

|                                                                                                                                                                                                       |                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                                                                         |
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| <b>Form 5500</b><br><br>Department of the Treasury<br>Internal Revenue Service<br><br>Department of Labor<br>Employee Benefits Security<br>Administration<br><br>Pension Benefit Guaranty Corporation | <b>Annual Return/Report of Employee Benefit Plan</b><br><br>This form is required to be filed for employee benefit plans under sections 104 and 4065 of the Employee Retirement Income Security Act of 1974 (ERISA) and sections 6047(e), and 6058(a) of the Internal Revenue Code (the Code).<br><br><p style="text-align: center;">▶ <b>Complete all entries in accordance with the instructions to the Form 5500.</b></p> | OMB Nos. 1210-0110<br>1210-0089<br><br><b>2009</b><br><br><b>This Form is Open to Public Inspection</b> |
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|                                                                                                          |                                                                                                                                                                                                                                           |
|----------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Part I</b>                                                                                            | <b>Annual Report Identification Information</b>                                                                                                                                                                                           |
| For calendar plan year 2009 or fiscal plan year beginning <u>01/01/2009</u> and ending <u>12/31/2009</u> |                                                                                                                                                                                                                                           |
| <b>A</b> This return/report is for:                                                                      | <input type="checkbox"/> a multiemployer plan; <input type="checkbox"/> a multiple-employer plan; or<br><input checked="" type="checkbox"/> a single-employer plan; <input type="checkbox"/> a DFE (specify) ____                         |
| <b>B</b> This return/report is:                                                                          | <input type="checkbox"/> the first return/report; <input type="checkbox"/> the final return/report;<br><input type="checkbox"/> an amended return/report; <input type="checkbox"/> a short plan year return/report (less than 12 months). |
| <b>C</b> If the plan is a collectively-bargained plan, check here. . . . .                               | <input type="checkbox"/>                                                                                                                                                                                                                  |
| <b>D</b> Check box if filing under:                                                                      | <input type="checkbox"/> Form 5558; <input type="checkbox"/> automatic extension; <input type="checkbox"/> the DFVC program;<br><input type="checkbox"/> special extension (enter description)                                            |

|                                                                                                                                                                                                                                                                    |                                                                                                                                                                                                                                                                                                                                        |                                                                     |                                                             |                                                             |  |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------|-------------------------------------------------------------|-------------------------------------------------------------|--|
| <b>Part II</b>                                                                                                                                                                                                                                                     | <b>Basic Plan Information</b> —enter all requested information                                                                                                                                                                                                                                                                         |                                                                     |                                                             |                                                             |  |
| <b>1a</b> Name of plan<br><u>EYECARE ASSOCIATES, INC. 401K PLAN</u>                                                                                                                                                                                                | <table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 80%;"><b>1b</b> Three-digit plan number (PN) ▶</td> <td style="width: 20%; text-align: center;"><u>001</u></td> </tr> <tr> <td colspan="2"><b>1c</b> Effective date of plan<br/><u>01/01/2002</u></td> </tr> </table>                        | <b>1b</b> Three-digit plan number (PN) ▶                            | <u>001</u>                                                  | <b>1c</b> Effective date of plan<br><u>01/01/2002</u>       |  |
| <b>1b</b> Three-digit plan number (PN) ▶                                                                                                                                                                                                                           | <u>001</u>                                                                                                                                                                                                                                                                                                                             |                                                                     |                                                             |                                                             |  |
| <b>1c</b> Effective date of plan<br><u>01/01/2002</u>                                                                                                                                                                                                              |                                                                                                                                                                                                                                                                                                                                        |                                                                     |                                                             |                                                             |  |
| <b>2a</b> Plan sponsor's name and address (employer, if for a single-employer plan)<br>(Address should include room or suite no.)<br><br><u>EYECARE ASSOCIATES, INC.</u><br><br><br><u>ONE PERIMETER PARK SOUTH, STE 155 S</u><br><u>BIRMINGHAM, AL 35243-3218</u> | <table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td><b>2b</b> Employer Identification Number (EIN)<br/><u>63-1159628</u></td> </tr> <tr> <td><b>2c</b> Sponsor's telephone number<br/><u>205-968-9196</u></td> </tr> <tr> <td><b>2d</b> Business code (see instructions)<br/><u>621320</u></td> </tr> </table> | <b>2b</b> Employer Identification Number (EIN)<br><u>63-1159628</u> | <b>2c</b> Sponsor's telephone number<br><u>205-968-9196</u> | <b>2d</b> Business code (see instructions)<br><u>621320</u> |  |
| <b>2b</b> Employer Identification Number (EIN)<br><u>63-1159628</u>                                                                                                                                                                                                |                                                                                                                                                                                                                                                                                                                                        |                                                                     |                                                             |                                                             |  |
| <b>2c</b> Sponsor's telephone number<br><u>205-968-9196</u>                                                                                                                                                                                                        |                                                                                                                                                                                                                                                                                                                                        |                                                                     |                                                             |                                                             |  |
| <b>2d</b> Business code (see instructions)<br><u>621320</u>                                                                                                                                                                                                        |                                                                                                                                                                                                                                                                                                                                        |                                                                     |                                                             |                                                             |  |

**Caution: A penalty for the late or incomplete filing of this return/report will be assessed unless reasonable cause is established.**

Under penalties of perjury and other penalties set forth in the instructions, I declare that I have examined this return/report, including accompanying schedules, statements and attachments, as well as the electronic version of this return/report, and to the best of my knowledge and belief, it is true, correct, and complete.

|                  |                                                   |            |                                                              |
|------------------|---------------------------------------------------|------------|--------------------------------------------------------------|
| <b>SIGN HERE</b> | Filed with authorized/valid electronic signature. | 07/27/2010 | C. THOMAS CROOKS, III                                        |
|                  | Signature of plan administrator                   | Date       | Enter name of individual signing as plan administrator       |
| <b>SIGN HERE</b> | Filed with authorized/valid electronic signature. | 07/27/2010 | C. THOMAS CROOKS, III                                        |
|                  | Signature of employer/plan sponsor                | Date       | Enter name of individual signing as employer or plan sponsor |
| <b>SIGN HERE</b> |                                                   |            |                                                              |
|                  | Signature of DFE                                  | Date       | Enter name of individual signing as DFE                      |

For Paperwork Reduction Act Notice and OMB Control Numbers, see the instructions for Form 5500.

Form 5500 (2009)  
v.092307.1

|                                                                                                                                                                                             |                                                                                                               |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------|
| <b>3a</b> Plan administrator's name and address (if same as plan sponsor, enter "Same")<br>EYECARE ASSOCIATES, INC.<br><br>ONE PERIMETER PARK SOUTH, STE 155 S<br>BIRMINGHAM, AL 35243-3218 | <b>3b</b> Administrator's EIN<br>63-1159628<br><br><b>3c</b> Administrator's telephone number<br>205-968-9196 |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------|

  

|                                                                                                                                                                                                                       |                                   |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------|
| <b>4</b> If the name and/or EIN of the plan sponsor has changed since the last return/report filed for this plan, enter the name, EIN and the plan number from the last return/report:<br><br><b>a</b> Sponsor's name | <b>4b</b> EIN<br><br><b>4c</b> PN |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------|

  

|                                                                                                                                                        |           |     |
|--------------------------------------------------------------------------------------------------------------------------------------------------------|-----------|-----|
| <b>5</b> Total number of participants at the beginning of the plan year                                                                                | <b>5</b>  | 133 |
| <b>6</b> Number of participants as of the end of the plan year (welfare plans complete only lines <b>6a</b> , <b>6b</b> , <b>6c</b> , and <b>6d</b> ). |           |     |
| <b>a</b> Active participants.....                                                                                                                      | <b>6a</b> | 136 |
| <b>b</b> Retired or separated participants receiving benefits.....                                                                                     | <b>6b</b> | 0   |
| <b>c</b> Other retired or separated participants entitled to future benefits.....                                                                      | <b>6c</b> | 3   |
| <b>d</b> Subtotal. Add lines <b>6a</b> , <b>6b</b> , and <b>6c</b> .....                                                                               | <b>6d</b> | 139 |
| <b>e</b> Deceased participants whose beneficiaries are receiving or are entitled to receive benefits.....                                              | <b>6e</b> | 0   |
| <b>f</b> Total. Add lines <b>6d</b> and <b>6e</b> .....                                                                                                | <b>6f</b> | 139 |
| <b>g</b> Number of participants with account balances as of the end of the plan year (only defined contribution plans complete this item).....         | <b>6g</b> | 88  |
| <b>h</b> Number of participants that terminated employment during the plan year with accrued benefits that were less than 100% vested.....             | <b>6h</b> | 0   |
| <b>7</b> Enter the total number of employers obligated to contribute to the plan (only multiemployer plans complete this item) .....                   | <b>7</b>  |     |

  

**8a** If the plan provides pension benefits, enter the applicable pension feature codes from the List of Plan Characteristic Codes in the instructions:  
 2E 2F 2G 2J 2K 3D

**b** If the plan provides welfare benefits, enter the applicable welfare feature codes from the List of Plan Characteristic Codes in the instructions:

|                                                                                                                                                                                                                                                                                               |                                                                                                                                                                                                                                                                                               |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>9a</b> Plan funding arrangement (check all that apply)<br>(1) <input checked="" type="checkbox"/> Insurance<br>(2) <input type="checkbox"/> Code section 412(e)(3) insurance contracts<br>(3) <input type="checkbox"/> Trust<br>(4) <input type="checkbox"/> General assets of the sponsor | <b>9b</b> Plan benefit arrangement (check all that apply)<br>(1) <input checked="" type="checkbox"/> Insurance<br>(2) <input type="checkbox"/> Code section 412(e)(3) insurance contracts<br>(3) <input type="checkbox"/> Trust<br>(4) <input type="checkbox"/> General assets of the sponsor |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|

  

**10** Check all applicable boxes in 10a and 10b to indicate which schedules are attached, and, where indicated, enter the number attached. (See instructions)

|                                                                                                                                                                                                                                                                                                                                                                                                                        |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>a Pension Schedules</b><br>(1) <input checked="" type="checkbox"/> <b>R</b> (Retirement Plan Information)<br>(2) <input type="checkbox"/> <b>MB</b> (Multiemployer Defined Benefit Plan and Certain Money Purchase Plan Actuarial Information) - signed by the plan actuary<br><br>(3) <input type="checkbox"/> <b>SB</b> (Single-Employer Defined Benefit Plan Actuarial Information) - signed by the plan actuary | <b>b General Schedules</b><br>(1) <input checked="" type="checkbox"/> <b>H</b> (Financial Information)<br>(2) <input type="checkbox"/> <b>I</b> (Financial Information – Small Plan)<br>(3) <input checked="" type="checkbox"/> <u>1</u> <b>A</b> (Insurance Information)<br>(4) <input checked="" type="checkbox"/> <b>C</b> (Service Provider Information)<br>(5) <input checked="" type="checkbox"/> <b>D</b> (DFE/Participating Plan Information)<br>(6) <input type="checkbox"/> <b>G</b> (Financial Transaction Schedules) |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|

|                                                                                                                                                                                                                                                                          |                                                                                                                                                                                                                                                                                                                           |                                                                                           |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------|
| <b>SCHEDULE A</b><br><b>(Form 5500)</b><br><small>Department of the Treasury<br/>Internal Revenue Service</small><br><hr/> <small>Department of Labor<br/>Employee Benefits Security Administration</small><br><hr/> <small>Pension Benefit Guaranty Corporation</small> | <b>Insurance Information</b><br><br>This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA).<br><br>▶ <b>File as an attachment to Form 5500.</b><br><br>▶ Insurance companies are required to provide the information pursuant to ERISA section 103(a)(2). | OMB No. 1210-0110<br><br><b>2009</b><br><br><b>This Form is Open to Public Inspection</b> |
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|                                                                                            |                                         |                                                             |
|--------------------------------------------------------------------------------------------|-----------------------------------------|-------------------------------------------------------------|
| For calendar plan year 2009 or fiscal plan year beginning 01/01/2009 and ending 12/31/2009 |                                         |                                                             |
| <b>A</b> Name of plan<br>EYECARE ASSOCIATES, INC. 401K PLAN                                | <b>B</b> Three-digit plan number (PN) ▶ | 001                                                         |
| <b>C</b> Plan sponsor's name as shown on line 2a of Form 5500.<br>EYECARE ASSOCIATES, INC. |                                         |                                                             |
|                                                                                            |                                         | <b>D</b> Employer Identification Number (EIN)<br>63-1159628 |

|               |                                                                                                                                                                                                                                                     |
|---------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Part I</b> | <b>Information Concerning Insurance Contract Coverage, Fees, and Commissions</b> Provide information for each contract on a separate Schedule A. Individual contracts grouped as a unit in Parts II and III can be reported on a single Schedule A. |
|---------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|

**1** Coverage Information:

(a) Name of insurance carrier  
MASSACHUSETTS MUTUAL LIFE INSURANCE COMPANY

| (b) EIN    | (c) NAIC code | (d) Contract or identification number | (e) Approximate number of persons covered at end of policy or contract year | Policy or contract year |            |
|------------|---------------|---------------------------------------|-----------------------------------------------------------------------------|-------------------------|------------|
|            |               |                                       |                                                                             | (f) From                | (g) To     |
| 04-1590850 | 65935         | RM 82813-1                            | 139                                                                         | 01/01/2009              | 12/31/2009 |

**2** Insurance fee and commission information. Enter the total fees and total commissions paid. List in item 3 the agents, brokers, and other persons in descending order of the amount paid.

|                                      |                               |
|--------------------------------------|-------------------------------|
| (a) Total amount of commissions paid | (b) Total amount of fees paid |
| 16217                                | 0                             |

**3** Persons receiving commissions and fees. (Complete as many entries as needed to report all persons).

|                                                                                                  |
|--------------------------------------------------------------------------------------------------|
| (a) Name and address of the agent, broker, or other person to whom commissions or fees were paid |
| CAPFINANCIAL PARTNERS, LLC<br>536850<br>ATLANTA, GA 30353                                        |

| (b) Amount of sales and base commissions paid | Fees and other commissions paid |             | (e) Organization code |
|-----------------------------------------------|---------------------------------|-------------|-----------------------|
|                                               | (c) Amount                      | (d) Purpose |                       |
| 16217                                         |                                 |             | 1                     |

(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid

| (b) Amount of sales and base commissions paid | Fees and other commissions paid |             | (e) Organization code |
|-----------------------------------------------|---------------------------------|-------------|-----------------------|
|                                               | (c) Amount                      | (d) Purpose |                       |
|                                               |                                 |             |                       |

---

**(a)** Name and address of the agent, broker, or other person to whom commissions or fees were paid

---

| <b>(b)</b> Amount of sales and base commissions paid | Fees and other commissions paid |                    | <b>(e)</b> Organization code |
|------------------------------------------------------|---------------------------------|--------------------|------------------------------|
|                                                      | <b>(c)</b> Amount               | <b>(d)</b> Purpose |                              |
|                                                      |                                 |                    |                              |

---

**(a)** Name and address of the agent, broker, or other person to whom commissions or fees were paid

---

| <b>(b)</b> Amount of sales and base commissions paid | Fees and other commissions paid |                    | <b>(e)</b> Organization code |
|------------------------------------------------------|---------------------------------|--------------------|------------------------------|
|                                                      | <b>(c)</b> Amount               | <b>(d)</b> Purpose |                              |
|                                                      |                                 |                    |                              |

---

**(a)** Name and address of the agent, broker, or other person to whom commissions or fees were paid

---

| <b>(b)</b> Amount of sales and base commissions paid | Fees and other commissions paid |                    | <b>(e)</b> Organization code |
|------------------------------------------------------|---------------------------------|--------------------|------------------------------|
|                                                      | <b>(c)</b> Amount               | <b>(d)</b> Purpose |                              |
|                                                      |                                 |                    |                              |

---

**(a)** Name and address of the agent, broker, or other person to whom commissions or fees were paid

---

| <b>(b)</b> Amount of sales and base commissions paid | Fees and other commissions paid |                    | <b>(e)</b> Organization code |
|------------------------------------------------------|---------------------------------|--------------------|------------------------------|
|                                                      | <b>(c)</b> Amount               | <b>(d)</b> Purpose |                              |
|                                                      |                                 |                    |                              |

---

**(a)** Name and address of the agent, broker, or other person to whom commissions or fees were paid

---

| <b>(b)</b> Amount of sales and base commissions paid | Fees and other commissions paid |                    | <b>(e)</b> Organization code |
|------------------------------------------------------|---------------------------------|--------------------|------------------------------|
|                                                      | <b>(c)</b> Amount               | <b>(d)</b> Purpose |                              |
|                                                      |                                 |                    |                              |

**Part II Investment and Annuity Contract Information**

Where individual contracts are provided, the entire group of such individual contracts with each carrier may be treated as a unit for purposes of this report.

|                                                                                                        |          |         |
|--------------------------------------------------------------------------------------------------------|----------|---------|
| <b>4</b> Current value of plan's interest under this contract in the general account at year end ..... | <b>4</b> |         |
| <b>5</b> Current value of plan's interest under this contract in separate accounts at year end .....   | <b>5</b> | 3629587 |

**6** Contracts With Allocated Funds:**a** State the basis of premium rates ▶

|                                                                                                                                                                                                                |           |  |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------|--|
| <b>b</b> Premiums paid to carrier .....                                                                                                                                                                        | <b>6b</b> |  |
| <b>c</b> Premiums due but unpaid at the end of the year .....                                                                                                                                                  | <b>6c</b> |  |
| <b>d</b> If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or retention of the contract or policy, enter amount. ....<br>Specify nature of costs ▶ | <b>6d</b> |  |

**e** Type of contract: (1) ☐ individual policies (2) ☐ group deferred annuity  
(3) ☐ other (specify) ▶

**f** If contract purchased, in whole or in part, to distribute benefits from a terminating plan check here ▶ ☐**7** Contracts With Unallocated Funds (Do not include portions of these contracts maintained in separate accounts)

**a** Type of contract: (1) ☐ deposit administration (2) ☐ immediate participation guarantee  
(3) ☐ guaranteed investment (4) ☒ other ▶ GROUP ANNUITY CONTRACT

|                                                        |           |        |
|--------------------------------------------------------|-----------|--------|
| <b>b</b> Balance at the end of the previous year ..... | <b>7b</b> | 323354 |
|--------------------------------------------------------|-----------|--------|

|                                                                       |              |        |  |
|-----------------------------------------------------------------------|--------------|--------|--|
| <b>c</b> Additions: (1) Contributions deposited during the year ..... | <b>7c(1)</b> | 623793 |  |
| (2) Dividends and credits .....                                       | <b>7c(2)</b> | 0      |  |
| (3) Interest credited during the year .....                           | <b>7c(3)</b> | 10929  |  |
| (4) Transferred from separate account .....                           | <b>7c(4)</b> | 56047  |  |
| (5) Other (specify below) .....                                       | <b>7c(5)</b> | 22264  |  |

▶ ROLLOVER

|                           |              |        |
|---------------------------|--------------|--------|
| (6) Total additions ..... | <b>7c(6)</b> | 713033 |
|---------------------------|--------------|--------|

|                                                                               |           |         |
|-------------------------------------------------------------------------------|-----------|---------|
| <b>d</b> Total of balance and additions (add <b>b</b> and <b>c(6)</b> ) ..... | <b>7d</b> | 1036387 |
|-------------------------------------------------------------------------------|-----------|---------|

**e** Deductions:

|                                                                                 |              |        |  |
|---------------------------------------------------------------------------------|--------------|--------|--|
| (1) Disbursed from fund to pay benefits or purchase annuities during year ..... | <b>7e(1)</b> | 0      |  |
| (2) Administration charge made by carrier .....                                 | <b>7e(2)</b> | 1880   |  |
| (3) Transferred to separate account .....                                       | <b>7e(3)</b> | 560085 |  |
| (4) Other (specify below) .....                                                 | <b>7e(4)</b> | 0      |  |

▶

|                            |              |        |
|----------------------------|--------------|--------|
| (5) Total deductions ..... | <b>7e(5)</b> | 561965 |
|----------------------------|--------------|--------|

|                                                                                             |           |        |
|---------------------------------------------------------------------------------------------|-----------|--------|
| <b>f</b> Balance at the end of the current year (subtract <b>e(5)</b> from <b>d</b> ) ..... | <b>7f</b> | 474422 |
|---------------------------------------------------------------------------------------------|-----------|--------|

**Part III Welfare Benefit Contract Information**

If more than one contract covers the same group of employees of the same employer(s) or members of the same employee organization(s), the information may be combined for reporting purposes if such contracts are experience-rated as a unit. Where contracts cover individual employees, the entire group of such individual contracts with each carrier may be treated as a unit for purposes of this report.

**8** Benefit and contract type (check all applicable boxes)

- a** ☐ Health (other than dental or vision)     
 **b** ☐ Dental     
 **c** ☐ Vision     
 **d** ☐ Life insurance  
**e** ☐ Temporary disability (accident and sickness)     
 **f** ☐ Long-term disability     
 **g** ☐ Supplemental unemployment     
 **h** ☐ Prescription drug  
**i** ☐ Stop loss (large deductible)     
 **j** ☐ HMO contract     
 **k** ☐ PPO contract     
 **l** ☐ Indemnity contract  
**m** ☐ Other (specify) ▶

**9** Experience-rated contracts:

|                                                                                                                                                   |                 |                 |  |
|---------------------------------------------------------------------------------------------------------------------------------------------------|-----------------|-----------------|--|
| <b>a</b> Premiums: (1) Amount received.....                                                                                                       | <b>9a(1)</b>    |                 |  |
| (2) Increase (decrease) in amount due but unpaid.....                                                                                             | <b>9a(2)</b>    |                 |  |
| (3) Increase (decrease) in unearned premium reserve.....                                                                                          | <b>9a(3)</b>    |                 |  |
| (4) Earned ((1) + (2) - (3)).....                                                                                                                 |                 | <b>9a(4)</b>    |  |
| <b>b</b> Benefit charges (1) Claims paid.....                                                                                                     | <b>9b(1)</b>    |                 |  |
| (2) Increase (decrease) in claim reserves.....                                                                                                    | <b>9b(2)</b>    |                 |  |
| (3) Incurred claims (add (1) and (2)).....                                                                                                        |                 | <b>9b(3)</b>    |  |
| (4) Claims charged.....                                                                                                                           |                 | <b>9b(4)</b>    |  |
| <b>c</b> Remainder of premium: (1) Retention charges (on an accrual basis) --                                                                     |                 |                 |  |
| (A) Commissions.....                                                                                                                              | <b>9c(1)(A)</b> |                 |  |
| (B) Administrative service or other fees.....                                                                                                     | <b>9c(1)(B)</b> |                 |  |
| (C) Other specific acquisition costs.....                                                                                                         | <b>9c(1)(C)</b> |                 |  |
| (D) Other expenses.....                                                                                                                           | <b>9c(1)(D)</b> |                 |  |
| (E) Taxes.....                                                                                                                                    | <b>9c(1)(E)</b> |                 |  |
| (F) Charges for risks or other contingencies.....                                                                                                 | <b>9c(1)(F)</b> |                 |  |
| (G) Other retention charges.....                                                                                                                  | <b>9c(1)(G)</b> |                 |  |
| (H) Total retention.....                                                                                                                          |                 | <b>9c(1)(H)</b> |  |
| (2) Dividends or retroactive rate refunds. (These amounts were <input type="checkbox"/> paid in cash, or <input type="checkbox"/> credited.)..... |                 | <b>9c(2)</b>    |  |
| <b>d</b> Status of policyholder reserves at end of year: (1) Amount held to provide benefits after retirement.....                                |                 | <b>9d(1)</b>    |  |
| (2) Claim reserves.....                                                                                                                           |                 | <b>9d(2)</b>    |  |
| (3) Other reserves.....                                                                                                                           |                 | <b>9d(3)</b>    |  |
| <b>e</b> Dividends or retroactive rate refunds due. (Do not include amount entered in c(2).).....                                                 |                 | <b>9e</b>       |  |

**10** Nonexperience-rated contracts:

|                                                                                                                                                                                                                                 |            |  |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------|--|
| <b>a</b> Total premiums or subscription charges paid to carrier.....                                                                                                                                                            | <b>10a</b> |  |
| <b>b</b> If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or retention of the contract or policy, other than reported in Part I, item 2 above, report amount. .... | <b>10b</b> |  |

Specify nature of costs ▶

**Part IV Provision of Information**

**11** Did the insurance company fail to provide any information necessary to complete Schedule A? ..... ☐ Yes ☒ No

**12** If the answer to line 11 is "Yes," specify the information not provided. ▶

|                                                                                                                                                                                                                           |                                                                                                                                                                                                                        |                                                             |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------|
| <b>SCHEDULE C</b><br><b>(Form 5500)</b><br><br>Department of the Treasury<br>Internal Revenue Service<br><br>Department of Labor<br>Employee Benefits Security Administration<br><br>Pension Benefit Guaranty Corporation | <b>Service Provider Information</b><br><br>This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA).<br><br>▶ <b>File as an attachment to Form 5500.</b> | OMB No. 1210-0110                                           |
|                                                                                                                                                                                                                           |                                                                                                                                                                                                                        | <b>2009</b>                                                 |
|                                                                                                                                                                                                                           |                                                                                                                                                                                                                        | <b>This Form is Open to Public Inspection.</b>              |
| For calendar plan year 2009 or fiscal plan year beginning 01/01/2009 and ending 12/31/2009                                                                                                                                |                                                                                                                                                                                                                        |                                                             |
| <b>A</b> Name of plan<br>EYECARE ASSOCIATES, INC. 401K PLAN                                                                                                                                                               |                                                                                                                                                                                                                        | <b>B</b> Three-digit plan number (PN) ▶ 001                 |
| <b>C</b> Plan sponsor's name as shown on line 2a of Form 5500<br>EYECARE ASSOCIATES, INC.                                                                                                                                 |                                                                                                                                                                                                                        | <b>D</b> Employer Identification Number (EIN)<br>63-1159628 |

|               |                                                        |
|---------------|--------------------------------------------------------|
| <b>Part I</b> | <b>Service Provider Information (see instructions)</b> |
|---------------|--------------------------------------------------------|

You must complete this Part, in accordance with the instructions, to report the information required for **each person** who received, directly or indirectly, \$5,000 or more in total compensation (i.e., money or anything else of monetary value) in connection with services rendered to the plan or the person's position with the plan during the plan year. If a person received **only** eligible indirect compensation for which the plan received the required disclosures, you are required to answer line 1 but are not required to include that person when completing the remainder of this Part.

**1 Information on Persons Receiving Only Eligible Indirect Compensation**

**a** Check "Yes" or "No" to indicate whether you are excluding a person from the remainder of this Part because they received only eligible indirect compensation for which the plan received the required disclosures (see instructions for definitions and conditions)..... ☐ Yes ☒ No

**b** If you answered line 1a "Yes," enter the name and EIN or address of each person providing the required disclosures for the service providers who received only eligible indirect compensation. Complete as many entries as needed (see instructions).

|                                                                                                                   |
|-------------------------------------------------------------------------------------------------------------------|
| <b>(b)</b> Enter name and EIN or address of person who provided you disclosures on eligible indirect compensation |
|-------------------------------------------------------------------------------------------------------------------|

|                                                                                                                  |
|------------------------------------------------------------------------------------------------------------------|
| <b>(b)</b> Enter name and EIN or address of person who provided you disclosure on eligible indirect compensation |
|------------------------------------------------------------------------------------------------------------------|

|                                                                                                                   |
|-------------------------------------------------------------------------------------------------------------------|
| <b>(b)</b> Enter name and EIN or address of person who provided you disclosures on eligible indirect compensation |
|-------------------------------------------------------------------------------------------------------------------|

|                                                                                                                   |
|-------------------------------------------------------------------------------------------------------------------|
| <b>(b)</b> Enter name and EIN or address of person who provided you disclosures on eligible indirect compensation |
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(b) Enter name and EIN or address of person who provided you disclosures on eligible indirect compensation

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**2. Information on Other Service Providers Receiving Direct or Indirect Compensation.** Except for those persons for whom you answered "yes" to line 1a above, complete as many entries as needed to list each person receiving, directly or indirectly, \$5,000 or more in total compensation (i.e., money or anything else of value) in connection with services rendered to the plan or their position with the plan during the plan year. (See instructions).

**(a)** Enter name and EIN or address (see instructions)

MASSACHUSETTS MUTUAL LIFE INSURANCE

04-1590850

| <b>(b)</b><br>Service Code(s) | <b>(c)</b><br>Relationship to employer, employee organization, or person known to be a party-in-interest | <b>(d)</b><br>Enter direct compensation paid by the plan. If none, enter -0-. | <b>(e)</b><br>Did service provider receive indirect compensation? (sources other than plan or plan sponsor) | <b>(f)</b><br>Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures? | <b>(g)</b><br>Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-. | <b>(h)</b><br>Did the service provider give you a formula instead of an amount or estimated amount? |
|-------------------------------|----------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------|
| 24 52 63 72                   | CONTRACT ADMINISTRATOR                                                                                   | 16777                                                                         | Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>                                         | Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>                                                                   | 0                                                                                                                                                                                      | Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>                                 |

**(a)** Enter name and EIN or address (see instructions)

ADMINISTRATIVE SERVICES, LLC

63-1239553

| <b>(b)</b><br>Service Code(s) | <b>(c)</b><br>Relationship to employer, employee organization, or person known to be a party-in-interest | <b>(d)</b><br>Enter direct compensation paid by the plan. If none, enter -0-. | <b>(e)</b><br>Did service provider receive indirect compensation? (sources other than plan or plan sponsor) | <b>(f)</b><br>Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures? | <b>(g)</b><br>Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-. | <b>(h)</b><br>Did the service provider give you a formula instead of an amount or estimated amount? |
|-------------------------------|----------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------|
| 13                            | TPA                                                                                                      | 0                                                                             | Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>                                         | Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>                                                                   | 272                                                                                                                                                                                    | Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>                                 |

**(a)** Enter name and EIN or address (see instructions)

| <b>(b)</b><br>Service Code(s) | <b>(c)</b><br>Relationship to employer, employee organization, or person known to be a party-in-interest | <b>(d)</b><br>Enter direct compensation paid by the plan. If none, enter -0-. | <b>(e)</b><br>Did service provider receive indirect compensation? (sources other than plan or plan sponsor) | <b>(f)</b><br>Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures? | <b>(g)</b><br>Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-. | <b>(h)</b><br>Did the service provider give you a formula instead of an amount or estimated amount? |
|-------------------------------|----------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------|
|                               |                                                                                                          |                                                                               | Yes <input type="checkbox"/> No <input type="checkbox"/>                                                    | Yes <input type="checkbox"/> No <input type="checkbox"/>                                                                              |                                                                                                                                                                                        | Yes <input type="checkbox"/> No <input type="checkbox"/>                                            |

**(a)** Enter name and EIN or address (see instructions)

| <b>(b)</b><br>Service<br>Code(s) | <b>(c)</b><br>Relationship to<br>employer, employee<br>organization, or<br>person known to be<br>a party-in-interest | <b>(d)</b><br>Enter direct<br>compensation paid<br>by the plan. If none,<br>enter -0-. | <b>(e)</b><br>Did service provider<br>receive indirect<br>compensation? (sources<br>other than plan or plan<br>sponsor) | <b>(f)</b><br>Did indirect compensation<br>include eligible indirect<br>compensation, for which the<br>plan received the required<br>disclosures? | <b>(g)</b><br>Enter total indirect<br>compensation received by<br>service provider excluding<br>eligible indirect<br>compensation for which you<br>answered "Yes" to element<br>(f). If none, enter -0-. | <b>(h)</b><br>Did the service<br>provider give you a<br>formula instead of<br>an amount or<br>estimated amount? |
|----------------------------------|----------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------|
|                                  |                                                                                                                      |                                                                                        | Yes <input type="checkbox"/> No <input type="checkbox"/>                                                                | Yes <input type="checkbox"/> No <input type="checkbox"/>                                                                                          |                                                                                                                                                                                                          | Yes <input type="checkbox"/> No <input type="checkbox"/>                                                        |

**(a)** Enter name and EIN or address (see instructions)

| <b>(b)</b><br>Service<br>Code(s) | <b>(c)</b><br>Relationship to<br>employer, employee<br>organization, or<br>person known to be<br>a party-in-interest | <b>(d)</b><br>Enter direct<br>compensation paid<br>by the plan. If none,<br>enter -0-. | <b>(e)</b><br>Did service provider<br>receive indirect<br>compensation? (sources<br>other than plan or plan<br>sponsor) | <b>(f)</b><br>Did indirect compensation<br>include eligible indirect<br>compensation, for which the<br>plan received the required<br>disclosures? | <b>(g)</b><br>Enter total indirect<br>compensation received by<br>service provider excluding<br>eligible indirect<br>compensation for which you<br>answered "Yes" to element<br>(f). If none, enter -0-. | <b>(h)</b><br>Did the service<br>provider give you a<br>formula instead of<br>an amount or<br>estimated amount? |
|----------------------------------|----------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------|
|                                  |                                                                                                                      |                                                                                        | Yes <input type="checkbox"/> No <input type="checkbox"/>                                                                | Yes <input type="checkbox"/> No <input type="checkbox"/>                                                                                          |                                                                                                                                                                                                          | Yes <input type="checkbox"/> No <input type="checkbox"/>                                                        |

**(a)** Enter name and EIN or address (see instructions)

| <b>(b)</b><br>Service<br>Code(s) | <b>(c)</b><br>Relationship to<br>employer, employee<br>organization, or<br>person known to be<br>a party-in-interest | <b>(d)</b><br>Enter direct<br>compensation paid<br>by the plan. If none,<br>enter -0-. | <b>(e)</b><br>Did service provider<br>receive indirect<br>compensation? (sources<br>other than plan or plan<br>sponsor) | <b>(f)</b><br>Did indirect compensation<br>include eligible indirect<br>compensation, for which the<br>plan received the required<br>disclosures? | <b>(g)</b><br>Enter total indirect<br>compensation received by<br>service provider excluding<br>eligible indirect<br>compensation for which you<br>answered "Yes" to element<br>(f). If none, enter -0-. | <b>(h)</b><br>Did the service<br>provider give you a<br>formula instead of<br>an amount or<br>estimated amount? |
|----------------------------------|----------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------|
|                                  |                                                                                                                      |                                                                                        | Yes <input type="checkbox"/> No <input type="checkbox"/>                                                                | Yes <input type="checkbox"/> No <input type="checkbox"/>                                                                                          |                                                                                                                                                                                                          | Yes <input type="checkbox"/> No <input type="checkbox"/>                                                        |

**Part I Service Provider Information (continued)**

**3** If you reported on line 2 receipt of indirect compensation, other than eligible indirect compensation, by a service provider, and the service provider is a fiduciary or provides contract administrator, consulting, custodial, investment advisory, investment management, broker, or recordkeeping services, answer the following questions for (a) each source from whom the service provider received \$1,000 or more in indirect compensation and (b) each source for whom the service provider gave you a formula used to determine the indirect compensation instead of an amount or estimated amount of the indirect compensation. Complete as many entries as needed to report the required information for each source.

| (a) Enter service provider name as it appears on line 2 | (b) Service Codes<br>(see instructions) | (c) Enter amount of indirect compensation |
|---------------------------------------------------------|-----------------------------------------|-------------------------------------------|
| ADMINISTRATIVE SERVICES, LLC                            | 13                                      | 272                                       |

| (d) Enter name and EIN (address) of source of indirect compensation | (e) Describe the indirect compensation, including any formula used to determine the service provider's eligibility for or the amount of the indirect compensation. |
|---------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| MASSACHUSETTS MUTUAL LIFE INSURANCE<br><br>04-1590850               | TPA FEES                                                                                                                                                           |

| (a) Enter service provider name as it appears on line 2 | (b) Service Codes<br>(see instructions) | (c) Enter amount of indirect compensation |
|---------------------------------------------------------|-----------------------------------------|-------------------------------------------|
| MASSACHUSETTS MUTUAL LIFE INSURANCE                     | 52                                      | 0                                         |

| (d) Enter name and EIN (address) of source of indirect compensation | (e) Describe the indirect compensation, including any formula used to determine the service provider's eligibility for or the amount of the indirect compensation. |
|---------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| AGGRESSIVE JOURNEY<br><br>04-1590850                                | BASIS POINTS*PLAN ASSETS                                                                                                                                           |

| (a) Enter service provider name as it appears on line 2 | (b) Service Codes<br>(see instructions) | (c) Enter amount of indirect compensation |
|---------------------------------------------------------|-----------------------------------------|-------------------------------------------|
| MASSACHUSETTS MUTUAL LIFE INSURANCE                     | 52                                      | 0                                         |

| (d) Enter name and EIN (address) of source of indirect compensation | (e) Describe the indirect compensation, including any formula used to determine the service provider's eligibility for or the amount of the indirect compensation. |
|---------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| CONSERVATIVE JOURNEY<br><br>04-1590850                              | BASIS POINTS*PLAN ASSETS                                                                                                                                           |

**Part I Service Provider Information (continued)**

**3** If you reported on line 2 receipt of indirect compensation, other than eligible indirect compensation, by a service provider, and the service provider is a fiduciary or provides contract administrator, consulting, custodial, investment advisory, investment management, broker, or recordkeeping services, answer the following questions for (a) each source from whom the service provider received \$1,000 or more in indirect compensation and (b) each source for whom the service provider gave you a formula used to determine the indirect compensation instead of an amount or estimated amount of the indirect compensation. Complete as many entries as needed to report the required information for each source.

| (a) Enter service provider name as it appears on line 2             | (b) Service Codes<br>(see instructions)                                                                                                                            | (c) Enter amount of indirect compensation |
|---------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------|
| MASSACHUSETTS MUTUAL LIFE INSURANCE                                 | 52                                                                                                                                                                 | 0                                         |
| (d) Enter name and EIN (address) of source of indirect compensation | (e) Describe the indirect compensation, including any formula used to determine the service provider's eligibility for or the amount of the indirect compensation. |                                           |
| MODERATE JOURNEY<br><br>04-1590850                                  | BASIS POINTS*PLAN ASSETS                                                                                                                                           |                                           |
| (a) Enter service provider name as it appears on line 2             | (b) Service Codes<br>(see instructions)                                                                                                                            | (c) Enter amount of indirect compensation |
| MASSACHUSETTS MUTUAL LIFE INSURANCE                                 | 52                                                                                                                                                                 | 0                                         |
| (d) Enter name and EIN (address) of source of indirect compensation | (e) Describe the indirect compensation, including any formula used to determine the service provider's eligibility for or the amount of the indirect compensation. |                                           |
| ULTRA AGGRESSIVE JOURNEY<br><br>04-1590850                          | BASIS POINTS*PLAN ASSETS                                                                                                                                           |                                           |
| (a) Enter service provider name as it appears on line 2             | (b) Service Codes<br>(see instructions)                                                                                                                            | (c) Enter amount of indirect compensation |
| MASSACHUSETTS MUTUAL LIFE INSURANCE                                 | 63                                                                                                                                                                 | 0                                         |
| (d) Enter name and EIN (address) of source of indirect compensation | (e) Describe the indirect compensation, including any formula used to determine the service provider's eligibility for or the amount of the indirect compensation. |                                           |
| GROWTH AMERICA AMERICAN<br><br>52-0792143                           | BASIS POINTS*PLAN ASSETS                                                                                                                                           |                                           |

**Part I Service Provider Information (continued)**

**3** If you reported on line 2 receipt of indirect compensation, other than eligible indirect compensation, by a service provider, and the service provider is a fiduciary or provides contract administrator, consulting, custodial, investment advisory, investment management, broker, or recordkeeping services, answer the following questions for (a) each source from whom the service provider received \$1,000 or more in indirect compensation and (b) each source for whom the service provider gave you a formula used to determine the indirect compensation instead of an amount or estimated amount of the indirect compensation. Complete as many entries as needed to report the required information for each source.

| (a) Enter service provider name as it appears on line 2 | (b) Service Codes<br>(see instructions) | (c) Enter amount of indirect compensation |
|---------------------------------------------------------|-----------------------------------------|-------------------------------------------|
| MASSACHUSETTS MUTUAL LIFE INSURANCE                     | 63                                      | 0                                         |

| (d) Enter name and EIN (address) of source of indirect compensation | (e) Describe the indirect compensation, including any formula used to determine the service provider's eligibility for or the amount of the indirect compensation. |
|---------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| INTERNATIONAL VALUE THORNBURG<br><br>85-0451747                     | BASIS POINTS*PLAN ASSETS                                                                                                                                           |

| (a) Enter service provider name as it appears on line 2 | (b) Service Codes<br>(see instructions) | (c) Enter amount of indirect compensation |
|---------------------------------------------------------|-----------------------------------------|-------------------------------------------|
| MASSACHUSETTS MUTUAL LIFE INSURANCE                     | 63                                      | 0                                         |

| (d) Enter name and EIN (address) of source of indirect compensation                                               | (e) Describe the indirect compensation, including any formula used to determine the service provider's eligibility for or the amount of the indirect compensation. |
|-------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| MID CAP GROWTH JENNISON DRYDEN<br>GATEWAY CENTER THREE<br>100 MULBERRY STREET, 4TH FLOOR<br>NEWARK, NJ 07102-4077 | BASIS POINTS*PLAN ASSETS                                                                                                                                           |

| (a) Enter service provider name as it appears on line 2 | (b) Service Codes<br>(see instructions) | (c) Enter amount of indirect compensation |
|---------------------------------------------------------|-----------------------------------------|-------------------------------------------|
| MASSACHUSETTS MUTUAL LIFE INSURANCE                     | 63                                      | 0                                         |

| (d) Enter name and EIN (address) of source of indirect compensation | (e) Describe the indirect compensation, including any formula used to determine the service provider's eligibility for or the amount of the indirect compensation. |
|---------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| MID CAP VALUE PERKINS<br><br>84-1458637                             | BASIS POINTS*PLAN ASSETS                                                                                                                                           |

**Part I Service Provider Information (continued)**

**3** If you reported on line 2 receipt of indirect compensation, other than eligible indirect compensation, by a service provider, and the service provider is a fiduciary or provides contract administrator, consulting, custodial, investment advisory, investment management, broker, or recordkeeping services, answer the following questions for (a) each source from whom the service provider received \$1,000 or more in indirect compensation and (b) each source for whom the service provider gave you a formula used to determine the indirect compensation instead of an amount or estimated amount of the indirect compensation. Complete as many entries as needed to report the required information for each source.

| (a) Enter service provider name as it appears on line 2 | (b) Service Codes<br>(see instructions) | (c) Enter amount of indirect compensation |
|---------------------------------------------------------|-----------------------------------------|-------------------------------------------|
| MASSACHUSETTS MUTUAL LIFE INSURANCE                     | 63                                      | 0                                         |

| (d) Enter name and EIN (address) of source of indirect compensation | (e) Describe the indirect compensation, including any formula used to determine the service provider's eligibility for or the amount of the indirect compensation. |
|---------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| NFJ SMALL CAP VALUE ALLIANZ<br><br>33-0434038                       | BASIS POINTS*PLAN ASSETS                                                                                                                                           |

| (a) Enter service provider name as it appears on line 2 | (b) Service Codes<br>(see instructions) | (c) Enter amount of indirect compensation |
|---------------------------------------------------------|-----------------------------------------|-------------------------------------------|
| MASSACHUSETTS MUTUAL LIFE INSURANCE                     | 63                                      | 0                                         |

| (d) Enter name and EIN (address) of source of indirect compensation | (e) Describe the indirect compensation, including any formula used to determine the service provider's eligibility for or the amount of the indirect compensation. |
|---------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| SMALL CAP GROWTH VAN KAMPEN<br><br>36-4353052                       | BASIS POINTS*PLAN ASSETS                                                                                                                                           |

| (a) Enter service provider name as it appears on line 2 | (b) Service Codes<br>(see instructions) | (c) Enter amount of indirect compensation |
|---------------------------------------------------------|-----------------------------------------|-------------------------------------------|
| MASSACHUSETTS MUTUAL LIFE INSURANCE                     | 63                                      | 0                                         |

| (d) Enter name and EIN (address) of source of indirect compensation | (e) Describe the indirect compensation, including any formula used to determine the service provider's eligibility for or the amount of the indirect compensation. |
|---------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| TOTAL RETURN PIMCO<br><br>33-0239892                                | BASIS POINTS*PLAN ASSETS                                                                                                                                           |

**Part I Service Provider Information (continued)**

**3** If you reported on line 2 receipt of indirect compensation, other than eligible indirect compensation, by a service provider, and the service provider is a fiduciary or provides contract administrator, consulting, custodial, investment advisory, investment management, broker, or recordkeeping services, answer the following questions for (a) each source from whom the service provider received \$1,000 or more in indirect compensation and (b) each source for whom the service provider gave you a formula used to determine the indirect compensation instead of an amount or estimated amount of the indirect compensation. Complete as many entries as needed to report the required information for each source.

| (a) Enter service provider name as it appears on line 2 | (b) Service Codes<br>(see instructions) | (c) Enter amount of indirect compensation |
|---------------------------------------------------------|-----------------------------------------|-------------------------------------------|
| MASSACHUSETTS MUTUAL LIFE INSURANCE                     | 63                                      | 0                                         |

| (d) Enter name and EIN (address) of source of indirect compensation | (e) Describe the indirect compensation, including any formula used to determine the service provider's eligibility for or the amount of the indirect compensation. |
|---------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| VALUE MFS<br><br>04-3287965                                         | BASIS POINTS*PLAN ASSETS                                                                                                                                           |

| (a) Enter service provider name as it appears on line 2 | (b) Service Codes<br>(see instructions) | (c) Enter amount of indirect compensation |
|---------------------------------------------------------|-----------------------------------------|-------------------------------------------|
| MASSACHUSETTS MUTUAL LIFE INSURANCE                     | 72                                      | 0                                         |

| (d) Enter name and EIN (address) of source of indirect compensation | (e) Describe the indirect compensation, including any formula used to determine the service provider's eligibility for or the amount of the indirect compensation. |
|---------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| GROWTH AMERICA AMERICAN<br><br>52-0792143                           | BASIS POINTS*PLAN ASSETS                                                                                                                                           |

| (a) Enter service provider name as it appears on line 2 | (b) Service Codes<br>(see instructions) | (c) Enter amount of indirect compensation |
|---------------------------------------------------------|-----------------------------------------|-------------------------------------------|
| MASSACHUSETTS MUTUAL LIFE INSURANCE                     | 72                                      | 0                                         |

| (d) Enter name and EIN (address) of source of indirect compensation | (e) Describe the indirect compensation, including any formula used to determine the service provider's eligibility for or the amount of the indirect compensation. |
|---------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| INTERNATIONAL VALUE THORNBURG<br><br>85-0451747                     | BASIS POINTS*PLAN ASSETS                                                                                                                                           |

**Part I Service Provider Information (continued)**

**3** If you reported on line 2 receipt of indirect compensation, other than eligible indirect compensation, by a service provider, and the service provider is a fiduciary or provides contract administrator, consulting, custodial, investment advisory, investment management, broker, or recordkeeping services, answer the following questions for (a) each source from whom the service provider received \$1,000 or more in indirect compensation and (b) each source for whom the service provider gave you a formula used to determine the indirect compensation instead of an amount or estimated amount of the indirect compensation. Complete as many entries as needed to report the required information for each source.

| (a) Enter service provider name as it appears on line 2 | (b) Service Codes<br>(see instructions) | (c) Enter amount of indirect compensation |
|---------------------------------------------------------|-----------------------------------------|-------------------------------------------|
| MASSACHUSETTS MUTUAL LIFE INSURANCE                     | 72                                      | 0                                         |

| (d) Enter name and EIN (address) of source of indirect compensation                                               | (e) Describe the indirect compensation, including any formula used to determine the service provider's eligibility for or the amount of the indirect compensation. |
|-------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| MID CAP GROWTH JENNISON DRYDEN<br>GATEWAY CENTER THREE<br>100 MULBERRY STREET, 4TH FLOOR<br>NEWARK, NJ 07102-4077 | BASIS POINTS*PLAN ASSETS                                                                                                                                           |

| (a) Enter service provider name as it appears on line 2 | (b) Service Codes<br>(see instructions) | (c) Enter amount of indirect compensation |
|---------------------------------------------------------|-----------------------------------------|-------------------------------------------|
| MASSACHUSETTS MUTUAL LIFE INSURANCE                     | 72                                      | 0                                         |

| (d) Enter name and EIN (address) of source of indirect compensation | (e) Describe the indirect compensation, including any formula used to determine the service provider's eligibility for or the amount of the indirect compensation. |
|---------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| MID CAP VALUE PERKINS<br><br>84-1458637                             | BASIS POINTS*PLAN ASSETS                                                                                                                                           |

| (a) Enter service provider name as it appears on line 2 | (b) Service Codes<br>(see instructions) | (c) Enter amount of indirect compensation |
|---------------------------------------------------------|-----------------------------------------|-------------------------------------------|
| MASSACHUSETTS MUTUAL LIFE INSURANCE                     | 72                                      | 0                                         |

| (d) Enter name and EIN (address) of source of indirect compensation | (e) Describe the indirect compensation, including any formula used to determine the service provider's eligibility for or the amount of the indirect compensation. |
|---------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| NFJ SMALL CAP VALUE ALLIANZ<br><br>33-0434038                       | BASIS POINTS*PLAN ASSETS                                                                                                                                           |

**Part I Service Provider Information (continued)**

**3** If you reported on line 2 receipt of indirect compensation, other than eligible indirect compensation, by a service provider, and the service provider is a fiduciary or provides contract administrator, consulting, custodial, investment advisory, investment management, broker, or recordkeeping services, answer the following questions for (a) each source from whom the service provider received \$1,000 or more in indirect compensation and (b) each source for whom the service provider gave you a formula used to determine the indirect compensation instead of an amount or estimated amount of the indirect compensation. Complete as many entries as needed to report the required information for each source.

| (a) Enter service provider name as it appears on line 2 | (b) Service Codes<br>(see instructions) | (c) Enter amount of indirect compensation |
|---------------------------------------------------------|-----------------------------------------|-------------------------------------------|
| MASSACHUSETTS MUTUAL LIFE INSURANCE                     | 72                                      | 0                                         |

| (d) Enter name and EIN (address) of source of indirect compensation | (e) Describe the indirect compensation, including any formula used to determine the service provider's eligibility for or the amount of the indirect compensation. |
|---------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| PREMIER CAPITAL APPRECIATION OFI<br><br>51-0529336                  | BASIS POINTS*PLAN ASSETS                                                                                                                                           |

| (a) Enter service provider name as it appears on line 2 | (b) Service Codes<br>(see instructions) | (c) Enter amount of indirect compensation |
|---------------------------------------------------------|-----------------------------------------|-------------------------------------------|
| MASSACHUSETTS MUTUAL LIFE INSURANCE                     | 72                                      | 0                                         |

| (d) Enter name and EIN (address) of source of indirect compensation | (e) Describe the indirect compensation, including any formula used to determine the service provider's eligibility for or the amount of the indirect compensation. |
|---------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| PREMIER CORE BOND BABSON<br><br>04-3277549                          | BASIS POINTS*PLAN ASSETS                                                                                                                                           |

| (a) Enter service provider name as it appears on line 2 | (b) Service Codes<br>(see instructions) | (c) Enter amount of indirect compensation |
|---------------------------------------------------------|-----------------------------------------|-------------------------------------------|
| MASSACHUSETTS MUTUAL LIFE INSURANCE                     | 72                                      | 0                                         |

| (d) Enter name and EIN (address) of source of indirect compensation | (e) Describe the indirect compensation, including any formula used to determine the service provider's eligibility for or the amount of the indirect compensation. |
|---------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| PREMIER INTL EQUITY OFI INST<br><br>04-3212044                      | BASIS POINTS*PLAN ASSETS                                                                                                                                           |

**Part I Service Provider Information (continued)**

**3** If you reported on line 2 receipt of indirect compensation, other than eligible indirect compensation, by a service provider, and the service provider is a fiduciary or provides contract administrator, consulting, custodial, investment advisory, investment management, broker, or recordkeeping services, answer the following questions for (a) each source from whom the service provider received \$1,000 or more in indirect compensation and (b) each source for whom the service provider gave you a formula used to determine the indirect compensation instead of an amount or estimated amount of the indirect compensation. Complete as many entries as needed to report the required information for each source.

| (a) Enter service provider name as it appears on line 2 | (b) Service Codes<br>(see instructions) | (c) Enter amount of indirect compensation |
|---------------------------------------------------------|-----------------------------------------|-------------------------------------------|
| MASSACHUSETTS MUTUAL LIFE INSURANCE                     | 72                                      | 0                                         |

| (d) Enter name and EIN (address) of source of indirect compensation | (e) Describe the indirect compensation, including any formula used to determine the service provider's eligibility for or the amount of the indirect compensation. |
|---------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| SEL AGGRESSIVE GR SANDS/DELAWARE<br><br>04-3512589                  | BASIS POINTS*PLAN ASSETS                                                                                                                                           |

| (a) Enter service provider name as it appears on line 2 | (b) Service Codes<br>(see instructions) | (c) Enter amount of indirect compensation |
|---------------------------------------------------------|-----------------------------------------|-------------------------------------------|
| MASSACHUSETTS MUTUAL LIFE INSURANCE                     | 72                                      | 0                                         |

| (d) Enter name and EIN (address) of source of indirect compensation | (e) Describe the indirect compensation, including any formula used to determine the service provider's eligibility for or the amount of the indirect compensation. |
|---------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| SELECT FOCUSED VALUE HARRIS<br><br>04-3512590                       | BASIS POINTS*PLAN ASSETS                                                                                                                                           |

| (a) Enter service provider name as it appears on line 2 | (b) Service Codes<br>(see instructions) | (c) Enter amount of indirect compensation |
|---------------------------------------------------------|-----------------------------------------|-------------------------------------------|
| MASSACHUSETTS MUTUAL LIFE INSURANCE                     | 72                                      | 0                                         |

| (d) Enter name and EIN (address) of source of indirect compensation | (e) Describe the indirect compensation, including any formula used to determine the service provider's eligibility for or the amount of the indirect compensation. |
|---------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| SELECT INDEXED EQTY NORTHRN TRUST<br><br>04-3410047                 | BASIS POINTS*PLAN ASSETS                                                                                                                                           |

**Part I Service Provider Information (continued)**

**3** If you reported on line 2 receipt of indirect compensation, other than eligible indirect compensation, by a service provider, and the service provider is a fiduciary or provides contract administrator, consulting, custodial, investment advisory, investment management, broker, or recordkeeping services, answer the following questions for (a) each source from whom the service provider received \$1,000 or more in indirect compensation and (b) each source for whom the service provider gave you a formula used to determine the indirect compensation instead of an amount or estimated amount of the indirect compensation. Complete as many entries as needed to report the required information for each source.

| (a) Enter service provider name as it appears on line 2 | (b) Service Codes<br>(see instructions) | (c) Enter amount of indirect compensation |
|---------------------------------------------------------|-----------------------------------------|-------------------------------------------|
| MASSACHUSETTS MUTUAL LIFE INSURANCE                     | 72                                      | 0                                         |

| (d) Enter name and EIN (address) of source of indirect compensation | (e) Describe the indirect compensation, including any formula used to determine the service provider's eligibility for or the amount of the indirect compensation. |
|---------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| SELECT LARGE CAP VALUE DAVIS<br><br>04-3513019                      | BASIS POINTS*PLAN ASSETS                                                                                                                                           |

| (a) Enter service provider name as it appears on line 2 | (b) Service Codes<br>(see instructions) | (c) Enter amount of indirect compensation |
|---------------------------------------------------------|-----------------------------------------|-------------------------------------------|
| MASSACHUSETTS MUTUAL LIFE INSURANCE                     | 72                                      | 0                                         |

| (d) Enter name and EIN (address) of source of indirect compensation | (e) Describe the indirect compensation, including any formula used to determine the service provider's eligibility for or the amount of the indirect compensation. |
|---------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| SELECT SM CAP GR W & R/WELLINGTON<br><br>04-3464205                 | BASIS POINTS*PLAN ASSETS                                                                                                                                           |

| (a) Enter service provider name as it appears on line 2 | (b) Service Codes<br>(see instructions) | (c) Enter amount of indirect compensation |
|---------------------------------------------------------|-----------------------------------------|-------------------------------------------|
| MASSACHUSETTS MUTUAL LIFE INSURANCE                     | 72                                      | 0                                         |

| (d) Enter name and EIN (address) of source of indirect compensation | (e) Describe the indirect compensation, including any formula used to determine the service provider's eligibility for or the amount of the indirect compensation. |
|---------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| SMALL CAP GROWTH VAN KAMPEN<br><br>36-4353052                       | BASIS POINTS*PLAN ASSETS                                                                                                                                           |

**Part I Service Provider Information (continued)**

**3** If you reported on line 2 receipt of indirect compensation, other than eligible indirect compensation, by a service provider, and the service provider is a fiduciary or provides contract administrator, consulting, custodial, investment advisory, investment management, broker, or recordkeeping services, answer the following questions for (a) each source from whom the service provider received \$1,000 or more in indirect compensation and (b) each source for whom the service provider gave you a formula used to determine the indirect compensation instead of an amount or estimated amount of the indirect compensation. Complete as many entries as needed to report the required information for each source.

| (a) Enter service provider name as it appears on line 2 | (b) Service Codes<br>(see instructions) | (c) Enter amount of indirect compensation |
|---------------------------------------------------------|-----------------------------------------|-------------------------------------------|
| MASSACHUSETTS MUTUAL LIFE INSURANCE                     | 72                                      | 0                                         |

| (d) Enter name and EIN (address) of source of indirect compensation | (e) Describe the indirect compensation, including any formula used to determine the service provider's eligibility for or the amount of the indirect compensation. |
|---------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| TOTAL RETURN PIMCO<br><br>33-0239892                                | BASIS POINTS*PLAN ASSETS                                                                                                                                           |

| (a) Enter service provider name as it appears on line 2 | (b) Service Codes<br>(see instructions) | (c) Enter amount of indirect compensation |
|---------------------------------------------------------|-----------------------------------------|-------------------------------------------|
| MASSACHUSETTS MUTUAL LIFE INSURANCE                     | 72                                      | 0                                         |

| (d) Enter name and EIN (address) of source of indirect compensation | (e) Describe the indirect compensation, including any formula used to determine the service provider's eligibility for or the amount of the indirect compensation. |
|---------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| VALUE MFS<br><br>04-3287965                                         | BASIS POINTS*PLAN ASSETS                                                                                                                                           |

| (a) Enter service provider name as it appears on line 2 | (b) Service Codes<br>(see instructions) | (c) Enter amount of indirect compensation |
|---------------------------------------------------------|-----------------------------------------|-------------------------------------------|
|                                                         |                                         |                                           |

| (d) Enter name and EIN (address) of source of indirect compensation | (e) Describe the indirect compensation, including any formula used to determine the service provider's eligibility for or the amount of the indirect compensation. |
|---------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------|
|                                                                     |                                                                                                                                                                    |

**Part II Service Providers Who Fail or Refuse to Provide Information**

**4** Provide, to the extent possible, the following information for each service provider who failed or refused to provide the information necessary to complete this Schedule.

| (a) Enter name and EIN or address of service provider (see instructions) | (b) Nature of Service Code(s) | (c) Describe the information that the service provider failed or refused to provide |
|--------------------------------------------------------------------------|-------------------------------|-------------------------------------------------------------------------------------|
|                                                                          |                               |                                                                                     |
| (a) Enter name and EIN or address of service provider (see instructions) | (b) Nature of Service Code(s) | (c) Describe the information that the service provider failed or refused to provide |
|                                                                          |                               |                                                                                     |
| (a) Enter name and EIN or address of service provider (see instructions) | (b) Nature of Service Code(s) | (c) Describe the information that the service provider failed or refused to provide |
|                                                                          |                               |                                                                                     |
| (a) Enter name and EIN or address of service provider (see instructions) | (b) Nature of Service Code(s) | (c) Describe the information that the service provider failed or refused to provide |
|                                                                          |                               |                                                                                     |
| (a) Enter name and EIN or address of service provider (see instructions) | (b) Nature of Service Code(s) | (c) Describe the information that the service provider failed or refused to provide |
|                                                                          |                               |                                                                                     |
| (a) Enter name and EIN or address of service provider (see instructions) | (b) Nature of Service Code(s) | (c) Describe the information that the service provider failed or refused to provide |
|                                                                          |                               |                                                                                     |

**Part III Termination Information on Accountants and Enrolled Actuaries (see instructions)**  
(complete as many entries as needed)

|                    |                     |
|--------------------|---------------------|
| <b>a</b> Name:     | <b>b</b> EIN:       |
| <b>c</b> Position: |                     |
| <b>d</b> Address:  | <b>e</b> Telephone: |
|                    |                     |

Explanation:

|                    |                     |
|--------------------|---------------------|
| <b>a</b> Name:     | <b>b</b> EIN:       |
| <b>c</b> Position: |                     |
| <b>d</b> Address:  | <b>e</b> Telephone: |
|                    |                     |

Explanation:

|                    |                     |
|--------------------|---------------------|
| <b>a</b> Name:     | <b>b</b> EIN:       |
| <b>c</b> Position: |                     |
| <b>d</b> Address:  | <b>e</b> Telephone: |
|                    |                     |

Explanation:

|                    |                     |
|--------------------|---------------------|
| <b>a</b> Name:     | <b>b</b> EIN;       |
| <b>c</b> Position: |                     |
| <b>d</b> Address:  | <b>e</b> Telephone: |
|                    |                     |

Explanation:

|                    |                     |
|--------------------|---------------------|
| <b>a</b> Name:     | <b>b</b> EIN;       |
| <b>c</b> Position: |                     |
| <b>d</b> Address:  | <b>e</b> Telephone: |
|                    |                     |

Explanation:

|                                                                                                                                                                                                           |                                                                                                                                                                                                                          |                                                                                            |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------|
| <b>SCHEDULE D</b><br><b>(Form 5500)</b><br><small>Department of the Treasury<br/>Internal Revenue Service</small><br><br><small>Department of Labor<br/>Employee Benefits Security Administration</small> | <b>DFE/Participating Plan Information</b><br><br>This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA).<br><b>► File as an attachment to Form 5500.</b> | OMB No. 1210-0110<br><br><b>2009</b><br><br><b>This Form is Open to Public Inspection.</b> |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------|

For calendar plan year 2009 or fiscal plan year beginning 01/01/2009 and ending 12/31/2009

|                                                                                                         |                                                                            |            |
|---------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------|------------|
| <b>A</b> Name of plan<br><u>EYECARE ASSOCIATES, INC. 401K PLAN</u>                                      | <b>B</b> Three-digit plan number (PN) <span style="float: right;">►</span> | <u>001</u> |
| <b>C</b> Plan or DFE sponsor's name as shown on line 2a of Form 5500<br><u>EYECARE ASSOCIATES, INC.</u> | <b>D</b> Employer Identification Number (EIN)<br><u>63-1159628</u>         |            |

|               |                                                                                                                                                                                  |
|---------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Part I</b> | <b>Information on interests in MTIAs, CCTs, PSAs, and 103-12 IEs (to be completed by plans and DFEs)</b><br>(Complete as many entries as needed to report all interests in DFEs) |
|---------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|

|                                                                                              |                               |                                                                                                                                              |
|----------------------------------------------------------------------------------------------|-------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------|
| <b>a</b> Name of MTIA, CCT, PSA, or 103-12 IE: <u>SIA-AC SELECT SM CAP GROWTH</u>            |                               |                                                                                                                                              |
| <b>b</b> Name of sponsor of entity listed in (a): <u>MASSACHUSETTS MUTUAL LIFE INSURANCE</u> |                               |                                                                                                                                              |
| <b>c</b> EIN-PN <u>04-1590850-012</u>                                                        | <b>d</b> Entity code <u>P</u> | <b>e</b> Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions) <span style="float: right;">0</span>     |
| <b>a</b> Name of MTIA, CCT, PSA, or 103-12 IE: <u>SIA-AD SELECT AGGRESSIVE GROWTH</u>        |                               |                                                                                                                                              |
| <b>b</b> Name of sponsor of entity listed in (a): <u>MASSACHUSETTS MUTUAL LIFE INSURANCE</u> |                               |                                                                                                                                              |
| <b>c</b> EIN-PN <u>04-1590850-013</u>                                                        | <b>d</b> Entity code <u>P</u> | <b>e</b> Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions) <span style="float: right;">0</span>     |
| <b>a</b> Name of MTIA, CCT, PSA, or 103-12 IE: <u>SIA-AE PREMIER CORE BOND</u>               |                               |                                                                                                                                              |
| <b>b</b> Name of sponsor of entity listed in (a): <u>MASSACHUSETTS MUTUAL LIFE INSURANCE</u> |                               |                                                                                                                                              |
| <b>c</b> EIN-PN <u>04-1590850-014</u>                                                        | <b>d</b> Entity code <u>P</u> | <b>e</b> Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions) <span style="float: right;">0</span>     |
| <b>a</b> Name of MTIA, CCT, PSA, or 103-12 IE: <u>SIA-AG PREMIER MONEY MARKET</u>            |                               |                                                                                                                                              |
| <b>b</b> Name of sponsor of entity listed in (a): <u>MASSACHUSETTS MUTUAL LIFE INSURANCE</u> |                               |                                                                                                                                              |
| <b>c</b> EIN-PN <u>04-1590850-016</u>                                                        | <b>d</b> Entity code <u>P</u> | <b>e</b> Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions) <span style="float: right;">54859</span> |
| <b>a</b> Name of MTIA, CCT, PSA, or 103-12 IE: <u>SIA-AI PREMIER INTERNATIONAL EQ</u>        |                               |                                                                                                                                              |
| <b>b</b> Name of sponsor of entity listed in (a): <u>MASSACHUSETTS MUTUAL LIFE INSURANCE</u> |                               |                                                                                                                                              |
| <b>c</b> EIN-PN <u>04-1590850-017</u>                                                        | <b>d</b> Entity code <u>P</u> | <b>e</b> Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions) <span style="float: right;">0</span>     |
| <b>a</b> Name of MTIA, CCT, PSA, or 103-12 IE: <u>SIA-AJ SELECT LARGE CAP VALUE</u>          |                               |                                                                                                                                              |
| <b>b</b> Name of sponsor of entity listed in (a): <u>MASSACHUSETTS MUTUAL LIFE INSURANCE</u> |                               |                                                                                                                                              |
| <b>c</b> EIN-PN <u>04-1590850-018</u>                                                        | <b>d</b> Entity code <u>P</u> | <b>e</b> Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions) <span style="float: right;">0</span>     |
| <b>a</b> Name of MTIA, CCT, PSA, or 103-12 IE: <u>SIA-AV SELECT FOCUSED VALUE</u>            |                               |                                                                                                                                              |
| <b>b</b> Name of sponsor of entity listed in (a): <u>MASSACHUSETTS MUTUAL LIFE INSURANCE</u> |                               |                                                                                                                                              |
| <b>c</b> EIN-PN <u>04-1590850-027</u>                                                        | <b>d</b> Entity code <u>P</u> | <b>e</b> Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions) <span style="float: right;">0</span>     |

|                                                                                                       |                                        |                                                                                                                            |
|-------------------------------------------------------------------------------------------------------|----------------------------------------|----------------------------------------------------------------------------------------------------------------------------|
| <b>a</b> Name of MTIA, CCT, PSA, or 103-12 IE: <a href="#">SIA-AX SELECT INDEXED EQUITY</a>           |                                        |                                                                                                                            |
| <b>b</b> Name of sponsor of entity listed in (a): <a href="#">MASSACHUSETTS MUTUAL LIFE INSURANCE</a> |                                        |                                                                                                                            |
| <b>c</b> EIN-PN <a href="#">04-1590850-028</a>                                                        | <b>d</b> Entity code <a href="#">P</a> | <b>e</b> Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions) <a href="#">185419</a> |
| <b>a</b> Name of MTIA, CCT, PSA, or 103-12 IE: <a href="#">SIA-DA AGGRESSIVE JOURNEY</a>              |                                        |                                                                                                                            |
| <b>b</b> Name of sponsor of entity listed in (a): <a href="#">MASSACHUSETTS MUTUAL LIFE INSURANCE</a> |                                        |                                                                                                                            |
| <b>c</b> EIN-PN <a href="#">04-1590850-037</a>                                                        | <b>d</b> Entity code <a href="#">P</a> | <b>e</b> Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions) <a href="#">911826</a> |
| <b>a</b> Name of MTIA, CCT, PSA, or 103-12 IE: <a href="#">SIA-DC CONSERVATIVE JOURNEY</a>            |                                        |                                                                                                                            |
| <b>b</b> Name of sponsor of entity listed in (a): <a href="#">MASSACHUSETTS MUTUAL LIFE INSURANCE</a> |                                        |                                                                                                                            |
| <b>c</b> EIN-PN <a href="#">04-1590850-038</a>                                                        | <b>d</b> Entity code <a href="#">P</a> | <b>e</b> Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions) <a href="#">43288</a>  |
| <b>a</b> Name of MTIA, CCT, PSA, or 103-12 IE: <a href="#">SIA-DE ULTRA AGGRESSIVE JOURNEY</a>        |                                        |                                                                                                                            |
| <b>b</b> Name of sponsor of entity listed in (a): <a href="#">MASSACHUSETTS MUTUAL LIFE INSURANCE</a> |                                        |                                                                                                                            |
| <b>c</b> EIN-PN <a href="#">04-1590850-039</a>                                                        | <b>d</b> Entity code <a href="#">P</a> | <b>e</b> Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions) <a href="#">58997</a>  |
| <b>a</b> Name of MTIA, CCT, PSA, or 103-12 IE: <a href="#">SIA-DJ INTERNATIONAL VALUE</a>             |                                        |                                                                                                                            |
| <b>b</b> Name of sponsor of entity listed in (a): <a href="#">MASSACHUSETTS MUTUAL LIFE INSURANCE</a> |                                        |                                                                                                                            |
| <b>c</b> EIN-PN <a href="#">04-1590850-423</a>                                                        | <b>d</b> Entity code <a href="#">P</a> | <b>e</b> Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions) <a href="#">217354</a> |
| <b>a</b> Name of MTIA, CCT, PSA, or 103-12 IE: <a href="#">SIA-DM MODERATE JOURNEY</a>                |                                        |                                                                                                                            |
| <b>b</b> Name of sponsor of entity listed in (a): <a href="#">MASSACHUSETTS MUTUAL LIFE INSURANCE</a> |                                        |                                                                                                                            |
| <b>c</b> EIN-PN <a href="#">04-1590850-040</a>                                                        | <b>d</b> Entity code <a href="#">P</a> | <b>e</b> Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions) <a href="#">746885</a> |
| <b>a</b> Name of MTIA, CCT, PSA, or 103-12 IE: <a href="#">SIA-HW GROWTH AMERICA</a>                  |                                        |                                                                                                                            |
| <b>b</b> Name of sponsor of entity listed in (a): <a href="#">MASSACHUSETTS MUTUAL LIFE INSURANCE</a> |                                        |                                                                                                                            |
| <b>c</b> EIN-PN <a href="#">04-1590850-419</a>                                                        | <b>d</b> Entity code <a href="#">P</a> | <b>e</b> Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions) <a href="#">270045</a> |
| <b>a</b> Name of MTIA, CCT, PSA, or 103-12 IE: <a href="#">SIA-OC PREMIER CAPITAL APPRECIATION</a>    |                                        |                                                                                                                            |
| <b>b</b> Name of sponsor of entity listed in (a): <a href="#">MASSACHUSETTS MUTUAL LIFE INSURANCE</a> |                                        |                                                                                                                            |
| <b>c</b> EIN-PN <a href="#">04-1590850-097</a>                                                        | <b>d</b> Entity code <a href="#">P</a> | <b>e</b> Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions) <a href="#">0</a>      |
| <b>a</b> Name of MTIA, CCT, PSA, or 103-12 IE: <a href="#">SIA-RD SMALL CAP GROWTH</a>                |                                        |                                                                                                                            |
| <b>b</b> Name of sponsor of entity listed in (a): <a href="#">MASSACHUSETTS MUTUAL LIFE INSURANCE</a> |                                        |                                                                                                                            |
| <b>c</b> EIN-PN <a href="#">04-1590850-440</a>                                                        | <b>d</b> Entity code <a href="#">P</a> | <b>e</b> Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions) <a href="#">118352</a> |
| <b>a</b> Name of MTIA, CCT, PSA, or 103-12 IE: <a href="#">SIA-T MID CAP GROWTH</a>                   |                                        |                                                                                                                            |
| <b>b</b> Name of sponsor of entity listed in (a): <a href="#">MASSACHUSETTS MUTUAL LIFE INSURANCE</a> |                                        |                                                                                                                            |
| <b>c</b> EIN-PN <a href="#">04-1590850-116</a>                                                        | <b>d</b> Entity code <a href="#">P</a> | <b>e</b> Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions) <a href="#">1994</a>   |

**a** Name of MTIA, CCT, PSA, or 103-12 IE: SIA-TI MID CAP VALUE**b** Name of sponsor of entity listed in (a): MASSACHUSETTS MUTUAL LIFE INSURANCE

|                                |                        |                                                                                                          |
|--------------------------------|------------------------|----------------------------------------------------------------------------------------------------------|
| <b>c</b> EIN-PN 04-1590850-017 | <b>d</b> Entity code P | <b>e</b> Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions) 2928 |
|--------------------------------|------------------------|----------------------------------------------------------------------------------------------------------|

**a** Name of MTIA, CCT, PSA, or 103-12 IE: SIA-UV VALUE**b** Name of sponsor of entity listed in (a): MASSACHUSETTS MUTUAL LIFE INSURANCE

|                                |                        |                                                                                                            |
|--------------------------------|------------------------|------------------------------------------------------------------------------------------------------------|
| <b>c</b> EIN-PN 04-1590850-125 | <b>d</b> Entity code P | <b>e</b> Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions) 650217 |
|--------------------------------|------------------------|------------------------------------------------------------------------------------------------------------|

**a** Name of MTIA, CCT, PSA, or 103-12 IE: SIA-WW NFJ SMALL CAP VALUE**b** Name of sponsor of entity listed in (a): MASSACHUSETTS MUTUAL LIFE INSURANCE

|                                |                        |                                                                                                          |
|--------------------------------|------------------------|----------------------------------------------------------------------------------------------------------|
| <b>c</b> EIN-PN 04-1590850-235 | <b>d</b> Entity code P | <b>e</b> Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions) 1085 |
|--------------------------------|------------------------|----------------------------------------------------------------------------------------------------------|

**a** Name of MTIA, CCT, PSA, or 103-12 IE: SIA-WZ TOTAL RETURN**b** Name of sponsor of entity listed in (a): MASSACHUSETTS MUTUAL LIFE INSURANCE

|                                |                        |                                                                                                            |
|--------------------------------|------------------------|------------------------------------------------------------------------------------------------------------|
| <b>c</b> EIN-PN 04-1590850-193 | <b>d</b> Entity code P | <b>e</b> Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions) 366338 |
|--------------------------------|------------------------|------------------------------------------------------------------------------------------------------------|

**a** Name of MTIA, CCT, PSA, or 103-12 IE:**b** Name of sponsor of entity listed in (a):

|                 |                      |                                                                                                     |
|-----------------|----------------------|-----------------------------------------------------------------------------------------------------|
| <b>c</b> EIN-PN | <b>d</b> Entity code | <b>e</b> Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions) |
|-----------------|----------------------|-----------------------------------------------------------------------------------------------------|

**a** Name of MTIA, CCT, PSA, or 103-12 IE:**b** Name of sponsor of entity listed in (a):

|                 |                      |                                                                                                     |
|-----------------|----------------------|-----------------------------------------------------------------------------------------------------|
| <b>c</b> EIN-PN | <b>d</b> Entity code | <b>e</b> Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions) |
|-----------------|----------------------|-----------------------------------------------------------------------------------------------------|

**a** Name of MTIA, CCT, PSA, or 103-12 IE:**b** Name of sponsor of entity listed in (a):

|                 |                      |                                                                                                     |
|-----------------|----------------------|-----------------------------------------------------------------------------------------------------|
| <b>c</b> EIN-PN | <b>d</b> Entity code | <b>e</b> Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions) |
|-----------------|----------------------|-----------------------------------------------------------------------------------------------------|

**a** Name of MTIA, CCT, PSA, or 103-12 IE:**b** Name of sponsor of entity listed in (a):

|                 |                      |                                                                                                     |
|-----------------|----------------------|-----------------------------------------------------------------------------------------------------|
| <b>c</b> EIN-PN | <b>d</b> Entity code | <b>e</b> Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions) |
|-----------------|----------------------|-----------------------------------------------------------------------------------------------------|

**a** Name of MTIA, CCT, PSA, or 103-12 IE:**b** Name of sponsor of entity listed in (a):

|                 |                      |                                                                                                     |
|-----------------|----------------------|-----------------------------------------------------------------------------------------------------|
| <b>c</b> EIN-PN | <b>d</b> Entity code | <b>e</b> Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions) |
|-----------------|----------------------|-----------------------------------------------------------------------------------------------------|

**a** Name of MTIA, CCT, PSA, or 103-12 IE:**b** Name of sponsor of entity listed in (a):

|                 |                      |                                                                                                     |
|-----------------|----------------------|-----------------------------------------------------------------------------------------------------|
| <b>c</b> EIN-PN | <b>d</b> Entity code | <b>e</b> Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions) |
|-----------------|----------------------|-----------------------------------------------------------------------------------------------------|

**Part II Information on Participating Plans (to be completed by DFEs)**

(Complete as many entries as needed to report all participating plans)

**a** Plan name**b** Name of  
plan sponsor**c** EIN-PN**a** Plan name**b** Name of  
plan sponsor**c** EIN-PN**a** Plan name**b** Name of  
plan sponsor**c** EIN-PN**a** Plan name**b** Name of  
plan sponsor**c** EIN-PN**a** Plan name**b** Name of  
plan sponsor**c** EIN-PN**a** Plan name**b** Name of  
plan sponsor**c** EIN-PN**a** Plan name**b** Name of  
plan sponsor**c** EIN-PN**a** Plan name**b** Name of  
plan sponsor**c** EIN-PN**a** Plan name**b** Name of  
plan sponsor**c** EIN-PN**a** Plan name**b** Name of  
plan sponsor**c** EIN-PN**a** Plan name**b** Name of  
plan sponsor**c** EIN-PN**a** Plan name**b** Name of  
plan sponsor**c** EIN-PN

|                                                                                                                                                                                                                           |                                                                                                                                                                                                                                                                              |                                               |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------|
| <b>SCHEDULE H</b><br><b>(Form 5500)</b><br><br>Department of the Treasury<br>Internal Revenue Service<br><br>Department of Labor<br>Employee Benefits Security Administration<br><br>Pension Benefit Guaranty Corporation | <b>Financial Information</b><br><br>This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA), and section 6058(a) of the Internal Revenue Code (the Code).<br><br><b>► File as an attachment to Form 5500.</b> | OMB No. 1210-0110                             |
|                                                                                                                                                                                                                           |                                                                                                                                                                                                                                                                              | <b>2009</b>                                   |
|                                                                                                                                                                                                                           |                                                                                                                                                                                                                                                                              | <b>This Form is Open to Public Inspection</b> |

|                                                                                            |                                                                 |     |
|--------------------------------------------------------------------------------------------|-----------------------------------------------------------------|-----|
| For calendar plan year 2009 or fiscal plan year beginning 01/01/2009 and ending 12/31/2009 |                                                                 |     |
| <b>A</b> Name of plan<br>EYECARE ASSOCIATES, INC. 401K PLAN                                | <b>B</b> Three-digit plan number (PN) ►                         | 001 |
|                                                                                            |                                                                 |     |
| <b>C</b> Plan sponsor's name as shown on line 2a of Form 5500<br>EYECARE ASSOCIATES, INC.  | <b>D</b> Employer Identification Number (EIN)<br><br>63-1159628 |     |

|               |                                      |
|---------------|--------------------------------------|
| <b>Part I</b> | <b>Asset and Liability Statement</b> |
|---------------|--------------------------------------|

**1** Current value of plan assets and liabilities at the beginning and end of the plan year. Combine the value of plan assets held in more than one trust. Report the value of the plan's interest in a commingled fund containing the assets of more than one plan on a line-by-line basis unless the value is reportable on lines 1c(9) through 1c(14). Do not enter the value of that portion of an insurance contract which guarantees, during this plan year, to pay a specific dollar benefit at a future date. **Round off amounts to the nearest dollar.** MTIAs, CCTs, PSAs, and 103-12 IEs do not complete lines 1b(1), 1b(2), 1c(8), 1g, 1h, and 1i. CCTs, PSAs, and 103-12 IEs also do not complete lines 1d and 1e. See instructions.

| Assets                                                                                            |                 | (a) Beginning of Year | (b) End of Year |
|---------------------------------------------------------------------------------------------------|-----------------|-----------------------|-----------------|
| <b>a</b> Total noninterest-bearing cash .....                                                     | <b>1a</b>       |                       |                 |
| <b>b</b> Receivables (less allowance for doubtful accounts):                                      |                 |                       |                 |
| <b>(1)</b> Employer contributions .....                                                           | <b>1b(1)</b>    |                       | 6584            |
| <b>(2)</b> Participant contributions .....                                                        | <b>1b(2)</b>    |                       | 17823           |
| <b>(3)</b> Other.....                                                                             | <b>1b(3)</b>    |                       |                 |
| <b>c</b> General investments:                                                                     |                 |                       |                 |
| <b>(1)</b> Interest-bearing cash (include money market accounts & certificates of deposit) .....  | <b>1c(1)</b>    |                       |                 |
| <b>(2)</b> U.S. Government securities.....                                                        | <b>1c(2)</b>    |                       |                 |
| <b>(3)</b> Corporate debt instruments (other than employer securities):                           |                 |                       |                 |
| <b>(A)</b> Preferred .....                                                                        | <b>1c(3)(A)</b> |                       |                 |
| <b>(B)</b> All other.....                                                                         | <b>1c(3)(B)</b> |                       |                 |
| <b>(4)</b> Corporate stocks (other than employer securities):                                     |                 |                       |                 |
| <b>(A)</b> Preferred .....                                                                        | <b>1c(4)(A)</b> |                       |                 |
| <b>(B)</b> Common .....                                                                           | <b>1c(4)(B)</b> |                       |                 |
| <b>(5)</b> Partnership/joint venture interests .....                                              | <b>1c(5)</b>    |                       |                 |
| <b>(6)</b> Real estate (other than employer real property) .....                                  | <b>1c(6)</b>    |                       |                 |
| <b>(7)</b> Loans (other than to participants) .....                                               | <b>1c(7)</b>    |                       |                 |
| <b>(8)</b> Participant loans .....                                                                | <b>1c(8)</b>    |                       |                 |
| <b>(9)</b> Value of interest in common/collective trusts.....                                     | <b>1c(9)</b>    |                       |                 |
| <b>(10)</b> Value of interest in pooled separate accounts.....                                    | <b>1c(10)</b>   | 2396974               | 3629587         |
| <b>(11)</b> Value of interest in master trust investment accounts .....                           | <b>1c(11)</b>   |                       |                 |
| <b>(12)</b> Value of interest in 103-12 investment entities .....                                 | <b>1c(12)</b>   |                       |                 |
| <b>(13)</b> Value of interest in registered investment companies (e.g., mutual funds).....        | <b>1c(13)</b>   |                       |                 |
| <b>(14)</b> Value of funds held in insurance company general account (unallocated contracts)..... | <b>1c(14)</b>   | 323354                | 474422          |
| <b>(15)</b> Other .....                                                                           | <b>1c(15)</b>   |                       |                 |

**1d** Employer-related investments:

|                                                                      |              | (a) Beginning of Year | (b) End of Year |
|----------------------------------------------------------------------|--------------|-----------------------|-----------------|
| (1) Employer securities .....                                        | <b>1d(1)</b> |                       |                 |
| (2) Employer real property .....                                     | <b>1d(2)</b> |                       |                 |
| <b>e</b> Buildings and other property used in plan operation .....   | <b>1e</b>    |                       |                 |
| <b>f</b> Total assets (add all amounts in lines 1a through 1e) ..... | <b>1f</b>    | 2720328               | 4128416         |

**Liabilities**

|                                                                           |           |   |   |
|---------------------------------------------------------------------------|-----------|---|---|
| <b>g</b> Benefit claims payable .....                                     | <b>1g</b> |   |   |
| <b>h</b> Operating payables .....                                         | <b>1h</b> |   |   |
| <b>i</b> Acquisition indebtedness .....                                   | <b>1i</b> |   |   |
| <b>j</b> Other liabilities .....                                          | <b>1j</b> |   |   |
| <b>k</b> Total liabilities (add all amounts in lines 1g through 1j) ..... | <b>1k</b> | 0 | 0 |

**Net Assets**

|                                                           |           |         |         |
|-----------------------------------------------------------|-----------|---------|---------|
| <b>l</b> Net assets (subtract line 1k from line 1f) ..... | <b>1l</b> | 2720328 | 4128416 |
|-----------------------------------------------------------|-----------|---------|---------|

**Part II Income and Expense Statement**

**2** Plan income, expenses, and changes in net assets for the year. Include all income and expenses of the plan, including any trust(s) or separately maintained fund(s) and any payments/receipts to/from insurance carriers. Round off amounts to the nearest dollar. MTIAs, CCTs, PSAs, and 103-12 IEs do not complete lines 2a, 2b(1)(E), 2e, 2f, and 2g.

**Income****a Contributions:**

|                                                                                                            |                 | (a) Amount | (b) Total |
|------------------------------------------------------------------------------------------------------------|-----------------|------------|-----------|
| (1) Received or receivable in cash from: <b>(A)</b> Employers .....                                        | <b>2a(1)(A)</b> | 178029     |           |
| <b>(B)</b> Participants .....                                                                              | <b>2a(1)(B)</b> | 470170     |           |
| <b>(C)</b> Others (including rollovers) .....                                                              | <b>2a(1)(C)</b> | 22264      |           |
| (2) Noncash contributions .....                                                                            | <b>2a(2)</b>    |            |           |
| (3) Total contributions. Add lines <b>2a(1)(A)</b> , <b>(B)</b> , <b>(C)</b> , and line <b>2a(2)</b> ..... | <b>2a(3)</b>    |            | 670463    |

**b Earnings on investments:****(1) Interest:**

|                                                                                                      |                 |  |   |
|------------------------------------------------------------------------------------------------------|-----------------|--|---|
| <b>(A)</b> Interest-bearing cash (including money market accounts and certificates of deposit) ..... | <b>2b(1)(A)</b> |  |   |
| <b>(B)</b> U.S. Government securities .....                                                          | <b>2b(1)(B)</b> |  |   |
| <b>(C)</b> Corporate debt instruments .....                                                          | <b>2b(1)(C)</b> |  |   |
| <b>(D)</b> Loans (other than to participants) .....                                                  | <b>2b(1)(D)</b> |  |   |
| <b>(E)</b> Participant loans .....                                                                   | <b>2b(1)(E)</b> |  |   |
| <b>(F)</b> Other .....                                                                               | <b>2b(1)(F)</b> |  |   |
| <b>(G)</b> Total interest. Add lines <b>2b(1)(A)</b> through <b>(F)</b> .....                        | <b>2b(1)(G)</b> |  | 0 |

|                                                                                           |                 |  |   |
|-------------------------------------------------------------------------------------------|-----------------|--|---|
| (2) Dividends: <b>(A)</b> Preferred stock .....                                           | <b>2b(2)(A)</b> |  |   |
| <b>(B)</b> Common stock .....                                                             | <b>2b(2)(B)</b> |  |   |
| <b>(C)</b> Registered investment company shares (e.g. mutual funds) .....                 | <b>2b(2)(C)</b> |  |   |
| <b>(D)</b> Total dividends. Add lines <b>2b(2)(A)</b> , <b>(B)</b> , and <b>(C)</b> ..... | <b>2b(2)(D)</b> |  | 0 |

|                 |              |  |  |
|-----------------|--------------|--|--|
| (3) Rents ..... | <b>2b(3)</b> |  |  |
|-----------------|--------------|--|--|

|                                                                                           |                 |  |   |
|-------------------------------------------------------------------------------------------|-----------------|--|---|
| (4) Net gain (loss) on sale of assets: <b>(A)</b> Aggregate proceeds .....                | <b>2b(4)(A)</b> |  |   |
| <b>(B)</b> Aggregate carrying amount (see instructions) .....                             | <b>2b(4)(B)</b> |  |   |
| <b>(C)</b> Subtract line <b>2b(4)(B)</b> from line <b>2b(4)(A)</b> and enter result ..... | <b>2b(4)(C)</b> |  | 0 |

|                                                                                                   |                 | (a) Amount | (b) Total |
|---------------------------------------------------------------------------------------------------|-----------------|------------|-----------|
| <b>2b</b> (5) Unrealized appreciation (depreciation) of assets: (A) Real estate.....              | <b>2b(5)(A)</b> |            |           |
| (B) Other .....                                                                                   | <b>2b(5)(B)</b> |            |           |
| (C) Total unrealized appreciation of assets.<br>Add lines <b>2b(5)(A)</b> and <b>(B)</b> .....    | <b>2b(5)(C)</b> |            | 0         |
| (6) Net investment gain (loss) from common/collective trusts .....                                | <b>2b(6)</b>    |            |           |
| (7) Net investment gain (loss) from pooled separate accounts .....                                | <b>2b(7)</b>    |            | 760845    |
| (8) Net investment gain (loss) from master trust investment accounts .....                        | <b>2b(8)</b>    |            |           |
| (9) Net investment gain (loss) from 103-12 investment entities .....                              | <b>2b(9)</b>    |            |           |
| (10) Net investment gain (loss) from registered investment<br>companies (e.g., mutual funds)..... | <b>2b(10)</b>   |            |           |
| <b>c</b> Other income.....                                                                        | <b>2c</b>       |            | 10930     |
| <b>d</b> Total income. Add all <b>income</b> amounts in column (b) and enter total.....           | <b>2d</b>       |            | 1442238   |

**Expenses**

|                                                                                            |              |       |       |
|--------------------------------------------------------------------------------------------|--------------|-------|-------|
| <b>e</b> Benefit payment and payments to provide benefits:                                 |              |       |       |
| (1) Directly to participants or beneficiaries, including direct rollovers .....            | <b>2e(1)</b> | 17373 |       |
| (2) To insurance carriers for the provision of benefits .....                              | <b>2e(2)</b> |       |       |
| (3) Other .....                                                                            | <b>2e(3)</b> |       |       |
| (4) Total benefit payments. Add lines <b>2e(1)</b> through <b>(3)</b> .....                | <b>2e(4)</b> |       | 17373 |
| <b>f</b> Corrective distributions (see instructions) .....                                 | <b>2f</b>    |       |       |
| <b>g</b> Certain deemed distributions of participant loans (see instructions).....         | <b>2g</b>    |       |       |
| <b>h</b> Interest expense.....                                                             | <b>2h</b>    |       |       |
| <b>i</b> Administrative expenses: (1) Professional fees .....                              | <b>2i(1)</b> |       |       |
| (2) Contract administrator fees .....                                                      | <b>2i(2)</b> | 16777 |       |
| (3) Investment advisory and management fees .....                                          | <b>2i(3)</b> |       |       |
| (4) Other .....                                                                            | <b>2i(4)</b> |       |       |
| (5) Total administrative expenses. Add lines <b>2i(1)</b> through <b>(4)</b> .....         | <b>2i(5)</b> |       | 16777 |
| <b>j</b> Total expenses. Add all <b>expense</b> amounts in column (b) and enter total..... | <b>2j</b>    |       | 34150 |

**Net Income and Reconciliation**

|                                                                               |              |  |         |
|-------------------------------------------------------------------------------|--------------|--|---------|
| <b>k</b> Net income (loss). Subtract line <b>2j</b> from line <b>2d</b> ..... | <b>2k</b>    |  | 1408088 |
| <b>l</b> Transfers of assets:                                                 |              |  |         |
| (1) To this plan.....                                                         | <b>2l(1)</b> |  | 0       |
| (2) From this plan .....                                                      | <b>2l(2)</b> |  | 0       |

**Part III Accountant's Opinion**

**3** Complete lines 3a through 3c if the opinion of an independent qualified public accountant is attached to this Form 5500. Complete line 3d if an opinion is not attached.

**a** The attached opinion of an independent qualified public accountant for this plan is (see instructions):

(1) ☐ Unqualified (2) ☐ Qualified (3) ☒ Disclaimer (4) ☐ Adverse

**b** Did the accountant perform a limited scope audit pursuant to 29 CFR 2520.103-8 and/or 103-12(d)? ☒ Yes ☐ No

**c** Enter the name and EIN of the accountant (or accounting firm) below:

(1) Name: L. PAUL KASSOUF & COMPANY, P.C.

(2) EIN: 63-0590670

**d** The opinion of an independent qualified public accountant is **not attached** because:

(1) ☐ This form is filed for a CCT, PSA, or MTIA. (2) ☐ It will be attached to the next Form 5500 pursuant to 29 CFR 2520.104-50.

**Part IV Compliance Questions**

- 4** CCTs and PSAs do not complete Part IV. MTIAs, 103-12 IEs, and GIAs do not complete 4a, 4e, 4f, 4g, 4h, 4k, 4m, 4n, or 5. 103-12 IEs also do not complete 4j and 4l. MTIAs also do not complete 4l.

During the plan year:

|                                                                                                                                                                                                                                                                                                                 | Yes | No | Amount |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----|----|--------|
| <b>a</b> Was there a failure to transmit to the plan any participant contributions within the time period described in 29 CFR 2510.3-102? Continue to answer "Yes" for any prior year failures until fully corrected. (See instructions and DOL's Voluntary Fiduciary Correction Program.).....                 |     | X  |        |
| <b>b</b> Were any loans by the plan or fixed income obligations due the plan in default as of the close of the plan year or classified during the year as uncollectible? Disregard participant loans secured by participant's account balance. (Attach Schedule G (Form 5500) Part I if "Yes" is checked.)..... |     | X  |        |
| <b>c</b> Were any leases to which the plan was a party in default or classified during the year as uncollectible? (Attach Schedule G (Form 5500) Part II if "Yes" is checked.) .....                                                                                                                            |     | X  |        |
| <b>d</b> Were there any nonexempt transactions with any party-in-interest? (Do not include transactions reported on line 4a. Attach Schedule G (Form 5500) Part III if "Yes" is checked.).....                                                                                                                  |     | X  |        |
| <b>e</b> Was this plan covered by a fidelity bond?.....                                                                                                                                                                                                                                                         | X   |    | 350000 |
| <b>f</b> Did the plan have a loss, whether or not reimbursed by the plan's fidelity bond, that was caused by fraud or dishonesty? .....                                                                                                                                                                         |     | X  |        |
| <b>g</b> Did the plan hold any assets whose current value was neither readily determinable on an established market nor set by an independent third party appraiser? .....                                                                                                                                      |     | X  |        |
| <b>h</b> Did the plan receive any noncash contributions whose value was neither readily determinable on an established market nor set by an independent third party appraiser? .....                                                                                                                            |     | X  |        |
| <b>i</b> Did the plan have assets held for investment? (Attach schedule(s) of assets if "Yes" is checked, and see instructions for format requirements.).....                                                                                                                                                   | X   |    |        |
| <b>j</b> Were any plan transactions or series of transactions in excess of 5% of the current value of plan assets? (Attach schedule of transactions if "Yes" is checked, and see instructions for format requirements.).....                                                                                    |     | X  |        |
| <b>k</b> Were all the plan assets either distributed to participants or beneficiaries, transferred to another plan, or brought under the control of the PBGC?.....                                                                                                                                              |     | X  |        |
| <b>l</b> Has the plan failed to provide any benefit when due under the plan? .....                                                                                                                                                                                                                              |     | X  |        |
| <b>m</b> If this is an individual account plan, was there a blackout period? (See instructions and 29 CFR 2520.101-3.).....                                                                                                                                                                                     |     | X  |        |
| <b>n</b> If 4m was answered "Yes," check the "Yes" box if you either provided the required notice or one of the exceptions to providing the notice applied under 29 CFR 2520.101-3. ....                                                                                                                        |     |    |        |

- 5a** Has a resolution to terminate the plan been adopted during the plan year or any prior plan year?  
If yes, enter the amount of any plan assets that reverted to the employer this year ..... ☐ Yes ☒ No Amount:

- 5b** If, during this plan year, any assets or liabilities were transferred from this plan to another plan(s), identify the plan(s) to which assets or liabilities were transferred. (See instructions.)

| 5b(1) Name of plan(s) | 5b(2) EIN(s) | 5b(3) PN(s) |
|-----------------------|--------------|-------------|
|                       |              |             |
|                       |              |             |
|                       |              |             |
|                       |              |             |

|                                                                                                                                                                                                                           |                                                                                                                                                                                                                                                                                            |                                                |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------|
| <b>SCHEDULE R</b><br><b>(Form 5500)</b><br><br>Department of the Treasury<br>Internal Revenue Service<br><br>Department of Labor<br>Employee Benefits Security Administration<br><br>Pension Benefit Guaranty Corporation | <b>Retirement Plan Information</b><br><br>This schedule is required to be filed under section 104 and 4065 of the Employee Retirement Income Security Act of 1974 (ERISA) and section 6058(a) of the Internal Revenue Code (the Code).<br><br>▶ <b>File as an attachment to Form 5500.</b> | OMB No. 1210-0110                              |
|                                                                                                                                                                                                                           |                                                                                                                                                                                                                                                                                            | <b>2009</b>                                    |
|                                                                                                                                                                                                                           |                                                                                                                                                                                                                                                                                            | <b>This Form is Open to Public Inspection.</b> |

For calendar plan year 2009 or fiscal plan year beginning 01/01/2009 and ending 12/31/2009

|                                                                                                  |                                                                    |
|--------------------------------------------------------------------------------------------------|--------------------------------------------------------------------|
| <b>A</b> Name of plan<br><u>EYECARE ASSOCIATES, INC. 401K PLAN</u>                               | <b>B</b> Three-digit plan number (PN) ▶<br><u>001</u>              |
| <b>C</b> Plan sponsor's name as shown on line 2a of Form 5500<br><u>EYECARE ASSOCIATES, INC.</u> | <b>D</b> Employer Identification Number (EIN)<br><u>63-1159628</u> |

|               |                      |
|---------------|----------------------|
| <b>Part I</b> | <b>Distributions</b> |
|---------------|----------------------|

All references to distributions relate only to payments of benefits during the plan year.

|                                                                                                                                                                                                                                                                    |          |          |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------|----------|
| <b>1</b> Total value of distributions paid in property other than in cash or the forms of property specified in the instructions.....                                                                                                                              | <b>1</b> | <u>0</u> |
| <b>2</b> Enter the EIN(s) of payor(s) who paid benefits on behalf of the plan to participants or beneficiaries during the year (if more than two, enter EINs of the two payors who paid the greatest dollar amounts of benefits):<br><br>EIN(s): <u>04-1590850</u> |          |          |
| Profit-sharing plans, ESOPs, and stock bonus plans, skip line 3.                                                                                                                                                                                                   |          |          |
| <b>3</b> Number of participants (living or deceased) whose benefits were distributed in a single sum, during the plan year.....                                                                                                                                    | <b>3</b> |          |

|                |                                                                                                                                                                              |
|----------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Part II</b> | <b>Funding Information</b> (If the plan is not subject to the minimum funding requirements of section 412 of the Internal Revenue Code or ERISA section 302, skip this Part) |
|----------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|

|                                                                                                                                                                                                                                                                                                                                                             |                              |                             |                              |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------|-----------------------------|------------------------------|
| <b>4</b> Is the plan administrator making an election under Code section 412(d)(2) or ERISA section 302(d)(2)?.....                                                                                                                                                                                                                                         | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> N/A |
| If the plan is a defined benefit plan, go to line 8.                                                                                                                                                                                                                                                                                                        |                              |                             |                              |
| <b>5</b> If a waiver of the minimum funding standard for a prior year is being amortized in this plan year, see instructions and enter the date of the ruling letter granting the waiver. Date: Month _____ Day _____ Year _____<br>If you completed line 5, complete lines 3, 9, and 10 of Schedule MB and do not complete the remainder of this schedule. |                              |                             |                              |
| <b>6 a</b> Enter the minimum required contribution for this plan year .....                                                                                                                                                                                                                                                                                 | <b>6a</b>                    |                             |                              |
| <b>b</b> Enter the amount contributed by the employer to the plan for this plan year .....                                                                                                                                                                                                                                                                  | <b>6b</b>                    |                             |                              |
| <b>c</b> Subtract the amount in line 6b from the amount in line 6a. Enter the result (enter a minus sign to the left of a negative amount).....                                                                                                                                                                                                             | <b>6c</b>                    |                             |                              |
| If you completed line 6c, skip lines 8 and 9.                                                                                                                                                                                                                                                                                                               |                              |                             |                              |
| <b>7</b> Will the minimum funding amount reported on line 6c be met by the funding deadline? .....                                                                                                                                                                                                                                                          | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> N/A |
| <b>8</b> If a change in actuarial cost method was made for this plan year pursuant to a revenue procedure providing automatic approval for the change or a class ruling letter, does the plan sponsor or plan administrator agree with the change?.....                                                                                                     | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> N/A |

|                 |                   |
|-----------------|-------------------|
| <b>Part III</b> | <b>Amendments</b> |
|-----------------|-------------------|

|                                                                                                                                                                                                                                |                                   |                                   |                               |                             |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------|-----------------------------------|-------------------------------|-----------------------------|
| <b>9</b> If this is a defined benefit pension plan, were any amendments adopted during this plan year that increased or decreased the value of benefits? If yes, check the appropriate box(es). If no, check the "No" box..... | <input type="checkbox"/> Increase | <input type="checkbox"/> Decrease | <input type="checkbox"/> Both | <input type="checkbox"/> No |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------|-----------------------------------|-------------------------------|-----------------------------|

|                |                                                                                                                                                   |
|----------------|---------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Part IV</b> | <b>ESOPs</b> (see instructions). If this is not a plan described under Section 409(a) or 4975(e)(7) of the Internal Revenue Code, skip this Part. |
|----------------|---------------------------------------------------------------------------------------------------------------------------------------------------|

|                                                                                                                                                                                              |                              |                             |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------|-----------------------------|
| <b>10</b> Were unallocated employer securities or proceeds from the sale of unallocated securities used to repay any exempt loan?.....                                                       | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| <b>11 a</b> Does the ESOP hold any preferred stock? .....                                                                                                                                    | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| <b>b</b> If the ESOP has an outstanding exempt loan with the employer as lender, is such loan part of a "back-to-back" loan? (See instructions for definition of "back-to-back" loan.) ..... | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| <b>12</b> Does the ESOP hold any stock that is not readily tradable on an established securities market? .....                                                                               | <input type="checkbox"/> Yes | <input type="checkbox"/> No |

For Paperwork Reduction Act Notice and OMB Control Numbers, see the instructions for Form 5500.

Schedule R (Form 5500) 2009  
v.092308.1

**Part V Additional Information for Multiemployer Defined Benefit Pension Plans**

**13** Enter the following information for each employer that contributed more than 5% of total contributions to the plan during the plan year (measured in dollars). See instructions. *Complete as many entries as needed to report all applicable employers.*

**a** Name of contributing employer

**b** EIN

**c** Dollar amount contributed by employer

**d** Date collective bargaining agreement expires (If employer contributes under more than one collective bargaining agreement, check box ☐ and see instructions regarding required attachment. Otherwise, enter the applicable date.) Month \_\_\_\_\_ Day \_\_\_\_\_ Year \_\_\_\_\_

**e** Contribution rate information (If more than one rate applies, check this box ☐ and see instructions regarding required attachment. Otherwise, complete items 13e(1) and 13e(2).)

(1) Contribution rate (in dollars and cents) \_\_\_\_\_

(2) Base unit measure: ☐ Hourly ☐ Weekly ☐ Unit of production ☐ Other (specify): \_\_\_\_\_

**a** Name of contributing employer

**b** EIN

**c** Dollar amount contributed by employer

**d** Date collective bargaining agreement expires (If employer contributes under more than one collective bargaining agreement, check box ☐ and see instructions regarding required attachment. Otherwise, enter the applicable date.) Month \_\_\_\_\_ Day \_\_\_\_\_ Year \_\_\_\_\_

**e** Contribution rate information (If more than one rate applies, check this box ☐ and see instructions regarding required attachment. Otherwise, complete items 13e(1) and 13e(2).)

(1) Contribution rate (in dollars and cents) \_\_\_\_\_

(2) Base unit measure: ☐ Hourly ☐ Weekly ☐ Unit of production ☐ Other (specify): \_\_\_\_\_

**a** Name of contributing employer

**b** EIN

**c** Dollar amount contributed by employer

**d** Date collective bargaining agreement expires (If employer contributes under more than one collective bargaining agreement, check box ☐ and see instructions regarding required attachment. Otherwise, enter the applicable date.) Month \_\_\_\_\_ Day \_\_\_\_\_ Year \_\_\_\_\_

**e** Contribution rate information (If more than one rate applies, check this box ☐ and see instructions regarding required attachment. Otherwise, complete items 13e(1) and 13e(2).)

(1) Contribution rate (in dollars and cents) \_\_\_\_\_

(2) Base unit measure: ☐ Hourly ☐ Weekly ☐ Unit of production ☐ Other (specify): \_\_\_\_\_

**a** Name of contributing employer

**b** EIN

**c** Dollar amount contributed by employer

**d** Date collective bargaining agreement expires (If employer contributes under more than one collective bargaining agreement, check box ☐ and see instructions regarding required attachment. Otherwise, enter the applicable date.) Month \_\_\_\_\_ Day \_\_\_\_\_ Year \_\_\_\_\_

**e** Contribution rate information (If more than one rate applies, check this box ☐ and see instructions regarding required attachment. Otherwise, complete items 13e(1) and 13e(2).)

(1) Contribution rate (in dollars and cents) \_\_\_\_\_

(2) Base unit measure: ☐ Hourly ☐ Weekly ☐ Unit of production ☐ Other (specify): \_\_\_\_\_

**a** Name of contributing employer

**b** EIN

**c** Dollar amount contributed by employer

**d** Date collective bargaining agreement expires (If employer contributes under more than one collective bargaining agreement, check box ☐ and see instructions regarding required attachment. Otherwise, enter the applicable date.) Month \_\_\_\_\_ Day \_\_\_\_\_ Year \_\_\_\_\_

**e** Contribution rate information (If more than one rate applies, check this box ☐ and see instructions regarding required attachment. Otherwise, complete items 13e(1) and 13e(2).)

(1) Contribution rate (in dollars and cents) \_\_\_\_\_

(2) Base unit measure: ☐ Hourly ☐ Weekly ☐ Unit of production ☐ Other (specify): \_\_\_\_\_

**a** Name of contributing employer

**b** EIN

**c** Dollar amount contributed by employer

**d** Date collective bargaining agreement expires (If employer contributes under more than one collective bargaining agreement, check box ☐ and see instructions regarding required attachment. Otherwise, enter the applicable date.) Month \_\_\_\_\_ Day \_\_\_\_\_ Year \_\_\_\_\_

**e** Contribution rate information (If more than one rate applies, check this box ☐ and see instructions regarding required attachment. Otherwise, complete items 13e(1) and 13e(2).)

(1) Contribution rate (in dollars and cents) \_\_\_\_\_

(2) Base unit measure: ☐ Hourly ☐ Weekly ☐ Unit of production ☐ Other (specify): \_\_\_\_\_

- 14** Enter the number of participants on whose behalf no contributions were made by an employer as an employer of the participant for:

|                                                                          |            |  |
|--------------------------------------------------------------------------|------------|--|
| <b>a</b> The current year .....                                          | <b>14a</b> |  |
| <b>b</b> The plan year immediately preceding the current plan year ..... | <b>14b</b> |  |
| <b>c</b> The second preceding plan year .....                            | <b>14c</b> |  |

- 15** Enter the ratio of the number of participants under the plan on whose behalf no employer had an obligation to make an employer contribution during the current plan year to:

|                                                                                                       |            |  |
|-------------------------------------------------------------------------------------------------------|------------|--|
| <b>a</b> The corresponding number for the plan year immediately preceding the current plan year ..... | <b>15a</b> |  |
| <b>b</b> The corresponding number for the second preceding plan year .....                            | <b>15b</b> |  |

- 16** Information with respect to any employers who withdrew from the plan during the preceding plan year:

|                                                                                                                                                                        |            |  |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------|--|
| <b>a</b> Enter the number of employers who withdrew during the preceding plan year .....                                                                               | <b>16a</b> |  |
| <b>b</b> If item 16a is greater than 0, enter the aggregate amount of withdrawal liability assessed or estimated to be assessed against such withdrawn employers ..... | <b>16b</b> |  |

- 17** If assets and liabilities from another plan have been transferred to or merged with this plan during the plan year, check box and see instructions regarding supplemental information to be included as an attachment. .... ☐

**Part VI Additional Information for Single-Employer and Multiemployer Defined Benefit Pension Plans**

- 18** If any liabilities to participants or their beneficiaries under the plan as of the end of the plan year consist (in whole or in part) of liabilities to such participants and beneficiaries under two or more pension plans as of immediately before such plan year, check box and see instructions regarding supplemental information to be included as an attachment ..... ☐

- 19** If the total number of participants is 1,000 or more, complete items (a) through (c)

**a** Enter the percentage of plan assets held as:  
 Stock: \_\_\_\_\_% Investment-Grade Debt: \_\_\_\_\_% High-Yield Debt: \_\_\_\_\_% Real Estate: \_\_\_\_\_% Other: \_\_\_\_\_%

**b** Provide the average duration of the combined investment-grade and high-yield debt:  
☐ 0-3 years ☐ 3-6 years ☐ 6-9 years ☐ 9-12 years ☐ 12-15 years ☐ 15-18 years ☐ 18-21 years ☐ 21 years or more

**c** What duration measure was used to calculate item 19(b)?  
☐ Effective duration ☐ Macaulay duration ☐ Modified duration ☐ Other (specify): \_\_\_\_\_

**EyeCare Associates, Inc.**

**401(k) Plan**

**Birmingham, Alabama**

**Financial Statements**

**December 31, 2009 and 2008**

EyeCare Associates, Inc.  
401(k) Plan  
Table of Contents  
December 31, 2009 and 2008

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**Independent Auditor's Report**

Trustee and Administrator  
EyeCare Associates, Inc.  
401(k) Plan  
Birmingham, Alabama

We were engaged to audit the financial statements of Eyecare Associates, Inc. 401(k) Plan as of December 31, 2009 and 2008, and for the years ended December 31, 2009 and 2008, and the supplemental schedule as of and for the year ended December 31, 2009 as listed in the accompanying table of contents. These financial statements and schedule are the responsibility of the Plan's management.

As permitted by 29 CFR 2520.103-8 of the Department of Labor's Rules and Regulations for Reporting and Disclosure under the Employee Retirement Income Security Act of 1974, the Plan administrator instructed us not to perform, and we did not perform, any auditing procedures with respect to the information summarized in Note 2, which was certified by Massachusetts Mutual Life Insurance Company, the custodian of the Plan, except for comparing the information with the related information included in the financial statements and supplemental schedule. We have been informed by the Plan administrator that the custodian holds the Plan's investment assets and executes investment transactions. The Plan administrator obtained certification from the custodian as of and for the years ended December 31, 2009 and 2008, that the information provided to the Plan administrator by the custodian is complete and accurate.

Because of the significance of the information that we did not audit, we are unable to, and do not express an opinion on the accompanying financial statements and schedule taken as a whole. The form and content of the information included in the financial statements and schedule, other than that derived from the information certified by the custodian, have been audited by us in accordance with auditing standards generally accepted in the United States of America and, in our opinion, are presented in compliance with the Department of Labor's Rules and Regulations for Reporting and Disclosure under the Employee Retirement Income Security Act of 1974.

L. PAUL KASSOUF & CO., P. C.

*L. Paul Kassouf & Co.*

Certified Public Accountants

July 14, 2010

**EyeCare Associates, Inc.**  
**401(k) Plan**  
**Statements of Net Assets Available for Benefits**  
**December 31, 2009 and 2008**

|                                                                                                | 2009                       | 2008                       |
|------------------------------------------------------------------------------------------------|----------------------------|----------------------------|
| <b>Assets</b>                                                                                  |                            |                            |
| <b>Investments</b>                                                                             |                            |                            |
| Pooled separate accounts                                                                       | \$ 3,629,587               | \$ 2,396,974               |
| Guaranteed investment contracts                                                                | 494,478                    | 300,612                    |
| Total Investments                                                                              | <u>4,124,065</u>           | <u>2,697,586</u>           |
| <b>Receivables</b>                                                                             |                            |                            |
| Employer contribution                                                                          | 6,584                      | -                          |
| Participant contributions                                                                      | 17,823                     | -                          |
| Total Receivables                                                                              | <u>24,407</u>              | <u>-</u>                   |
| <b>Liabilities</b>                                                                             | <u>-</u>                   | <u>-</u>                   |
| <b>Net Assets Available for Benefits at Fair Value</b>                                         | 4,148,472                  | 2,697,586                  |
| Adjustment from fair value to contract value for fully-benefit responsive investment contracts | <u>(20,056)</u>            | <u>22,742</u>              |
| <b>Net Assets Available for Benefits</b>                                                       | <u><u>\$ 4,128,416</u></u> | <u><u>\$ 2,720,328</u></u> |

See independent auditor's report and accompanying notes.

**EyeCare Associates, Inc.**  
**401(k) Plan**  
**Statements of Changes in Net Assets Available for Benefits**  
**December 31, 2009 and 2008**

|                                                              | 2009                | 2008                |
|--------------------------------------------------------------|---------------------|---------------------|
| <b>Additions to Net Assets Attributed to:</b>                |                     |                     |
| <b>Contributions</b>                                         |                     |                     |
| Employer                                                     | \$ 178,029          | \$ 169,569          |
| Employee                                                     | 470,170             | 446,353             |
| Rollover                                                     | 22,264              | -                   |
| Total Contributions                                          | <u>670,463</u>      | <u>615,922</u>      |
| <b>Investment Income</b>                                     |                     |                     |
| Investment interest                                          | 10,930              | 5,660               |
| Net appreciation (depreciation) in fair value of investments | 760,845             | (1,170,855)         |
| Net Investment Income                                        | <u>771,775</u>      | <u>(1,165,195)</u>  |
| Total Additions                                              | <u>1,442,238</u>    | <u>(549,273)</u>    |
| <b>Deductions from Net Assets Attributed to:</b>             |                     |                     |
| Benefit payments                                             | 17,373              | 44,253              |
| Administrative expenses                                      | 16,777              | 16,640              |
| Total Deductions                                             | <u>34,150</u>       | <u>60,893</u>       |
| Net increase (decrease)                                      | 1,408,088           | (610,166)           |
| <b>Net Assets Available for Benefits:</b>                    |                     |                     |
| Beginning of year                                            | <u>2,720,328</u>    | <u>3,330,494</u>    |
| End of year                                                  | <u>\$ 4,128,416</u> | <u>\$ 2,720,328</u> |

See independent auditor's report and accompanying notes.

**EyeCare Associates, Inc.**  
**401(k) Plan**  
**Notes to Financial Statements**  
**December 31, 2009 and 2008**

Note 1. Description of Plan and Summary of Accounting Policies

Description of Plan

The following description of the EyeCare Associates, Inc. 401(k) Plan (the Plan) provides general information. Participants should refer to the Plan agreement for a complete description of the Plan's provisions.

- A. **General** - The Plan is a defined contribution plan created on January 1, 2002, covering substantially all full-time employees of EyeCare Associates, Inc. (the Company) who have at least one year of service (1,000 hours), and have attained age twenty-one or older. The Plan is subject to the provisions of the Employee Retirement Income Security Act of 1974 (ERISA).
- B. **Contributions** - Each year, participants may contribute a percentage of pretax annual compensation, as defined in the Plan. Participants may also contribute amounts representing distributions from other qualified defined benefit or contribution plans. The Company's matching contribution is calculated as 100 percent of the first three percent deferred by the participant, with an additional 50 percent of the deferral between three and five percent. Additional amounts may be contributed at the option of the Company's board of directors. Contributions are subject to certain limitations.
- C. **Participant Accounts** - Each participant's account is credited with the participant's contribution and allocation of (a) the Company's contribution and, (b) Plan earnings, and charged with an allocation of administrative expenses. Allocations are based on participant earnings or account balances, as defined in the Plan agreement. The benefit to which a participant is entitled is the benefit that can be provided from the participant's vested account.
- D. **Vesting** - Participants are 100 percent vested in the contribution portion of their accounts (with exception to certain discretionary contributions made by the Company) plus actual earnings. Certain discretionary Company contributions are 100 percent vested after six years of credited service.
- E. **Investment Options** - A participant may direct account balances and contributions in one percent increments into any of the pooled separate accounts and guaranteed investment accounts offered by Massachusetts Mutual Life Insurance Company (Mass Mutual). Participants may change investment options daily.

**EyeCare Associates, Inc.**  
**401(k) Plan**  
**Notes to Financial Statements - Continued**  
**December 31, 2009 and 2008**

Note 1. Description of Plan and Summary of Accounting Policies - Continued

- F. **Forfeited Accounts** - If any portion of a participant's matching contribution account is forfeited during a plan year, it will be used to reduce the employer matching fund contribution and allocated among the accounts of the participants who receive a matching contribution for the plan year based on their compensation. At December 31, 2009 and 2008, the Plan did not hold a balance in its forfeited nonvested account.
- G. **Payment of Benefits** - Upon retirement, death or disability, a participant (or beneficiary) may elect to receive the entire amount of his/her account in one lump sum payment. If employment is terminated for reasons other than retirement, death or disability, participants may be entitled to all or part of their account, depending on their vesting percentage.
- H. **Administration** - The Plan's administrator is the Company. Mass Mutual Insurance Company (Mass Mutual) is the appointed custodian of the Plan. Certain administrative expenses are paid directly by the Company. Administrative and trust expenses paid by the Company and not charged to the plan were \$5,169 and \$5,863 for the years ended December 31, 2009 and 2008, respectively. Fees paid to national broker-dealers for the maintenance and custody of the Plan's assets are paid from the assets of the Plan.

Basis of Accounting

The Plan's policy is to prepare their financial statements on the accrual basis of accounting in accordance with accounting principles generally accepted in the United States of America. Revenues are recognized in the period in which they are earned. Expenses are recognized in the period in which they are incurred.

As described in Financial Accounting Standards Board Staff Position, FSP AAG INV-1 and SOP 94-4-1, Reporting of Fully Benefit-Responsive Investment Contracts Held by Certain Investment Companies Subject to the AICPA Investment Company Guide and Defined Contribution Health and Welfare and Pension Plans (the "FSP"), investment contracts held by a defined contribution plan are required to be reported at fair value. However, contract value is the relevant measurement attribute for that portion of the net assets available for benefits of a defined-contribution plan attributable to fully benefit-responsive investment contracts because contract value is the amount participants would receive if they were to initiate permitted transactions under the terms of the Plan. As required by the FSP, the statement of net assets available for benefits should present the fair value of the investment contracts as well as the adjustment of the fully benefit-responsive investment contracts from fair value to contract value. The statement of changes in net assets available for benefits is prepared on a contract value basis.

**EyeCare Associates, Inc.**  
**401(k) Plan**  
**Notes to Financial Statements - Continued**  
**December 31, 2009 and 2008**

Note 1. Description of Plan and Summary of Accounting Policies - Continued

The pooled separate accounts are stated at fair value based on quoted market prices, if available. Guaranteed investment contracts are stated at net contract value.

Purchases and sales of securities are recorded on a trade-date basis. Net appreciation or depreciation in fair value of investments is the difference between the proceeds received or aggregate fair market value of investments determined at the end of the year and the aggregate fair value of investments determined at the beginning of the year or cost if acquired during the year. Dividends are recorded on the ex-dividend date.

Estimates

The preparation of financial statements in conformity with accounting principles generally accepted in the United States of America requires the Plan Administrator to make estimates and assumptions that affect certain reported amounts and disclosures. Accordingly, actual results may differ from those estimates.

Payment of Benefits

Benefits are recorded when paid.

Note 2. Information Prepared and Certified by Custodian (Unaudited)

The following information included in the accompanying financial statements was obtained from data that has been prepared and certified as complete and accurate by the custodian.

Certain balances shown below may differ from the accompanying financial statements due to in-transit items at December 31, 2009 and 2008.

|                                 | 2009         | 2008         |
|---------------------------------|--------------|--------------|
| Investments:                    |              |              |
| Pooled separate accounts        | \$ 3,629,587 | \$ 2,396,974 |
| Guaranteed investment contracts | 494,478      | 300,612      |
| Investment income               | 771,775      | (1,165,195)  |

**EyeCare Associates, Inc.**  
**401(k) Plan**  
**Notes to Financial Statements - Continued**  
**December 31, 2009 and 2008**

**Note 3. Investment Contract with Insurance Contract**

MassMutual Retirement Services' (MMRS) general investment account investment option for defined contribution plans is a guaranteed interest account provided through a group annuity contract. Under the terms of the group annuity contract, a crediting rate is established for amounts invested in the guaranteed interest account and participants may direct permitted withdrawal and/or transfer transactions of all or a portion of their account balance at contract value. Contract value represents contributions plus credited interest less participant withdrawals and fees. Contract value is also often referred to as "Book Value". MMRS considers this investment option to be fully benefit-responsive notwithstanding the liquidation value events under the contract that limit the ability of the plan to transact at contract value. The fair value presented below represents the estimated liquidation value determined within contract specifications (see the termination provisions stated within the contract). During 2008, MMRS modified the guaranteed interest account liquidation formula by changing the index used as the prevailing market rate from the Moody's Baa Corporate Bond Yield Average Index to the Lehman Brothers U.S. Aggregate Index, excluding treasuries. (Note that during the fourth quarter of 2008, the Lehman indices have been rebranded by Barclays Capital under the "Barclays Capital Indices"). The plan's contract has a liquidation formula with the Moody's index, MMRS would give contract holders upon discontinuance the option of using either the Moody's or the Lehman (Barclays Capital) index when calculating the liquidation value, depending on which produces the higher value. As of December 31, 2009, MMRS' good faith estimate of fair value, in all instances, is based on the Lehman (Barclays Capital) index.

As described in Note 1, because the guaranteed investment contract is fully benefit-responsive, contract value is the relevant measurement attribute for that portion of the net assets available for benefits attributable to the guaranteed investment contract. Contract value, as reported to the plan by MMRS, represents contributions plus credited interest less participant withdrawals and fees. Participants may ordinarily direct the withdrawal or transfer of all or a portion of their investment at contract value.

There are no reserves against contract value for credit risk of the contract issuer or otherwise. The fair value of the investment contract at December 31, 2009 and 2008 was \$494,478 and \$300,612, respectively. Under the terms of the group annuity contract, a crediting rate is established for amounts invested in the guaranteed interest account.

**EyeCare Associates, Inc.**  
**401(k) Plan**  
**Notes to Financial Statements - Continued**  
**December 31, 2009 and 2008**

**Note 3. Investment Contract with Insurance Contract - Continued**

Certain events may limit the ability of the Plan to transact at contract value. Such events include, but may not be limited to, the following: (1) temporary absence; (2) change in position or other occurrence qualifying as a temporary break in service under the Plan; (3) transfer or other change in position resulting in employment by an entity controlling, controlled by, or under common control with the employer; (4) cessation of an employment relationship resulting from an reorganization, merger, layoff or sale or discontinuance of all or any part of the Plan sponsor's business; (5) removal from the plan of one or more groups or classifications of participants; (6) partial or complete plan termination; or (7) plan disqualification.

The guaranteed investment contract does not permit the insurance company to terminate the agreement prior to the scheduled maturity date.

|                                                 |             |             |
|-------------------------------------------------|-------------|-------------|
| Average Yields:                                 | <b>2009</b> | <b>2008</b> |
| Based on actual earnings                        | 2.75%       | 2.85%       |
| Based on interest rate credited to participants | 2.75%       | 2.85%       |

**Note 4. Plan Termination**

Although it has not expressed any intent to do so, the Company has the right under the Plan to discontinue its contributions at any time and to terminate the Plan subject to the provisions of ERISA.

**Note 5. Tax Status**

On January 1, 2007, the Plan administrator submitted a certification to the Internal Revenue Service stating that they intended to adopt a prototype plan that qualifies under Section 401 (a) of the Internal Revenue Code. A determination letter specific to the Plan has not been received; however, the Plan administrator believes that the Plan is currently being operated in accordance with the Internal Revenue Code.

**Note 6. Risks and Uncertainties**

The Plan may invest in various types of investment securities. Investment securities are exposed to various risks, such as interest rate, market, and credit risks. Due to the level of risk associated with certain investment securities, it is at least reasonably possible that changes in the values of investment securities will occur in the near term and that such changes could materially affect the amounts reported in the statement of net assets available for plan benefits.

**EyeCare Associates, Inc.**  
**401(k) Plan**  
**Notes to Financial Statements - Continued**  
**December 31, 2009 and 2008**

**Note 7. Related Party Transactions**

The investments of the Plan are shares of mutual funds managed by the custodian, and therefore, these transactions qualify as party-in-interest transactions.

**Note 8. Investments**

The Plan maintained investments in the following pooled separate accounts and guaranteed investment contracts that represent more than 5% of the Plan's net assets:

|                                 | <b>2009</b> | <b>2008</b> |
|---------------------------------|-------------|-------------|
| Pooled separate accounts:       |             |             |
| Aggressive Journey              | \$ 911,826  | \$ 556,026  |
| Growth America                  | 270,045     | *           |
| International Value             | 217,354     | *           |
| Moderate Journey                | 746,885     | 617,591     |
| Premier Core Bond               | *           | 159,468     |
| Select Focused Value            | *           | 241,041     |
| Select Large Cap Value          | *           | 179,374     |
| Total Return                    | 366,338     | *           |
| Value MFS                       | 650,217     | *           |
| Guaranteed Investment Contracts | 494,478     | 300,612     |

\* Less than 5%

**Note 9. ERISA Bond Requirement**

The Employee Retirement Income Security Act of 1974 (ERISA) requires that every person who handles funds or other property of the Plan be bonded. The bond coverage is to be determined by the balance of the total plan assets, and is required to be the lesser of 10% of the plan's assets at the beginning of the plan year or \$500,000. At December 31, 2009 and 2008, the Plan's sponsor maintained bond coverage in the amount of \$350,000.

**Note 10. Amendments**

There were no amendments to the Plan for the year ended December 31, 2009 or through the date of our report.

**EyeCare Associates, Inc.**  
**401(k) Plan**  
**Notes to Financial Statements - Continued**  
**December 31, 2009 and 2008**

Note 11. Fair Value of Assets and Liabilities

Effective January 1, 2008, the Plan adopted Statement of Financial Accounting Standards No. 157, Fair Value Measurements (SFAS 157), which provides a framework for measuring fair value under GAAP. Subsequent to adoption, SFAS 157 was incorporated in the FASB Accounting Standards Codification as FASB ASC 820 (ASC 820). FASB ASC 820 defines fair value as the exchange price that would be received for an asset or paid to transfer a liability (an exit price) in the principal or most advantageous market for the asset or liability in an orderly transaction between market participants on the measurement date. FASB ASC 820 requires that valuation techniques maximize the use of observable input and minimize the use of unobservable inputs. ASC 820 also establishes a fair value hierarchy, which prioritizes the valuation inputs into three broad levels.

Level 1 Inputs to the valuation methodology are unadjusted prices for identical assets or liabilities in active markets that the Plan has the ability to access.

Level 2 Inputs to the valuation methodology include:

- Quoted prices for similar assets or liabilities in active markets;
- Quoted prices for identical or similar assets in inactive markets;
- Inputs other than quoted prices that are observable for the asset or liability;
- Inputs that are derived principally from or corroborated by observable market data by correlation or other means.

If the asset or liability has specified (contractual) term, the Level 2 input must be observable for substantially the full term of the asset or liability.

Level 3 Inputs to the valuation methodology are unobservable and significant to the fair value measurement.

The asset's or liability's fair value measurement level within the fair value hierarchy is based on the lowest level any input that is significant to the fair value measurement. Valuation techniques used need to maximize the use of observable inputs and minimize the use of unobservable inputs.

Following is a description of the valuation methodologies used for assets measured at fair value. There have been no changes in the methodologies used at December 31, 2009 and 2008.

*Common stock, corporate bonds and U.S. government securities:* Valued at the closing price reported on the active market on which the individual securities are traded.

*Mutual funds:* Valued at the net asset value ("NAV") of shares held by the plan at year end.

**EyeCare Associates, Inc.**  
**401(k) Plan**  
**Notes to Financial Statements - Continued**  
**December 31, 2009 and 2008**

Note 11. Fair Value of Assets and Liabilities - Continued

*Guaranteed investment contract:* Valued at fair value by discounting the related cash flows based on current yields of similar instruments with comparable durations considering the credit-worthiness of the issuer.

The methods described above may produce a fair value calculation that may not be indicative of net realizable value or reflective of future fair values. Furthermore, while the Plan believes its valuation methods are appropriate and consistent with other market participants, the use of different methodologies or assumptions to determine the fair value of certain financial instruments could result in a different fair value measurement at the reporting date.

Assets and liabilities itemized below were measured at fair value during the year ended December 31, 2009 using the market and income approaches. The market approach and income approach was used for Level 2 and Level 3, respectively.

|                                 | <u>Fair Value</u>   | <u>Level 1</u> | <u>Level 2</u>      | <u>Level 3</u>    |
|---------------------------------|---------------------|----------------|---------------------|-------------------|
| Investment in mutual funds      | \$ 3,629,587        | \$ -           | \$ 3,629,587        | \$ -              |
| Guaranteed investment contracts | 494,478             | -              | -                   | 494,478           |
| Total                           | <u>\$ 4,124,065</u> | <u>\$ -</u>    | <u>\$ 3,629,587</u> | <u>\$ 494,478</u> |

Level 3 Gains and Losses

The following table sets forth a summary of changes in the fair value of the Plan's level 3 assets for the year ended December 31, 2009.

|                                                    | <u>Guaranteed investment contract</u> |
|----------------------------------------------------|---------------------------------------|
| Beginning of year                                  | \$ 300,612                            |
| Total gain (loss) realized and unrealized          | 42,797                                |
| Purchases, sales, issuances, and settlements (net) | 151,069                               |
| End of year                                        | <u>\$ 494,478</u>                     |

**EyeCare Associates, Inc.**  
**401(k) Plan**  
**Notes to Financial Statements - Continued**  
**December 31, 2009 and 2008**

Note 12.     Income Taxes

In June 2006, the Financial Accounting Board (FASB) issued FIN 48, "Accounting for Uncertainty in Income Taxes," an interpretation of FASB Statement No. 109, that clarifies the accounting and recognition for income tax positions taken or expected to be taken in the Plan's income tax returns. FIN 48 was incorporated in the FASB codification as ASC 740-10. The Plan's income tax filings are subject to audit by various taxing authorities. The Plan has evaluated its tax positions and interpretations, and believes its positions are appropriate based on current facts and circumstances.

Note 13.     Subsequent Events

The Plan administrator of the Eyecare Associates, Inc. 401(k) Plan has evaluated events through July 14, 2010, the date which the financial statements were available to be issued.

## **Supplemental Information**

**Eyecare Associates, Inc. 401(k) Plan**  
 EIN 63-1159628      PLN 001  
 Attachment to Form 5500 Schedule H Item 4i

**Schedule of Assets Held for Investment Purposes at End of Year**

| (A) | (B) Identity of issuer, borrower, lessor,<br>or similar party | (C) Description of investment including<br>maturity date, rate of interest,<br>collateral, par or maturity value | (D) Cost | (E) Current value   |
|-----|---------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------|----------|---------------------|
| *   | Mass Mutual Life Insurance Company (USA)                      | Agressive Journey                                                                                                | **       | \$ 911,826          |
| *   | Mass Mutual Life Insurance Company (USA)                      | Conservative Journey                                                                                             | **       | 43,288              |
| *   | Mass Mutual Life Insurance Company (USA)                      | Growth America (American)                                                                                        | **       | 270,045             |
| *   | Mass Mutual Life Insurance Company (USA)                      | Guaranteed Interest Account                                                                                      | **       | 494,478             |
| *   | Mass Mutual Life Insurance Company (USA)                      | Holding account                                                                                                  | **       | 4                   |
| *   | Mass Mutual Life Insurance Company (USA)                      | International Value (Thornburg)                                                                                  | **       | 217,354             |
| *   | Mass Mutual Life Insurance Company (USA)                      | Mid Cap Growth (JemnisonDryden)                                                                                  | **       | 1,994               |
| *   | Mass Mutual Life Insurance Company (USA)                      | Mid Cap Value (Perkins)                                                                                          | **       | 2,928               |
| *   | Mass Mutual Life Insurance Company (USA)                      | Moderate Journey                                                                                                 | **       | 746,885             |
| *   | Mass Mutual Life Insurance Company (USA)                      | NFJ Small Cap Val (Allianz)                                                                                      | **       | 1,085               |
| *   | Mass Mutual Life Insurance Company (USA)                      | Prm Money Mrkt (Babson)                                                                                          | **       | 54,855              |
| *   | Mass Mutual Life Insurance Company (USA)                      | Sel Indexed Eqty (Northrn Trst)                                                                                  | **       | 185,419             |
| *   | Mass Mutual Life Insurance Company (USA)                      | Small Cap Growth (Van Kampen)                                                                                    | **       | 118,352             |
| *   | Mass Mutual Life Insurance Company (USA)                      | Total Return (PIMCO)                                                                                             | **       | 366,338             |
| *   | Mass Mutual Life Insurance Company (USA)                      | Ultra Agressive Journey                                                                                          | **       | 58,997              |
| *   | Mass Mutual Life Insurance Company (USA)                      | Value (MFS)                                                                                                      | **       | 650,217             |
|     |                                                               |                                                                                                                  |          | <u>\$ 4,124,065</u> |

\* A party-in-interest as defined by ERISA.

\*\* Cost omitted for participant-directed investments

See independent auditors report and accompanying notes.

**EYECARE ASSOCIATES, INC.**  
**401(K) PLAN**  
EIN 63-1287956      PLN 001  
Attachment to Form 5500 Schedule H Item 4i

**SCHEDULE OF ASSETS HELD FOR INVESTMENT PURPOSES AT END OF YEAR**

| (A) | (B) Identity of Issue, Borrower, Lessor, or similar party | (C) Description of investment including maturity date,<br>rate of interest, collateral, par or maturity value | (D) Cost | (E) Current Value |
|-----|-----------------------------------------------------------|---------------------------------------------------------------------------------------------------------------|----------|-------------------|
| *   | MassMutual                                                | Guaranteed Interest Account                                                                                   | 474,422  | 474,422           |
| *   | MassMutual                                                | Holding Account-SIA-AG                                                                                        | 0        | 4                 |
| *   | MassMutual                                                | SIA-AC                                                                                                        | 0        | 0                 |
| *   | MassMutual                                                | SIA-AD                                                                                                        | 0        | 0                 |
| *   | MassMutual                                                | SIA-AE                                                                                                        | 0        | 0                 |
| *   | MassMutual                                                | SIA-AG                                                                                                        | 54,506   | 54,855            |
| *   | MassMutual                                                | SIA-AI                                                                                                        | 0        | 0                 |
| *   | MassMutual                                                | SIA-AJ                                                                                                        | 0        | 0                 |
| *   | MassMutual                                                | SIA-AV                                                                                                        | 0        | 0                 |
| *   | MassMutual                                                | SIA-AX                                                                                                        | 185,065  | 185,419           |
| *   | MassMutual                                                | SIA-DA                                                                                                        | 846,213  | 911,826           |
| *   | MassMutual                                                | SIA-DC                                                                                                        | 39,170   | 43,288            |
| *   | MassMutual                                                | SIA-DE                                                                                                        | 49,181   | 58,997            |
| *   | MassMutual                                                | SIA-DJ                                                                                                        | 186,026  | 217,354           |
| *   | MassMutual                                                | SIA-DM                                                                                                        | 669,376  | 746,885           |
| *   | MassMutual                                                | SIA-HW                                                                                                        | 233,880  | 270,045           |
| *   | MassMutual                                                | SIA-OC                                                                                                        | 0        | 0                 |
| *   | MassMutual                                                | SIA-RD                                                                                                        | 103,631  | 118,352           |
| *   | MassMutual                                                | SIA-T                                                                                                         | 1,858    | 1,994             |
| *   | MassMutual                                                | SIA-TI                                                                                                        | 2,833    | 2,928             |
| *   | MassMutual                                                | SIA-UV                                                                                                        | 562,898  | 650,217           |
| *   | MassMutual                                                | SIA-WW                                                                                                        | 1,048    | 1,085             |
| *   | MassMutual                                                | SIA-WZ                                                                                                        | 344,038  | 366,338           |