x.xx | |
| Parent & Child(ren) | $x.xx | |
| Husband & Wife | $x.xx | |
| Family | $x.xx | |
| **Rate Guarantee** | x-years thru 12/31/20xx | |
| **Commission Level** | Net of Commissions | |
| **Multi-Year "Lock-in" OR "Lock-out" provision?** | None | |
| **Minimum Participation Requirement** | xx% of eligible group or a minimum of x enrollees, whichever is greater. | |



*This Document and all its contents are CONFIDENTIAL and PROPRIETARY and cannot be disclosed to any third party without the prior, written consent of Willis Towers Watson Northeast, Inc.*

## State of Delaware Current Vision P
## Fully-Insured Vision Proposal Tem

**Instructions: Please populate columns F-I with your pr**

| | Fill in your Proposed Plan Design information below - LOW PLAN | | Fill in your Proposed Plan Design information below - HIGH PLAN | |
|---|---|---|---|---|
| **Underwritten by:** | | | | |
| **Financial Ratings:**<br>AM Best<br>S&P | | | | |
| **Comprehensive Initial Eye Examination** | | | | |
| **Materials:** | | | | |
| **Standard Frames** | | | | |
| **Lenses:** | | | | |
| Single Vision | | | | |
| Bifocal | | | | |
| Trifocal | | | | |
| Lenticular | | | | |
| **Contact Lenses:** | | | | |
| Evaluation and Fitting ---<br>Standard Fit (or Covered-In-Full Contacts) | | | | |
| Evaluation and Fitting ---<br>Specialty/Premium Fit (or All Other Contacts) | | | | |
| Cosmetic (Elective) Lenses ---<br>Conventional (or Covered-In-Full Contact) | | | | |
| Cosmetic (Elective) Lenses ---<br>Disposable (or All Other Contacts) | | | | |
| Medically Necessary Lenses | | | | |
| **Cosmetic Lens Options:** | | | | |
| -Solid Tint | | | | |
| -Fashion Gradient Tint | | | | |
| -Standard Scratch-Resistant Coating | | | | |
| -Premium Scratch-Resistant Coating | | | | |
| - Ultra-Violet (UV) Protection (Frontside) | | | | |
| - Ultra-Violet (UV) Protection (Backside) | | | | |
| -Standard Anti-Reflective Coating | | | | |
| -Premium Anti-Reflective Coating (Tier 1) | | | | |
| -Premium Anti-Reflective Coating (Tier 2) | | | | |
| -Premium Anti-Reflective Coating (Tier 3) | | | | |
| -Glass Photogrey (Single Vision) | | | | |
| -Glass Photogrey (Multi-Focal) | | | | |
| -Plastic Photochromic Tints (Single Vision) | | | | |
| -Plastic Photochromic Tints (Multifocal) | | | | |
| -Polarized Lenses | | | | |
| -Plastic Photosensitive Lenses | | | | |



*This Document and all its contents are CONFIDENTIAL and PROPRIETARY and cannot be disclosed to any third party without the prior, written consent of Willis Towers Watson Northeast, Inc.*

## State of Delaware Current Vision P
## Fully-Insured Vision Proposal Tem

**Instructions: Please populate columns F-I with your pr**

| | Fill in your Proposed Plan Design information below - LOW PLAN | | Fill in your Proposed Plan Design information below - HIGH PLAN | |
|---|---|---|---|---|
| -Progressive Standard Lenses | | | | |
| -Progressive Premium Lenses | | | | |
| -Progressive Custom Lenses | | | | |
| -Digital Progressive Lenses | | | | |
| -Computer / Near Variable Lenses | | | | |
| -Blue Blocker Lenses | | | | |
| -Transitions Single Vision Standard | | | | |
| -Transitions Multi-Focal Standard | | | | |
| -Polycarbonate (Single Vision) | | | | |
| -Polycarbonate (Bifocal) | | | | |
| -Polycarbonate (Trifocal) | | | | |
| -Blended Bifocal (Segment) | | | | |
| -High Index Plastic | | | | |
| -Other | | | | |
| **Frequency Limitations:** | | | | |
| Eye Examination | | | | |
| Contact Lens Fitting and Follow-Up | | | | |
| Lenses | | | | |
| Contacts | | | | |
| Frames | | | | |
| **Contact Lens Replacement by Mail Program** | | | | |
| **Are contact lenses and associated expenses provided in lieu of all other lens and frame benefits available herein?** | | | | |



*This Document and all its contents are CONFIDENTIAL and PROPRIETARY and cannot be disclosed to any third party without the prior, written consent of Willis Towers Watson Northeast, Inc.*

## State of Delaware Current Vision P
## Fully-Insured Vision Proposal Tem

**Instructions: Please populate columns F-I with your pr**

| | Fill in your Proposed Plan Design information below - LOW PLAN | | Fill in your Proposed Plan Design information below - HIGH PLAN | |
|---|---|---|---|---|
| **Low Vision**<br>(Professional services, as necessary, for severe visual problems not correctable with regular lenses) | | | | |
| **Supplemental Primary Eyecare Plan Rider**<br>(designed for the detection, treatment and management of ocular conditions and/or systemic conditions that produce ocular or visual symptoms) | | | | |
| **Laser Vision Correction** | | | | |
| **Safety Glasses** | | | | |
| **Hearing Aid Program** | | | | |
| **Diabetic Eye Care Program** | | | | |
| **Retinal Imaging Benefit** | | | | |
| **Eye Health Management Program** | | | | |
| **Non-Covered Glasses and/or Supplies at Participating Providers** | | | | |
| **What is the wholesale allowance for frames?** | | | | |
| **What is the equivalent retail allowance for frames?** | | | | |
| **Dependent Child Definition** | | | | |



*This Document and all its contents are CONFIDENTIAL and PROPRIETARY and cannot be disclosed to any third party without the prior, written consent of Willis Towers Watson Northeast, Inc.*

## State of Delaware Current Vision P
## Fully-Insured Vision Proposal Tem

**Instructions: Please populate columns F-I with your pr**

| | Fill in your Proposed Plan Design information below - LOW PLAN | Fill in your Proposed Plan Design information below - HIGH PLAN |
|---|---|---|
| **Telemedicine** | | |
| **Contribution** | | |
| **Proposed Monthly Rates:**<br>Single<br>Parent & Child(ren)<br>Husband & Wife<br>Family | | |
| **Rate Guarantee** | | |
| **Commission Level** | | |
| **Multi-Year "Lock-in" OR "Lock-out" provision?** | | |
| **Minimum Participation Requirement** | | |



*This Document and all its contents are CONFIDENTIAL and PROPRIETARY and cannot be disclosed to any third party without the prior, written consent of Willis Towers Watson Northeast, Inc.*

# Alternate

## State of Delaware Alternate Vision Plan Offerings
## Fully-Insured Vision Proposal Template

**Instructions: Please populate columns F-I with your proposed Plan Design that allows for an alternate Low Plan design, but matches the existing High Plan design**

| | Proposed Plan Design - LOW PLAN Summary | | Proposed Plan Design - HIGH PLAN Summary | |
|---|---|---|---|---|
| **Underwritten by:** | Please fill in underlying Insurance Company name | | Please fill in underlying Insurance Company name | |
| **Financial Ratings:** | | | | |
| AM Best | Please fill in AM Best rating for underlying Insurance Company | | Please fill in AM Best rating for underlying Insurance Company | |
| S&P | Please fill in S&P rating for underlying Insurance Company | | Please fill in S&P rating for underlying Insurance Company | |
| **Comprehensive Initial Eye Examination** | $10 co-pay<br>Dilation as necessary $0<br>Refraction $0 | Up to $30 | $5 co-pay<br>Dilation as necessary $0<br>Refraction $0 | Up to $30 |
| **Materials:** | $25 copayment | No deductible | | |
| **Standard Frames** | $0 copay, plus 80% of balance over $160 | Up to $45 | $0 copay, plus 80% of balance over $210 | |
| **Lenses:** | Standard Plastic | Standard Plastic | Standard Plastic | Standard Plastic |
| Single Vision | $20 copay | Up to $25 | $10 copay | Up to $25 |
| Bifocal | $20 copay | Up to $40 | $10 copay | Up to $40 |
| Trifocal | $20 copay | Up to $55 | $10 copay | Up to $55 |
| Lenticular | $20 copay | Up to $55 | $10 copay | Up to $55 |
| **Contact Lenses:** | | | | |
| Evaluation and Fitting ---<br>Standard Fit (or Covered-In-Full Contacts) | Up to $40; contact lens fit & up to two follow-up visits | N/A | Up to $40; contact lens fit & up to two follow-up visits | N/A |
| Evaluation and Fitting ---<br>Specialty/Premium Fit (or All Other Contacts) | 90% of retail price | N/A | 90% of retail price | N/A |
| Cosmetic (Elective) Lenses ---<br>Conventional (or Covered-In-Full Contact) | $0 copay, plus 85% of balance over $160 | Up to $105 | $0 copay, plus 85% of balance over $210 | Up to $170 |
| Cosmetic (Elective) Lenses ---<br>Disposable (or All Other Contacts) | $0 copay, plus 100% of balance over $160 | Up to $105 | $0 copay, plus 100% of balance over $210 | Up to $170 |
| Medically Necessary Lenses | $0 copay (paid in full by Plan) | Up to $200 | $0 copay (paid in full by Plan) | Up to $200 |
| **Cosmetic Lens Options:** | | | | |
| -Solid Tint | $15 | Not Covered | $0 | Up to $5 |
| -Fashion Gradient Tint | $15 | Not Covered | $0 | Up to $5 |
| -Standard Scratch-Resistant Coating | $0 | Up to $5 | $0 | Up to $5 |
| -Premium Scratch-Resistant Coating | $xx member charge (quote standard) | Not Covered | $xx member charge (quote standard) | Not Covered |
| - Ultra-Violet (UV) Protection (Frontside) | $15 | Up to $5 | $0 | Up to $5 |
| - Ultra-Violet (UV) Protection (Backside) | $15 | Up to $5 | $0 | Up to $5 |
| -Standard Anti-Reflective Coating | $45 | Up to $5 | $0 | Up to $5 |
| -Premium Anti-Reflective Coating (Tier 1) | $57 | Up to $5 | $57 | Up to $5 |
| -Premium Anti-Reflective Coating (Tier 2) | $68 | Up to $5 | $68 | Up to $5 |
| -Premium Anti-Reflective Coating (Tier 3) | $100 | Up to $5 | $100 | Up to $5 |
| -Glass Photogrey (Single Vision) | $xx member charge (quote standard) | Not Covered | | |
| -Glass Photogrey (Multi-Focal) | $xx member charge (quote standard) | Not Covered | | |
| -Plastic Photochromic Tints (Single Vision) | $75 | Not Covered | $75 | Not Covered |
| -Plastic Photochromic Tints (Multifocal) | $75 | Not Covered | $75 | Not Covered |
| -Polarized Lenses | 80% of retail price | Not Covered | 80% of retail price | Not Covered |
| -Plastic Photosensitive Lenses | $xx member charge (quote standard) | Not Covered | | |



*This Document and all its contents are CONFIDENTIAL and PROPRIETARY and cannot be disclosed to any third party without the prior, written consent of Willis Towers Watson Northeast, Inc.*

wtw

## State of Delaware Alternate Vision Plan Offerings
## Fully-Insured Vision Proposal Template

**Instructions: Please populate columns F-I with your proposed Plan Design that allows for an alternate Low Plan design, but matches the existing High Plan design**

| | Proposed Plan Design - LOW PLAN Summary | | Proposed Plan Design - HIGH PLAN Summary | |
|---|---|---|---|---|
| -Progressive Standard Lenses | $85 copay | Up to $40 | $10 copay | |
| -Progressive Premium Lenses | Tier 1 $105 copay<br>Tier 2 $115 copay<br>Tier 3 $130 copay<br>Tier 4 $235 copay | Tier 1 Up to $40<br>Tier 2 Up to $40<br>Tier 3 Up to $40<br>Tier 4 Up to $40 | Tier 1 $95 copay<br>Tier 2 $105 copay<br>Tier 3 $120 copay<br>Tier 4 $225 copay | Tier 1 Up to $40<br>Tier 2 Up to $40<br>Tier 3 Up to $40<br>Tier 4 Up to $40 |
| -Progressive Custom Lenses | $xx member charge (quote standard) | Not Covered | | |
| -Digital Progressive Lenses | $xx member charge (quote standard) | Not Covered | | |
| -Computer / Near Variable Lenses | $xx member charge (quote standard) | Not Covered | | |
| -Blue Blocker Lenses | $xx member charge (quote standard) | Not Covered | | |
| -Transitions Single Vision Standard | $xx member charge (quote standard) | Not Covered | | |
| -Transitions Multi-Focal Standard | $xx member charge (quote standard) | Not Covered | | |
| -Polycarbonate (Single Vision) | Under Age 19<br>$0 member charge<br>Age 19 and over<br>$0 member charge | Under Age 19<br>Up to $5<br>Age 19 and over<br>Up to $5 | Under Age 19<br>$0 member charge<br>Age 19 and over<br>$0 member charge | Under Age 19<br>Up to $5<br>Age 19 and over<br>Up to $5 |
| -Polycarbonate (Bifocal) | Under Age 19<br>$0 member charge<br>Age 19 and over<br>$0 member charge | Under Age 19<br>Up to $5<br>Age 19 and over<br>Up to $5 | Under Age 19<br>$0 member charge<br>Age 19 and over<br>$0 member charge | Under Age 19<br>Up to $5<br>Age 19 and over<br>Up to $6 |
| -Polycarbonate (Trifocal) | Under Age 19<br>$0 member charge<br>Age 19 and over<br>$0 member charge | Under Age 19<br>Up to $5<br>Age 19 and over<br>Up to $5 | Under Age 19<br>$0 member charge<br>Age 19 and over<br>$0 member charge | Under Age 19<br>Up to $5<br>Age 19 and over<br>Up to $7 |
| -Blended Bifocal (Segment) | $xx member charge (quote standard) | Not Covered | | |
| -High Index Plastic | $xx member charge (quote standard) | Not Covered | | |
| -Other | 80% of retail price | Not Covered | 80% of retail price | Not Covered |
| **Frequency Limitations:** | Measured from last date of service | | Measured from last date of service | |
| Eye Examination | Adults and Children | Once every plan year | Adults and Children | Once every plan year |
| Contact Lens Fitting and Follow-Up | Adults and Children | Once every plan year | Adults and Children | Once every plan year |
| Lenses | Adults and Children | Once every plan year | Adults and Children | Once every plan year |
| Contacts | Adults and Children | Once every plan year | Adults and Children | Once every plan year |
| Frames | Adults and Children | Once every plan year | Adults and Children | Once every plan year |
| **Contact Lens Replacement by Mail Program** | | | | |
| **Are contact lenses and associated expenses provided in lieu of all other lens and frame benefits available herein?** | | | | |



*This Document and all its contents are CONFIDENTIAL and PROPRIETARY and cannot be disclosed to any third party without the prior, written consent of Willis Towers Watson Northeast, Inc.*

## State of Delaware Alternate Vision Plan Offerings
## Fully-Insured Vision Proposal Template

**Instructions: Please populate columns F-I with your proposed Plan Design that allows for an alternate Low Plan design, but matches the existing High Plan design**

| | Proposed Plan Design - LOW PLAN Summary | | Proposed Plan Design - HIGH PLAN Summary | |
|---|---|---|---|---|
| **Low Vision**<br>(Professional services, as necessary, for severe visual problems not correctable with regular lenses) | Quote standard benefit and fill in description here, including frequency limits. | <u>Supplemental Testing</u><br>Quote standard benefit and fill in description here, including frequency limits.<br><u>Supplemental Aids</u><br>Quote standard benefit and fill in description here, including frequency limits. | | |
| **Supplemental Primary Eyecare Plan Rider**<br>(designed for the detection, treatment and management of ocular conditions and/or systemic conditions that produce ocular or visual symptoms) | Fill in description of benefit offering or note as "Not Applicable. | | | |
| **Laser Vision Correction** | 85% of retail price or 95% of promotional price Whichever is lesser | Not Covered | 85% of retail price or 95% of promotional price Whichever is lesser | Not Covered |
| **Safety Glasses** | Fill in description of benefit offering or note as "Not Applicable. | Not Covered | | |
| **Hearing Aid Program** | Up to 66% off hearing aids; call 1.877.203.0675 (Amplifon Network) | Not Covered | Up to 66% off hearing aids; call 1.877.203.0675 (Amplifon Network) | Not Covered |
| **Diabetic Eye Care Program** | $0 copay | Copay varies | $0 copay | Copay varies |
| **Retinal Imaging Benefit** | Up to $39 | Not Covered | Up to $39 | Not Covered |
| **Eye Health Management Program** | Fill in description of benefit offering or note as "Not Applicable. | | | |
| **Non-Covered Glasses and/or Supplies at Participating Providers** | Fill in description of benefit offering or note as "Not Applicable. | | | |
| **What is the wholesale allowance for frames?** | Not applicable | | | |
| **What is the equivalent retail allowance for frames?** | $180 Retail Allowance, with xx% discount on overage. | | | |
| **Dependent Child Definition** | To age 26 | | To age 26 | |



*This Document and all its contents are CONFIDENTIAL and PROPRIETARY and cannot be disclosed to any third party without the prior, written consent of Willis Towers Watson Northeast, Inc.*

## State of Delaware Alternate Vision Plan Offerings
## Fully-Insured Vision Proposal Template

**Instructions: Please populate columns F-I with your proposed Plan Design that allows for an alternate Low Plan design, but matches the existing High Plan design**

| | Proposed Plan Design - LOW PLAN Summary | Proposed Plan Design - HIGH PLAN Summary |
|---|---|---|
| **Telemedicine** | Practices participation in our network offering telemedicine will include the notation "Telemedicine Services Available." Services can vary by location, so contact your provider for details on specific telemedicine services provided. Common types of telemedicine services include, but are not limited to: remote visits/consultation, including triaging issues like pink eye, remote treatment options, like online vision therapy, remote monitoring of common conditions like dry eyes, remote review and analysis of digital images, remote follow up care, including prescriptions and virtual frame try-on. | |
| **Contribution** | Contributory (Employees will "buy-up" by paying the premium difference between the Low Plan and High Plan) | |
| **Proposed Monthly Rates:** | | |
| Single | $x.xx | |
| Parent & Child(ren) | $x.xx | |
| Husband & Wife | $x.xx | |
| Family | $x.xx | |
| **Rate Guarantee** | x-years thru 12/31/20xx | |
| **Commission Level** | Net of Commissions | |
| **Multi-Year "Lock-in" OR "Lock-out" provision?** | None | |
| **Minimum Participation Requirement** | xx% of eligible group or a minimum of x enrollees, whichever is greater. | |



*This Document and all its contents are CONFIDENTIAL and PROPRIETARY and cannot be disclosed to any third party without the prior, written consent of Willis Towers Watson Northeast, Inc.*

## State of Delaware Alternate Vision Pla
## Fully-Insured Vision Proposal Templat

Instructions: Please populate columns F-I with your propos

| | Fill in your Proposed Plan Design information below - LOW PLAN | | Fill in your Proposed Plan Design information below - HIGH PLAN | |
|---|---|---|---|---|
| **Underwritten by:** | | | | |
| **Financial Ratings:**<br>AM Best<br>S&P | | | | |
| **Comprehensive Initial Eye Examination** | | | | |
| **Materials:** | | | | |
| **Standard Frames** | | | | |
| **Lenses:** | | | | |
| Single Vision | | | | |
| Bifocal | | | | |
| Trifocal | | | | |
| Lenticular | | | | |
| **Contact Lenses:** | | | | |
| Evaluation and Fitting ---<br>Standard Fit (or Covered-In-Full Contacts) | | | | |
| Evaluation and Fitting ---<br>Specialty/Premium Fit (or All Other Contacts) | | | | |
| Cosmetic (Elective) Lenses ---<br>Conventional (or Covered-In-Full Contact) | | | | |
| Cosmetic (Elective) Lenses ---<br>Disposable (or All Other Contacts) | | | | |
| Medically Necessary Lenses | | | | |
| **Cosmetic Lens Options:** | | | | |
| -Solid Tint | | | | |
| -Fashion Gradient Tint | | | | |
| -Standard Scratch-Resistant Coating | | | | |
| -Premium Scratch-Resistant Coating | | | | |
| - Ultra-Violet (UV) Protection (Frontside) | | | | |
| - Ultra-Violet (UV) Protection (Backside) | | | | |
| -Standard Anti-Reflective Coating | | | | |
| -Premium Anti-Reflective Coating (Tier 1) | | | | |
| -Premium Anti-Reflective Coating (Tier 2) | | | | |
| -Premium Anti-Reflective Coating (Tier 3) | | | | |
| -Glass Photogrey (Single Vision) | | | | |
| -Glass Photogrey (Multi-Focal) | | | | |
| -Plastic Photochromic Tints (Single Vision) | | | | |
| -Plastic Photochromic Tints (Multifocal) | | | | |
| -Polarized Lenses | | | | |
| -Plastic Photosensitive Lenses | | | | |



*This Document and all its contents are CONFIDENTIAL and PROPRIETARY and cannot be disclosed to any third party without the prior, written consent of Willis Towers Watson Northeast, Inc.*

## State of Delaware Alternate Vision Pla
## Fully-Insured Vision Proposal Templat

**Instructions: Please populate columns F-I with your propos**

| | Fill in your Proposed Plan Design information below - LOW PLAN | | Fill in your Proposed Plan Design information below - HIGH PLAN | |
|---|---|---|---|---|
| -Progressive Standard Lenses | | | | |
| -Progressive Premium Lenses | | | | |
| -Progressive Custom Lenses | | | | |
| -Digital Progressive Lenses | | | | |
| -Computer / Near Variable Lenses | | | | |
| -Blue Blocker Lenses | | | | |
| -Transitions Single Vision Standard | | | | |
| -Transitions Multi-Focal Standard | | | | |
| -Polycarbonate (Single Vision) | | | | |
| -Polycarbonate (Bifocal) | | | | |
| -Polycarbonate (Trifocal) | | | | |
| -Blended Bifocal (Segment) | | | | |
| -High Index Plastic | | | | |
| -Other | | | | |
| **Frequency Limitations:** | | | | |
| Eye Examination | | | | |
| Contact Lens Fitting and Follow-Up | | | | |
| Lenses | | | | |
| Contacts | | | | |
| Frames | | | | |
| **Contact Lens Replacement by Mail Program** | | | | |
| **Are contact lenses and associated expenses provided in lieu of all other lens and frame benefits available herein?** | | | | |



*This Document and all its contents are CONFIDENTIAL and PROPRIETARY and cannot be disclosed to any third party without the prior, written consent of Willis Towers Watson Northeast, Inc.*

## State of Delaware Alternate Vision Pla
## Fully-Insured Vision Proposal Templat

**Instructions: Please populate columns F-I with your propos**

| | Fill in your Proposed Plan Design information below - LOW PLAN | | Fill in your Proposed Plan Design information below - HIGH PLAN | |
|---|---|---|---|---|
| **Low Vision**<br>(Professional services, as necessary, for severe visual problems not correctable with regular lenses) | | | | |
| **Supplemental Primary Eyecare Plan Rider**<br>(designed for the detection, treatment and management of ocular conditions and/or systemic conditions that produce ocular or visual symptoms) | | | | |
| **Laser Vision Correction** | | | | |
| **Safety Glasses** | | | | |
| **Hearing Aid Program** | | | | |
| **Diabetic Eye Care Program** | | | | |
| **Retinal Imaging Benefit** | | | | |
| **Eye Health Management Program** | | | | |
| **Non-Covered Glasses and/or Supplies at Participating Providers** | | | | |
| **What is the wholesale allowance for frames?** | | | | |
| **What is the equivalent retail allowance for frames?** | | | | |
| **Dependent Child Definition** | | | | |



*This Document and all its contents are CONFIDENTIAL and PROPRIETARY and cannot be disclosed to any third party without the prior, written consent of Willis Towers Watson Northeast, Inc.*

## State of Delaware Alternate Vision Pla
## Fully-Insured Vision Proposal Templat

Instructions: Please populate columns F-I with your propos

| | Fill in your Proposed Plan Design information below - LOW PLAN | Fill in your Proposed Plan Design information below - HIGH PLAN |
|---|---|---|
| **Telemedicine** | | |
| **Contribution** | | |
| **Proposed Monthly Rates:**<br>Single<br>Parent & Child(ren)<br>Husband & Wife<br>Family | | |
| **Rate Guarantee** | | |
| **Commission Level** | | |
| **Multi-Year "Lock-in" OR "Lock-out" provision?** | | |
| **Minimum Participation Requirement** | | |



*This Document and all its contents are CONFIDENTIAL and PROPRIETARY and cannot be disclosed to any third party without the prior, written consent of Willis Towers Watson Northeast, Inc.*