Short Term Disability Income Plan

Augusta Health Care, Inc.

BOOKLET

PLAN EFFECTIVE DATE: July 1, 2024

All Other Full-Time and Part-Time Employees

The Plan is a self-funded welfare benefit plan (the "Plan") providing Short Term Disability benefits ("STD") to eligible participants under the terms and conditions of the Plan. Sun Life Assurance Company of Canada ("Sun Life") is the Claims Administrator and provides certain claim administration services to the Plan. The Plan Administrator, *Augusta Health Care, Inc.*, retains discretion to make the final claim decision. The Plan is not insured by Sun Life and Sun Life has not issued any insurance policy to fund benefits under the Plan, nor is Sun Life responsible for the payment of any benefits under the Plan. All benefits are funded by *Augusta Health Care, Inc.*

This booklet is intended to provide a summarized explanation of the current Plan benefits. The description of Eligible Classes in the Schedule of Benefits will help you determine what benefits apply to you. In the event of any changes in benefits or Plan provisions, the Plan Administrator will provide you with a new booklet that describes any changes.

Possession of this booklet does not necessarily mean you are covered under the Plan. The requirements for becoming eligible for coverage under the Plan and the dates your coverage begins or ceases are explained within this booklet.

This booklet uses terms and phrases that are listed in the Definitions Section.

For information, please contact your Human Resources contact at *Augusta Health Care, Inc.* or Sun Life at (888) 444-0239.

THE PLAN MAY BE AMENDED OR TERMINATED BY *Augusta Health Care, Inc.* AT ANY TIME AND FOR ANY REASON.

READ THIS DOCUMENT CAREFULLY

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BENEFITS FOR YOU

Short Term Disability Coverage

The Plan pays you a portion of your income earnings as a benefit for a period of Short-Term Disability caused by an Illness or Injury that occurs while your coverage is in effect and so long as you meet all requirements under the Plan to receive benefits. You must provide the Plan, at your own expense, satisfactory Proof of Disability before benefits will be paid.

Coverage under this Plan is non-occupational. Only non-occupational injuries and non-occupational illnesses are covered.

Please refer to the following provisions for more details about your coverage.

BENEFIT HIGHLIGHTS

Eligible Employee's
All Full-Time United States Employees working in the United States who are scheduled to work at least 36 hours per week, excluding Directors, Physicians, Physician Assistants, Nurse Practitioners and Executive Officers.

All Part-Time United States Employees working in the United States who are scheduled to work at least 20 hours per week, excluding Directors, Physicians, Physician Assistants, Nurse Practitioners and Executive Officers.

Eligibility Waiting Period
First of the month coinciding with or next following the date of hire

Elimination Period
7 days for injury or illness

Note: Benefits will begin on the first day following the completion of the Elimination Period.

Gross Disability Benefit
60% of weekly Covered Earnings

For any partial week of Disability, payment is made at the daily rate of 1/7th of the weekly benefit payable.

Maximum Weekly Benefit
$2,500

Maximum Benefit Payable Period
The earlier of:

a. end of the Disability; or
b. 25 weeks

Benefits Actually Payable
Any benefit actually payable to you will be reduced by Other Income Benefits or Other Income Earnings.

ELIGIBILITY AND EFFECTIVE DATES

Eligibility Requirements for Plan Benefits
The eligibility requirements for Plan benefits are shown in the Benefit Highlights.

When is the Employee Eligible for Plan Benefits?
The Employee is initially eligible for Plan benefits on the latest date of:

1. This Plan's effective date; or
2. The day after the Employee completes the Eligibility Waiting Period shown in the Benefit Highlights.

Plan Eligibility Effective Date
Eligibility will be effective at 12:01 A.M. - Local Time at 78 Medical Center Dr., Fishersville, VA 22939 determined as follows, but only if the Employee's application or enrollment is made in a form or format satisfactory to the Plan.

An Employee is covered on his Eligibility Date.

When Does a Change in benefits Start?
If the Employee is in Active Service, any increase in benefits will start:

1. Immediately upon the date of change, if the Employee transfers to a different class of eligible Employees; or
2. Immediately upon the date of change, for an increase in the Employee's Covered Earnings.

Delayed Effective Date
The effective date of any initial, increased or additional coverage will be delayed for an individual if he is not in Active Service because of Injury or Illness. The initial, increased or additional coverage will begin on the date the individual returns to Active Service.

What happens if the Employer rehires the Employee?
If the Employer rehires an Employee within 1 month of the date employment ends, coverage may reinstate. The reinstated coverage will:

1. Be the same for which the Employee was covered prior to termination of employment;
2. Be subject to all the terms and provisions of the Plan.

If the Employee had partially met the Eligibility Waiting Period prior to the termination of employment, the previous time employed with the Employer will count towards the completion of the Eligibility Waiting Period. The Eligibility Date will be the later of the date the Employee is rehired or the day after completion of the Eligibility Waiting Period.

If the Employer rehires the Employee 1 month or later after the date employment terminates, the coverage will not be reinstated. The employee will be eligible on the day after the Employee completes a new Eligibility Waiting Period.

DISABILITY INCOME BENEFITS

Disability Benefit
When Sun Life receives Proof that a Covered Person is Disabled due to Injury or Illness and requires the Appropriate and Continuing Care by a Physician, the Plan will pay the Covered Person a Weekly Benefit after the end of the Elimination Period, subject to any other provisions of this Plan. The benefit will be paid for the period of Disability if the Covered Person gives to Sun Life Proof of continued:

1. Disability;
2. Appropriate and Continuing Care by a Physician; and
3. Appropriate Available Treatment.

The Proof must be given upon the Plan's request and at the Covered Person's expense. In determining whether the Covered Person is Disabled, the Plan will not consider employment factors including, but not limited to, interpersonal conflict in the workplace, recession, job obsolescence, pay cuts, job sharing and loss of a professional or occupational license or certification.

For purposes of determining Disability, the Injury must occur and Disability must begin while the Employee is covered under the Plan.

The Weekly Benefit will not:

1. Exceed the Covered Person's Amount of Coverage; or
2. Be paid for longer than the Maximum Benefit Period.

The Amount of Coverage and the Maximum Benefit Period are shown in the Benefit Highlights.

Amount of Disability Weekly Benefit
To figure the amount of Weekly Benefit:

1. Take the lesser of:
    a. The Covered Person's Covered Earnings multiplied by the benefit percentage shown in the Benefit Highlights; or
    b. The Maximum Weekly Benefit shown in the Benefit Highlights; and then
2. Deduct Other Income Benefits and Other Income Earnings, (shown in the Other Income Benefits and Other Income Earnings provision of this Plan), from this amount.

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.

Return to Work Incentive Benefit Calculation
You may work for wage or profit while Disabled. In any week in which you work and a Disability Benefit is payable, the Return to Work Incentive Benefit Calculation applies.

For each week that Disability Benefits are payable, your benefits are calculated as follows:

1. Add your Gross Disability Benefit and Covered Earnings
2. Compare the sum from 1 to your Covered Earnings.
3. If the sum from 1 exceeds 80% of your Covered Earnings, then subtract the Covered Earnings from the sum in 1.

4. Your Gross Disability Benefit will be reduced by the difference from 3, as well as by Other Income Benefits.
5. If the sum from 1 does not exceed 80% of your Covered Earnings, your Gross Disability Benefit will be reduced by the Other Income Benefits.

The Plan will review your status from time to time and will require satisfactory proof of earnings, and continued Disability.

No Disability Benefits are paid, and participation will end if the Plan determines you are able to work under a modified work arrangement and you refuse to do so without Good Cause.

Other Income Benefits

The Disability benefit will be reduced by any of the following which are available to the Participant, or to the Participant's spouse or child(ren), if applicable, for the same period for which the Disability benefit is payable hereunder:

1. primary retirement benefits under the Federal Social Security Act, or any similar plan or act; provided, however, that any cost-of-living increases in such benefits, effective after the initial reduction in the Plan benefit, will not serve to further reduce the Plan benefit;
2. benefits under any plan, fund or other arrangement, by whatever name called, providing disability benefits pursuant to any compulsory benefit act or law of any government;
3. temporary and permanent disability payments (whether total or partial), vocational rehabilitation payments, and any other amounts awarded to or allocated for the Participant under any workers' compensation law, occupational disease law, or any other legislation or law of similar purpose where Workers' Compensation benefits have initially been denied;
4. benefits under a state-mandated Disability plan or a Company plan established in lieu thereof;
5. disability benefits under any other Company-sponsored or Company funded plan; and
6. any work loss provision in mandatory "No-Fault" automobile insurance.

* 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 are 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 Covered Earnings.

Lump Sum Payments

Other Income Benefits or earnings paid in a lump sum are prorated over the period for which the sum is given. If no time is stated, the lump sum is 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 Covered 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.

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 are reduced to recover the overpayment.

Right of Recovery
The Plan has the right to recover any overpayment of benefits caused by, but not limited to, the following:

1. Fraud;
2. Any error made in processing a claim;
3. The Covered Person's receipt of any Other Income Benefits.

The Plan may recover and overpayment by, but not limited to, the following:

1. Requesting a lump sum payment of the overpaid amount;
2. Reducing any benefits payable under this Plan;
3. Taking any appropriate collection activity available including any legal action needed; and

It is required that full reimbursement be made to the Plan.

Successive Periods of Disability
A separate period of Disability is 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 30 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.

EXCLUSIONS AND LIMITATIONS

Disability Benefit Exclusions

The Plan will not pay any Disability Benefits for a Disability that result, 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 Illness 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 Illness in the locality in which the surgery is performed. The Plan will pay benefits if you donating an organ in a non-experimental organ transplant procedure cause the Disability.
7. An Injury or Illness for which the Employee is entitled to benefits from Workers' Compensation or occupational disease law.

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

Disability Benefit Limitations

No benefit is payable to you under the Plan for any period of Disability or other loss:

1. While you are not under the Continuing Care of a Physician for the Injury or Illness causing your Disability, unless you have reached your maximum point of recovery and are still Disabled;
2. For any period you do not submit to any medical examination or clinical assessment requested by The Plan.

TERMINATION PROVISIONS

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.

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 terminates.
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.

CONTINUATION AND REINSTATEMENT OF PLAN PARTICIPATION

Continuation of Plan Participation
If the Employee is absent due to an Injury or Illness, the Employee's Plan Participation will continue during the Elimination Period.

While the Plan is in force and subject to the conditions stated in the Plan, the Employer may continue the Employee's coverage for any of the following reasons: Layoff – up to 1 month

- Leave of Absence – up to 6 months
- Vacation – up to 3 months

While the Plan is in force, the Employee may be eligible to continue their coverage pursuant to the Family and Medical Leave Act (FMLA) of 1993, as amended or continue coverage pursuant to a state required continuation period (if any).

While the Plan is in force, the Employee may be eligible to continue their insurance pursuant to the Uniformed Services Employment and Reemployment Rights Act (USERRA), as amended.

Reinstatement of Plan Participation
Your participation may reinstate 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.

GENERAL 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.
The Plan reserves the right to determine if the Covered Person's Proof of loss is satisfactory.

Notice of Claim
Notice of claim must be given to the Plan within 30 days of the date of the loss on which the claim is based. If that is not possible, the Plan must be notified as soon as it is reasonably possible to do so. Such notice of claim must be received in a form or format satisfactory to the Plan.

When written notice of claim is applicable and has been received by the Plan the Covered Person will be sent claim forms. If the forms are not received within 15 days after written notice of claim is sent, the Covered Person can send The Plan written Proof of claim without waiting for the forms.

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.

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 require an autopsy unless prohibited by law at its expense.

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 Proceedings

A claimant or the claimant's authorized representative cannot start any legal action:

1. Until 60 days after Proof of claim has been given; or
2. More than three years after the time Proof of claim is required.

Legal Action
You must use and exhaust this Plan's administrative claims and appeals procedures before bringing a lawsuit. Any legal action brought to recover payment of any benefit under this Plan must be initiated before the earlier to occur of the following:

- Two years after the date of the final decision on the final appeal of the denial of your claim;
- Three years from the date your claim for benefits was first denied.

Payment of Claims
The benefit is payable to the Covered Person. But, if a benefit is payable to a Covered Person's estate, a Covered Person who is a minor, or who is not competent, The Plan has the right to pay up to $2,000 to any of the Covered Person's relatives or any other person whom the Plan considers entitled thereto by reason of having incurred expense for the maintenance, medical attendance or burial of the Covered Person. If the Plan in good faith pays the benefit in such a manner, any such payment shall fulfill the Plan's responsibility for the amount paid.

Subrogation and Reimbursement
When a Covered Person's Injury appears to be someone else's fault, benefits otherwise payable under this Plan for loss of time as a result of that Injury will not be paid unless the Covered Person or his legal representative agree(s):

1. To repay the Plan for such benefits to the extent they are for the losses for which compensation is paid to the Covered Person by or on behalf of the person at fault;
2. To allow the Plan a lien on such compensation and to hold such compensation in trust for the Plan and
3. To execute and give to the Plan any instruments needed to secure the rights under 1. and 2. Above.

Further, when the Plan has paid benefits to or on behalf of the injured Covered Person, the Plan will be subrogated to all rights of recovery that the Covered Person has against the person at fault. These subrogation rights will extend only to recovery of the amount the Plan has paid. The Covered Person must execute and deliver any instruments needed and do whatever else is necessary to secure those rights to The Plan.

DEFINITIONS

Active Service
If you are an Employee, you are in Active Service 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 day.

You are 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 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.

Continuing Care means the Employee visits a Physician whose medical specialty is the most appropriate specialty to evaluate, manage, or treat their Injury or Illness. The Employee receives care and treatment as frequently as is medically necessary according to the generally accepted medical standards.

Covered Earnings means your basic weekly earnings as reported by your Employer immediately before the first date your Total Disability begins. Total Weekly Earnings includes incentive pay and deductions made for pre-tax contributions to a qualified deferred compensation plan, Section 125 plan, health savings account or flexible spending account, but does not include income received due to commissions, bonuses, overtime pay or any other extra compensation.

If your current weekly earnings includes incentive pay, your incentive pay will be averaged over the previous 26 pay periods immediately before the first date your Total Disability begins or averaged from your date of employment, whichever is less.

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

Disability or Disabled means the Covered Person, as a result of Injury or Sickness, is unable to perform the Material and Substantial Duties of his Regular Occupation.

Eligibility Date means the date an Employee becomes eligible for insurance under this plan. Eligibility Requirements are shown in the Schedule of Benefits.

Eligibility Waiting Period means the continuous length of time an Employee must be in Active Service in an eligible class to reach his Eligibility Date.

Elimination Period means 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.

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.

Good Cause means a medical reason preventing the Employee's participation in the Return to Work Incentive Plan. The Employee must provide satisfactory Proof of Good Cause to The Plan. **Illness** means any physical or mental illness or disease including pregnancy or complications of pregnancy.

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

Material and Substantial Duties means responsibilities that are normally required to perform the Covered Person's Regular Occupation and cannot be reasonably eliminated or modified.

Mental Illness means a psychiatric or psychological condition classified as such in the most current edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM) regardless of the underlying cause of the Mental Illness. If the DSM is discontinued, Sun life will use the replacement chosen or published by the American Psychiatric Association.

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 spouse, or a person living in your household.

It does not include a Covered Person, any family member or domestic partner.

Plan
Refers to the Short Term Disability benefits provided by the Employer as an in effect from time to time.

Regular Occupation means 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.

Treatment means consulting, receiving care or services provided by or under the direction of a Physician including diagnostic measures, being prescribed drugs and/or medicines, whether the Covered Person chooses to take them or not, and taking drugs and/or medicines.

Weekly Benefit means the weekly amount payable by the Plan to the Disabled or Partially Disabled Covered Person.

CLAIMS APPEAL AND REVIEW PROCESS

Claim Determinations
The Claims Administrator will make notification of a claim determination as soon as possible but not later than 45 calendar days after the claim is made. The Claims Administrator may determine that due to matters beyond its control an extension of this 45 calendar days claim determination period is required. Such an extension, of not longer than 30 additional calendar days, will be allowed if the Claims Administrator notifies you within the first 45 calendar days period. If prior to the end of the first 30 calendar days extension period, the Claims Administrator again determines that due to matters beyond its control a decision cannot be made within that extension period, the claim determination period may be extended for an additional 30 calendar days. The Claims Administrator must notify you, prior to the end of the first extension period, of the circumstance requiring the extension and the date by which a decision can be expected.

The notice of any extension by the Claims Administrator shall specifically explain:

- the standards on which entitlement to a benefit is based;
- the unresolved issues that prevent a decision on the claim; and
- the additional information needed to resolve those issues.

The claimant will have 45 calendar days, from the date of the notice, to provide the Claims Administrator with the required information.

What if my claim is denied?

If your claim is denied in whole or in part, you will be notified in writing, in a culturally and linguistically appropriate manner, which will inform you of:

1. the specific reason(s) for the denial, and the Plan provisions on which the denial is based;
2. the identity of any medical or vocational experts whose advice was obtained in connection with the claim, regardless of whether the advice was relied upon to deny the claim;
3. if applicable, why we did not agree with or follow: 1) the views of healthcare professionals treating you or vocational professionals who evaluated you; 2) the views of medical or vocational experts whose advice we obtained, without regard to whether we relied upon that advice; and 3) a disability determination made by the Social Security Administration, if applicable.
4. the identity of (and upon request, the right to receive a copy of) any internal rule, guideline, protocol or other similar criterion relied upon to deny the claim; or a statement that such does not exist;
5. your right to request and receive, at no charge, copies of the information relevant to your benefits claim;
6. a description of any additional material or information needed to prove entitlement to benefits and an explanation of why such material or information is necessary;
7. a description of the appeal procedures and time limits;
8. your right to bring a civil action under ERISA, §502(a) following an adverse determination on review;

Appeals of Adverse Benefit Determinations
You may submit an appeal if the Claims Administrator gives notice of an adverse benefit determination.

You have 180 calendar days following the receipt of notice of an adverse benefit determination to request your appeal. Your appeal must be submitted in writing and should include:

- Your name;
- Your reasons for making the appeal; and
- Any other information you would like to have considered.

You may submit written comments, documents, records, and other information relating to your claim, whether or not the comments, documents, records, or information were submitted in connection with the initial claim. You may also request that the Plan provide you, free of charge, copies of all documents, records, and other information relevant to the claim.

Send in your appeal to the address shown on the notice of adverse benefit determination.

You may also choose to have another person (an authorized representative) make the appeal on your behalf by providing written consent to the Claims Administrator.

Appeal Procedure
The Claims Administrator shall issue a decision within 45 calendar days of receipt of the request for an appeal. If The Claims Administrator determines that due to special circumstances an extension of time for claim processing is required, such an extension, if not longer than 45 additional calendar days, will be allowed if the Claims Administrator notifies you within the first 45 calendar day period. The extension notice shall indicate the special circumstances requiring an extension of time and the date by which a decision can be expected.

What if my claim is denied on appeal?
If your claim is denied in whole or in part, you will be notified in writing, in a culturally and linguistically appropriate manner, which will inform you of:

1. the specific reason(s) for the denial, and the Plan provisions on which the denial is based;
2. your right to request and receive, at no charge, copies of the information relevant to your benefits claim;
3. your right to bring a civil action under ERISA, §502(a), and the time in which you have to bring such an action, including the calendar date upon which such time expires;
4. the identity of (and upon request, the right to receive a copy of) any internal rule, guideline, protocol or other similar criterion relied upon to deny the claim; or a statement that such does not exist;
5. the identity of any medical or vocational experts whose advice was obtained for the appeal, regardless of whether the advice was relied upon to deny the claim on appeal; and
6. if applicable, why we did not agree with or follow: 1) the views of healthcare professionals treating you or vocational professionals who evaluated you; 2) the views of medical or vocational experts whose advice we obtained, without regard to whether we relied upon that advice; and 3) a disability determination made by the Social Security Administration, if applicable.

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 disability benefit or exercising your rights under ERISA.

Enforce Your Rights
If your claim for a disability 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, 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.

PLAN ADMINISTRATION

The Plan is established and maintained by *Augusta Health Care, Inc.*

The Employer Identification Number (EIN) is *54-1453954*

The Plan Number is 510.

The Plan Administrator is:

Augusta Health Care, Inc.
78 Medical Center Drive
Fishersville, VA 22939

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 31st*

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.