HCA HEALTHCARE, INC.

EMPLOYEE HEALTH AND SAFETY PROGRAM BENEFIT PLAN
SUMMARY PLAN DESCRIPTION

GENERAL INFORMATION

HCA Healthcare, Inc. (the "Sponsor") adopted for its Affiliated Employers, as listed on Exhibit "2", an Employee Health and Safety Program Benefit Plan ("Plan") for the prevention of on-the-job work-related injuries.

The Plan is intended to comply with applicable state and federal laws, and is maintained for the exclusive benefit of eligible Employees of the Affiliated Employers whose principal place of employment is located in Texas. Generally, under the Plan, certain medical treatment is provided to eligible Employees for work-related, on-the-job injuries. Under certain conditions, wage replacement benefits will be paid.

For purposes of Section 3(16) of the Employee Retirement Income Security Act of 1974 ("ERISA"), the Affiliated Employers are the Administrators of the Plan.

This Summary is intended to briefly describe the principal provisions of the Plan. A complete copy of the Plan document is available for copying or review by any eligible Employee desiring more detailed information. If a question should arise concerning the Plan, the Plan document (and not this Summary) shall govern and determine your rights. The interpretation of the Plan by the Plan Administrator shall be conclusive as to all matters.

The Affiliated Employers are non-subscribers to the Texas Workers' Compensation Act and thus, do not provide workers' compensation insurance benefits to Employees.

WHAT IS THE EMPLOYEE HEALTH AND SAFETY PROGRAM?

The Employee Health and Safety Program is a plan for the prevention of work-related injuries but also provides eligible Participants with certain medical care and treatment for accidental on-the-job injuries; and certain wage replacement benefits because of such injuries.

WHO IS ELIGIBLE TO PARTICIPATE IN THE PLAN?

Every Employee of an Affiliated Employer whose principal place of employment for the Affiliated Employer is located in Texas is eligible to elect to participate in the Plan. The Plan Year begins on January 1 and ends on the following December 31. The records of the Plan will be kept on a calendar year basis.

In order to participate in the Plan an Employee of an Affiliated Employer must make a written election to participate in the Plan. Under such election, the Participant agrees that all types of disputes or differences arising out of or relating to the Participant's work-related injuries and/or death, between the Participant and the Sponsor, Affiliated Employers, and/or subsidiaries and/or their directors, officers, shareholders, employees and/or agents during or following the Participant's employment with an Affiliated Employer are subject to final and binding arbitration. The Agreement to Submit to Arbitration will be in the form attached to this Summary Plan Description as Exhibit "1." A Participant waives, releases, and gives up any rights that the Participant has to sue in civil court and to have a jury determine a dispute for claims including, but not limited to (i) application and interpretation of Exhibit "1" and breach thereof; and (ii) any potential action as to the negligent cause of a Participant's work- related

injuries and/or death. All claims and disputes that a Participant, or the Participant's heirs, beneficiaries or assigns, has or may have in the future against the Sponsor, Affiliated Employers, subsidiaries and/or successors and/or their officers, directors, shareholders, employees and/or agents, and all of these persons' and entities' claims and disputes against the Participant are subject to binding arbitration under the terms specified in Exhibit "1." If a Participant should violate Exhibit "1" by filing a negligence lawsuit in civil court, then the Participant will be financially responsible for any costs and/or reasonable attorney's fees incurred by the party sued upon.

Notwithstanding an Employee's failure to execute, agree to, and deliver an Election to Participate in the Employee Health and Safety Program Benefit Plan and Agreement to Submit to Arbitration (Exhibit "1"), he or she shall become a Participant under this Plan upon receipt and acceptance of any benefits under this Plan and shall be bound by the terms of the Plan and by the terms of Exhibit "1" the same as if he or she had complied with all of the requirements to be a Participant and the same as if he or she had fully executed and agreed to an Election to Participate in the Employee Health and Safety Program Benefit Plan and Agreement to Submit to Arbitration (Exhibit "1").

The arbitrators who will decide disputes under Exhibit "1", will be provided by Judicial Workplace Arbitrations, Inc. ("JWA), an organization that is wholly unrelated to the Sponsor and the Affiliated Employers. The JWA arbitrators deciding disputes under the Election the Participate, Exhibit "1," will be completely independent and will have the authority to award any relief available in a State District Court of Law.

DEFINITIONS*

"Affiliated Employer" shall mean a corporation or other business entity which is a separate, but affiliated entity of HCA Healthcare, Inc. Affiliated Employers include the Employers who have adopted this Plan and its provisions and act as individual Plan Administrators for their employees. The Affiliated Employers are listed in Exhibit "2" of this document, as it may from time to time be amended by the Sponsor. As a practical matter, Affiliated Employer is the Participant's Employer.

"Course and Scope of Employment" shall mean an activity that originates in the work, business, trade or profession of an Employer that is performed by an Employee while solely engaged in or about the furtherance of the affairs or business of an Employer. The term includes activities conducted on the premises of an Employer or at other locations designated by an Employer. This term does not include:

1. an Employee's transportation to and from his place of employment and/or to and from his first and last, or the only, daily work assignment(s), unless the transportation is furnished as part of the employment arrangement or paid for by the Employer, or the means of transportation are under the control of the Employer, or the Employee is directed, as part of his or her employment, to proceed from one place to another place.

2. travel by the Employee in furtherance of the affairs or business of the Employer if such travel is also in furtherance of personal or private affairs of the Employee, unless: (i) the travel to the place of occurrence of the Injury would have been made even had there been no personal or private affairs of the Employee to be furthered by the travel; and (ii) the travel would not have been made had there been no affairs or business of the Employer to be furthered by the travel.

"Cumulative Trauma" shall mean the physical injury of a Participant which results from repetitious activity over an extended period of time in the course and scope of the Participant's performance of the

duties of his/her usual occupation, and as diagnosed by a Provider. A Cumulative Trauma is not caused by an Occurrence. The date of occurrence for Cumulative Trauma is the date the Participant knows or should know that the Cumulative Trauma may be a work-related condition.

"Emergency" shall mean the sudden onset of acute symptoms of sufficient severity that in the absence of immediate medical attention could reasonably be expected to (1) result in death, disfigurement, or permanent disability, or (2) result in serious impairment of any bodily organ, part or function.

"Employee" shall mean each person who is solely employed in the State of Texas by an Employer as defined herein, but shall not include any person who performs services for an Employer as an independent contractor or otherwise in a non-employee status.

"Employer" shall mean the Plan Administrator. An Employee's Employer shall be the entity that provides its federal tax identification number for payroll purposes of the particular Employee.

"Injury" shall mean the identifiable physical condition, including death, that results directly from an Occurrence, Occupational Disease or Cumulative Trauma, and that occurred in the course and scope of the Participant's employment. Injury does not include an identifiable physical condition that is related to or caused by, in whole or in part, a prior or pre-existing condition; or mental, psychological, emotional or stress related conditions, other than Post-traumatic Stress Disorder as defined in Section 2.20 of the Benefit Plan and as diagnosed by a Provider.

"Maximum Medical Improvement" shall mean the point at which a Provider determines that a Participant who suffered an on-the-job Injury will not improve substantially as a result of additional medical treatment or physical therapy, or surgical intervention.

"Modified Duty" shall mean limited duty assigned by the Employer to a Participant according to his physical limitations as identified by a Provider. Modified duty does not guarantee a temporary position or one that is comparable with pre-injury job duties.

"Occupational Disease" shall mean an unhealthy physical condition which is generally accepted to be a disease or condition of the body that is contracted in the course and scope of the Participant's employment. An Occupational Disease is a condition that may or may not be caused by an Occurrence. If it is a condition that is not caused by an Occurrence, then date of occurrence for an Occupational Disease is the date the Participant knows or should know that the Occupational Disease may be a work-related condition.

"Occurrence" shall mean an unexpected, unforeseen and unanticipated event that occurs at a specifically identifiable time and place during the course and scope of employment, and in the furtherance of the business of the Employer, and that may or may not result in a Participant's Injury.

"Participant" shall mean an eligible Employee who satisfies all requirements for participation in the Plan, who has elected to participate in the Plan by executing Exhibit "1", and whose participation has not been terminated as provided herein.

"Post-traumatic Stress Disorder" shall mean a neurotic disorder experienced by a Participant who sustained an Injury as defined herein, and produced by exposure to an overwhelming environmental stress and characterized by recurrent episodes of re-experiencing the traumatic event, numbing of emotional responsiveness, and dysphoric general hyper arousal; and, as diagnosed by a Provider.

"Pre-existing Condition" shall mean any illness, injury, disease, or other physical or mental condition, whether or not work-related, which originated or existed prior to the date of Injury.

"Provider" shall mean a health care provider (including but not limited to: physician(s), hospitals, physical therapists and pharmacies) designated by the Plan Administrator to administer medical treatment, physical therapy and drugs for which reimbursement is authorized under this Plan.

*A complete list of definitions is in the Plan document and is available for copying or review by any employee desiring more information.

WHAT ARE THE PLAN BENEFITS?

Under the Plan, in the event of an accidental on-the-job work related injury, the Affiliated Employer will provide (i) certain medical benefits; and (ii) certain wage replacement benefits. The Plan Administrator has the sole discretionary authority to determine benefit eligibility.

Medical Benefits

The medical benefits that are paid under the Plan will be one hundred percent (100%) of reasonable and customary charges for hospital confinement, physician's services, prescription drugs, physical rehabilitation, emergency room and/or out-patient services, necessary as a result of an accidental on-the-job work related injury and that are pre-approved by the Plan Administrator or designee. The medical benefits will continue until the earlier of (i) the date that a physician approved by the Plan Administrator determines that the Participant has reached maximum medical improvement; (ii) the date on which the Plan Administrator determines that the benefits should be terminated in accordance with this Plan, including without limitation, the Participant's failure to comply with this Plan; or (iii) the date on which the Participant ceases to be an Employee.

Wage Replacement Benefits

The wage replacement benefits will apply only if the physician approved by the Plan Administrator has ordered the Participant not to return to full or modified dutywork.

For non-exempt Participants, from the time the Provider orders the Participant not to return to full or modified duty work, the daily wage replacement benefits are 100% of the Participant's average hourly base wage rate (does not include overtime, shift differential, premium or bonus pay) during the 13 week period immediately preceding the Injury, multiplied by the average number of hours per work day that the Participant worked during the same 13 weeks, for the first 30 calendar days of lost time. Average number of hours per work day is calculated by dividing the total number of hours worked and/or paid for by the Affiliated Employer, e.g., PTO, during the 13 week period by the total number of days worked and/or paid for in the 13 week period. The first 30 calendar days of lost time may not be consecutive. For example, if an employee begins missing work on the 3rd of the month and returns on the 14th, that represents 11 days of lost time. If the employee again begins missing work on the 21st and returns on the 28th, that represents 7 days, for a total of 18 calendar days of lost time. This method will continue until the first 30 calendar days of lost time has expired.

If the Participant has not worked at least 13 weeks prior to the Injury, the daily wage replacement benefit will be calculated as set forth above, based on the number of work-weeks completed by the Participant, or as may be otherwise determined by the Plan Administrator. The daily wage replacement benefit will be multiplied by the number of regularly scheduled work days not worked by the Participant due to the Provider's order. In no event will the wage replacement benefit paid be in excess of forty (40) hours in a scheduled work-week. Upon expiration of the first 30 calendar days of lost time, the Participant will receive 90% of his/her daily wage replacement benefit as calculated above, until the end of the wage replacement period as set forth below.

For exempt Participants, from the time the Provider orders the Participant not to return to full or modified duty work, the wage replacement benefits are 100% of the Participant's average salary received per week for the 13 week period immediately preceding the Injury for each full week not worked per the Provider's order. If the Participant has not worked at least 13 weeks prior to the Injury, the wage replacement benefit will be calculated as set forth above, based on the number of work- weeks completed by the Participant, or as may be otherwise determined by the Plan Administrator. Benefits for partial weeks not worked will be pro-rated based on the number of days that the Participant is regularly scheduled to work. Upon expiration of the first 30 calendar days of lost time, the Participant will receive 90% of his/her wage replacement benefit as calculated above, until the end of the wage replacement period as set forth below.

If, within the 13 weeks prior to the Injury, a Participant's (non-exempt or exempt) employment classification (i.e., full-time, part-time, PRN, etc.) changes, then the wage replacement benefits will be calculated using the average wages for the number of weeks following the change in classification, rather than the 13 weeks immediately preceding the Injury, and otherwise as set forth above.

If, after an Injury, a Participant (non-exempt or exempt) voluntarily changes his/her employment classification to limit the Participant's availability for work (i.e., full-time to part-time, full-time to PRN, or part-time to PRN, etc.), then the wage replacement benefits will be calculated based upon the Participant's availability for work, or as may be otherwise determined by the Plan Administrator, rather than the 13 weeks immediately preceding the Injury, and otherwise as set forth above.

If a Participant (non-exempt or exempt) is released for part-time work, his/her wage replacement benefits will be the difference between his/her compensation for the part-time work and what his average compensation has been, based upon the computation described above.

These wage replacement benefits will continue until the earlier of (i) the date that the Participant is released by a physician approved by the Plan Administrator to return to regular or modified duty work; (ii) the date on which a physician approved by the Plan Administrator determines that the Participant has reached maximum medical improvement; (iii) the date that the Plan Administrator determines that benefits should be terminated in accordance with this Plan, including without limitation the Participant's failure to comply with this Plan; or (iv) the date on which the Participant ceases to be an Employee.

Modified Duty

When a Participant is given a release to return to work with restrictions (modified duty), subsequent to a work-related injury, the Participant's Supervisor, in coordination with the Employee Health Nurse/Injury Coordinator, will determine what work is available and will attempt to place the Participant according to his/her limitations as identified by the Provider. Such work may not be on the Participant's usual scheduled days, his/her usual scheduled shift or involve his/her regular job duties. A Participant

returned to modified duty will receive 100% of his/her base pay as calculated above; however, in no event will the wage replacement benefit and modified duty benefit be combined to exceed forty (40) hours in a scheduled work-week. Modified duty does not have to be associated with the Participant's job description and/or any other defined job description.

Modified duty may be provided, at the option of the Plan Administrator, until the earlier of (i) the date that a physician approved by the Plan Administrator determines that the Participant has reached maximum medical improvement; (ii) the date that a physician approved by the Plan Administrator releases the Participant to return to regular duty work; (iii) the date on which the Plan Administrator determines that benefits should be terminated in accordance with this Plan, including without limitation the Participant'[s failure to comply with this Plan; or (iv) the date on which the Participant ceases to be an Employee.

Permanent Disability Benefits

In the case of a Participant's permanent disability as the result of an on the job injury, which means that the Provider has determined that the Participant has reached maximum medical improvement and can no longer perform on a regular basis, with or without reasonable accommodations, the essential physical duties as described in his/her job description, a settlement offer may be made to the Participant. Any potential settlement offer will require a full release of liability and be computed at the maximum amount of three (3) weeks of the Participant's average weekly wages for each percentage point of the Participant's whole body impairment rating assigned by the Provider, utilizing the rating system specified under the American Medical Association's (AMA's) guidelines.

Death Benefits

In the case of a Participant's death as the result of an on the job injury, a settlement offer may be made to the Participant's beneficiaries. Any potential settlement offer will require a full release of liability.

GENERAL INFORMATION REGARDING BENEFITS

The above benefits are referred to as the "Benefits."

In order to receive Benefits under the Plan, a Participant must keep the Plan Administrator or designee informed of the Participant's condition after each medical visit and fully cooperate with the Plan Administrator and the physician approved by the Plan Administrator. This cooperation includes, without limitation, (i) giving the Plan Administrator and/or designee access to all medical records pertaining to the injury; (ii) allowing the Plan Administrator and/or designee to attend scheduled appointments with medical providers (however, the Participant may request that the Plan Administrator and/or designee wait outside of the examination room); and (iii) allowing the Plan Administrator and/or designee to discuss the injury with the medical provider.

To receive Benefits, the Participant must obtain prior written authorization from the Plan Administrator or designee to be treated by an approved health care provider ("Provider") unless in emergency situations. To be eligible to receive Benefits, the Participant must comply with all the requirements of the Plan.

WHAT MUST A PARTICIPANT DO TO BE ENTITLED TO BENEFITS?

In the event of a work-related on-the-job occurrence, the Participant must notify his/her Supervisor or, in his/her absence, the Department Manager immediately (or no later than the end of the shift on which the occurrence occurred), if it is within regular business hours, i.e., Monday -- Friday, 8AM -- 5PM. If it is not within regular business hours, the Participant must notify his/her Supervisor or, in his/her absence, the House Supervisor. In addition, the Participant must complete an Employee Occurrence Report by signing, dating and turning it in to his/her Supervisor, the Department Manager or the House Supervisor before leaving the premises. If the facility utilizes a different reporting mechanism such as a telephone hotline and/or electronic reporting, the Participant must follow the appropriate reporting procedures established by the facility and, in any event, must report his/her occurrence no later than the end of the shift on which it occurred. During regular business hours, the Employee Health Nurse will assist the Participant in obtaining necessary medical treatment from a Provider. If it is not during regular business hours, the House Supervisor will assist the Participant in obtaining necessary medical treatment from a Provider. Immediately after primary medical treatment and after each succeeding appointment with the Provider, the Participant must return the Physician's Report to the Employee Health Nurse. The Employee Health Nurse will periodically and/or as requested update the Human Resources Director/Injury Coordinator/Designated Person in Charge of the Employee Health and Safety Program of the status of the Participant's medical care. The Plan Administrator shall be entitled to obtain records, consultation, prognosis and return to work information from any Provider; and, by participation in this Plan, the Participant authorizes the foregoing receipt of records and communication.

The provision of or payment for a Participant's initial visit(s) to a Provider shall not constitute a determination that the Participant is entitled to further Benefits under this Plan.

The Participant shall not be entitled the Benefits or continued Benefits under the Plan if any of the following occur:

1. if the alleged injury is not an Injury as defined in this Plan, or if the alleged injury is discovered to have been intentional, self-inflicted, whether sane or insane, feigned, or an attempt to defraud the Affiliated Employer, or if the alleged injury is an exacerbation, complication or aggravation of a pre-existing condition that was not an Injury;

2. if the alleged injury results from the act of a third person intended to injure the Participant because of personal reasons and not directed at the Participant as an employee because of his/her employment with an Affiliated Employer;

3. if the alleged injury results from an act of God, unless the Participant's employment exposes him/her to a greater risk of injury from an act of God than ordinarily applies to the general public;

4. if the Participant fails to comply with any of the requirements or provisions of the Plan;

5. if the Participant fails to report the occurrence to the Participant's Supervisor, the Department Manager, the House Supervisor, the Employee Health Nurse, the Injury Coordinator, the Human Resources Director or the Designated Person in Charge of the Employee Health and Safety Program Benefit Plan immediately (or no later than the end of the shift on which the occurrence occurred);

6. if the Participant fails to complete an Employee Occurrence Report by dating, signing

and giving it to his/her Supervisor, the Department Manager, the House Supervisor, the Employee Health Nurse, the Injury Coordinator, the Human Resources Director or the Designated Person in Charge of the Employee Health and Safety Program Benefit Plan immediately or no later than the end of the shift on which the occurrence occurred (or before leaving the premises that same date);

7. if the Participant obtains medical care in a non-emergency situation without prior approval from the Plan Administrator or designee;

8. if the Participant does not follow the directions of the Provider (i.e., physician, physical therapist, etc.);

9. if the Participant fails to report for work (modified or full duty) as released by the Provider;

10. if the Participant is determined to be in violation of the Affiliated Substance Use in the Workplace Policy at the time of the occurrence or any time thereafter, or if the Participant refuses to submit to drug and alcohol testing at the time of the occurrence or any time thereafter, if requested;

11. if the Participant was untruthful in regard to any aspect of the required information supplied as part of the employment process or any time thereafter;

12. if the Participant's alleged injury resulted from the Participant's own reckless or malicious behavior or horseplay; malicious behavior denotes a Participant's refusal to follow written or verbal instructions, warnings or reprimands from the Participant's supervisor;

13. if the Participant is or becomes self-employed or employed by another employer and performs duties that exceed the Provider's restrictions;

14. if the Participant voluntarily participates in any off-duty recreational, social, athletic or other activity that exceeds the Provider's restrictions;

15. if the Participant fails to cooperate in regard to communications with, or instructions provided by, the Plan Administrator and/or its designees, i.e., the Department Manager, the House Supervisor, the Employee Health Nurse, the Injury Coordinator, the Human Resources Director or the Designated Person in Charge of the Employee Health and Safety Program Benefit Plan;

16. if the Participant is persistently nonresponsive to treatment, including, but not limited to, non-responsiveness due to the need for Participant behavioral modification recommended by a Provider;

17. if the Participant is in violation of the Election to Participate in the Employee Health and Safety Program Benefit Plan and Agreement to Submit to Binding Arbitration ("Exhibit 1") by filing a civil lawsuit for negligence against the Sponsor, the Company, a Plan Administrator and/or an Affiliated Employer.

18. if the Participant's occurrence, based on a preponderance of evidence, was caused

by the negligence of a third party;

19. if the alleged injury results from the Participant's participation in an assault or a felony, except an assault committed in defense of an Affiliated Employer's business or property;

20. if the alleged injury results from the Participant's voluntary participation in any recreational, social or athletic activity not constituting part of the Participant's Course and Scope of Employment at the time of the injury producing event;

21. if the Participant is placed in jail, deported or detained by or at the request of any government agency or foreign government or has left the local area for an extended period of time;

22. if the Participant's employment terminates;

23. if a Provider determines that the Participant can no longer perform on a regular basis the essential functions as described in the Participant's job description;

24. if a Provider determines that the Participant has reached maximum medical improvement.

During an extended period of absence from work when the Participant is receiving medical care and treatment from a Provider, the Participant must follow the advice and recommendations of the Provider to remain eligible for continuing medical treatment. In addition, the failure of the Participant to keep scheduled appointments with Providers and to follow the prescribed treatment plan may result in forfeiture of continued Benefits under this Plan.

If a third party is or may be responsible or partially responsible for the injuries or death suffered by a Participant, the Plan shall have the right to recover monies from the third party, which it pays to or on behalf of the Participant related to such injuries or death. By participating in this Plan, the Participant, his beneficiaries, heirs, estate and/or their family members assign to the Plan the right to recover from a third party monies which the Plan paid or may reasonably be required to pay for or on behalf of the Participant related to the injuries or death, and agrees to execute a document assigning the Participant's rights to the Plan. Thus, the Plan will have an opportunity to recover its expenses from the third party which caused the Participant's injury or death. If the Participant fails to assist the Plan in its attempt to recover monies from the third party, the Participant shall not be entitled to continued benefits under the Plan.

The Plan shall have the first lien recovery against any benefits paid or to be paid by the Plan. The Plan shall also have the right to bring a lawsuit and assert a constructive trust or other interest against any and all persons that have assets that the Plan can claim rights to. The Plan has the right of first recovery from any judgment, settlement or other payment, regardless of whether the Participant, his beneficiaries, heirs, estate and/or their family members have been "made whole."

The Plan's subrogation rights and first lien will not be reduced by attorney's fees or expenses incurred by any party in pursuing recovery against a third party and the "common fund" doctrine shall not apply. Any attorneys' fees and/or expenses incurred by, or at the request of, the Participant, his beneficiaries, heirs, estate and/or their family members in a third party or other action shall be the sole responsibility of such party that incurred the expenses.

If an injured Participant receives benefits from another plan as a result of an on-the-job work related injury or death, the Benefits under this Plan will be reduced so that the total Benefits received by the Participant will not exceed the Benefits that are to be provided under this Plan.

WHO ADMINISTERS THE PLAN AND WHAT ARE HIS/HER DUTIES?

The Plan Administrator is an individual or group who is appointed by the Affiliated Employer. The Plan Administrator is charged with the general administration of the Plan and is given the responsibility to make the rules of administering the Plan, to construe its provisions, to correct its defects and supply any omissions or reconcile any inconsistencies which may resolve all controversies. Its actions in these matters, when performed in good faith and in its sole judgment, shall be final as to all parties. If the Affiliated Employer does not designate a Plan Administrator, the Affiliated Employer shall itself act as Plan Administrator.

HOW DO BENEFITS BEGIN?

If an occurrence occurs, no matter how minor, the Participant must report it immediately (but not later than the end of the shift on which it occurred) to his/her Supervisor or, in his/her absence, the Department Manager, if it is within regular business hours, i.e., Monday -- Friday, 8AM -- 5PM. If it is not within regular business hours, the Participant must notify his/her Supervisor or, in his/her absence, the House Supervisor. In addition, the Participant must complete an Employee Occurrence Report by signing, dating and turning it in to his/her Supervisor, the Department Manager or the House Supervisor before leaving the premises. If the facility utilizes a different reporting mechanism such as a telephone hotline and/or electronic reporting, the Participant must follow the appropriate reporting procedures established by the facility and, in any event, must report his/her occurrence no later than the end of the shift on which it occurred. During regular business hours, the Employee Health Nurse will assist the Participant in obtaining necessary medical treatment from a Provider. If it is not during regular business hours, the House Supervisor will assist the Participant in obtaining necessary medical treatment from a Provider. To ensure that medical benefits will be considered under the Plan, you will also need to:

1. receive authorization for payment; and,

2. obtain a Physician's Report form.

Charges for medical evaluation or treatment must be pre-approved in writing by the Plan Administrator or its designee. If the approved Provider restricts the Participant from returning to work, wage replacement will begin as outlined under “Wage Replacement Benefits.”

When an occurrence is reported, the report will be acted upon by the Plan Administrator within 72 hours if it is an urgent care situation. For all non-urgent care claims, however, the report will be acted upon by the Plan Administrator within 15 days. In special circumstances the decision may be delayed but must, in any event, be made no later than 30 days after the occurrence is reported. This time period may be extended twice by 30 days if wage replacement benefits are at issue and if it is determined that such an extension is necessary due to matters beyond control of the Plan and if the Plan Administrator notifies the Participant of the circumstances requiring the extension of time and the date by which the Plan Administrator expects to render a decision. If such an extension is necessary due to the Participant’s failure to submit the information necessary to render a decision, the notice of extension will specifically describe the required information, and the Participant will be afforded at least 45 days from receipt of

the notice within which to provide the specified information. If the Participant delivers the requested information with the time period specified, any 30 day extension period will begin after the Participant has provided that information. If the Participant fails to deliver the requested information within the time specified, the Plan Administrator may render a decision without that information. If benefits are denied or ceased for any reason, the Plan Administrator will (i) notify the Participant of his action and reasons why, with specific references to the Plan provisions that apply; (ii) describe additional material or information necessary to complete the claim and why such information is necessary; (iii) describe Plan procedures and time limits for appealing the determination, and the Participant's right to obtain information about those procedures and the right to sue in federal court; (iv) disclose any internal rule, guidelines, protocol or similar criterion relied on in making the adverse determination (or state that such information will be provided free of charge upon request).

WHAT SHOULD I DO IF MY BENEFITS ARE DENIED OR CEASED?

If a Participant's benefits are denied or ceased, he/she may file an appeal with the Review Committee. In order to make an appeal, the Participant must submit a written request to the Review Committee within 180 days after his/her claim is first denied or ceased.

For urgent care claims, the Review Committee must make its decision within72 hours after it receives the appeal. For non-urgent care claims, the Review Committee must make its decision within 30 days after it receives the appeal. In special circumstances, and if wage replacement benefits are at issue, the decision may be delayed but must, in any event, be made no later than 75 days after the appeal is received. If an extension of time for a decision upon a claim is required because of special circumstances, the Review Committee will notify the Participant of the extension in writing and will indicate the special circumstances.

If an extension is necessary due to the Participant's failure to submit the information necessary to decide the appeal, the notice of extension will specifically describe the required information, and the Participant will be afforded at least 45 days from receipt of the notice to provide the specified information. If the Participant delivers the requested information within the time specified, the 45 day extension of the appeal period will begin after the Participant has provided that information. If the Participant fails to deliver the requested information within the time specified, the Review Committee may decide the Participant's appeal without that information.

The Participant will have the opportunity to submit written comments, documents, or other information in support of his/her appeal. The Participant will have access to all relevant documents as defined by applicable U.S. Department of Labor regulations. The review of the adverse benefit determination will take into account all new information, whether or not presented or available at the initial determination. No deference will be afforded to the initial determination.

The review will be conducted by a Review Committee and will be made by persons different from the person, acting on behalf of the Plan Administrator, who made the initial determination and such persons will not be the original decision maker's subordinate. In the case of a claim denied on the grounds of a medical judgment, the Review Committee will consult with a health care professional with appropriate training and experience. The health care professional who is consulted on appeal will not be the individual who was consulted during the initial determination or a subordinate. If the advice of a medical or vocational expert was obtained by the Plan Administrator in connection with the denial of cessation of the Participant's claim, the Review Committee will provide the Participant with the names of each such expert, regardless of whether the advice was relied upon.

The decision on appeal will be in writing. If the appeal is denied, the written notification will contain the following information: (i) the specific reason(s) for the decision, with specific reference to Plan provisions that apply; (ii) a statement disclosing any internal rule, guidelines, protocol or similar criterion relied on in making the adverse determination (or a statement that such information will be provided free to charge upon request); (iii) a statement describing the Participant's right to bring a civil suit under federal law; (iv) a statement that the Participant is entitled to receive upon request, and without charge, reasonable access to copies of all documents, records or other information relevant to the determination; and (v) a statement that the Participant or the Plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact the local U.S. Department of Labor Office and the State's

ARBITRATION PROCEDURES

The Arbitration Agreement <u>does not apply</u> to disputes regarding benefits under the Plan. The process to apply for benefits, and to appeal any denial of benefits, is described in the section above. Legal action to contest a Plan decision may be initiated – after exhausting the administrative remedies through the internal appeal process – in federal court as provided in the ERISA statute.

The arbitration agreement <u>does apply</u> to:

1. All claims of whatever sort regarding the terms or applicability or validity of the arbitration agreement itself.

2. All claims resulting from an on-the-job injury, whether resulting from a single injury, cumulative trauma or occupational disease, and whether causing physical, mental, emotional, or economic harm. This includes claims of negligence, gross negligence, intentional torts, crimes, injuries by co-workers, as well as alleged damages from alleged violations of any other legal standard whatsoever forming the basis of a personal injury claim.

3. All such claims now existing or yet to arise.

4. All such claims brought by the Participant, or through the Participant's spouse, children, parents, heirs, beneficiaries, (*e.g.*, claims under survival act or wrongful death statutes), assigns, or anyone else claiming through the Participant directly or derivatively.

5. All such claims whether specifically against the Sponsor, the Participant's employer, any Affiliated Employer, as well as claims against the employees, agents, owners, shareholders, directors, officers, attorneys, insurers, and independent contractors of such parties.

The Arbitration agreement applies equally to the Participant and the Employer and other entities listed, except that the cost to the Participant will be less, as explained below.

The Participant, Sponsor and Affiliated Employers agree that all applicable Texas statute of limitations will apply. Written notice to the Sponsor, or its Affiliated Employers, subsidiaries, successors, officers, directors, shareholders, employees or agents shall be sent to the Plan Administrator at the corresponding address, as listed in Exhibit "2" (or other such person or address as the Plan Administrator

may specify.) If the Sponsor or an Affiliated Employer wishes to invoke arbitration, it will give written notice to the Participant at the last address or most recent known address, if any. This notice shall be sent to the other party (or parties) by certified or registered mail, return receipt requested.

Any party may be represented during pre-hearing procedures (as defined below) and/or at the arbitration hearing by an attorney or other representative selected by the party.

The Sponsor, Affiliated Employers and Participant agree that the arbitration hearing will be conducted before one arbitrator from the JWA (hereinafter the "hearing arbitrator"). The Sponsor, Affiliated Employers and Participant recognize that the JWA's rules for the resolution of disputes and the terms and procedures of this section (as set forth in Section Seven of the Benefit Plan and incorporated by reference into Exhibit "1") may conflict on certain issues and agree to the extent that the procedures set forth in this section and Section Seven of the Benefit Plan conflict with the JWA's rules, the procedures of this section and Section Seven of the Benefit Plan shall control and be applied by the hearing arbitrator.

The hearing arbitrator shall apply the substantive law (and the laws of remedies, if applicable), of Texas, or federal law, or both, depending upon the claim(s) asserted. The hearing arbitrator shall also generally apply the Texas Rules of Civil Procedure and Texas Rules of Evidence, mindful of the purpose of arbitration being more efficient than trial in court. The hearing arbitrator shall provide brief findings of fact and conclusions of law. All arbitration decisions and awards rendered pursuant to Exhibit "1" shall be kept strictly confidential and shall not be disclosed to anyone who is not a witness, attorney, party representative, or party who actually attended the arbitration hearing.

The hearing arbitrator shall have jurisdiction to hear and rule on pre-hearing disputes and is authorized to hold pre-hearing conferences by telephone or in person as the arbitrator deems necessary. The hearing arbitrator will have the authority to hear a motion to dismiss and/or a motion for summary judgment by any part and in so doing shall apply the standards governing such motions under the Texas Rules of Civil Procedure.

Each party will have the right to take the deposition of two individuals and any expert witness designated by another party. Each party will have the right to subpoena witnesses in accordance with the agreement of the parties or the rulings of the hearing arbitrator in accordance with the Texas Rules of Civil Procedure. Additional discovery may be had only where the hearing arbitrator so orders, upon a showing of reasonable need.

The Sponsor, Affiliated Employers and Participant acknowledge that there will be fees and expenses associated with a mediation and for an arbitration hearing under Exhibit "1," and agree as follows:

1. Each party shall be responsible for their own attorney's fees; however, where a claim is brought pursuant to a statute that allows recovery of costs and attorney's fees by a successful claimant, the arbitrator is authorized to award attorney's fees and costs by applying the same standards which would be used by a civil court hearing in the same case.

2. All administrative costs will be paid by the Sponsor or Affiliated Employer, except that the Participant shall pay a one-time contribution toward administrative costs in the amount of $125 when a request for mediation/arbitration is filed. The only exception to the one-time contribution requirement by the Participant is if the arbitrator determines, upon written request with supporting evidence by the Participant, that the Participant is

financially unable to pay the $125.00 one-time contribution prior to a final award by the arbitrator. In such a case, the Sponsor or Affiliated Employer shall pay the funds, but receive a credit in that amount from any award given by the arbitrator to the Participant. All arbitrator compensation and expenses will be paid by the Sponsor or Affiliated Employer. A Participant may elect, however, to pay up to one-half of the mediator's and/or arbitrator's compensation and expenses.

3. If either party pursues a claim covered by this section and Section Seven of the Benefit Plan, and incorporated by reference into Exhibit "1", by any means other than those set forth, the responding party shall be entitled to dismissal of such action, and the recovery of all costs and attorney's fees and losses related to such action.

In the event the Participant prevails and is awarded damages in a negligence claim against the Sponsor and/or an Affiliated Employer, the Affiliated Employer and/or Sponsor shall receive a credit in the amount of benefits paid to and/or on behalf of the Participant by the Plan.

The Participant understands and agrees that the Sponsor and the Affiliated Employers are involved in transactions involving interstate commerce (e.g., purchasing goods and services from outside Texas which are shipped to Texas; utilizing the interstate mail, telephone and highway systems; operating facilities serving people from various states; and recruiting and advertising outside Texas) and that Participant's employment at the Affiliated Employer and participation in the Plan involve such commerce. The Federal Arbitration Act, Title 9 of the United States Code, will govern the interpretation, enforcement, and all judicial proceedings under and/or with respect to Exhibit "1", this section and Section Seven of the Benefit Plan.

ARE PLAN BENEFITS INSURED?

No, Plan Benefits will be paid from the general assets of the Affiliated Employers and are not guaranteed under a policy associated with this Plan. This Plan is a non-funded occupational welfare benefit plan for eligible Texas employees.

WHAT ARE MY EMPLOYEE RETIREMENT INCOME SECURITY ACT OF 1974 (ERISA) RIGHTS?

As a Participant covered by this Plan, you have certain rights and protections under ERISA, which provide that all Plan participants shall be entitled to:

1. examine, without charge, at the Plan Administrator's office and at other locations such as worksites, all Plan documents filed by the Plan with the U.S. Department of Labor; and

2. obtain copies of all Plan documents and other Plan information upon written request to the Plan Administrator (the Plan Administrator may make a reasonable charge for the copies).

In addition to creating rights for Plan participants, ERISA imposes duties upon the people who are responsible for the operation of the 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. No one, including the Plan Administrator or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a Benefit or exercising your rights under ERISA. If your claim for a Benefit is denied in whole or in part, you must receive a written explanation of the reason for the denial. You have the right to have a Review Committee review and reconsider your claim. 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 thirty (30) days, you may file suit in federal court. In such a case, the court may require the Plan Administrator to provide you the materials and pay you up to $110 (or more) a day until you receive the materials, unless the materials were not sent because of reasons beyond the reasonable control of the Plan 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. 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, you should contact the nearest Area Office of the U.S. Labor-Management Services Administration, Department of Labor at 525 S. Griffin, Dallas, Texas 75202, 214/767-6831.

PRIVATE HEALTH INFORMATION

A federal law, the Health Insurance Portability and Accountability Act of 1996 (HIPAA), requires that health plans protect the confidentiality of your private health information. A complete description of your rights under HIPAA can be found in the Plan's privacy notice attached hereto.

This Plan, the Plan Sponsor and Plan Administrator, will not use or further disclose information that is protected by HIPAA ("protected health information") except as necessary for treatment, payment, health plan operations and plan administration, or as permitted or required by law. By law, the Plan has required all of its business associates to also observe HIPAA's privacy rules.

Under HIPAA, you have certain rights with respect to your protected health information, including certain rights to see and copy the information, receive an accounting of certain disclosures of the information and, under certain circumstances, amend the information. You also have the right to file a complaint with the Plan or with the U. S. Department of Health and Human Services if you believe your rights under HIPAA have been violated.

This Plan maintains a privacy notice, which provides a complete description of your rights

Under HIPAA's privacy rules. For a copy of the notice, for questions about the privacy of your health information, or to file a complaint under HIPAA, please contact the designated Privacy Official for the Plan as identified in the Privacy Notice attached hereto.

CAN THE PLAN BE AMENDED?

The provisions of this Plan may be amended at any time and from time to time by the Sponsor provided notice of such amendments is provided to the Participants at least ten (10) days prior to the adoption of those changes. Equivalent notice will also be provided of any changes to the alternative dispute resolution procedures. The Participant will be given an opportunity to acknowledge and accept or reject any such amendment though agreed to continued, or rejected, participation in the Plan at that time. Any amendment made to the Plan will only apply to occurrences that occur after the effective date of said amendment.

HOW LONG WILL THE PLAN CONTINUE?

The Sponsor or an Affiliated Employer may terminate the Plan at any time if the Sponsor or Affiliated Employer has sent to the Plan Participants at least ten (10) days prior written notice of its intention to terminate the Plan. Termination of the Plan applies equally to the Sponsor's, Affiliated Employer(s)' and Participant's claims, and will not affect occurrences that occurred prior to the effective date of the termination.

PARA LOS EMPLEADOS QUE HABLAN ESPANOL

ESTE RESUMEN DE LA DESCRIPCION DEL PLAN CONTIENE UN RESUMEN EN INGLES DE LOS DERECHOS Y BENEFICIOS DE SU PLAN DE BENEFICIOS EN CASO DE LESIONES DE EMPLEADOS DEL PATROCINADOR. SI TIENE ALGUNA DIFICULTAD PARA ENTENDER ALGUNA PARTE DE ESTE RESUMEN DE DESCRIPCION DEL PLAN, USTED DEBE COMUNICARSE CON SU SUPERVISOR DURANTE LAS HORAS NORMALES DE TRABAJO. TAMBIEN PUEDE COMUNICARSE CON EL ADMINISTRADOR DEL PLAN O LLAMANDO AL NUMERO DE TELEFONO QUE A LA ANOTACION EN EL DOCUMENTO DE PRUEBA "B" QUE SE INCLUYE EN EL PLAN. SE ATIENDE DE LUNES A VIERNES DESDE LAS 8:00 A.M. HASTA LAS 5:00 P.M.

PLAN DIRECTORY

Listed below is other pertinent information concerning the Plan:

Sponsor:	HCA Healthcare, Inc. 1100 Charlotte Ave., Suite 800 Nashville, TN 37203 Telephone: 615-344-5875
Agent for Service of Legal Process:	Service of legal process may be made upon the Plan Administrator at the corresponding address, as listed in Exhibit "2".
Sponsor Identification Number	75-2497104
Plan Fiscal Year:	January 1 to December 31
Plan Effective Date and Amendment Dates:	December 1, 1993 December 1, 1995, November 1, 1997, June 17, 2001, January 1, 2003, April 14, 2004 and December 1, 2017. In the limited instances where an Employee of an Affiliated Employer acquired by HCA Healthcare, Inc. between July 1, 2017 and November 30, 2017, elects to participate in the Plan prior to December 1, 2017, the amendments effective December 1, 2017, will be effective for such an Employee on the date he/she signs the Election to Participate in the Employee Health and Safety Program Benefit Plan of HCA Healthcare, Inc. and Agreement to Submit to Arbitration.
Plan Number:	511

Notice of Privacy Practices
HCA Healthcare, Inc.'s Employee Health and Safety Program Benefit Plan

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

The Health Insurance Portability and Accountability Act of 1996 (**HIPAA**), and the rules to carry out this law (**Privacy Rules**), require health plans to notify participants and beneficiaries about the policies and practices the plan has adopted to protect the confidentiality of their health information, including health care payment information.

This Notice summarizes the privacy policies of the self-funded medical benefits under the HCA Healthcare, Inc. Employee Health and Safety Program Benefit Plan (**Plan**), sponsored by HCA Healthcare, Inc. (**Company**).

The Privacy Rules require the Plan to protect the confidentiality of your protected Health Information. "**Protected Health Information**" or "**PHI**" includes any information, whether oral or recorded, in any form or medium that is created or received by the Plan that relates to your past, present, or future physical or mental health, including the provision of and payment for care, that identifies you or provides a reasonable basis for your identification. PHI includes ePHI. Electronic Protected Health Information or ePHI means PHI stored, maintained or transmitted electronically.

PHI does not include de-identified health information or health information that the Company and/or its Affiliated Employers are entitled to under applicable law (for example, FMLA, Americans with Disabilities Act, Occupational Safety and Health Act, workers' compensation laws and other state and federal laws), or health information that the Company and/or its Affiliated Employers obtain through sources other than the Plan and retain as part of your employment records (for example, drug screening tests, fitness for duty examination results or other types of similar information). This type of information, therefore, is not subject to the Privacy Rule, nor the restrictions described in this document.

Third parties assist in administering your health benefits under the Plan. These entities keep and use most of the medical information maintained by the Plan such as information about your health condition, the health care services you receive and the payments for such services. They use this information to process your benefit claims. They are required to use the same privacy protections as the Plan.

The law requires the Plan to maintain the privacy of your PHI, to provide you with this Notice of its legal duties, and to abide by the terms of this Notice. In general, the Plan may only use and/or disclose your PHI where required or permitted by law or when you authorize the use or disclosure. The Plan may also only use the minimum amount of your PHI that is necessary to accomplish the intended purpose of the use or disclosure as permitted by HIPAA.

WHEN THE PLAN MUST DISCLOSE YOUR PHI
The Plan must disclose your PHI:

- to you;
- to the Secretary of the United States Department of Health and Human Services (**DHHS**) to determine whether the Plan is in compliance with HIPAA; and
- where required by law. This means the Plan will make the disclosure only when the law requires it do so, but not if the law would just allow it to do so.

WHEN THE PLAN MAY USE OR DISCLOSE YOUR PHI WITHOUT YOUR AUTHORIZATION
The Plan may use and/or disclose your PHI as follows:

For Treatment. The Plan does not provide medical treatment directly, but it may disclose your PHI to a health care provider who is giving treatment. For example, the Plan may disclose the types of prescription drugs you currently take to an emergency room physician, if you are unable to provide your medical history due to an accident.

For Payment. The Plan may disclose your PHI, as needed, to pay for your medical benefits. For example, the Plan may tell a doctor whether you are eligible for coverage or what percentage of the bill the Plan might pay. The Plan may also use or disclose your PHI in other ways to administer benefits; for example, to process and review claims, to coordinate benefits with other health plans, to exercise its subrogation rights, and to do utilization review and pre-authorizations.

For Health Care Operations. The Plan may use and/or disclose your PHI to make sure the Plan is well run, administered properly and does not waste money. For example, the Plan may use information about your claims to project future benefit costs or audit the accuracy of its claims processing functions. The Plan may also disclose your PHI for a claim under a stop-loss or re-insurance policy. Among other things, the Plan may also use your PHI to undertake underwriting, premium rating and other insurance activities relating to changing health insurance contracts or health benefits. However, federal law prohibits the Plan from using or disclosing PHI that is genetic information (e.g., family medical history) for underwriting purposes, which include eligibility determinations, calculating premiums, applications or any pre-existing condition exclusions

and any other activities related to the creation, renewal or replacement of a health insurance contract or health benefits.

For Special Information. In addition to the Privacy Rule, special protections under state or other federal law may apply to the use and disclosure of your PHI. The Plan will comply with these state or federal laws where they are more protective of your privacy. The Plan will comply with any other laws protecting your privacy only to the extent these laws are not preempted by ERISA.

To the Company and/or its Affiliated Employers. In certain cases, the Plan may disclose your PHI to the Company and/or its Affiliated Employers.

- Some of the people who administer the Plan work for the Company and/or its Affiliated Employers. Before your PHI can be used by or disclosed to these employees, the Company and/or Affiliated Employer must certify that it has: (1) amended the Plan documents to explain how your PHI will be protected; (2) identified the Company and/or Affiliated Employer employees who need your PHI to carry out their duties to administer the Plan; and (3) separated the work of these employees from the rest of the workforce so that the Company and/or Affiliated Employer cannot use your PHI for employment-related purposes or to administer other benefit plans. For example, these designated employees will be able to contact an insurer or third party administrator to find out about the status of your benefit claims without your specific authorization.
- Plan may disclose information to the Company and/or its Affiliated Employers that summarizes the claims experience of Plan participants as a group, but without identifying specific individuals, to get new benefit insurance or to change or terminate the Plan. For example, if the Company wants to consider adding or changing certain health benefits, it may receive this summary health information to assess the costs of those services.
- The Plan may also disclose limited health information to the Company and/or its Affiliated Employers in connection with the enrollment or disenrollment of individuals into or out of the Plan.

To Business Associates. The Plan may hire third parties that may need your PHI to perform certain services on behalf of the Plan. These third parties are "Business Associates" of the Plan. Business Associates must protect any PHI they receive from, or create and maintain on behalf of, the Plan. For example, the Plan may hire a third party administrator to process claims, an auditor to review how an insurer or third party administrator is processing claims, or an insurance agent to assess coverages and help with claim problems or a service provider to provide health benefits.

To Individuals Involved with Your Care or Payment for Your Care. The Plan may disclose your PHI to adult members of your family or another person identified by you who is involved with your care or payment for your care if: (1) you are present and agree to the disclosure; (2) the Plan informs you that it intends to do so and you do not object; or (3) you are not present or you are not capable of agreeing to the disclosure and the Plan infers from the circumstances, based upon professional judgment, that you do not object to the disclosure. The Plan may release claims payment information to spouses, parents or guardians.

To Personal Representatives. The Plan may disclose your PHI to someone who is your personal representative. Before the Plan will give that person access to your PHI or allow that person to take any action on your behalf, it will require him/her to give proof that he/she may act on your behalf; for example, a court order or power of attorney granting that person such power. Generally, the parent of a minor child will be the child's personal representative. In some cases, however, state law allows minors to obtain treatment (e.g., sometimes for pregnancy or substance abuse) without parental consent, and in those cases the Plan may not disclose certain information to the parents. The Plan may also deny a personal representative access to PHI to protect people, including minors, who may be subject to abuse or neglect.

For Treatment Alternatives or Health-Related Benefits and Services. The Plan may contact you to provide information about treatment alternatives or other health-related benefits or services that may be of interest to you.

For Public Health Purposes. The Plan may: (1) report specific disease or birth/death information to a public health authority authorized to collect that information; (2) report reactions to medication or problems with medical products to the Food and Drug Administration to help ensure the quality, safety, or effectiveness of those medications or medical products; or (3) if authorized by law, disclose PHI to a person who may have been exposed to a communicable disease or who may otherwise be at risk of contracting or spreading a disease or medical condition.

To Report Violence and Abuse. The Plan may report information about victims of abuse, neglect or domestic violence to the proper authorities.

For Health Oversight Activities. The Plan may disclose PHI for civil, administrative or criminal investigations, oversight inspections, licensure or disciplinary actions (e.g., to investigate complaints against medical providers), and other activities for the oversight of the health care system or to monitor government benefit programs.

For Lawsuits and Disputes. The Plan may disclose PHI in response to an order of a court or administrative agency, but only to the extent expressly authorized in the order. The Plan may also disclose PHI in response to a subpoena, a lawsuit discovery request, or other lawful process, but only if the Plan has received adequate assurances that the information to be disclosed will be protected. The Plan may also disclose PHI in a lawsuit if necessary for payment or health care operations purposes.

For Law Enforcement. The Plan may disclose PHI to law enforcement officials for law enforcement purposes and to correctional institutions regarding inmates.

To Coroners, Funeral Directors and Medical Examiners. The Plan may disclose PHI to a coroner or medical examiner; for example, to identify a person or determine the cause of death. The Plan may also release PHI to a funeral director who needs it to perform his or her duties.

For Organ Donations. The Plan may disclose PHI to organ procurement organizations to facilitate organ, eye or tissue donations.

For Limited Data Sets. The Plan may disclose PHI for use in a limited data set for purposes of research, public health or health care operations, but only if a data use agreement has been signed.

To Avert Serious Threats to Health or Safety. The Plan may disclose PHI to avert a serious threat to your health or safety or that of members of the public.

For Special Governmental Functions. The Plan may disclose PHI to authorized federal officials in certain circumstances. For example, disclosure may be made for national security purposes or for members of the armed forces if required by military command authorities.

For Workers' Compensation. The Plan may disclose PHI for workers' compensation if necessary to comply with these laws.

For Research. The Plan may disclose PHI for research studies, subject to special procedures intended to protect the privacy of your PHI.

For Emergencies and Disaster Relief. The Plan may disclose PHI to organizations engaged in emergency and disaster relief efforts.

WRITTEN AUTHORIZATION
The Plan will not use or disclose your PHI without your written authorization for (1) uses and disclosures for marketing purposes, (2) uses and disclosures that constitute the sale of PHI, (3) most uses and disclosures of psychotherapy notes, and (4) any other uses and disclosures not described in this Notice. The authorization must meet the requirements of the Privacy Rules. If you give the Plan a written authorization, you may cancel your authorization, except for uses or disclosures that have already been made based on your authorization. You may not, however, cancel your authorization if it was obtained as a condition for obtaining insurance coverage and if your cancellation will interfere with the insurer's right to contest your claims for benefits under the insurance policy.

YOUR INDIVIDUAL RIGHTS
You have certain rights under the Privacy Rules relating to your PHI maintained by the Plan. All requests to exercise those rights must be made in writing to the Privacy Official. The Plan's third party administrators keep their own records, and you must make your requests relating to your PHI in those records directly to that third party administrator. Your rights are:

Right to Request Restrictions on Uses and Disclosures of Your PHI. You may request that the Plan restrict any of the permitted uses and disclosures of your PHI listed above. The Plan, however, does not have to agree to your requested restriction. However, the Plan will accommodate a reasonable request to communicate with you in confidence about your PHI if you provide a clear statement that disclosure of all of part of your PHI could endanger you (as explained in "Right to Request Restrictions and Confidential Communications" below). You may also request that your health care provider not disclose your PHI for a health care operations if you have paid for the item or service out-of-pocket in full. A restriction cannot prevent uses or disclosures that are required by the Secretary of DHHS to determine or investigate the Plan's compliance with the Privacy Rules, or that are otherwise required by law.

Right to Access or Copy Your PHI. You generally have a right to access your PHI that is kept in the Plan's records, except for: (1) psychotherapy notes (as defined in the Privacy Rules); or (2) information compiled in reasonable anticipation of, or for use in, a civil, criminal or administrative action or proceeding. The Plan may deny you access to your PHI in the Plan's records. You may, under some circumstances, request a review of that denial. If the Plan or its Business Associates maintain electronic records of your PHI, you may request an electronic copy of your PHI. You may also request that your electronic records be sent to a third party.
The Plan may charge you a reasonable fee for copying the information you request and the cost of any mailing or the cost to provide access to your PHI electronically, but cannot charge you for time spent finding and assembling the requested information.

Right to an Accounting of Disclosures. At your request, the Plan must provide you with a list of the Plan's disclosures of your PHI made within the six-year period just before the date of your request, except disclosures made:

- for purposes of treatment, payment or health care operations;
- directly to you or close family members involved in your care;
- for purposes of national security;
- incidental to otherwise permitted or required disclosures;
- as part of a limited data set;
- to correctional institutions or law enforcement officials; and
- with your express authorization.

You may request one accounting, which the Plan must provide at no charge, within a single 12-month period. If you request more than one accounting within the same 12-month period. If you request more than one accounting within the same 12-month period, the Plan may charge you a reasonable fee.

Right to Amend. You may request that the Plan change your PHI that is kept in the Plan's records, but the Plan does not have to agree to your request. The Plan may deny your request if the information in its records: (1) was not created by the Plan; (2) is not part of the Plan's records; (3) would not be information to which you would have a right of access; or (4) is deemed by the Plan to be complete and accurate as it then exists.

Right to Request Restrictions and Confidential Communications. You have the right to request that the Plan communicate with you in a confidential manner, for example, by sending information to an alternative address or by an alternative means. The Plan will accommodate your request if your request is reasonable and you provide a clear statement that disclosure of all or part of the information will endanger you. Any alternative used must still allow for payment information to be effectively communicated and for payments to be made.

Right to File a Complaint. If you believe your rights have been violated, you have a right to file a written complaint with the Plan's Privacy Official or with the Secretary of the DHHS. The Plan will not retaliate against you for filing a complaint and cannot condition your enrollment or your entitlement to benefits on your waiving these rights. If your complaint is with the Plan, you may submit your complaint in writing to:

HCA Healthcare, Inc.
Texas EHSP- HIPAA Privacy Official
1100 Charlotte Ave., Suite 800
Nashville, TN 37203

To file a complaint with the Secretary of the DHHS, you must submit your complaint in writing, either on paper or electronically, within 180 days of the date you knew or should have known that the violation occurred. You must state who you are complaining about and the acts or

omissions you believe are violations of the Privacy Rules. Complaints sent to the Secretary must be addressed to the regional office of the DHHS' Office of Civil Rights (OCR) for the state in which the alleged violation occurred. For information on which regional office at which you must file your complaint, and the address of that regional office, go to the OCR Web site at **www.hhs.gov/ocr/hipaa.**

Right to Receive a Paper Copy of This Notice Upon Request. You have a right to obtain a paper copy of this Notice upon request. You may also print or view a copy of this Notice.

To exercise your rights under this notice and for further information about matters covered by this notice, please contact the Environmental and Employee Safety Department at the corporate office and ask to speak to the EHSP Benefit Plan Privacy Official. The corporate office number is (615) 344-5875.

Right to Receive Notification. You have a right to receive notification of a break of your unsecured PHI.

CHANGES TO THE NOTICE
The Plan reserves the right to change the terms of this Notice and to make the new revised Notice provisions effective for all PHI that it maintains, including any PHI created, received or maintained by the Plan before the date of the revised Notice. If you agree, the Plan may provide you with a revised Notice electronically. Otherwise, the Plan will provide you with a paper copy of the revised Notice.

CONTACT THE PLAN OFFICIAL FOR MORE INFORMATION
If you have any questions regarding this Notice or if you wish to exercise any of your rights described in this Notice, you may contact the Privacy Official at the address and/or phone number listed above.