ARDENT HEALTH SERVICES

WELFARE BENEFIT PLAN

SUMMARY PLAN DESCRIPTION

Effective January 1, 2013

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ARDENT HEALTH SERVICES

WELFARE BENEFIT PLAN

SUMMARY PLAN DESCRIPTION

I. INTRODUCTION

This booklet is the summary plan description for the Ardent Health Services Welfare Benefit Plan (the "Plan"), which is sponsored by AHS Management Company, Inc. ("AHS"). This booklet brings together information concerning all of the various welfare benefits sponsored by AHS and its affiliates.

The balance of this summary plan description ("SPD") will provide a brief overview of certain administrative information concerning the Plan, the different types of benefits available under the Plan, and certain rights all participants in the Plan have under the Employee Retirement Income Security Act of 1974 ("ERISA"). As you will note, the specific information concerning each type of component benefit program available under the Plan is summarized in separate documents (also referred to in certain instances as summary plan descriptions or certificate of insurance booklets) that have been provided to you. Those other documents are prepared by AHS or the insurance companies or other providers underwriting each type of component benefit program.

In the event any of the information concerning the Plan set forth in this SPD shall conflict with the Plan, the terms of the Plan shall control. Also, in the event that any of the summary plan descriptions or other documents previously noted regarding each component benefit program conflict with this SPD, the terms of this SPD shall control to the extent required under ERISA.

II. GENERAL PLAN INFORMATION

A. Name of the Plan

Ardent Health Services Welfare Benefit Plan

B. Plan Administrator

Benefits Committee
AHS Management Company, Inc.
One Burton Hills Boulevard, Suite 250
Nashville, Tennessee 37215
(615) 296-3000

The Plan Administrator is the named fiduciary with respect to self-funded component benefit programs, and the insurer is the named fiduciary with respect to insured component benefit programs.

C. Type of Administration

Self and insurer administration.

D. Plan Sponsor

AHS and the other affiliated employers for whom this Plan is adopted are the sponsoring employers. A complete list of the employers sponsoring the Plan may be obtained by participants and beneficiaries upon written request to the Plan Administrator and is available for examination by participants and beneficiaries, as required by Department of Labor Regulation Sections 2520.104b-1 and 2520.104b-30.

E. Plan Sponsor's Identification Number (EIN)

62-1743438

F. Plan Number

501

G. Type of Benefits Provided under the Plan

Medical, Dental, Vision, Prescription, Health Care Flexible Spending Accounts, Life, Long-Term Disability

H. Agent for Service of Legal Process

Plan Administrator
AHS Management Company, Inc.
One Burton Hills Boulevard, Suite 250
Nashville, Tennessee 37215
(615) 296-3000

I. Plan Year

January 1 through December 31.

J. Statement of ERISA Rights

As a participant in the Plan, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all plan participants shall be entitled to:

- Examine, without charge, at the Plan Administrator's office and at other specified locations, such as work sites and union halls, all documents governing the Plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Pension and Welfare Benefit Administration.

- Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated summary plan description. The Administrator may make a reasonable charge for the copies.

- Receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report.

- Continue health care coverage for yourself, spouse or dependents if there is a loss of coverage under the Plan as a result of a qualifying event. You or your dependents may have to pay for such coverage. Review this summary plan description and the documents governing the Plan on the rules governing your COBRA continuation coverage rights.

- Reduce or eliminate exclusionary periods of coverage for preexisting conditions under your group health plan, if you have creditable coverage from another plan. You should be provided a certificate of creditable coverage, free of charge, from your group health plan or health insurance issuer when you lose coverage under the plan, when you become entitled to elect COBRA continuation coverage, when your COBRA continuation coverage ceases, if you request it before losing coverage, or if you request it up to 24 months after losing coverage. Without evidence of creditable coverage, you may be subject to a preexisting condition exclusion for 12 months (18 months for late enrollees) after your enrollment date in your coverage.

Under federal law, a health plan or health insurance issuer generally may not restrict benefits for any hospital length of stay for a mother or newborn child to less than 48 hours following a normal vaginal delivery, or less than 96 hours following a caesarean section, or require that a provider obtain preauthorization from the plan or the insurance issuer for prescribing stays within these time frames. Federal law generally does not prohibit the attending provider, after

consulting with the mother, from discharging the mother or newborn earlier than the 48- or 96-hour periods.

In addition to creating rights for Plan participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate your plan, called "fiduciaries" of the plan, have a duty to do so prudently and in the interest of you and other Plan participants and beneficiaries. No one, including your employer, your union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA.

If your claim for a welfare benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request materials from the Plan and do not receive them within 30 days, you may file suit in a Federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the administrator.

If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or Federal court. In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a medical child support order, you may file suit in Federal court.

If it should happen that Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If you are successful the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

If you have any questions about your Plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue NW., Washington, DC 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration at 1-800-998-7542.

III. SUMMARY OF ELIGIBILITY, BENEFITS, AND FUNDING

A. ELIGIBILITY

1. When Eligibility Begins

Eligibility to participate in the Plan is determined under the terms of the various component benefit programs provided through the Plan. You may be eligible to participate in and receive certain benefits but not others. You must refer to the separate underlying component benefit program documents and, specifically, the separate eligibility provisions that set forth the conditions pertaining to eligibility to receive those specific benefits.

2. Termination of Eligibility

The circumstances under which your eligibility may be terminated are set forth in the component benefit program documents for the benefits offered under the Plan. You must refer to the separate underlying component benefit program documents to identify circumstances that may result in your disqualification, ineligibility, denial, loss, forfeiture, or suspension of the benefits provided therein.

B. PLAN BENEFITS

Several different types of benefits are available under the Plan through different component benefit programs. The benefits provided under the Plan are set forth in individual and separate documents for the component benefit programs. You must refer to the individual documents providing the benefits for the component benefit programs listed below in order to determine the specific benefits provided. The different types of benefits that are available to you are as follows:

- Medical
- Dental
- Vision
- Prescription
- Health Care Flexible Spending Accounts
- Life
- Long-Term Disability

C. FUNDING

1. Type of Funding

Each individual benefit provided under the Plan may be funded through an insurance contract or may be self-funded. To determine the funding of one of the available component benefit programs, you must read the underlying documents with respect to that component benefit program.

2. *Source of Funding*

Contributions Made by Your Employer: Your employer may pay for some or all the cost of the individual welfare benefits under the Plan by paying a portion or all of the respective premiums. However, you must read each individual component benefit program document to determine whether your employer is paying for a portion or all of the premium cost with respect to that individual benefit.

Contributions Made by the Employee: Your employer may require participating employees to make contributions toward the cost of paying for the individual welfare benefits under the Plan in a manner consistent with the provisions of the underlying documents for any of the individual component benefit programs.

IV. PROCEDURE FOR FILING OF CLAIMS

A. Claims for Fully Insured Benefits

For purposes of determining the amount of, and entitlement to, benefits of the component benefit programs provided under insurance policies or contracts, the respective insurer is the named fiduciary under the Plan, with the full power to interpret and apply the terms of the Plan as they relate to the benefits provided under the applicable insurance contract. To obtain benefits from the insurer of a component benefit program, you must follow the claims procedures under the applicable insurance policy or contract, which may require you to complete, sign, and submit a written claim on the insurer's form. The insurer will decide your claim in accordance with its reasonable claims procedures, as required by ERISA and other applicable laws. The insurer has the right to secure independent medical advice and to require such other evidence as it deems necessary in order to decide your claim, as provided under ERISA. If the insurer denies your claim in whole or in part, you will receive a written notification setting forth the reason(s) for the denial. If your claim is denied, you may appeal to the insurer for a review of the denied claim. The insurer will decide your appeal in accordance with its reasonable claims procedures, as required by ERISA and other applicable law. If you do not appeal on time, you will lose your right to file suit in a state or federal court, because you will not have exhausted your internal administrative appeal rights (which generally is a prerequisite to bringing suit in state or federal court). Note that under certain circumstances, you may also have the right to obtain external review (that is, review outside of the Plan).

B. Claims for Self-Funded Benefits

For purposes of determining the amount of, and entitlement to, benefits under the component benefit programs provided through the Company's general assets, the Plan Administrator is the named fiduciary under the Plan, with the full power to make factual determinations and to interpret and apply the terms of the Plan as they relate to the benefits provided through a self-funded arrangement. To obtain benefits from a self-funded arrangement, you must complete, execute, and submit to the Plan Administrator a written claim on the form available from the Plan Administrator. The Plan Administrator has the right to secure

independent medical advice and to require such other evidence as it deems necessary to decide your claim, as provided under ERISA. The Plan Administrator will decide your claim in accordance with reasonable claims procedures, as required by ERISA. If the Plan Administrator denies your claim in whole or in part, then you will receive a written notification setting forth the reason(s) for the denial. If your claim is denied, you may appeal to the Plan Administrator for a review of the denied claim. The Plan Administrator will decide your appeal in accordance with reasonable claims procedures, as required by ERISA. If you do not appeal on time, you will lose your right to file suit in a state or federal court, because you will not have exhausted your internal administrative appeal rights (which generally is a prerequisite to bringing a suit in state or federal court).

V. CONTINUATION COVERAGE

There are several types of continuation coverage that may apply to particular component benefit programs. For more information, you should refer to the underlying documents for the component benefit programs. Generally, if medical or dental coverage for you or your eligible family members ceases because of certain "qualifying events" specified in COBRA (for example, termination of employment, reduction in hours, divorce, death, or a child's ceasing to meet the definition of dependent), then you and your eligible family members may have the right to purchase continuation coverage for a temporary period of time. Continuation and reinstatement rights may also be available if you are absent from employment due to service in the uniformed services pursuant to USERRA. Note also that state law may provide continuation and/or conversion coverage.

Note: This section is not intended to provide and shall not be construed to provide any rights greater than those provided under COBRA or other applicable laws.

VI. QUALIFIED MEDICAL CHILD SUPPORT ORDERS

In accordance with Section 609(a) of ERISA, the Plan must, as required by law, observe the terms of any qualified medical child support order ("QMCSO"). A QMCSO is any judgment, decree or order (including approval of a settlement agreement) issued by a court either (1) pursuant to state domestic relations law and providing for child support or health benefit coverage with respect to a child of a participant in the Plan and relating to benefits under the Plan; or, (2) to enforce a state law relating to medical child support with respect to a group health plan.

The Plan does not have to comply with a medical child support order unless it is "qualified." For such an order to be qualified, it must satisfy the requirements of relevant sections of ERISA. Generally, the order must specify that it applies to benefits under the Plan. The order must include the name and last known mailing address of the participant and each child covered by the order. The order must also provide a reasonable description of the type of coverage to be provided by the Plan to each child, specify the period to which the order applies, and specify each plan to which the order applies. The order will not be qualified if it provides for any type or form of benefit or any other option not otherwise available under the Plan, except to the extent necessary to comply with state medical child support laws.

The Plan Administrator will review any order submitted and determine within a reasonable period of time whether the order is qualified. All persons named in the order will be appropriately notified of the Plan Administrator's determination. You may obtain without charge a copy of the procedures governing qualified medical child support orders from the Plan Administrator.

VII. AMENDMENT AND TERMINATION

The Plan Sponsor, acting through any duly-authorized officer of the Plan Sponsor, reserves the right to terminate, suspend, withdraw, amend, or modify the Plan in whole or in part at any time, subject to the applicable provisions of the Plan. No amendment shall deprive any participant or beneficiary of any benefit to which he or she is entitled under this Plan with respect to contributions previously made; and no amendment shall provide for the use of funds or assets other than for the benefit of participants and their beneficiaries, except as may be specifically authorized by statute or regulation.

VIII. HIPAA PRIVACY STANDARDS

The following are required provisions under the Privacy Standards for Individually Identifiable Health Information (45 C.F.R. § 164.102 et seq.) (the "Privacy Standards") as promulgated pursuant to the Health Insurance Portability and Accountability Act of 1996 by the U.S. Department of Health and Human Services regarding the protection of your private health information. The following provisions establish the circumstances under which the Plan may share your Protected Health Information with the Plan Sponsor and limit the uses and disclosures that the Plan Sponsor may make of your Protected Health Information ("PHI").[1]

There are three circumstances under which the Plan may disclose information about you to the Plan Sponsor. First, the Plan may inform the Plan Sponsor whether you are participating in the Plan or are enrolled in or have disenrolled from a health issuer or HMO offered by the Plan. Second, the Plan may disclose to the Plan Sponsor information that summarizes claims history, claims expenses, or types of claims without directly identifying you.[2] The Plan Sponsor must limit its use of such "summary health information" to obtaining quotes from insurers or modifying, amending, or terminating the Plan.[3] Third, the Plan may disclose your PHI to the

[1] For purposes of the following provisions, "Protected Health Information" is individually identifiable information, transmitted or maintained in any form or medium, that is created or received by an entity covered by the Privacy Standards (for example, the Plan) or an employer and relates to your past, present or future physical or mental health or condition, the provision of health care to you, or the past, present or future payment for the provision of health care to you. However, Protected Health Information does not include individually identifiable information held by the Plan Sponsor in its role as an employer.

[2] Summary health information excludes information that may directly identify you, such as your name, address and phone number, the day or month of dates directly related to you (such as your birth date), and your social security and health plan beneficiary numbers, except that it may contain geographic information to the extent it is aggregated by five-digit zip code.

[3] For purposes of these provisions, "summary health information" is information that may be individually identifiable information and that summarizes the claims history, claims expenses, or type claims experienced by you and for which the Plan Sponsor has provided benefits to you under the Plan.

Plan Sponsor for purposes relating to administration of the Plan, including payment of benefits or health care operations.

The Plan Sponsor shall certify to the Plan that the terms of the Plan have been amended to incorporate, and the Plan Sponsor has agreed to abide by the terms of, the following provisions. The Plan Sponsor will use and disclose your PHI only as required or permitted by the Plan, or as required by law. The Plan Sponsor has the following obligations with regard to your PHI received for purposes related to administering the Plan:

- If the Plan Sponsor discloses any of your PHI to any of its agents or subcontractors, the Plan Sponsor will require the agent or subcontractor to agree to the same restrictions and conditions that apply to the Plan Sponsor with respect to the disclosed PHI.

- The Plan Sponsor will not use or disclose your PHI for employment-related actions or decisions or in connection with any other benefits or benefit plan of the Plan Sponsor.

- The Plan Sponsor will promptly report to the Plan any use or disclosure of your PHI that is inconsistent with the uses or disclosures allowed under the Plan of which the Plan Sponsor becomes aware.

- The Plan Sponsor will allow you to inspect and copy any of your PHI that is in the Plan Sponsor's custody and control. However, your access to such PHI is subject to certain exceptions and restrictions under § 164.524 of the Privacy Standards. You may make a request for access to your PHI in writing to the Plan Sponsor. The Plan Sponsor may impose a reasonable, cost-based fee for providing a copy of your PHI.

  The Plan Sponsor may provide you with a summary of the PHI requested, provided that you agree in advance to such summary and to the fees imposed, if any, for such summary. The Plan Sponsor must provide you the requested access to your PHI or, if the Plan Sponsor denies your request, in whole or in part, the Plan Sponsor must provide you with a written denial, no later than 30 days after receipt of your request. If your request for access is for PHI that is not maintained or accessible to the Plan Sponsor on site, the Plan Sponsor must take action on your request by no later than 60 days from the receipt of your request.

  If the Plan Sponsor is unable to provide access or a written denial of your request within such time, the Plan Sponsor may extend the time to provide either by no more than 30 days, provided that the Plan Sponsor provides you with a written statement within the initial 30-day period of the reasons for the delay and the date by which the Plan Sponsor will either provide access or a written denial of your request. The Plan Sponsor may have only one extension of time for action on your request for access.

  If the Plan Sponsor denies in whole or in part your request for access, the Plan Sponsor must provide you a timely written denial that is in plain language and contains (1) the basis for the denial; (2) a statement of any review rights that you may have, including a description of how you may exercise such review rights; and (3) a description of how you may complain to the Plan Sponsor or the U.S. Department of Health and Human Services pursuant to the procedures set forth in the Privacy Standards. Such description will include the name, or title, and telephone number of the contact person or office of the Plan Sponsor designated to receive such complaints pursuant to the Privacy Standards. You may have the right to have the denial reviewed by a licensed health care professional

who is designated by the Plan Sponsor and who did not participate in the original decision to deny. If you have the right to have the denial reviewed by a licensed health care professional, the Plan Sponsor must promptly refer your request for review to such designated reviewing official, who must determine, within a reasonable period of time, whether to deny the access requested pursuant to the Privacy Standards. The Plan Sponsor must promptly provide you written notice of the determination of the designated reviewing official and take such other action as may be required to carry out the designated reviewing official's determination.

- The Plan Sponsor will make available for amendment and incorporate any amendments to any portion of your PHI to the extent permitted or required under § 164.526 of the Privacy Standards. The Plan Sponsor may deny your request for amendment under certain circumstances. You may request an amendment of your PHI in writing. The Plan Sponsor must act on your request no later than 60 days after receipt of your request. If the Plan Sponsor is unable to act within such time, the Plan Sponsor may extend the time for such action by no more than 30 days, provided the Plan Sponsor provides you within the original 60-day period with a written statement of the reasons for the delay and the date by which the Plan Sponsor will complete its action on your request. The Plan Sponsor may have only one such extension of time for action on a request for an amendment.

  If the Plan Sponsor accepts the requested amendment, in whole or in part, the Plan Sponsor must make the appropriate amendment to your PHI that is the subject of your request for amendment by, at a minimum, identifying the records that are affected by the amendment and appending or otherwise providing a link to the amendment. The Plan Sponsor must also provide you with timely notice that the amendment is accepted and obtain your identification of, and agreement to have the Plan notify, the relevant persons with whom the amendment needs to be shared. Such relevant persons include persons identified by you as having received PHI about you and needing the amendment, and persons that the Plan Sponsor knows have the PHI that is the subject of the amendment and who may have relied, or could foreseeably rely, on such information to your detriment.

  If the Plan Sponsor denies your requested amendment, in whole or in part, the Plan Sponsor must provide you with a timely written denial. Such denial must use plain language and contain (1) the basis for the denial; (2) your right to submit a written statement disagreeing with the denial and how you may file such a statement; (3) a statement that, if you do not submit a statement of disagreement, you may request that the Plan Sponsor provide your request for amendment and the denial with any future disclosures of the PHI that is the subject of the amendment; and (4) a description of how you may complain to the Plan Sponsor or to the U.S. Department of Health and Human Services pursuant to the Privacy Standards. Such description will include the name, or title, and telephone number of the contact person or office of the Plan Sponsor designated to receive such complaints pursuant to the Privacy Standards. The Plan Sponsor must permit you to submit a written statement disagreeing with the denial of all or part of a requested amendment and the basis of such disagreement. The Plan Sponsor may prepare a written rebuttal to your statement of disagreement. Whenever such a rebuttal is prepared, the Plan Sponsor must provide a copy to you.

- The Plan Sponsor will maintain an accounting of certain kinds of disclosures of your PHI as required under § 164.528 of the Privacy Standards. Such accounting must be made for certain disclosures of PHI made by the Plan Sponsor during the six years prior to the date on which you request the accounting (but not before April 14, 2003). The Plan Sponsor does not have to maintain an accounting of disclosures made for certain purposes related to the administration of the Plan, including payment of benefits or health care operations and certain other disclosures. You may request in writing an accounting of disclosures by the Plan Sponsor of your PHI. The Plan Sponsor must act on your request no later than 60 days after receipt of your request by either providing you with the accounting requested or by extending the time to provide the accounting by no more than 30 days. The Plan Sponsor may extend the time to act upon your request provided that the Plan Sponsor provides you with a written statement of the reasons for the delay and the date by which the Plan Sponsor will provide the accounting. The Plan Sponsor must provide the first accounting to you in any 12-month period without charge. The Plan Sponsor may impose a reasonable, cost-based fee for each subsequent request for an accounting by you within the 12-month period, provided the Plan Sponsor informs you in advance of the fee and provides you with an opportunity to withdraw or modify the request for a subsequent accounting in order to avoid or reduce the fee.

- The Plan Sponsor will make its internal practices, books, and records relating to its use and disclosure of your PHI available to the U.S. Department of Health and Human Services for purposes of determining compliance by the Plan with the Privacy Standards.

- The Plan Sponsor will, if feasible, return or destroy all of your PHI that the Plan Sponsor still maintains in any form and retain no copies of your PHI received from the Plan when the Plan Sponsor no longer needs your PHI for the purpose for which disclosure was made. If it is not feasible for the Plan Sponsor to return or destroy your PHI, the Plan Sponsor will limit the use or disclosure of any PHI that it cannot feasibly return or destroy to those purposes that make return or destruction of the information infeasible.

- The Plan Sponsor will provide for an adequate separation between the Plan and the Plan Sponsor. The following classes of employees or persons under the control of the Plan Sponsor may be given access to your PHI for purposes consistent with the terms of the Plan:

  Senior Vice President, Human Resources

  Vice President, Compensation and Benefits

  Benefits Specialist

  Director, Human Resources (Facility)

  Benefit Committee Members

  This list includes every class of employees or other persons under the control of the Plan Sponsor who may receive your PHI in the ordinary course of business related to the administration of the Plan, including payment of benefits, health care operations, or other matters pertaining to the Plan. Such employees' access to and use of your PHI is restricted to administrative functions that the Plan Sponsor performs for the Plan. For

purposes of these provisions, administrative functions include, for example, the activities undertaken to obtain premiums or to provide benefits under the Plan and quality assurance, auditing, planning and development, and general administration. Administrative functions do not include any employment-related functions or functions in connection with any other benefit or benefit plans maintained by the Plan Sponsor.

The Plan Sponsor will provide an effective mechanism for resolving any issues of non-compliance by its employees or other persons under the control of the Plan Sponsor with the provisions of the Plan pertaining to PHI. If any employees or other persons under the control of the Plan Sponsor use or disclose your PHI in violation of the terms of the Plan, they will be subject to disciplinary action and sanctions, including the possibility of termination of employment. If the Plan Sponsor becomes aware of any such violations, the Plan Sponsor will promptly report the violation to the Plan and will cooperate with the Plan to correct the violation, to impose appropriate sanctions, and to mitigate any harmful effects to you.

IX. HIPAA SECURITY STANDARDS

The following are required provisions under the Security Standards for the Protection of Electronic PHI (45 C.F.R. Parts 160 and 164, Subparts A and C) as promulgated pursuant to the Health Insurance Portability and Accountability Act of 1996 by the U.S. Department of Health and Human Services. Effective April 20, 2005, the Plan Sponsor shall reasonably and appropriately safeguard Electronic Protected Health Information[4] ("EPHI") created, received, maintained, or transmitted to or by the Plan Sponsor on behalf of the Plan as follows:

- The Plan Sponsor shall implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the EPHI that the Plan Sponsor creates, receives, maintains, or transmits on behalf of the Plan.
- The Plan Sponsor shall implement administrative, physical, and technical safeguards to ensure that only the following classes of employees or other persons under the control of the Plan Sponsor may have access to EPHI in the ordinary course of business related to administration of the Plan:

[4] For purposes of the following provisions, "EPHI" means Protected Health Information that is transmitted by or maintained in (1) electronic storage media including memory devices in computers (hard drives) and any removable/transportable digital memory medium, such as magnetic tape or disk, optical disk, or digital memory card; or (2) transmission media used to exchange information already in electronic storage media. "Transmission media" include, for example, the internet (wide-open), extranet (using internet technology to link a business with information accessible only to collaborating parties), leased lines, dial-up lines, private networks, and the physical movement of removable/transportable electronic storage media. Certain transmissions, including of paper, via facsimile, and of voice, via telephone, are not considered to be transmissions via electronic media, because the information being exchanged did not exist in electronic form before the transmission.

Senior Vice President, Human Resources

Vice President, Compensation and Benefits

Benefits Specialist

Director, Human Resources (Facility)

Benefit Committee Members

The Plan Sponsor will take reasonable steps to ensure that such employees' access to and use of EPHI is restricted to administrative functions that the Plan Sponsor performs for the Plan.

- The Plan Sponsor shall ensure that any agent, including a subcontractor, to whom the Plan Sponsor provides EPHI agrees to implement reasonable and appropriate security measures to protect such EPHI.
- The Plan Sponsor shall report to the Plan any security incident of which the Plan Sponsor becomes aware.