

Southern Medical Corporation



A Cardiovascular Resource Company

2009 Benefit Summary

The following is a list of all benefits provided to or for Southern Medical Corporation full-time employees:

1. **Health Insurance** (Blue Cross Blue Shield) – Portion of employee premium paid by SMC.
2. **Dental Insurance** (AlwaysCare Dental) – Portion of employee premium paid by SMC.
3. **Vision Insurance** (AlwaysCare Vision) – Portion of employee premium paid by SMC.
4. **Life Insurance** (Assurant, \$15,000) – Employee premium paid 100% by SMC.
5. **Long Term Disability** (Assurant) – Employee premium paid 100% by SMC.
6. **Retirement Plan** (Fidelity 401K) – SMC will match up to 5% of contributions. See enclosed information for further details of eligibility and participation.
7. **Additional Insurance** (Colonial Life) – Colonial Life offers our employees additional coverage for Short-Term Disability, Long-Term Disability, Accident, Cancer, Critical Illness, and Life Insurance. Any of these plans may be purchased in addition to the employee's other benefits. SMC will pay up to \$15.00 per month toward the employee's premium; any amount over the allowable bank (\$15.00) is paid by the employee via bi-weekly payroll deduction.
8. **Vacation, sick days, etc.** are explained in the policy manual.

Notes:

Upon termination of employment, health insurance benefits will be offered to former employee under Cobra plan and Colonial premiums will become the sole responsibility of the former employee.

Employee becomes eligible for coverage on the 1st of the month following 30 days of employment.



BLUE CROSS BLUE SHIELD



Option #1

PremierBlue – PPO

Health Insurance

BENEFIT	PREFERRED PROVIDER ORGANIZATION	
	In-Network	Out of Network
Calendar Year Deductible Individual Family	\$500 Three per Family	
Coinsurance Limit Individual Family	\$3,000 \$6,000	
Coinsurance	90%	70%
Lifetime Maximum	\$5,000,000	
Physician In - Office Visits	\$30 Co-pay per visit	70% after deductible
Wellness Option	No deductible then 100%	70% after deductible
Physician Inpatient Services	90% after deductible	70% after deductible
Surgery	90% after deductible	70% after deductible
Hospital Inpatient Coverage	90% after deductible	70% after deductible
Hospital Outpatient Coverage	90% after deductible	70% after deductible
Accidental Injury Benefit	100% up to \$300, then subject to a deductible & 90% coinsurance	100% up to \$300, then subject to the deductible & 70% coinsurance
Diagnostic X-Ray & Laboratory	90% after deductible	70% after deductible
Mental & Nervous Disorders Inpatient – 45 days per Cal Yr Outpatient – 52 visits per Cal Yr	90% after deductible 90% after deductible	70% after deductible 70% after deductible
*Alcohol & Drug Addiction Inpatient – 7 days per Cal Yr Outpatient – 20 Visits per Cal Yr	90% after deductible 90% after deductible	70% after deductible 70% after deductible
*Note: Coinsurance for Alcohol & Drug Addiction does not accrue towards the Out of Pocket Maximum		
Prescription Drug Co-payments <i>Refer to the contract for applicable supply limitations</i> <i>Retail – up to 30 day supply</i> <i>Mail Order – up to 90 day supply</i> <i>[Prescription Drug Deductible]</i>	Generic / Preferred Brand / Non-Preferred Brand / Multi-Source / Injectables Contraceptives Included – \$4 / \$30 / \$55 / \$70 / \$50 \$12 / \$75 / \$120 / \$165 / \$150 [\$100 per family member/per Calendar Year]	

Providers for this PPO plan are listed in the BlueCross & Blue Shield of Louisiana PremierBlue Provider Network Directory or any Blue Cross & Blue Shield Blue Card PPO [directory](#) nationwide.

This outline is presented for general information only. It is not a contract, nor intended to be a contract. If there is any discrepancy between this document and the Benefit Plan, the provisions of the Benefit Plan will govern. *Out of Network Deductible and Out of Pocket amounts will be credited toward the In Network Deductible and Out of Pocket. In Network Deductibles and Out of Pocket amount will not be credited towards the Out of Network Deductible and Out of Pocket.

BCBSLA Customer Service: 1-800-599-2583

Express Script Customer Service: 1-866-781-7533



BLUE CROSS BLUE SHIELD



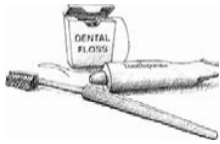
Option #2

Blue Savor – HSA

Health Insurance

BENEFIT	PREFERRED PROVIDER ORGANIZATION	
	In-Network	Out of Network
Calendar Year Deductible Individual Family (aggregate)	\$1,700 \$3,450*	
*(The family aggregate deductible applies for contracts with more than 1 member)		
Coinsurance Limit Individual Family (aggregate) Includes deductible & eligible coinsurance	\$3,000 \$6,000	
*(The family aggregate Coinsurance applies for contracts with more than 1 member)		
Coinsurance	100%	80%
Lifetime Maximum	\$5,000,000	
Physician Office Visits	\$100 after deductible	80% after deductible
Wellness Option	100% not subject to deductible	80% not subject to deductible
Physician Inpatient Services	100% after deductible	80% after deductible
Surgery	100% after deductible	80% after deductible
Hospital Inpatient Coverage	100% after deductible	80% after deductible
Hospital Outpatient Coverage	100% after deductible	80% after deductible
Diagnostic X-Ray & Laboratory	100% after deductible	80% after deductible
Mental & Nervous Disorders Inpatient – 45 days per Cal Yr Outpatient – 52 visits per Cal Yr	100% after deductible 100% after deductible	80% after deductible 80% after deductible
*Alcohol & Drug Addiction Inpatient – 7 days per Cal Yr Outpatient – 20 Visits per Cal Yr	100% after deductible 100% after deductible	80% after deductible 80% after deductible
Note: Coinsurance is applicable to the out of pocket maximum for the Mental & Nervous benefits only.		
Prescription Drug Card Brand Generic	80% after deductible* 100% after deductible*	
*(Prescription Drugs must be paid for at the point of sale. You will receive reimbursement from BCBSLA for prescriptions purchased after your deductible is met.)		

This is only an outline; all benefits are subject to the terms and conditions of the Master Contract. Providers for this HSA plan are listed in the [Blue Cross & Blue Shield of Louisiana Preferred Care Provider Network Directory](#) or any [Blue Cross & Blue Shield Blue Card HSA directory](#) nationwide.



BENEFIT SUMMARY



AlwaysCare Dental Insurance

TYPES OF COVERAGE	COVERAGE AMOUNTS
Annual Deductible Employee Family (up to 3 persons individually) <i>The individual deductible does not apply to Class I Dental Services</i>	\$50 per calendar year \$50 per person per calendar year
Benefit Maximums Benefit Year Maximum per Person Overall Benefit Maximums for TMJ	\$1,000 \$1,000
Co-Insurance Percentages Class A, Preventative Services <i>Limited to one visit every 6 months and 1 set of bitewing x-rays per calendar year.</i> Class B, Basic Services Class C, Major Services Class D, Orthodontics	100% 80% 50% 50%
Carryover Benefits Threshold Limit Carryover Account Maximum	\$250 \$500 \$1,000
<i>Employee becomes eligible for coverage on the 1st of the month following 30 days of employment.</i>	

AlwaysCare Vision Insurance

TYPES OF COVERAGE	WAL-MART COPAYS	OTHER PARTICIPATING PROVIDER COPAYS	OUT OF NETWORK ALLOWANCES
Vision Care Services Exam (Once per 12 month period) Materials (see below)	\$10 \$0	\$10 \$15	Up to \$30
Materials – Eye Glass Lenses <i>(once per 12 month period)</i> Single Vision Bifocal Trifocal Lenticular Progressive Lens Options: Scratch Resistant Coating Polycarbonate Lenses for Children	Covered Covered Covered \$80 allowance \$70 allowance Covered Covered	Covered Covered Covered \$80 allowance \$70 allowance N/A N/A	Up to \$25 Up to \$40 Up to \$50 Up to \$50 Up to \$40 N/A N/A
Materials – Frames <i>(Once per 24 month period)</i> Members choose from any frame available at Providers locations.	Up to \$74 retail allowance – covers 2/3 of frames available at Wal-Mart.	\$100 retail frame allowance. Covers a wide selection of frames.	Up to \$50 retail
Materials – Contact Lenses <i>(once per 12 month period)</i> Elective Medically Necessary	Up to \$130 retail Up to \$120 retail	Up to \$130 retail Up to \$210 retail	Up to \$100 retail Up to \$210 retail
<i>Employee becomes eligible for coverage on the 1st of the month following 30 days of employment.</i>			

Assurant Insurance Long-Term Disability Benefit

TYPES OF COVERAGE	BENEFIT AMOUNTS
Employee	60% of employee income
<i>Employee becomes eligible for coverage on the 1st of the month following 30 days of employment.</i>	

Assurant Insurance Life Insurance

TYPES OF COVERAGE	BENEFIT AMOUNTS
Employee	\$15,000
Family: <i>(only available if employee has Health Insurance through SMC)</i>	
Spouse	\$5,000
Children	\$2,000
<i>Employee becomes eligible for coverage on the 1st of the month following 30 days of employment.</i>	

Fidelity – 401K Retirement Plan

TYPES OF COVERAGE	BENEFIT AMOUNTS
Employee <i>(May contribute up to 25%)</i>	Employer matches employee contributions, up to a maximum of 5%
<i>Employee becomes eligible for coverage on the 1st of the month following 90 days of employment.</i>	
<i>SMC will deduct the processing fee charged by Fidelity for any loans drawn by a participant against their 401k account. This will be deducted \$25.00 per paycheck for 7 payroll cycles, total of \$175.00. SMC will pay this amount directly to Fidelity. This fee is non-negotiable. Deductions will begin with your first payment.</i>	

Colonial Life Optional Insurance

TYPES OF COVERAGE	BENEFIT AMOUNTS
Employee <i>May choose to elect additional "Optional Insurances". Insurances available may include, but are not limited to:</i> Short Term Disability Life Cancer Critical Illness	<i>Benefit amounts vary based upon the choices made for coverage by the employee. SMC provides \$15 per month allowance toward premium of one optional insurance, if elected.</i>
<i>Employee becomes eligible for coverage on the 1st of the month following 30 days of employment.</i>	

Accrued Time

See policy manual for more details regarding eligibility and rules

TERMS OF BENEFIT	BENEFIT AMOUNTS
Vacation 0-1 years of service 1-4 years of service 5-9 years of service 10 or more years of service	0 days 10 days 15 days 20 days
Paid Holidays	New Year's Day Independence Day Good Friday Thanksgiving Day Christmas Day Labor Day
Personal Time 1-9 years of service 10 or more years of service	2 days 5 days