Exhibit A

SCHEDULE OF BENEFITS
Signature Plan B

GENERAL

This Schedule lists the vision care benefits to which Covered Persons of VISION SERVICE PLAN ("VSP") are entitled, subject to any applicable Copayments and other conditions, limitations and/or exclusions stated herein. If Plan Benefits are available for Non-VSP Provider services, as indicated by the reimbursement provisions below, vision care benefits may be received from any licensed eye care provider whether VSP Network Doctors or Non-VSP Providers. This Schedule forms a part of the Plan and Certificate of Coverage to which it is attached.

When Plan Benefits are received from VSP Network Doctors, benefits appearing in the VSP Network Doctor Benefit column below are applicable subject to any applicable Copayments and other conditions, limitations and/or exclusions as stated below. When Plan Benefits are available and received from Non-VSP Providers, the Covered Person is reimbursed for such benefits according to the schedule in the Non-VSP Provider Benefit column below, less any applicable Copayment. The Covered Person pays the provider the full fee at the time of service and submits an itemized bill to VSP for reimbursement. Discounts do not apply for vision care benefits obtained from Non-VSP Providers.

ELIGIBILITY

The following are Covered Persons under this Plan:

- Enrollee.
- The legal spouse of Enrollee.*
- Any child of Enrollee, including any natural child from the moment of birth, legally adopted child from the moment of placement for adoption with the Enrollee, the child of the spouse/domestic partner, or other child for whom a court or administrative agency holds the Enrollee responsible.
- The domestic partner of the same or opposite gender as Enrollee.

Dependent children are covered up to the end of the month in which they turn age 26.

A dependent, unmarried child over the limiting age may continue to be eligible as a dependent if the child is incapable of self-sustaining employment because of mental or physical disability, and chiefly dependent upon Enrollee for support and maintenance.

See schedule below for Plan Benefits, payments and/or reimbursement subject to any Copayment(s) as stated:

* Pursuant to RCW 26.60.015, all provisions applying to legal spouses shall apply equally to registered domestic partners

COPAYMENT

The benefits herein are available to each Covered Person subject only to payment of the applicable Copayment by the Covered Person. Plan Benefits received from VSP Network Doctors and Non-VSP Providers require Copayments. Covered Persons must also follow Benefit Authorization procedures.

There shall be a Copayment of $10.00 for the examination payable by the Covered Person at the time services are rendered. If materials (lenses, frames or Necessary Contact Lenses) are provided, there shall be an additional $25.00 Copayment payable at the time materials are ordered. The Copayment shall not apply to Elective Contact Lenses.

PLAN BENEFITS

SERVICE OR MATERIAL	VSP NETWORK DOCTOR BENEFIT	NON-VSP PROVIDER BENEFIT	FREQUENCY
Eye Examination	Covered in full*	Up to $ 50.00*	Available once each 12 months**
Complete initial vision analysis: includes appropriate examination of visual functions and prescription of corrective eyewear where indicated. *Less any applicable Copayment. **Beginning with the first date of service.			

SERVICE OR MATERIAL	VSP NETWORK DOCTOR BENEFIT	NON-VSP PROVIDER BENEFIT	FREQUENCY
Lenses			Available once each 12 months**
Single Vision	Covered in full *	Up to $ 50.00*	
Bifocal	Covered in full *	Up to $ 75.00*	
Trifocal	Covered in full *	Up to $ 100.00*	
Lenticular	Covered in full *	Up to $ 125.00*	
Plan Benefits for lenses are per complete set, not per lens. *Less any applicable Copayment. **Beginning with the first date of service.			

SERVICE OR MATERIAL	VSP NETWORK DOCTOR BENEFIT	NON-VSP PROVIDER BENEFIT	FREQUENCY
FRAMES	Covered up to Plan Allowance*	Up to $ 70.00*	Available once each 24 months**
Benefits for lenses and frames include reimbursement for the following necessary professional services: 1. Prescribing and ordering proper lenses; 2. Assisting in frame selection; 3. Verifying accuracy of finished lenses; 4. Proper fitting and adjustments of frames; 5. Subsequent adjustments to frames to maintain comfort and efficiency; 6. Progress or follow-up work as necessary.			
*Less any applicable Copayment. **Beginning with the first date of service. Frame allowance may be applied towards non-prescription sunglasses for post PRK, LASIK, or Custom LASIK patients.			

SERVICE OR MATERIAL	VSP NETWORK DOCTOR BENEFIT	NON-VSP PROVIDER BENEFIT Professional Fees and Materials	FREQUENCY
ELECTIVE CONTACT LENSES	Elective Contact Lens fitting and evaluation services*** are covered in full once every 12 months**, after a $ 60.00 Copayment		Available once each 12 months**
Materials	Up to $ 130.00	Up to $ 105.00	
*Less any applicable Copayment **Beginning with the first date of service. ***Additional Discount applies to VSP Network Doctor's usual and customary professional fees for contact lens evaluation and fitting.			
Elective Contact Lenses are provided in lieu of all other lens and frame benefits available herein. When contact lenses are obtained, the Covered Person shall not be eligible for lenses and frames again for 12 months.			

PLAN BENEFITS REQUIRING PRE-CERTIFICATION

The following Plan Benefits are available to Covered Persons subject to review for medical necessity by VSP's Optometric Consultants. If approved, VSP will provide certification to the Covered Person's VSP Network Doctor or Non-VSP Provider.

SERVICE OR MATERIAL	VSP NETWORK DOCTOR BENEFIT	NON-VSP PROVIDER BENEFIT	FREQUENCY
VISUALLY NECESSARY CONTACT LENSES			Available once each 12 months**
Professional Fees and Materials	Covered in full *	Up to $ 210.00*	
*Less any applicable Copayment **Beginning with the first date of service. ***Additional Discount applies to VSP Network Doctor's usual and customary professional fees for contact lens evaluation and fitting.			
Visually Necessary Contact Lenses are provided in lieu of all other lens and frame benefits available herein. When contact lenses are obtained, the Covered Person shall not be eligible for lenses and frames again for 12 months.			

LOW VISION

Professional services, as necessary, for severe visual problems not correctable with regular lenses, including:

Supplemental Testing	Covered in full	Up to $125.00	*
	(Includes evaluation, diagnosis and prescription of vision aids where indicated.)		
Supplemental Aids	75% of approved amount up to $1000.00*	75% of approved amount up to $1000.00*	*

*Maximum benefit for all Low Vision services and materials is $1000.00 every two (2) years.

Low Vision benefits secured from Non-VSP Providers (if covered) are subject to the same time and Copayment provisions described above for VSP Network Doctors. The Covered Person should pay the Non-VSP Provider's full fee at the time of service. If Low Vision services are approved, Covered Person will be reimbursed an amount not to exceed what VSP would pay a VSP Network Doctor for the same services and/or materials.

THERE IS NO ASSURANCE THAT THE AMOUNT REIMBURSED WILL COVER 75% OF THE PROVIDER'S FULL FEE.

ADDITIONAL DISCOUNT

Each Covered Person shall be entitled to receive a discount of twenty percent (20%)* toward the purchase of non-covered materials from any VSP Network Doctor when a complete pair of glasses is dispensed. Also, Covered Persons shall be entitled to receive a discount of fifteen percent (15%) off of contact lens examination services from any VSP Network Doctor.**

Discounts are applied to the VSP Network Doctor's usual and customary fees for such services and are unlimited for 12 months on or following the date of the patient's last eye exam.**

LIMITATIONS:

- Discounts do not apply to vision care benefits obtained from Non-VSP Providers.
- 20% discount applies to complete pairs of glasses only.
- Discounts do not apply if prohibited by the manufacturer.
- Discounts do not apply to sundry items: e.g., contact lens solutions, cases, cleaning products or repairs of spectacle lenses or frames.

*Note: For Plan B patients (12/12/24), the 20% discount applies to the frame on the off year.

**Professional judgment will be applied when evaluating prescriptions written by another provider. VSP Network Doctors may request a discounted additional exam.

EXCLUSIONS AND LIMITATIONS OF BENEFITS

PATIENT OPTIONS

This Plan is designed to cover visual needs rather than cosmetic materials. When a Covered Person selects any of the following extras, the Plan will pay the basic cost of the allowed lenses, and the Covered Person will pay the additional costs for the options.

- Optional cosmetic processes.
- Anti-reflective coating.
- Color coating.
- Mirror coating.
- Scratch coating.
- Blended lenses.
- Cosmetic lenses.
- Laminated lenses.
- Oversize lenses.
- Polycarbonate lenses.
- Photochromic lenses, tinted lenses except Pink #1 and Pink #2.
- Progressive multifocal lenses.
- UV (ultraviolet) protected lenses.
- Certain limitations on low vision care.

NOT COVERED

There are no benefits for professional services or materials connected with:

- Orthoptics or vision training and any associated supplemental testing.
- Corneal Refractive Therapy (CRT)
- Orthokeratology (a procedure using contact lenses to change the shape of the cornea in order to reduce myopia).
- Refitting of contact lenses after the initial (90-day) fitting period.
- Plano lenses (lenses with refractive correction of less than ± .50 diopter).
- Two pair of glasses in lieu of bifocals.
- Replacement of lenses and frames furnished under this Plan which are lost or broken, except at the normal intervals when services are otherwise available.
- Medical or surgical treatment of the eyes.
- Corrective vision treatment of an Experimental Nature.
- Plano contact lenses to change eye color cosmetically.
- Artistically-painted contact lenses.
- Contact lens insurance policies or service contracts.
- Additional office visits associated with contact lens pathology.
- Contact lens modification, polishing, or cleaning.
- Costs for services and/or materials above Plan Benefit allowances.
- Services or materials of a cosmetic nature.
- Services and/or materials not indicated on this Schedule as covered Plan Benefits.