EXHIBIT A

EASTERN VISION SERVICE PLAN, INC.
SCHEDULE OF BENEFITS
VSP Choice Plan®

GENERAL

This Schedule of Benefits lists the vision care services and materials to which Covered Persons of EASTERN VISION SERVICE PLAN, 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 Preferred Providers are those doctors that have agreed to participate in VSP's Choice Network.

BENEFIT PERIOD

A twelve-month period beginning on January 1st and ending on December 31st.

ELIGIBILITY

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

- Enrollee
- Legal Spouse or Domestic Partner of Enrollee
- Children of Enrollee, including enrollee's natural Children, legally adopted Children, step Children, and Children for whom Enrollee is the proposed adoptive parent without regard to financial dependence, residency with Enrollee, student status or employment. A proposed adopted Child is eligible for coverage on the same basis as a natural Child during any waiting period prior to the finalization of the Child's adoption. Coverage lasts until the end of the year in which Child turns 26 years of age. Coverage also includes Children for whom Enrollee is the legal guardian if the Children are chiefly dependent upon Enrollee for support and Enrollee has been appointed the legal guardian by a court order. Any unmarried dependent Child, regardless of age, who is incapable of self-sustaining employment by reason of mental illness, developmental disability, mental retardation (as defined in the Mental Hygiene Law), or physical handicap and who became so incapable prior to attainment of the age at which the Child's coverage would otherwise terminate and who is chiefly dependent upon Enrollee for support and maintenance, will remain covered while Enrollee's insurance remains in force and Enrollee's Child remains in such condition. Enrollee has 31 days from the date of Enrollee's Child's attainment of the termination age to submit an application to request that the Child be included in Enrollee's coverage and proof of the Child's incapacity. Foster and grandchildren are not covered. VSP has the right to check whether a Child is and continues to be eligible for coverage.

PLAN BENEFITS
VSP PREFERRED 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. Additionally, a separate Copayment, as stated in the Lens Options section below, shall also apply.

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 they attain age 26.
Standard Progressive Lenses covered in full

LENS OPTIONS

Anti-reflective coating covered in full[1] once every 12 months.**
Scratch coating covered in full once every 12 months.**

1. Less a $25.00 Copayment

** Beginning with the first day of the Benefit Period.

FRAMES - Covered up to the Plan allowance* once every 12 months**

The VSP Preferred 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**

The Elective Contact Lens fitting and evaluation services are covered in full once every 12 months**, after a maximum $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 Preferred Provider.

Contact Lenses are provided in place of spectacle lens and frame benefits available herein.
*Less any applicable Copayment.
** beginning with the first day of the Benefit Period.

LOW VISION

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

Supplemental Testing: Covered in full*.

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

Supplemental Aids: 75% of VSP Preferred 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 Preferred Provider.

EXCLUSIONS AND LIMITATIONS OF BENEFITS

Some brands of spectacle frames may be unavailable for purchase as Plan Benefits, or may be subject to additional limitations. Covered Persons may obtain details regarding frame 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 allowed 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.
- Contact lens modification, polishing or cleaning.
- Local, state and/or federal taxes, except where VSP is required by law to pay.
- 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 $ 45.00* once every 12 months**
Comprehensive examination of visual functions and prescription of corrective eyewear.

SPECTACLE LENSES

Single Vision Up to $ 30.00* once every 12 months**

Bifocal Up to $ 50.00* once every 12 months**

Trifocal Up to $ 65.00* once every 12 months**

Lenticular Up to $100.00* once every 12 months**

FRAMES: Covered up to $ 70.00* once every 12 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 day of the Benefit Period.

LOW VISION

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

Supplemental Testing: Up to $125.00*.

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

Supplemental Aids: 75% of VSP Preferred 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 Preferred Provider.

OPEN ACCESS PROVIDERS

- Exclusions and limitations of benefits described above for VSP Preferred 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 Preferred 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.

Kate Renwick-Espinosa, President

Exhibit B

EASTERN VISION SERVICE PLAN, INC. (VSP)
SCHEDULE OF PREMIUMS
VSP Choice Plan

VSP shall be entitled to receive premiums for each month on behalf of each Enrollee and his/her Eligible Dependents, if any, in the amounts specified below.

$	7.27	per month for each eligible Enrollee without dependents.
$	14.54	per month for each eligible Enrollee with an eligible spouse or Domestic Partner.
$	15.56	per month for each eligible Enrollee with eligible child(ren).
$	24.86	per month for each eligible Enrollee with eligible spouse and child(ren).

NOTICE: The premium under this Policy is subject to change upon renewal (after the end of the initial Policy Term or any subsequent Policy Term), or upon change of the Schedule of Benefits or a material change in any other terms or conditions of the Policy.

Kate Renwick-Espinosa, President

Exhibit C

EASTERN VISION SERVICE PLAN, INC.
ADDITIONAL BENEFIT RIDER
DIABETIC EYECARE PLUS PROGRAM

GENERAL

This Rider lists additional vision care benefits to which Covered Persons of EASTERN VISION SERVICE PLAN, 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 Policy 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
- Children of Enrollee, including enrollee's natural Children, legally adopted Children, step Children, and Children for whom Enrollee is the proposed adoptive parent without regard to financial dependence, residency with Enrollee, student status or employment. A proposed adopted Child is eligible for coverage on the same basis as a natural Child during any waiting period prior to the finalization of the Child's adoption. Coverage lasts until the end of the year in which Child turns 26 years of age. Coverage also includes Children for whom Enrollee is the legal guardian if the Children are chiefly dependent upon Enrollee for support and Enrollee has been appointed the legal guardian by a court order. Any unmarried dependent Child, regardless of age, who is incapable of self-sustaining employment by reason of mental illness, developmental disability, mental retardation (as defined in the Mental Hygiene Law), or physical handicap and who became so incapable prior to attainment of the age at which the Child's coverage would otherwise terminate and who is chiefly dependent upon Enrollee for support and maintenance, will remain covered while Enrollee's insurance remains in force and Enrollee's Child remains in such condition. Enrollee has 31 days from the date of Enrollee's Child's attainment of the termination age to submit an application to request that the Child be included in Enrollee's coverage and proof of the Child's incapacity. Foster and grandchildren are not covered. VSP has the right to check whether a Child is and continues to be eligible for coverage.

PROGRAM DESCRIPTION

The Diabetic Eyecare Program ("DEP") is intended to be a supplement to Covered Person's group medical plan. Providers will first submit a claim to Covered Person's group medical insurance plan, and then to VSP. Any amounts not paid by the medical plan will be considered for payment by VSP. (This is referred to as "Coordination of Benefits" or "COB." Please refer to the Coordination of Benefits section of Covered Person's Evidence of Coverage for additional information regarding COB.) If Covered Person does not have a group medical plan, providers will submit claims directly to VSP.

Examples of symptoms which may result in an Covered Person seeking services under DEP Plus may include, but are not limited to:

- blurry vision
- transient loss of vision
- tunnel vision
- trouble focusing
- "floating" spots
- visual distortion

Examples of conditions which may require management under DEP Plus may include, but are not limited to:

- diabetic retinopathy
- rubeosis
- diabetic macular edema
- age-related macular degeneration
- glaucoma

PROCEDURES FOR OBTAINING DIABETIC EYECARE PLUS SERVICES

COVERED PERSON HAS A GROUP MEDICAL PLAN

The DEP Plus Program provides coverage for certain vision-related medical services as a supplement to Covered Person's group medical plan. Covered Persons should refer to the plan booklet, certificate of coverage or other benefits description for their group medical plan to determine how to obtain plan benefits.

The provider should first submit a claim to Covered Person's group medical insurance plan. Any amounts not paid by the medical plan may then be considered for payment by VSP. (This is referred to as "Coordination of Benefits" or "COB." Please refer to the Coordination of Benefits section of Covered Person's Evidence of Coverage for additional information regarding COB.)

COVERED PERSON DOES NOT HAVE A GROUP MEDICAL PLAN

When Covered Person does not have a group medical plan, the DEP Plus Program provides Plan Benefits as follows:

1. Covered Person contacts a VSP Network Doctor and makes an appointment.

2. Covered Person pays the applicable Copayment at the time of each DEP Plus Program visit and amounts for any additional services not covered by the Plan.

REFERRALS

If Covered Person's Member Doctor cannot provide Covered Services, the doctor will refer the Covered Person to another Member Doctor or to a physician whose offices provide the necessary services.

If the Covered Person requires services beyond the scope of DEP Plus, the Member Doctor will refer the Insured to a physician.

Referrals are intended to insure that Covered Persons receive the appropriate level of care for their presenting condition. **Covered Persons do not require a referral from a Member Doctor in order to obtain Plan Benefits.**

PLAN BENEFITS
VSP PREFERRED PROVIDER

COVERED SERVICES

Eye Examination: Covered in full after a Copayment of $20.00.

Special Ophthalmological Services: Covered in Full.

EXCLUSIONS AND LIMITATIONS OF BENEFITS

The Diabetic Eyecare Plus Program provides coverage for limited, vision-related medical 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.

NOT COVERED

1. Services and/or materials not specifically included in this Rider as covered Plan Benefits.
2. Frames, spectacle lenses, contact lenses or any other ophthalmic materials.
3. Orthoptics or vision training and any associated supplemental testing.
4. Surgery of any type, and any pre- or post-operative services and/or supplies.
5. Treatment for any pathological conditions.
6. An eye exam required 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.

DIABETIC EYECARE PLUS PROGRAM DEFINITIONS

AMD	Age-related macular degeneration (AMD) is a disease that destroys the clear, "straight ahead" central vision necessary for reading, driving, identifying faces and performing other daily tasks.
Diabetes	A disease where the pancreas has a problem either making, or making and using, insulin.
Type 1 Diabetes	A disease in which the pancreas stops making insulin.
Type 2 Diabetes	A disease in which the pancreas either makes too little insulin or cannot properly use the insulin it makes to convert blood glucose to energy.
Diabetic Retinopathy	A weakening in the small blood vessels at the back of the eye.
Rubeosis	Abnormal blood vessel growth on the iris and the structures in the front of the eye.
Diabetic Macular Edema	Swelling of the retina in diabetes mellitus due to leaking of fluid from blood vessels within the macula.
Glaucoma	A disease in which damage to the optic nerve leads to progressive, irreversible vision loss.
Special Ophthalmological Services	Medical eyecare procedures for the investigation and management of ocular disorders associated with diabetic eye disease, glaucoma and/or AMD.

Kate Renwick-Espinosa, President