EXHIBIT "A"

Effective January 1, 2025

		OPTION 1 Delta Dental (VSP) Delta Vision 150 Enhanced	
		Network	Non-Network
Deductible/Copayments		$10 Exam $10 Materials	No Copay
Exam Frequency		once every 12 months	
Lens Frequency		once every 12 months	
Frames Frequency		once every 12 months	
Exam Benefit		100%	up to $45 reimbursement
Frame Allowance		$150 allowance, then 20% off	up to $70 reimbursement
Lens Allowance			
	Single	100%	up to $30 reimbursement
	Bifocal	100%	up to $50 reimbursement
	Trifocal	100%	up to $65 reimbursement
Contact Lenses (medically necessary)		100%	up to $210 reimbursement
Contact Lenses (cosmetic/elective)		$150 allowance	up to $105 reimbursement
Notes		Contact Lens Fitting costs up to $60 copay	
Network		VSP Choice	
Rate Guarantee		12 months (1/1/2025 - 12/31/2025)	
		OPTION 1	
47	Employee	$9.48	
28	EE+SP	$18.96	
8	EE+CH	$20.31	
56	Family	$32.44	
TOTAL MONTHLY PREMIUM		**$2,955.56**	
TOTAL ANNUAL PREMIUM		**$35,466.72**	