EXHIBIT A

SCHEDULE OF BENEFITS
VSP Signature Plan®

GENERAL

This Schedule of Benefits lists the vision care services and materials to which Covered Persons of VSP Vision Care, Inc.("VSP") are entitled, subject to any Copayments and other conditions, limitations and/or exclusions stated herein, and forms a part of the Policy or Evidence of Coverage to which it is attached.

VSP Network Doctors are those doctors who have agreed to participate in VSP's Signature Network.

ELIGIBILITY

The following are Covered Persons under this Plan, pursuant to eligibility criteria established by Client:

- Enrollee
- Legal Spouse or Domestic Partner of Enrollee
- Any child of Enrollee, including a natural child from date of birth, legally adopted child from the date of placement for adoption with the Enrollee, the child of the spouse/registered domestic partner, or other child for whom a court or administrative agency holds the Enrollee responsible is covered up to the end of the month in which they attain 26 years of age. A dependent 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.

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

PLAN BENEFITS
VSP NETWORK PROVIDERS

COPAYMENT

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 the materials are ordered. The Copayment shall not apply to Elective Contact Lenses.

COVERED SERVICES AND MATERIALS

EYE EXAMINATION- Covered in full* once every 12 months**

Comprehensive examination of visual functions and prescription of corrective eyewear.

LENSES: Covered in full* once every 12 months**
Lenses (Single, Lined Bifocal, Lined Trifocal or Lenticular)

Polycarbonate lenses are covered in full for dependent children up to the end of the month in which they turn age 26.
Standard Progressive Lenses covered in full

FRAMES - Covered up to the Plan allowance* once every 24 months**

The VSP Network Provider will prescribe and order Covered Person's lenses, verify the accuracy of finished lenses, and assist Covered Person with frame selection and adjustment.

CONTACT LENSES

ELECTIVE

Elective Contact Lenses (materials only) are covered up to $160.00 once every 12 months**

Elective Contact Lens fitting and evaluation services are covered in full once every 12 months**, after a $60.00 Copayment.

NECESSARY
Necessary Contact Lenses are covered in full* once every 12 months**

Necessary Contact Lenses are a Plan Benefit when specific benefit criteria are satisfied and when prescribed by Covered Person's VSP Network Provider.

Contact Lenses are provided in place of spectacle lens and frame benefits available herein.

*Less any applicable Copayment.
**beginning with the first date of service.

LOW VISION

Professional services for severe vision problems that cannot be corrected with regular lenses, including:

Supplemental Testing: Covered in full*.

-Includes evaluation, diagnosis and prescription of vision aids where indicated.

Supplemental Aids: 75% of VSP Network Provider's fee, up to $1000.00*

*Maximum benefit for all Low Vision services and materials is $1000.00 every two (2) years and a maximum of two supplemental tests within a two-year period.

Low Vision Services are a Plan Benefit when specific benefit criteria are satisfied and when prescribed by Covered Person's VSP Network Provider.

EXCLUSIONS AND LIMITATIONS OF BENEFITS

Some brands of spectacle frames and/or lenses may be unavailable for purchase as Plan Benefits, or may be subject to additional limitations. Covered Persons may obtain details regarding frame and lens brand availability from their VSP Member Doctor or by calling VSP's Customer Care Division at (800) 877-7195.

NOT COVERED

- Services and/or materials not specifically included in this Schedule as covered Plan Benefits.
- Plano lenses (lenses with refractive correction of less than ± .50 diopter), except as specifically under the Suncare enhancement,if purchased by Client.
- Two pair of glasses instead of bifocals.
- Replacement of lenses, frames and/or contact lenses furnished under this Plan which are lost or damaged, except at the normal intervals when Plan Benefits are otherwise available.
- Orthoptics or vision training and any associated supplemental testing.
- Medical or surgical treatment of the eyes.
- Contact lens insurance policies or service agreements.
- Refitting of contact lenses after the initial (90-day) fitting period.
- Services associated with Corneal Refractive Therapy (CRT) or Orthokeratology.

REIMBURSEMENT SCHEDULE
OPEN ACCESS PROVIDERS

COPAYMENT

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 the materials are ordered. The Copayment shall not apply to Elective Contact Lenses.

COVERED SERVICES AND MATERIALS

EYE EXAMINATION: Up to $ 50.00* once every 12 months**
Comprehensive examination of visual functions and prescription of corrective eyewear.

LENSES - Up to $ 50.00 - 125.00 once every 12 months**

Spectacle Lenses (Single, Lined Bifocal, Lined Trifocal or Lenticular) including Lens Enhancements, if purchased by Client.

FRAMES: Covered up to $ 70.00* once every 24 months**

CONTACT LENSES

ELECTIVE
Elective Contact Lenses are covered up to $105.00 once every 12 months**

The Elective Contact Lens allowance applies to both the doctor's fitting and evaluation fees, and to materials.

NECESSARY
Necessary Contact Lenses are covered up to $210.00* once every 12 months**

Necessary Contact Lenses are a Plan Benefit when specific benefit criteria are satisfied and when prescribed by Covered Person's Doctor.

Contact Lenses are provided in place of spectacle lens and frame benefits available herein.

*Less any applicable Copayment.

**beginning with the first date of service.

LOW VISION

Professional services for severe vision problems that cannot be corrected with regular lenses, including:

Supplemental Testing: Up to $125.00*.

-Includes evaluation, diagnosis and prescription of vision aids where indicated.

Supplemental Aids: 75% of Open Access Provider's fee.

*Maximum benefit for all Low Vision services and materials is $1000.00 every two (2) years and a maximum of two supplemental tests within a two-year period.

Low Vision Services are a Plan Benefit when specific benefit criteria are satisfied and when prescribed by Covered Person's Doctor.

EXCLUSIONS AND LIMITATIONS OF BENEFITS
OPEN ACCESS PROVIDERS

- Exclusions and limitations of benefits described above for VSP Network Providers shall also apply to services rendered by Open Access Providers.
- Services from an Open Access Provider are in lieu of services from a VSP Network Provider.
- There is no guarantee that the amount reimbursed will be sufficient to pay the cost of services or materials in full.
- VSP is unable to require Open Access Providers to adhere to VSP's quality standards.

Exhibit C

ADDITIONAL BENEFIT RIDER
DIABETIC EYECARE PLUS PROGRAM

GENERAL

This Rider lists additional vision care benefits to which Covered Persons of VSP Vision Care, Inc. ("VSP") are entitled, subject to any applicable Copayments and other conditions, limitations and/or exclusions stated herein or in the Schedule of Benefits with which it is associated. Plan Benefits under the Diabetic Eyecare Plus Program are available to Covered Persons who have been diagnosed with type 1 or type 2 diabetes and specific ophthalmological conditions. This Rider forms a part of the Plan or Evidence of Coverage to which it is attached.

ELIGIBILITY

The following are Covered Persons under this Plan, pursuant to eligibility criteria established by Client:

- Enrollee
- Legal Spouse or Domestic Partner of Enrollee
- Any child of Enrollee, including a natural child from date of birth, legally adopted child from the date of placement for adoption with the Enrollee, the child of the spouse/registered domestic partner, or other child for whom a court or administrative agency holds the Enrollee responsible is covered up to age 26. A dependent 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.

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

SYMPTOMS

Examples of symptoms which may result in a patient seeking services under the Diabetic Eyecare Plus Program may include, but are not limited to:

- blurry vision
- transient loss of vision
- trouble focusing
- “floating” spots

CONDITIONS

Examples of conditions which may require management under the Diabetic Eyecare Plus Program may include, but are not limited to:

- diabetic retinopathy
- diabetic macular edema
- rubeosis

PROCEDURES FOR OBTAINING DIABETIC EYECARE PLUS SERVICES

Covered Person’s VSP Network Doctor will provide services under the Diabetic Eyecare Plus Program as needed following Covered Person’s routine eye examination.

PLAN BENEFITS
VSP NETWORK DOCTORS

COPAYMENT

A Copayment of $ 20.00 shall be payable by the Covered Person at the time of each Diabetic Eyecare Plus Program office visit to a VSP Network Doctor.

COVERED SERVICES

Eye Examination: Covered in Full*.

Special Ophthalmological Services†: Covered in Full.

*Less any applicable Copayment.

†Specific procedures under this Diabetic Eyecare Plus Program are provided at the discretion of the physician rendering the services. A current list of these procedures will be made available to Covered Persons upon request. The frequency at which these services may be provided is dependent upon the specific service and the diagnosis associated with such service.

EXCLUSIONS AND LIMITATIONS OF BENEFITS

NOT COVERED

1. Services and/or materials not included in this Rider as covered Plan Benefits.
2. Costs associated with securing frames, lenses, contact lenses or any other materials.
3. Orthoptics or vision training and any associated supplemental testing.
4. Surgical procedures, including Laser or any other form of refractive surgery, and any pre- or post-operative services.
5. Pathological treatment of any type for any condition.
6. Any eye examination required by an employer as a condition of employment.
7. Insulin or any medications or supplies of any type.
8. Local, state and/or federal taxes, except where VSP is required by law to pay.

Exhibit C

ADDITIONAL BENEFIT RIDER
DIABETIC EYECARE PLUS PROGRAM

GENERAL

This Rider lists additional vision care benefits to which Covered Persons of VSP Vision Care, Inc. ("VSP") are entitled, subject to any applicable Copayments and other conditions, limitations and/or exclusions stated herein or in the Schedule of Benefits with which it is associated. Plan Benefits under the Diabetic Eyecare Plus Program are available to Covered Persons who have been diagnosed with type 1 or type 2 diabetes and specific ophthalmological conditions. This Rider forms a part of the Plan or Evidence of Coverage to which it is attached.

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

SYMPTOMS

Examples of symptoms which may result in a patient seeking services under the Diabetic Eyecare Plus Program may include, but are not limited to:

- blurry vision
- transient loss of vision
- trouble focusing
- “floating” spots

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Examples of conditions which may require management under the Diabetic Eyecare Plus Program may include, but are not limited to:

- diabetic retinopathy
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PLAN BENEFITS
VSP NETWORK DOCTORS

COPAYMENT

A Copayment of $ 20.00 shall be payable by the Covered Person at the time of each Diabetic Eyecare Plus Program office visit to a VSP Network Doctor.

COVERED SERVICES

Eye Examination: Covered in Full*.

Special Ophthalmological Services†: Covered in Full.

*Less any applicable Copayment.

†Specific procedures under this Diabetic Eyecare Plus Program are provided at the discretion of the physician rendering the services. A current list of these procedures will be made available to Covered Persons upon request. The frequency at which these services may be provided is dependent upon the specific service and the diagnosis associated with such service.

EXCLUSIONS AND LIMITATIONS OF BENEFITS

NOT COVERED

1. Services and/or materials not included in this Rider as covered Plan Benefits.
2. Costs associated with securing frames, lenses, contact lenses or any other materials.
3. Orthoptics or vision training and any associated supplemental testing.
4. Surgical procedures, including Laser or any other form of refractive surgery, and any pre- or post-operative services.
5. Pathological treatment of any type for any condition.
6. Any eye examination required by an employer as a condition of employment.
7. Insulin or any medications or supplies of any type.
8. Local, state and/or federal taxes, except where VSP is required by law to pay.

Summary of Benefits and Coverage
SIGNATURE PLAN

Prepared for: **HEALTH ALLIANCE FOR TECHNOLOGY HEALTH TRUST**
Group ID: **30086118**
Effective Date: **JANUARY 1, 2019**

The Affordable Care Act requires that health insurance companies and group health plans provide consumers with a simple and consistent benefit and coverage information document, beginning September 23, 2012. This document is a Summary of Benefits and Coverage (SBC).

The grid below is being provided for your convenience and mirrors the sample SBC that the U.S. Department of Labor has published. All the information provided is relative to your plan and described in detail in the preceding Evidence of Coverage.

Common Medical Event	Services You May Need	Your cost if you use an		Limitations and Exceptions
		In-Network Provider	Out-of-Network Provider	
If you or your dependents (if applicable) need eyecare	Eye Exam	$10.00 Copay	Reimbursed up to $50.00	Exam covered in full every 12 months**
	Frames, Lenses or Contacts	Glasses: $25.00 Copay (lenses and/or frames only); Up to $60.00 copay for Contact Lens Exam	Frames reimbursed up to $ 70.00 SV Lenses reimbursed up to $ 50.00 Bi-Focal Lenses reimbursed up to $ 75.00 Tri-Focal Lenses reimbursed up to $100.00 Lenticular Lenses reimbursed up to $125.00 ECL reimbursed up to $105.00	Frames covered every 24 months** Lenses covered every 12 months**
	Fees			

** Beginning with the first date of service.

Your Grievance and Appeals Rights:
If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to appeal or file a grievance. For questions about your rights, this notice, or assistance, you can contact: 800-877-7195.