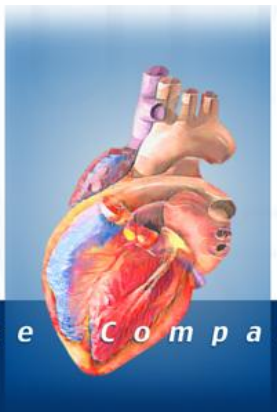
Southern Medical Corporation

A Cardiovascular Resource Company



2013 SMC Benefit & Premium Summary

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

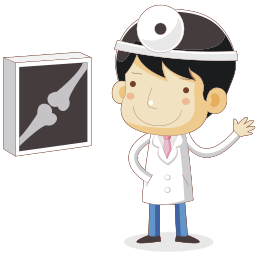
1. **Health Insurance** (Blue Cross Blue Shield) – Portion of employee premium paid by SMC.
2. **Dental Insurance** (AlwaysCare Dental) – Portion of employee premium paid by SMC.
3. **Vision Insurance** (AlwaysCare Vision) – Portion of employee premium paid by SMC.

Premiums are " per month" for all employees, excluding the Cath Lab. Below is the employee monthly portion of the benefits. Employee may choose to waive any benefit offered.

TYPE OF COVERGE	HEALTH *GROUPCARE* PPO 2000	ALWAYSCARE DENTAL	ALWAYSCARE VISION	TOTAL
Employee ONLY	$144.00	$20.00	$12.00	$176.00
Employee & ONE	$440.00	$46.00	$20.00	$506.00
Employee & FAMILY	$630.00	$64.00	$24.00	$718.00

TYPE OF COVERAGE	HEALTH *GROUPCARE* PPO 1500	ALWAYSCARE DENTAL	ALWAYSCARE VISION	TOTAL
Employee ONLY	$154.00	$20.00	$12.00	$186.00
Employee & ONE	$480.00	$46.00	$20.00	$546.00
Employee & FAMILY	$680.00	$64.00	$24.00	$768.00

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.



BLUE CROSS BLUE SHIELD

GroupCare – PPO2000

Health Insurance

BENEFIT	PREFERRED PROVIDER ORGANIZATION	
	In-Network	Out of Network
Calendar Year Deductible Individual Family	 $2,000 $6,000	 $2,000 $6,000
Maximum Out of Pocket *(Includes Stop Loss & Deductible, but not copay)* Individual Family	 $7,000 $16,000	 $7,000 $16,000
Coinsurance	70%	50%
Physician In - Office Visits	$40 Copay per visit	50% after deductible
Wellness Option	Copay applies	50% after deductible
Physician Inpatient & Outpatient Services	70% after deductible	50% after deductible
Emergency Room	$100 Copay	50% after deductible
Surgery	70% after deductible	50% after deductible
Hospital Inpatient Coverage	70% after deductible	50% after deductible
Hospital Outpatient Coverage	70% after deductible	50% after deductible
Accidental Injury Benefit	Up to $350	50% after deductible
Diagnostic X-Ray & Laboratory	70% after deductible	50% after deductible
Mental & Nervous Disorders Inpatient *Limitation*	70% after deductible	50% after deductible
Prescription Drug Card *Refer to the contract for applicable supply limitations* *Retail – up to 30 day supply* *Mail Order – up to 90 day supply* *[Prescription Drug Deductible]*	Generic / Preferred Brand / Non-Preferred Brand / Multi-Source / Injectables Contraceptives Included – *(includes Lead with Generics)* $7 / $30 / $55 / $70 / $50 $21 / $90 / $165 / $210 / $150 [$100 per family member/per Calendar Year]	

Providers for this PPO plan are listed in the BlueCross & Blue Shield of Louisiana GroupCare 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

GroupCare – PPO 1500

Health Insurance

BENEFIT	PREFERRED PROVIDER ORGANIZATION	
	In-Network	Out of Network
Calendar Year Deductible *Individual* *Family*	 $1,500 $4,500	 $1,500 $4,500
Maximum Out of Pocket (Includes Stop Loss & Deductible, but not copay) *Individual* *Family*	 $6,500 $14,500	 $6,500 $14,500
Coinsurance	70%	50%
Physician In - Office Visits	$40 Copay per visit	50% after deductible
Wellness Option	Copay applies	50% after deductible
Physician Inpatient & Outpatient Services	70% after deductible	50% after deductible
Emergency Room	$100 Copay	50% after deductible
Surgery	70% after deductible	50% after deductible
Hospital Inpatient Coverage	70% after deductible	50% after deductible
Hospital Outpatient Coverage	70% after deductible	50% after deductible
Accidental Injury Benefit	Up to $350	50% after deductible
Diagnostic X-Ray & Laboratory	70% after deductible	50% after deductible
Mental & Nervous Disorders *Inpatient* *Limitation*	70% after deductible	50% after deductible
Prescription Drug Card *Refer to the contract for applicable supply limitations* *Retail – up to 30 day supply* *Mail Order – up to 90 day supply* *[Prescription Drug Deductible]*	Generic / Preferred Brand / Non-Preferred Brand / Multi-Source / Injectables Contraceptives Included – *(includes Lead with Generics)* $7 / $30 / $55 / $70 / $50 $21 / $90 / $165 / $210 / $150 [$100 per family member/per Calendar Year]	

Providers for this PPO plan are listed in the BlueCross & Blue Shield of Louisiana GroupCare Provider Network Directory or any Blue Cross & Blue Shield Blue Card PPO directory nationwide.

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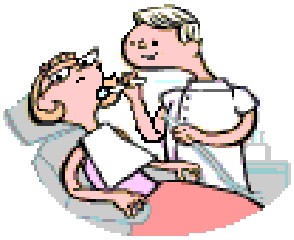

BENEFIT SUMMARY

AlwaysCare
Dental Insurance

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

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)*	$10	$10	Up to $30
Materials *(see below)*	$0	$15	
Materials – Eye Glass Lenses *(once per 12 month period)*			
Single Vision	Covered	Covered	Up to $25
Bifocal	Covered	Covered	Up to $40
Trifocal	Covered	Covered	Up to $50
Lenticular	$80 allowance	$80 allowance	Up to $50
Progressive	$70 allowance	$70 allowance	Up to $40
Lens Options:			
Scratch Resistant Coating	Covered	N/A	N/A
Polycarbonate Lenses for Children	Covered	N/A	N/A
Materials – Frames *(Once per 24 month period)*			
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 *(once per 12 month period)*			
Elective	Up to $130 retail	Up to $130 retail	Up to $100 retail
Medically Necessary	Up to $120 retail	Up to $210 retail	Up to $210 retail
Employee becomes eligible for coverage on the 1st of the month following 30 days of employment.			

Assurant Insurance

Long-Term Disability Benefit

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

Assurant Insurance

Life Insurance

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

Fidelity – 401K

Retirement Plan

TYPES OF COVERAGE	BENEFIT AMOUNTS
Employee *(May contribute up to 25%)*	Employer matches employee contributions, up to a maximum of 5%
Employee becomes eligible for coverage on the 1st of the month following 90 days of employment. *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.*	

Enrollment and information on your retirement account can be done at www.401k.com or calling 1-800-835-5097.

Colonial Life

Optional Insurance

TYPES OF COVERAGE	BENEFIT AMOUNTS
Employee *May choose to elect additional "Optional Insurances".* *Insurances available may include, but are not limited to:* *Short Term Disability* *Life* *Cancer* *Critical Illness*	*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.*
Employee becomes eligible for coverage on the 1st of the month following 30 days of employment.	

Accrued Time

See policy manual for more details regarding eligibility and rules

TERMS OF BENEFIT	BENEFIT AMOUNTS
PTO (Based on full-time Hire Date) 0-1 years of service 1-4 years of service 5-9 years of service 10 or more years of service	 16 hours *(after 6 months of full time employment)* 96 hours 136 hours 200 hours
Paid Holidays	New Year's Day Independence Day Good Friday Thanksgiving Day Christmas Day Labor Day
Sick Time Accrual per pay period	1.85 hours

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 (exception on retirement benefits – 90 days).