GROUP BENEFIT SOLUTIONS

SHORT TERM DISABILITY INCOME PLAN

for the

Employees

of

AHS MANAGEMENT COMPANY, INC. DBA ARDENT HEALTH SERVICES

Plan Effective Date:	November 1, 2017
Plan Anniversary Date:	January 1
Plan Change Effective Date:	January 1, 2024

The following information constitutes the Summary Plan Description required by the Employee Retirement Income Security Act of 1974 (ERISA).

IN THE EVENT THERE IS A CONFLICT BETWEEN THE TERMS OF THIS DOCUMENT AND THE FORMAL PLAN DOCUMENT, THE TERMS OF THE FORMAL PLAN DOCUMENT WILL CONTROL

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SECTION 1

SCHEDULE OF BENEFITS

Classes of Eligible Employees

Class 1: All active, full-time and part time Employees of the Employer (formerly known as St. Francis) regularly scheduled to work a minimum of 20 hours per week, excluding Executives and Physicians.

SCHEDULE OF BENEFITS FOR CLASS 1

Eligibility Waiting Period
If you were hired on or before the Plan Effective Date:
The first of the month coincident with or following the date of hire.

If you were hired after the Plan Effective Date:
The first of the month coincident with or following the date of hire.

The Eligibility Waiting Period does not apply if you were an active full-time or part-time Employee of a company acquired by the Employer and had satisfied the Eligibility Waiting Period under the former company's plan. If you did not fully satisfy the Eligibility Waiting Period, credit will be given for any time that was satisfied.

Definition of Disability/Disabled
You are considered Disabled if, solely because of a covered Injury or Sickness, you are:
1. unable to perform all the material duties of your Regular Occupation, and
2. unable to earn 80% or more of your Covered Earnings from working in your Regular Occupation.

The Plan will require proof of earnings and continued Disability.

Definition of Covered Earnings
Covered Earnings means your wage or salary as reported by the Employer for work performed for the Employer as in effect just prior to the date Disability begins. Covered Earnings are determined initially on the date you apply for coverage. A change in the amount of Covered Earnings is effective on the January 1 the change.

It does not include amounts received as bonus, commissions, overtime pay or other extra compensation.

Any increase in your Covered Earnings will not be effective during a period of continuous Disability.

Elimination Period

For Accident:	7 calendar days
For Sickness:	7 calendar days

Gross Disability Benefit	The lesser of 60% of an Employee's weekly Covered Earnings rounded to the nearer dollar, if not already a multiple thereof or the Maximum Disability Benefit.
Maximum Disability Benefit	$2,500.00 per week

Disability Benefit Calculation
The Disability Benefit for any week you are Disabled is the Gross Disability Benefit minus Other Income Benefits.

"Other Income Benefits" means any benefits listed in the Other Income Benefits provision that you receive on your own behalf or for dependents, or which the Employee's dependents receive because of the Employee's entitlement to Other Income Benefits.

Maximum Benefit Period

For Accident:	180 days for each period of disability
For Sickness:	180 days for each period of disability

SECTION 2

ELIGIBILITY FOR PLAN PARTICIPATION

If you are in one of the Classes of Eligible Employees shown in the Schedule of Benefits, you are eligible to participate on the Plan Effective Date, or the day after you complete the Eligibility Waiting Period, if later. The Eligibility Waiting Period is the period of time you must be in Active Service to be eligible for participation. It will be extended by the number of days you are not in Active Service.

Except as noted in the Reinstatement Provision, if you terminate participation in the Plan and later wish to reapply, or if you are rehired, a new Eligibility Waiting Period must be satisfied. You are not required to satisfy a new Eligibility Waiting Period if Plan participation ends because you are no longer in a Class of Eligible Employees, but continue to be employed and within one year become a member of an eligible class.

SECTION 3

EFFECTIVE DATE OF PLAN PARTICIPATION

You will be covered under the Plan on the date you become eligible, if you are not required to contribute to the cost of this Plan participation.

If you are not in Active Service on the date Plan participation would otherwise be effective, it will be effective on the date you return to any occupation for your Employer on a Full-time basis.

SECTION 4

TERMINATION OF PLAN PARTICIPATION

Your participation will end on the earliest of the following dates:

1. the date you are eligible for participation under a plan intended to replace this Plan.
2. the date the Plan is terminated.
3. the date you are no longer in an eligible class.
4. the day after the end of the period for which you cease to make your contribution to the Plan, if applicable.
5. the date you are no longer in Active Service.
6. the date benefits end for failure to comply with the terms and conditions of the Plan.

SECTION 5

CONTINUATION OF PLAN PARTICIPATION

This Continuation of Plan Participation provision modifies the Termination of Plan Participation provision to allow participation to continue under certain circumstances if you are no longer in Active Service. Coverage that is continued under this provision is subject to all other terms of the Termination of Plan Participation provisions.

Disability participation under the Plan continues if your Active Service ends due to a Disability for which benefits under the Plan are or may become payable . If you do not return to Active Service, the participation under the Plan ends when the Disability ends or when benefits are no longer payable, whichever comes first.

If your Active Service ends due to personal or family medical leave approved timely by the Employer, your participation under the Plan will continue for up to the later of the period of the approved FMLA leave or the leave period required by law in the state in which you are employed.

If your Active Service ends due to any other leave of absence approved in writing by the Employer prior to the date you cease work, your participation under the Plan will continue for up to 26 week(s). An approved leave of absence does not include Furlough, layoff or termination of employment.

If your Active Service ends due to any other excused short term absence from work that is reported to the Employer timely in accordance with the Employer's reporting requirements for such short term absence, your participation under the Plan will continue until the earliest of:

a) the date your employment relationship with the Employer terminates;
b) the end of the 30-day period that begins with the first day of such excused absence;
c) the end of the period for which such short term absence is excused by the Employer.

Notwithstanding any other provision of this Plan, if your Active Service ends due to layoff, termination of employment, or any other termination of the employment relationship, participation under the Plan will terminate and Continuation of Plan Participation under this provision will not apply.

If your participation is continued pursuant to this Continuation of Plan Participation provision, and you become Disabled during such period of continuation, Disability Benefits will not begin until the later of the date the Elimination Period is satisfied or the date you are scheduled to return to Active Service.

SECTION 6

DESCRIPTION OF BENEFITS
The following provisions explain the benefits available under the Plan. Please see the Schedule of Benefits for the applicability of these benefits to each Class of Eligible Employees.

Disability Benefits
The Plan will pay Disability Benefits if you become Disabled while covered under this Plan. You must satisfy the Elimination Period, be under the Appropriate Care of a Physician, and meet all the other terms and conditions of the Plan. You must provide the Plan, at your own expense, satisfactory proof of Disability before benefits will be paid. The Disability Benefit is shown in the Schedule of Benefits.

The Plan will require continued proof of your Disability for benefits to continue.

Elimination Period
The Elimination Period is the period of time you must be continuously Disabled before Disability Benefits are payable. The Elimination Period is shown in the Schedule of Benefits.

A period of Disability is not continuous if separate periods of Disability result from unrelated causes.

Disability Benefit Calculation
The Disability Benefit Calculation is shown in the Schedule of Benefits. Disability Benefits are based on the number of days in a normally scheduled work week for you immediately before the onset of Disability. They will be prorated if payable for any period less than a week. If you are working while Disabled, the Disability Benefit Calculation will be the Return to Work Incentive Benefit Calculation.

Minimum Benefit
The Plan will pay the Minimum Benefit regardless of any reductions made for Other Income Benefits. However, if there is an overpayment due, this benefit may be reduced to recover the overpayment.

Other Income Benefits
If Disability Benefits are payable to you under this Plan, you may be eligible for benefits from Other Income Benefits. If so, the Plan may reduce the Disability Benefits by the amount of such Other Income Benefits.

Other Income Benefits include:

1. any amounts received (or assumed to be received*) by you or your dependents under:
   (a) the Canada and Quebec Pension Plans;
   (b) the Railroad Retirement Act;
   (c) any local, state, provincial or federal government disability or retirement plan or law payable for Injury or Sickness provided as a result of employment with the Employer;
   (d) sick leave or salary continuation plan of the Employer;
   (e) any work loss provision in mandatory "No-Fault" auto insurance;

2. any Social Security disability or retirement benefits you or any third party receives (or is assumed to receive*) on your own behalf or for your dependents; or which your dependents receive (or are assumed to receive*) because of your entitlement to such benefits;
3. any Retirement Plan benefits funded by the Employer. "Retirement Plan" means any defined benefit or defined contribution plan sponsored or funded by the Employer. It does not include an individual deferred compensation agreement; a profit sharing or any other retirement or savings plan maintained in addition to a defined benefit or other defined contribution pension plan, or any employee savings plan including a thrift, stock option or stock bonus plan, individual retirement account or 40l(k) plan;
4. any proceeds payable under any franchise or group insurance or similar plan. If other insurance applies to the same claim for Disability, and contains the same or similar provision for reduction because of other insurance, the Plan will pay for its pro rata share of the total claim. "Pro rata share" means the proportion of the total benefit that the amount payable under one policy, without other insurance, bears to the total benefits under all such policies;
5. any amounts paid because of loss of earnings or earning capacity through settlement, judgment, arbitration or otherwise, where a third party may be liable, regardless of whether liability is determined.

Dependents include any person who receives (or is assumed to receive*) benefits under any applicable law because of your entitlement to benefits.

* See the Assumed Receipt of Benefits provision.

Increases in Other Income Benefits
Any increase in Other Income Benefits during a period of Disability due to a cost of living adjustment will not be considered in calculating your Disability Benefits after the first reduction is made for any Other Income Benefits. This section does not apply to any cost of living adjustment for Disability Earnings.

Lump Sum Payments
Other Income Benefits or earnings paid in a lump sum will be prorated over the period for which the sum is given. If no time is stated, the lump sum will be prorated over five years.

If no specific allocation of a lump sum payment is made, then the total payment will be an Other Income Benefit.

Assumed Receipt of Benefits
The Plan will assume you and your dependents are receiving benefits for which you are eligible from Other Income Benefits. The Plan will reduce your Disability Benefits by the amount from Other Income Benefits it estimates are payable to you and your dependents.

The Plan will waive Assumed Receipt of Benefits, except for Disability Earnings for work you perform while Disability Benefits are payable, if you:

1. provide satisfactory proof of application for Other Income Benefits;
2. sign a Reimbursement Agreement;
3. provide satisfactory proof that all appeals for Other Income Benefits have been made unless the Plan determines that further appeals are not likely to succeed; and
4. submit satisfactory proof that Other Income Benefits were denied.

The Plan will not assume receipt of any pension or retirement benefits that are actuarially reduced according to applicable law, until you actually receive them.

The Plan may limit its waiver of Assumed Receipt of Benefits at its discretion.

Successive Periods of Disability

A separate period of Disability will be considered continuous:

1. if it results from the same or related causes as a prior Disability for which weekly benefits were payable; and
2. if, after receiving Disability Benefits, you return to work in your Regular Occupation for less than 7 consecutive days; and
3. if you earn less than the percentage of Covered Earnings that would still qualify you to meet the definition of Disability/Disabled during at least one week.

Any later period of Disability, regardless of cause, that begins when you are eligible for participation under another group disability plan provided by any employer will not be considered a continuous period of Disability.

For any separate period of disability which is not considered continuous, you must satisfy a new Elimination Period.

SECTION 7

RECOVERY OF OVERPAYMENT

The Plan has the right to recover any benefits it has overpaid. The Plan may use any or all of the following to recover an overpayment:

1. request a lump sum payment of the overpaid amount;
2. reduce any amounts payable under this Plan; and/or
3. take any appropriate collection activity available to it.

The Minimum Benefit amount will not apply when Disability Benefits are reduced in order to recover any overpayment.

If an overpayment is due when you die, any benefits payable under the Plan will be reduced to recover the overpayment.

SECTION 8

ADDITIONAL BENEFITS

Termination of Disability Benefits

Benefits will end on the earliest of the following dates:

1. the date you earn more than the percentage of Covered Earnings set forth in the definition of Disability from any occupation.
2. the date the Plan determines you are not Disabled.
3. the end of the Maximum Benefit Period.
4. the date you die.
5. the date you are no longer receiving Appropriate Care.
6. the date you fail to cooperate with the Plan in the administration of the claim. Such cooperation includes, but is not limited to, providing any information or documents needed to determine whether benefits are payable or the actual benefit amount due.

SECTION 9

EXCLUSIONS

The Plan will not pay any Disability Benefits for a Disability that results, directly or indirectly, from:

1. suicide, attempted suicide, or self-inflicted injury while sane or insane.
2. war or any act of war, whether or not declared.
3. active participation in a riot.
4. commission of a felony.
5. the revocation, restriction or non-renewal of your license, permit or certification necessary to perform the duties of your occupation unless due solely to Injury or Sickness otherwise covered by the Plan.
6. any cosmetic surgery or surgical procedure that is not Medically Necessary. ‘’Medically Necessary’’ means the surgical procedure is: (a) prescribed by a Physician as required treatment of the Injury or Sickness; and (b) appropriate according to conventional medical practice for the Injury or Sickness in the locality in which the surgery is performed. The Plan will pay benefits if the Disability is caused by you donating an organ in a non-experimental organ transplant procedure.
7. an Injury or Sickness for which you are entitled to benefits from Worker’s Compensation or occupational disease law.
8. an Injury or Sickness that is work-related.

In addition, the Plan will not pay Disability Benefits for any period of Disability during which you are incarcerated in a penal or corrections institution.

SECTION 10

DEFINITIONS
Please note, certain words used in this plan document have specific meanings. These terms will be capitalized throughout this document. The definition of any word, if not defined in the text where it is used, may be found either in this Definitions section or in the Schedule of Benefits.

Accident
An Accident is a sudden, unforeseeable external event that causes bodily Injury to you while participation is in force under the Plan.

Active Service
You will be considered in Active Service with the Employer on a day which is one of the Employer's scheduled work days if either of the following conditions are met.

1. You are performing your Regular Occupation for the Employer on a Full-time basis. You must be working at one of the Employer's usual places of business or at some location to which the Employer's business requires you to travel.
2. The day is a scheduled holiday or vacation day and you were performing your Regular Occupation on the preceding scheduled work day.

You are considered in Active Service on a day which is not one of the Employer's scheduled work days only if you were in Active Service on the preceding scheduled work day.

Appropriate Care
Appropriate Care means the determination of an accurate and medically supported diagnosis of your Disability by a Physician, or a plan established by a Physician of ongoing medical treatment and care of the Disability that conforms to generally accepted medical standards, including frequency of treatment and care.

Claim Administrator
The Claim Administrator is the person or entity chosen by the Plan to review claims for benefits provided under the Plan, as provided for by ERISA.

Disability Earnings
Any wage or salary for any work performed for any Employer during your Disability, including commissions, bonus, overtime pay or other extra compensation.

Employee
For eligibility purposes, you are an Employee if you work for the Employer and are in one of the Classes of Eligible Employees. Otherwise, you are an Employee if you are an employee of the Employer who participates under this Plan.

Employer
The Employer and any affiliates or subsidiaries covered under the Plan.

Full-time
Full-time means the number of hours set by the Employer as a regular work day for Employees in your eligibility class.

Injury
Any accidental loss or bodily harm which results directly or indirectly of all other causes from an Accident.

Physician
Physician means a licensed doctor practicing within the scope of his or her license and rendering care and treatment to you that is appropriate for your condition and locality. The term does not include you, your spouse, the immediate family (including parents, children, siblings or spouses of any of the foregoing, whether the relationship derives from blood or marriage), of you or your spouse, or a person living in your household.

Plan
Refers to the short term disability benefits provided by the Employer and affiliates as in effect from time to time.

Plan Administrator
The Plan Administrator is the person or entity chosen by the Plan to act as the administrator of the Plan, as provided for by ERISA.

Prior Plan
The Prior Plan refers to the plan of coverage or insurance providing similar benefits sponsored by the Employer in effect directly prior to the Plan Effective Date. A Prior Plan will include the plan of a company in effect on the day prior to that company's addition to this Plan after the Plan's Effective Date.

Regular Occupation
The occupation you routinely perform at the time the Disability begins. In evaluating Disability, the Plan will consider the duties of the occupation as it is normally performed in the general labor market in the national economy. It is not work tasks that are performed for a specific employer or at a specific location.

Sickness
Any physical or mental illness or disease.

You
A person covered under the Plan.

SECTION 11

ADMINISTRATIVE PROVISIONS

Reinstatement of Plan Participation
Your participation may be reinstated if it ends because you are on an unpaid leave of absence.

Your participation may be reinstated only if a written request for reinstatement is received by the Plan within 31 days from the date you return to Active Service from an Employer approved unpaid leave of absence or from the military service pursuant to the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA). For participation to be reinstated the following conditions must be met.

1. You must be in a Class of Eligible Employees.
2. The required contribution must be paid, if applicable.

Reinstated participation will be effective on the date you return to Active Service. If you did not fully satisfy the Eligibility Waiting Period before participation ended due to an unpaid leave of absence, credit will be given for any time that was satisfied.

SECTION 12

CLAIM PROVISIONS

Claimant Cooperation Provision
Your failure to cooperate with the Plan in the administration of the claim may result in termination of the claim. Such cooperation includes, but is not limited to, providing any information or documents needed to determine whether benefits are payable or the actual benefit amount due.

Proof of Loss
Written proof of loss must be given to the Plan within 90 days after the date of the loss for which a claim is made. If written proof of loss is not given in that time, the claim will not be invalidated nor reduced if it is shown that written proof of loss was given as soon as was reasonably possible. In any case, written proof must be given not more than a year after that 90 day period. If written proof of loss is provided outside of these time limits, the claim will be denied. These time limits will not apply while the person making the claim lacks legal capacity.

Within 30 days of a request, written proof of continued Disability and Appropriate Care by a Physician must be given to the Plan.

Time of Payment
Disability Benefits will be paid at regular intervals of not less frequently than once a week. Any balance, unpaid at the end of any period for which the Plan is liable, will be paid at that time.

To Whom Payable
Disability Benefits will be paid to you. If any person to whom benefits are payable is a minor or is declared by a court as incompetent or, in the opinion of the Plan, is not able to give a valid receipt, such payment will be made to his or her legal guardian. However, if no request for payment has been made by the legal guardian, the Plan, may at its option, make payment to the person or institution appearing to have assumed custody and support.

If you die while any Disability Benefits remain unpaid, the Plan may, at its option, make direct payment to any of the following living relatives of you: spouse, mother, father, children, brothers or sisters; or to the executors or administrators of your estate. The Plan may reduce the amount payable by any indebtedness due.

Payment in the manner described above will release the Plan from all liability for any payment made.

Physical Examination and Autopsy
The Plan, at its expense, will have the right to examine any person for whom a claim is pending as often as it may reasonably require. The Plan may, at its expense, require an autopsy unless prohibited by law.

Physician/Patient Relationship
You will have the right to choose any Physician who is practicing legally. The Plan will in no way disturb the Physician/patient relationship.

Legal Actions
For any action directly or indirectly related to Plan benefits or for the alleged interference with ERISA protected rights, no action at law or in equity may be brought in state or federal court more than two years after i) the benefit recipient has received the initial calculation of benefits that are the subject of the claim or action, or ii) the last payment of Plan benefits, or iii) the date of notice of final adverse determination on administrative appeal.

CLAIM PROCEDURES

The Plan Administrator is the named fiduciary for deciding claims for benefits under the Plan, and for deciding any appeals of adverse decisions. The Plan Administrator shall have the authority, in its discretion, to interpret the terms of the Plan, to decide questions of eligibility for coverage or benefits under the Plan, and to make any related findings of fact. All decisions made by the Plan Administrator shall be final and binding on Participants and Beneficiaries to the full extent permitted by law.

Claims for Disability Benefits (The following is applicable to claims filed before April 1, 2018)

The Plan Administrator is the named fiduciary for adjudicating claims for benefits under the Plan, and for deciding any appeals of denied claims. The Plan Administrator shall have the authority, in its discretion, to interpret the terms of the Plan, to decide questions of eligibility for coverage or benefits under the Plan, and to make any related findings of fact. All decisions made by the Plan Administrator shall be final and binding on Participants and Beneficiaries to the full extent permitted by law.

The Plan has 45 days from the date it receives your claim to determine whether or not benefits are payable to you in accordance with the terms and provisions of the Plan. The Plan may require more time to review your claim if necessary due to circumstances beyond its control. If this should happen, the Plan must notify you in writing that its review period has been extended for up to two additional periods of 30 days. If this extension is made because you must furnish additional information, these extension periods will begin when the additional information is received. You have up to 45 days to furnish the requested information.

During the review period, the Plan may require a medical examination of the Participant, at the Plan's own expense; or additional information regarding the claim. If a medical examination is required, the Plan will notify you of the date and time of the examination and the physician's name and location. It is important that you keep any appointments made since rescheduling examinations will delay the claim process. If additional information is required, the Plan must notify you, in writing, stating the information needed and explaining why it is needed.

If your claim is approved, you will receive the appropriate benefit from the Plan.

If your claim is denied, in whole or in part, you must receive a written notice from the Plan within the review period. The written notice must include the following information:

1. The specific reason(s) the claim was denied.
2. Specific reference to the Plan provision(s) on which the denial was based.
3. Any additional information required by your claim to be reconsidered, and the reason this information is necessary.
4. Identification of any internal rule, guideline or protocol relied on in making the claim decision, and an explanation of any medically-related exclusion or limitation involved in the decision.
5. A statement informing you of your right to appeal the decision, and an explanation of the appeal procedure, as outlined below.

Appeal Procedure for Denied Claims (The following is applicable to claims filed before April 1, 2018)

Whenever a claim is denied, you have the right to appeal the decision. You (or your duly authorized representative) must make a written statement for appeal to the Plan Administrator within 180 days from the date you receive the denial. If you do not make this request within that time, you will have waived your right to appeal.

Once your request has been received by the Plan Administrator, a prompt and complete review of your claim must take place. This review will give no deference to the original claim decision, and will not be made by the person who made the initial claim decision. During the review, you (or your duly authorized representative) have the right to review any documents that have a bearing on the claim, including the documents which establish and control the Plan. Any medical or vocational experts consulted by the Plan will be identified. You may also submit issues and comments that you feel might affect the outcome of the review.

The Plan has 45 days from the date it receives your request to review your claim and notify you of its decision. Under special circumstances, the Plan may require more time to review your claim. If this should happen, the Plan must notify you, in writing, that its review period has been extended for an additional 45 days. Once its review is complete, the Plan must notify you, in writing, of the results of the review and indicate the Plan provisions upon which it based its decision.

Claims for Disability Benefits (applicable to claims filed on or after April 1, 2018)

When you are eligible to receive benefits under the Plan, you must request a claim form or obtain instructions for submitting your claim telephonically or electronically, from the Plan Administrator or the Claim Administrator. All claims you submit must be on the claim form or in the electronic or telephonic format provided by the Plan Administrator or the Claim Administrator. You must complete your claim according to directions provided by the Plan Administrator or the Claim Administrator. If these forms or instructions are not available, you must provide a written statement of proof of loss. After you have completed the claim form or written statement, you must file it by submitting it to the Plan Administrator. Properly filed claims will be decided with independence and impartiality.

The Plan has 45 days from the date it receives a claim for disability benefits to determine whether or not benefits are payable in accordance with the terms of the Plan. The Plan may require more time to review the claim if necessary due to matters beyond its control. The review period may be extended for up to two additional 30 day periods. If this should happen, the Plan must provide its extension notice in writing before expiration of the curent decision period, explaining the circumstances requiring extension and the date a decision is expected. If the extension is made because additional information must be furnished, the claimant has 45 days within which to provide the requested information and the time for the Plan's decision shall be tolled (stopped) from the date on which the notification of the extension was sent until the date the Plan Administrator receives the claimant's response or upon the date the requested information is required to be furnished expires, whichever is sooner.

During the review period, the Plan may require a medical examination of the claimant, at its own expense, or additional information regarding the claim. If a medical examination is required, the Plan will notify the claimant of the date and time of the examination and the physician's name and location. If additional information is required, the Plan will notify the claimant, in writing, stating what information is needed and why it is needed.

If the claim is approved, the Plan will pay the appropriate benefit. If the claim decision is adverse, in whole or in part, the Plan will provide written or electronic notice which will include the following information:

1. The specific reason(s) for the claim decision;
2. Specific reference to the Plan provision(s) on which the decision was based;
1. A description of any additional information required to perfect the claim, and the reason this information is necessary;
2. A description of the review procedures and the time limits applicable to those procedures, including a statement of the claimant's right to bring a civil action under section 502(a) of ERISA after the claimant appeals and after the claimant receives an adverse decision on appeal;
3. A discussion of the decision, including an explanation of the basis for disagreeing with or not following: (i) the views presented by the claimant to the Plan of the health care professionals treating the claimant and vocational professionals who evaluated the claimant; (ii) the views of medical or vocational experts whose advice was obtained on behalf of the Plan in connection with the claimant's adverse benefit decision, without regard to whether the advice was relied upon in making the benefit decision; and (iii) a disability decision regarding the claimant presented by the claimant to the Plan made by the Social Security Administration;
4. Either the specific internal rules, guidelines, protocols, standards or other similar Plan criteria the Plan relied upon in making the decision, or, alternatively, a statement that such rules, guidelines, protocols, standards or other similar Plan criteria do not exist;
5. If the adverse decision is based upon medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the decision, applying the terms of the Plan to the claimant's medical circumstances, or a statement that such explanation will be provided free of charge upon request;
6. A statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claim for benefits; and
7. A notice provided in a culturally and linguistically appropriate manner, to the extent required by ERISA.

Appeal of Denied Disability Claims (applicable to claims filed on or after April 1, 2018)

Whenever a claim decision is fully or partially adverse, unless ERISA provides otherwise, the claimant must appeal once to the Plan Administrator. As part of the claimant's appeal, the claimant may receive, upon request, free of charge, copies of all documents, records, and other information relevant to the claim for benefits, and the claimant may submit to the Plan, written comments, documents, records, and other information relating to the claim. The review will take into account all comments, documents, records and other information the claimant submits related to the claim, without regard to whether such information was submitted or considered in the initial claim decision. Once an appeal request has been received by the Plan, a full and fair review of the claim appeal will take place.

File the wrtitten appeal with the Plan Administrator. The Plan Administrator is authorized to receive appeals on the Plan Administrator's behalf. The written request for appeal must be received by the Plan Administrator within 180 days from the date the claimant received the denial. If an appeal request is not received within that time, the right to appeal will have been waived. The Plan has 45 days from the date it receives a request for appeal to provide its decision. Under special circumstances, the Plan may require more time to review the claim and can extend the time for decision, once, by an additional 45 days. If this should happen, the Plan must provide the extension notice, in writing, before expiration of the initial decision period, indicating the special circumstances and the date a decision is expected. If the extension is made because additional information must be furnished, the claimant has 45 days within which to provide the requested information and the time for the Plan's decision shall be tolled (stopped) from the date on which the notification of the extension was sent until the date the Plan Administrator receives the claimant's response or upon the date the requested information is required to be furnished expires, whichever is sooner.

The review will give no deference to the original claim decision. The review will not be made by the person who made the initial claim decision, or a subordinate of that person. When deciding an appeal based in whole or in part upon medical judgment, the Plan will consult with a medical professional having the appropriate training and experience in the field of medicine involved in the medical judgment. Any medical or vocational experts consulted by the Plan for the review will be identified and will not be the expert who was consulted during the initial claim decision or a subordinate of that expert.

During the appeal, the Plan may require a medical examination of the claimant, at its own expense, or additional information regarding the claim. If a medical examination is required, the Plan will notify the claimant of the date and time of the examination and the physician's name and location. If additional information is required, the Plan will notify the claimant, in writing, stating what information is needed and why it is needed.

Before the Plan issues an adverse benefit decision on appeal, if the Plan considered, relied upon, or generated any new or additional evidence in connection with the claim, and/or if the Plan intends to rely on any new or additional rationale in connection with that review, then such evidence and/or rationale will be provided to the claimant, free of charge, as soon as possible and sufficiently in advance of the date that the decision on appeal is required to be made, giving the claimant a reasonable opportunity to respond.

If the claim is approved, the Plan will pay the appropriate benefit. If the claim decision on appeal is adverse, in whole or in part, the Plan will provide written or electronic notice that includes:

1. The specific reason(s) for the decision;
2. Specific reference to the Plan provision(s) on which the decision was based;
3. A statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claim for benefits;
4. A statement describing any voluntary appeal procedures offered, and the claimant's right to obtain the information about those procedures;
5. A statement of claimant's right to bring a civil action under section 502(a) of ERISA, including a description of any applicable contractual limitations period that applies to the claimant's right to bring such an action, and the calendar date on which the contractual limitations perod expires for the claim;
6. A discussion of the decision, including an explanation of the basis for disagreeing with or not following: (i) the views presented by the claimant to the Plan of the health care professionals treating the claimant and vocational professionals who evaluated the claimant; (ii) the views of medical or vocational experts whose advice was obtained on behalf of the Plan in connection with the adverse decision, without regard to whether the advice was relied upon in making the adverse decision; and (iii) a disability decision regarding the claimant presented by the claimant to the Plan made by the Social Security Administration;
7. Either the specific internal rules, guidelines, protocols, standards or other similar plan criteria the Plan relied upon in making the decision, or, alternatively, a statement that such rules, guidelines, protocols, standards or other similar plan criteria do not exist;
8. If the adverse decision is based upon medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the decision, applying the terms of the Plan to the claimant's medical circumstances, or a statement that such explanation will be provided free of charge upon request; and
9. A notice provided in a culturally and linguistically appropriate manner, to the extent required by ERISA.

SECTION 13

YOUR RIGHTS AS SET FORTH BY ERISA

As a participant in this 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:

Receive Information About Your Plan and Benefits

Examine, without charge, at the Plan Administrator's office and at other specified locations, such as worksites 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 Employee Benefit Security 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.

Prudent Actions by Plan Fiduciaries
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.

Enforce Your Rights
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 a copy of Plan documents or the latest annual report 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, and if you have exhausted the claims procedures available to you under the Plan, you may file suit in a state or 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.

Assistance with Your Questions
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 Benefit Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefit Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefit Security Administration.

This Plan is designed to provide you with short term disability income benefits in the event of your covered Disability. Every effort has been made to assure the accuracy of this Summary Plan Description. To the extent that the terms of the Plan Document differ from this Summary Plan Description, the Plan Document will prevail.

SECTION 14

PLAN ADMINISTRATION

The Plan is established and maintained by AHS Management Company, Inc. dba Ardent Health Services

The Employer Identification Number (EIN) is 62-1743438

The Plan Number is 501.

The Plan Administrator is:	AHS Management Company, Inc. dba Ardent Health Services 340 Seven Springs Way Suite 100 Brentwood, TN 37027 615-296-3325
The Claim Administrator is:	Life Insurance Company of North America P.O. Box 16491 Pittsburgh, PA 15242

Service of Legal Process may be made upon the Plan Administrator. The Plan Administrator has authority to control and manage the operation and administration of the plan.

This plan of benefits is self-insured by the Employer and its cost is financed by the Employer.

Date of the end of the Plan Year:	December 31.
PLAN TERMINATION:	The right is reserved in the plan for the Employer to terminate, suspend, withdraw or amend the plan in whole or in part at any time.

Ardent℠
HEALTH SERVICES