Dimensions Healthcare System

2011 BENEFITS GUIDE

Carrier	Phone Number	Website
Medical Plans		
UnitedHealthcare (UHC) Options PPO	1-866-633-2446	www.myuhc.com Group Number - 715360
UnitedHealthcare (UHC) Choice HMO	1-888-350-5614	www.myuhc.com Group Number - 715360
UnitedHealthcare (UHC) Choice Plus POS	1-866-633-2446	www.myuhc.com Group Number - 715360
CareFirst PPO (SEIU 1199 RNs only) Argus Health Systems (prescription drugs) Walgreens (prescription drugs – mail order)	1-800-424-7474 1-800-241-3371 1-800-745-6285	www.carefirst.com www.carefirst.com/rx Group Number - OQBQ
Dental Plans		
MetLife PDP	1-800-474-7371	www.metlife.com/dental Group Number – 300563
DentaQuest ePPO	1-800-334-6277	www.dentaquestdental.com Group Number – 021456
Vision Care		
National Vision Administrators, LLC (NVA)	1- 800-672-7723	www.e-nva.com Group Number – 12660001
Flexible Spending Accounts		
Conexis	1-888-442-6272	www.conexis.org
Retirement Plan		
MassMutual Retirement Plan	1-800-743-5274	www.massmutual.com
Other Benefits		
Tuition Reimbursement	301-618-2260	https://sss2.ceridian.com/dimensionshealth
Employee Assistance and Work Life Program	1-800-346-0110	www.healthy-exchange.com/inovaeap/spring
Credit Union – Money One FCU	1-800-638-0232	www.moneyonefcu.org
Banking Services – Bank of America	1-800-782-2265	www.bankofamerica.com/bankatwork
Whole Life Insurance – Boston Mutual	1-800-669-2668	www.bostonmutual.com
Critical Illness, Accident, Short-Term Disability – UNUM	1-800-635-5597	www.unumprovident.com

BENEFIT HIGHLIGHTS GUIDE

Your commitment to deliver and support exceptional patient care is in line with Dimensions Healthcare System's desire to nurture your career! We offer attractive compensation and outstanding growth potential, as well as many competitive benefits to:

- Support and improve your health
- Provide financial security
- Help you balance your work and personal life

This guide provides you with important information about your benefits, including eligibility and enrollment information, a description of your benefit options, and the cost of your coverage. If you have questions about your benefit options after you review this guide, contact the benefits staff at:

- PGHC/GSSHC: x82260
- LRH/BHC/Glenridge: x72941

INTRODUCTION TO YOUR BENEFITS

Your Benefits At-A-Glance

Benefits For Your Health	Benefits For Your Financial Security	Benefits For Balancing Your Work And Life
▸ Medical ○ UnitedHealthcare Choice HMO ○ UnitedHealthcare Choice Plus POS ○ UnitedHealthcare Options PPO ○ CareFirst PPO (SEIU 1199 FT & PTR RNs only) ▸ Dental ○ MetLife PDP ○ DentaQuest ePPO ▸ Vision ○ NVA	▸ Life Insurance ▸ Accidental Death & Dismemberment (AD&D) Coverage ▸ Long Term Disability ○ Travel Assistance ○ Ability Assist ▸ Flexible Spending Accounts (FSAs) ○ Health Care FSA ○ Dependent Care FSA ▸ Dimensions Health Corporation Retirement Savings Plan	▸ Paid Leave ○ Paid Time Off (PTO) ○ Holidays ○ Jury And Witness Duty ▸ Tuition Reimbursement ▸ Voluntary Benefits ○ Short Term Disability ○ Critical Illness Insurance ○ Accident Insurance ○ Whole Life Insurance ○ Term Life Insurance for You and Your Dependents ▸ Other Benefits

Who Is Eligible

You are eligible to participate in the benefits described in this guide if you are an active full-time (FT) or active part-time regular (PTR) employee (unless specified otherwise). On-Call Float Pool RNs may participate in core benefit programs by paying the entire group-rate premiums on an after-tax basis.

You may choose to cover your eligible dependents under some of your benefit options, as outlined in this guide.

For most benefits, your eligible dependents include:

- Your spouse;
- Your unmarried dependent children under age 25 living with you; and
- Your disabled children of any age, if disabled before the age of 25.

For medical coverage, your dependent children are eligible up to age 26, regardless of student or marital status.

Establishing Dependent Eligibility for Health Insurance Coverage

If you elect to participate in Dimensions' health plans and provide coverage to your dependents, they must meet our eligibility requirements and you must provide Dimensions with proof of their eligibility by the end of the month in which you became eligible for benefits. *This is a hard deadline and, should you fail to establish your dependents' eligibility, they will be removed from coverage and not be eligible for continuation of benefits under COBRA.* Your next opportunity to provide your dependents with DHS health insurance coverage will be the next plan year with the election being made during the next Open Enrollment. The list of acceptable documentation is shown below.

Dependents	Eligibility Definition	Documentation Required
Spouse	The Participant's legal spouse.	• **TAX RETURN**: Photocopy of the front page of the participant's most recent federal tax return that includes the participant's spouse (you may black out all financial information), **OR** • Photocopy of marriage certificate, **AND** **ONE (1)** copy of proof of joint debt/ownership showing the participant's and spouse's names, dated within the past 90 days. Acceptable documents include: o Joint bank account monthly statement o Monthly mortgage payment statement or lease/rent statement o Motor vehicle loan statement o Property tax bill (home or auto) o Credit card bill o Utility bill o A participant's will that designates the spouse as primary beneficiary o Participant's retirement plan or life insurance policy designating spouse as primary beneficiary o Homeowner's insurance bill (currently in force) o Auto insurance bill (currently in force)
Child	The natural daughter or son of the participant who is under age 26. **Note:** Coverage for eligible dependents is through the end of the month of their 26th birthday.	• **TAX RETURN:** Photocopy of the front page of the participant's most recent federal tax return that includes the child (you may black out all financial information), **OR** • Photocopy of birth certificate showing participant's/spouse's name.

Stepchild	The stepdaughter or stepson of the participant, who is under age 26. **Note:** Coverage for eligible dependents is through the end of the month of their 26th birthday.	• **TAX RETURN:** Photocopy of the participant's most recent federal tax return that includes the child (you may black out all financial information), **OR** • Photocopy of birth certificate showing participant's/spouse's name, **AND** • Photocopy of a marriage certificate showing the participant and child's parent's name.
Legal Dependent	A child, under the age of 26, for whom legal guardianship has been awarded to the participant or the participant's spouse. This includes a legally adopted child; a child placed for adoption; a child for whom legal guardianship has been awarded to the participant or the participant's spouse; a QMCSO (Qualified Medical Child Support Order); or other court or administrative order that specifically states providing medical coverage. **Note:** Coverage for eligible dependents is through the end of the month of their 26th birthday.	• **TAX RETURN:** Photocopy of the participant's most recent federal tax return that includes the child (you may black out all financial information), **OR** • **ONE (1)** of the following as applicable to the child dependent type: ○ Photocopy of an Adoption Final Decree or an Interlocutory Decree of Adoption with the presiding judge's signature and seal. ○ Photocopy of the child's birth certificate showing the participant as the adopting parent. ○ Photocopy of the final court order, with the presiding judge's signature and seal, affirming the participant as the child's legal guardian. ○ Photocopy of the Qualified Medical Child Support Order. ○ Photocopy of the court or administrative order requiring medical coverage by the participant
Dependent Child with Disability (Age 26 or Older)	A child, disabled prior to age 26, not able to be self-supporting due to mental or physical disability and relies on the participant for support. Please note that this audit is only verifying the child's eligibility as a dependent. Your health carrier determines the disability status of the child.	• **TAX RETURN:** Photocopy of the front page of the participant's most recent federal tax return that includes the child (you may black out all financial information), **OR** • Photocopy of birth certificate showing participant's/spouse's name; **AND** • Proof of receipt of, or current pending application to receive, Supplemental Security Income (SSI) benefits.

How To Enroll

If you want to have coverage in the following core benefits, you will need to enroll within 30 days of the date you first become eligible for benefits coverage (such as the date you are first hired, or the date you become a benefit-eligible FT or PTR employee). You become eligible for benefits coverage after you satisfy a waiting period, which is the first day of the month after 30 days of employment for a new hire. For a change in status or an employee that is returning from a leave of absence, it is the first day of the month after the change in status.

Your benefits include:

- Medical/Prescription Drug
- Dental
- Vision
- Life Insurance
- AD&D
- Long Term Disability
- Flexible Spending Accounts
- Retirement Savings Plan

If you do not enroll within 30 days of your eligibility date, unless you experience a qualifying event, you will not have coverage for these benefits for the rest of the plan year, which is through December 31.

HOW TO ENROLL IN VOLUNTARY BENEFITS

IF YOU CHOOSE TO ENROLL IN VOLUNTARY BENEFITS, YOU WILL NEED TO ENROLL WITHIN 45 DAYS OF THE DATE YOU FIRST BECOME ELIGIBLE. TO ENROLL, CALL 1-888-9ENROLL.

YOUR NEXT OPPORTUNITY TO ENROLL FOR COVERAGE WILL BE DURING THE NEXT OPEN ENROLLMENT PERIOD.* ENROLLERS WILL BE ON-SITE IF YOU CHOOSE TO ENROLL DURING OPEN ENROLLMENT.

*** If you experience a qualifying life event during the year, you may change your whole life insurance outside of the open enrollment period.**

Important Note: the CareFirst PPO medical plan (available to 1199 SEIU RNs only) has a pre-existing condition clause. This means that if you do not enroll in the plan when you are first eligible and do not have other health coverage that is considered to be "creditable coverage," or if you have a break in coverage of more than 63 days, certain medical services and supplies may not be covered under the plan if they are determined to be related to a pre-existing condition. Beginning January 1, 2011, this provision does not apply to your eligible dependents who are under age 19.

Your next opportunity to enroll for coverage will be during the next open enrollment period for coverage that will begin the following January 1, unless you experience a qualifying life event as described under **Making Changes**. You may enroll in or change your election in the Dimensions Health Corporation Retirement Savings Plan at any time during the year.

To enroll, follow these steps:

- Using a computer with Internet access, visit https://sss2.ceridian.com/dimensionshealth.
- Enter your User ID (this is the first five letters of your last name and the last four digits of your Social Security number). For example, if your Name is Mary Johnson and your Social Security number is 987-654-3210, your User ID is johns3210. If your last name is less than five letters (e.g., Doe), provide your full last name: doe3210.
- Enter your Password (if you are a new employee, your password is your month and year of birth; for example, if your birthday is March 3, 1967, your password is 031967).
- If you are a new employee, change your password once you have successfully logged in (be sure to remember your new password for future use).
- Follow the instructions to select the benefit options you want.
- When you are finished, click the Save button.
- Print your confirmation statement for your records.

IF YOU ENROLL IN THE CAREFIRST PPO MEDICAL PLAN (AVAILABLE TO 1199 SEIU RNS ONLY), YOU MUST ALSO COMPLETE A PAPER ENROLLMENT FORM.

Computer Kiosk Locations
Employee computer kiosks are available in the following locations:

PG
HR Corridor
Cafeteria

Bowie
Hallway adjacent to Pediatrics 1 and 2

Spellman
Employee Break Room

Laurel
Cafeteria
Office between Security and Benefits

*Making Changes**

When you enroll, choose your benefits carefully, because they will stay in effect for the entire plan year – from January 1 through December 31. You may only change your benefits during the plan year if you experience a qualifying life event. When you make a change due to a qualifying life event, you may only make a change that is consistent with the change in life event.

Qualifying life events include:

- Marriage, divorce, legal separation, and annulment
- Birth, adoption, placement for adoption, or appointment of legal guardianship of your child
- Your death or death of your covered dependent
- You or your dependent losing or gaining employment
- A change in your (or your dependent's) employment status due to an increase or decrease in your benefits status (e.g., switch between FT and PTR or PTR and FT, a strike, or a lockout)
- A change in your dependent's eligibility (e.g., due to being over the age limit)
- A change in your (or your dependent's) place of residence or work
- Your requirement to cover your dependent child(ren) according to a judgment, decree, or order resulting from your divorce, legal separation, annulment, or change in legal custody (that requires health coverage for your dependent child(ren)), or death of your spouse
- Your (or your dependent's) eligibility for COBRA
- Your (or your dependent's) eligibility for Medicare or Medicaid (you may change the current election for the eligible person only)
- A change in your spouse's or dependent's coverage during their annual enrollment period when the other plan had a different period of coverage
- Exercise of special enrollment rights under HIPAA
- Significant change in cost of coverage
- An unpaid leave of absence for you or your spouse under the Family and Medical Leave Act (FMLA)

* Special rules apply to FSAs. Contact the benefits staff to determine what qualifying life events permit you to make changes to your FSA contributions.

IF YOU NEED TO MAKE A CHANGE TO YOUR BENEFITS DUE TO A QUALIFYING LIFE EVENT, CONTACT THE BENEFITS STAFF IMMEDIATELY. PLEASE NOTE, ALL CHANGES MUST BE MADE WITHIN 60 DAYS OF THE EVENT.

THE DIMENSIONS BENEFIT PROGRAM

Dimensions employees are dedicated to providing exceptional care and service to our patients every day, and that's why we are committed to providing you with competitive and valuable benefits in return for your dedication!

Take a closer look…

Benefits For Your Health

As an important part of our region's healthcare industry, we know the value of improving and maintaining health – for our patients, our community, and our employees. That's why we offer these valuable health benefit options for you and your family.

Medical Benefits

Dimensions offers you three medical plan options through UnitedHealthcare: Choice HMO (Health Maintenance Organization), Choice Plus POS (Point-of-Service), or an Options PPO (Preferred Provider Organization) plan. All three medical plan options provide benefits for a variety of medical supplies and services, including prescription drugs.

Full-Time and Part-Time Regular 1199 SEIU RNs have the option to participate in a CareFirst PPO (Preferred Provider Organization) plan, as well. The CareFirst PPO plan has a pre-existing condition clause. This means that if you do not enroll in the plan when you are first eligible and do not have other health coverage that is considered to be "creditable coverage," or if you have a break in coverage of more than 63 days, certain medical services and supplies may not be covered under the plan if they are determined to be related to a pre-existing condition. Beginning January 1, 2011, this provision does not apply to your eligible dependents who are under age 19.

If you choose to enroll in medical benefits, you may choose from the following coverage levels:

- Employee only
- Employee and one dependent (spouse or child)
- Family

You may elect different coverage levels for medical, dental and vision. For example, you may elect family for medical, employee and one dependent for dental and employee only for vision. You choose the benefits and the level of coverage that you and your family need.

Medical Highlights (additional coverage information available on carrier web sites)	UHC Choice HMO (in-network only)	UHC Choice Plus POS		UHC Options PPO (no network restrictions)	For FT & PTR1199 SEIU RNs only CareFirst PPO	
		In-Network	Out-Of-Network		In-Network	Out-Of-Network
Coverage Area	MD, DC, VA, WV, DE	Nation-wide		Nation-wide	Nation-wide	
Annual Deductible	None	$150/person $450/family	$500/person $1,500/family	$150/person $300/family	$150/person $300/family	
Annual Out-Of-Pocket Limit	$2,000/person $4,000/family	$1,000/person $2,000/family	$4,000/person $12,000/family	$850/person $1,700/family	$850/person $1,000/family	
Office Visits Primary care Specialist	$15 copay $25 copay	$20 copay $25 copay	Plan pays 60% after deductible	Plan pays 85% after deductible	$20 copay	
Hospitalization	Plan pays 100%	Plan pays 80% after deductible	Plan pays 60% after deductible	Plan pays 85% after deductible	Plan pays 80% after separate $200 per admission deductible	Plan pays 65% after separate $200 per admission deductible
Outpatient Surgery	Plan pays 100%	Plan pays 80% after deductible	Plan pays 60% after deductible	Plan pays 85% after deductible	Plan pays 80% after deductible	Plan pays 65% after deductible
Diagnostic Testing And X-Rays (excludes CAT, PET, MRI, Nuclear)	Plan pays 100%	Plan pays 100%	Plan pays 60% after deductible	Plan pays 85% after deductible	Plan pays 80% after deductible	Plan pays 65% after deductible
Emergency Room Visits	$75 copay, waived if admitted	$75 copay, waived if admitted		Plan pays 85% after deductible, waived if admitted	Plan pays 80% after deductible and $50 copay, waived if admitted	
	Services that do not meet the Plan definition of Emergency are not covered					
Urgent Care Facility Visits	$25 copay	$25 copay	Plan pays 60% after deductible	Plan pays 85% after deductible	$20 copay	Plan pays 65% of allowed amount after deductible

Medical Highlights	UHC Choice HMO (in-network only)	UHC Choice Plus POS		UHC Options PPO (network restrictions apply for prescription drugs)	For FT & PTR 1199 SEIU RNs only CareFirst PPO	
		In-Network	Out-Of-Network		In-Network	Out-Of-Network
Prescription Drugs						
Tier 1 Tier 2 Tier 3	$7 copay $20 copay $35 copay Mail order is 2 times copay If you elect Tier 2 or 3 drug when Tier 1 drug is available, you pay Tier 1 copay plus difference between cost of Tier 1 drug and Tier 2 or 3 drug	$7 copay $20 copay $35 copay Mail order is 2 times copay If you elect Tier 2 or 3 drug when Tier 1 drug is available, you pay Tier 1 copay plus difference between cost of Tier 1 drug and Tier 2 or 3 drug If you fill your prescription at an out-of-network pharmacy, you are responsible for any difference between what the out-of-network pharmacy charges for the medication and the amount UHC would have paid for the same prescription at an in-network pharmacy		$7 copay $20 copay $35 copay Mail order is 2 times copay If you elect Tier 2 or 3 drug when Tier 1 drug is available, you pay Tier 1 copay plus difference between cost of Tier 1 drug and Tier 2 or 3 drug **Out-of-Network:** 80% after deductible	$8 copay $20 copay $35 copay Infertility drugs paid at 50% Mail order is 2 times copay Infertility drugs paid at 50% No deductibles	

Note: the CareFirst PPO medical plan (available to Full-time & Part-Time Regular 1199 SEIU RNs only) has a pre-existing condition clause. This means that if you do not enroll in the plan when you are first eligible and do not have other health coverage that is considered to be "creditable coverage," or if you have a break in coverage of more than 63 days, certain medical services and supplies may not be covered under the plan if they are determined to be related to a pre-existing condition. Beginning January 1, 2011, this provision does not apply to your eligible dependents who are under age 19.

NOTE: WE ENCOURAGE YOU TO USE DIMENSIONS FACILITIES FOR YOUR HEALTH CARE NEEDS. HOWEVER, KEEP IN MIND THAT YOU WILL STILL BE REQUIRED TO PAY APPLICABLE COPAYS, COINSURANCE, AND DEDUCTIBLES FOR YOUR CARE.

Dental Benefits

Dimensions offers two dental plan options: MetLife Preferred Dental Provider (PDP) or DentaQuest ePPO. The dental plans provide benefits to help cover the cost of dental services and supplies such as routine checkups, fillings, and crowns.

If you choose to enroll in dental benefits, you may choose from the following coverage levels:

- Employee only
- Employee and one dependent (spouse or child)
- Family

You do not have to elect the same coverage level for dental coverage that you choose for medical and vision coverage.

Dental Highlights	MetLife PDP		DentaQuest ePPO (in-network only) Schedule available through Ceridian Self Service > Benefits > Benefit Forms > Summary: DentaQuest (2011)
	In-Network	Out-Of-Network	
Annual Deductible	$50/person; $100/family		$25/person; $75/family
Benefit Maximums	$1,500/person per year (excluding orthodontia)		$2,000/person per year
Maximum Rollover	N/A		$600 per year* (you are only eligible for a maximum rollover if your yearly claims do not exceed $800)
	Plan pays:	**Plan pays:**	**Plan pays:**
Preventive/Diagnostic Care	100%, no deductible	80% after deductible	Most preventive and diagnostic care is paid at 100%, no deductible Benefits are paid based on a fee schedule; refer to DentaQuest ePPO Plan Fee Schedule C2 for more information.
Minor Restorative Care	80% after deductible	50% after deductible	Benefits are paid based on a fee schedule; refer to DentaQuest ePPO Plan Fee Schedule C2 for more information
Major Restorative Care	60% after deductible	50% after deductible	
Orthodontia	50%, no deductible, up to $1,000 per person per lifetime (for children up to the end of the month they turn age 19)		You may purchase separate orthodontia coverage for children and adults; coverage is $49 per person for the 2-year plan ($99 if not enrolled in the ePPO) You may purchase the discount plan at any time during the year Visit human resources for more information

* Your accumulated rollover total is capped at $1,500, for a benefit maximum of $3,500.

Vision Benefits

Beginning January 1, 2011, National Vision Administrators, LLC (NVA) will administer the Dimensions vision benefits. You may choose to see a provider that is part of the NVA network or that is out-of-network. However, the plan will pay higher benefits when you see a provider that is part of the network.

If you choose to enroll in vision benefits, you may choose from the following coverage levels:

- Employee only
- Employee and one dependent (spouse or child)
- Family

You do not have to elect the same coverage level for vision coverage that you choose for medical and dental coverage.

Vision Highlights	NVA	
	In-Network	**Out-Of-Network**
Exam	You pay $10 copay	Plan pays $43
Frames	Frame of your choice, covered up to $130; plus 20% off any out-of-pocket costs	Plan pays $45
Lenses (standard glass or plastic)	You pay:	Plan pays:
Single vision	$15 copay	$35
Bifocal	$15 copay	$51
Trifocal	$15 copay	$68
Lenticular	$15 copay	$80
Medically Necessary Contact Lenses	Covered in full	Plan pays $210
Elective Contact Lenses (instead of glasses)	Plan pays up to $95; plus 15% off conventional and 10% off disposable out-of-pocket costs	Plan pays $95
Additional Discounts	**Laser vision correction:** discounts available **Glasses and sunglasses:** lens options, including scratch-resistant and anti-reflective coatings, progressive lenses and more, have set discounted prices.	No Additional Discounts
Provider Network: NVA offers a wide provider network including many national chains with locations in Maryland and beyond. Available providers include America's Best, JC Penney Optical, Pearl Vision, Sears Optical, Target Optical, United Optical, and many more. Individual chains may provide different out of pocket discounts than listed. For a complete provider listing go to www.e-nva.com and scroll down on the home page and click on "Find Providers." Enter your zip code and 12660001, our group number.		

Note: Vision benefits outlined above are covered once every 24 months.

FLEX CREDIT OPT OUT PROGRAM: IF YOU DECIDE THAT YOU DO NOT NEED MEDICAL, DENTAL, OR VISION COVERAGE THROUGH DIMENSIONS BECAUSE YOU HAVE COVERAGE ELSEWHERE, YOU CAN OPT OUT OF DIMENSIONS COVERAGE AND RECEIVE A CREDIT IN 24 OF YOUR PAYCHECKS IN THE FORM OF ADDITIONAL INCOME. TO BE ELIGIBLE FOR THIS CREDIT, YOU WILL NEED TO PROVIDE PROOF OF OTHER COVERAGE. REFER TO THE "YOUR COST FOR COVERAGE" SECTION OF THIS GUIDE FOR MORE INFORMATION.

Benefits For Your Financial Security

Financial security is more than just planning for retirement or investing in the stock market – it is also planning for the unexpected things that can happen in life, and making sure that you and your family are as protected as you can be. That's why Dimensions offers several benefit options to help our employees build financial security.

Life Insurance

Dimensions provides a comprehensive term life insurance program with four components:

- Core Life Insurance for yourself,
- Life Insurance Credit,
- Supplemental Life Insurance for yourself, and
- Dependent Life Insurance for your spouse and child(ren).

Core Life Insurance: Dimensions provides all FT employees with basic life insurance coverage equal to one times your annualized budgeted base pay (up to $500,000). PTR employees are provided with coverage equal to their full-time equivalent annual base pay (example: half-time employee's actual annualized budgeted base pay is $25,000 and his/her coverage would be $50,000). Coverage is rounded down to the next lowest $1,000 increment.

Life Insurance Credit: Dimensions provides all FT employees with a Life Credit, that is, an additional amount in your pay equal to the premium of one times (managers/directors receive two times) your annualized salary of Supplemental Life Insurance coverage. You may elect to use the Life Credit to purchase Supplemental Life Insurance or, if you do nothing, you will receive it as additional pay.

Supplemental Life Insurance: You have the option to purchase additional coverage in multiples of:

- 1 times
- 2 times
- 2.5 times
- 3 times

Your supplemental coverage cannot be more than 3 times your pay or $750,000, whichever is less. The total amount of your coverage (basic and supplemental combined) cannot be more than $1,250,000.

When you first become eligible to enroll for coverage, you may enroll for any coverage level you wish up to the maximums described earlier without providing evidence of good health. In future years, you may keep your coverage level the same or increase your coverage by one level without providing evidence of good health. However, if you wish to increase your coverage by two or more levels, you must provide evidence of good health and be approved by the insurance carrier before your coverage becomes effective.

For example, let's assume your coverage level is 2 times pay. During open enrollment, you may choose coverage equal to 2.5 times pay without providing evidence of good health. But if you choose 3 times pay, you will have to provide evidence of good health and be approved by the insurance carrier before your coverage goes into effect. If you do not provide evidence of good health, you will automatically be increased to 2.5 times pay.

Dependent Life Insurance for Your Spouse and Child(ren): You have the option to purchase term life insurance coverage for your eligible spouse and dependent child(ren) in the following amounts:

- Spouse: in $10,000 increments up to $50,000
- Child(ren) (ages 15 days to 19, or 25 if a full-time student: $5,000); $10,000; or $20,000

You will need to submit evidence of insurability for amounts of $20,000 or more for spouse and $5,000 or more for children before coverage becomes effective.

Special Will Preparation Service for Free: If you choose to purchase supplemental life coverage, you get a special will preparation service for free. Having an up-to-date will is one of the most important things you can do for your family. Without a will, your assets may be distributed according to state law and not in accordance with your wishes. This service is offered through Hyatt Legal Plans, a MetLife Company. To take advantage of this service, call Hyatt Legal Plans at 1-800-821-6400 and provide the Dimensions Healthcare System Group Number (121395).

EVIDENCE OF GOOD HEALTH

EVIDENCE OF GOOD HEALTH IS A FORM THAT THE INSURANCE CARRIER REQUIRES YOU TO COMPLETE. ON THIS FORM, YOU WILL NEED TO PROVIDE PERSONAL INFORMATION AND THEN ANSWER MEDICAL QUESTIONS. GENERALLY, IF YOU ANSWER 'YES' TO ANY OF THE MEDICAL QUESTIONS, YOU WILL NEED TO PROVIDE ADDITIONAL INFORMATION. ONCE YOU SUBMIT THE FORM, THE INSURANCE CARRIER MAY REQUIRE YOU TO PROVIDE EVEN MORE MEDICAL INFORMATION THROUGH A PHYSICAL EXAM, PARAMEDICAL EXAM, OR AN ATTENDING PHYSICIAN REPORT. YOU WILL BE NOTIFIED IF THIS APPLIES TO YOU.

Accidental Death And Dismemberment (AD&D) Coverage

Dimensions provides all FT and PTR employees with basic AD&D coverage equal to $5,000, at no cost to you. You have the option to purchase additional coverage for yourself equal to $10,000 or $20,000. You may also purchase coverage for your spouse and children, if you purchase additional coverage for yourself as follows:

- If you purchase $10,000 of coverage for yourself, you may also purchase $5,000 for your spouse and $2,000 for your child(ren)
- If you purchase $20,000 of coverage for yourself, you may also purchase $10,000 for your spouse and $4,000 for your child(ren).

Long Term Disability Coverage

Long term disability coverage may provide you with a portion of your income if you are unable to work due to a qualifying disability. The plan pays benefits after you have been unable to work for 90 days. Dimensions automatically provides all eligible FT employees with coverage that would pay you a benefit equal to 50% of your monthly income, up to $5,000 per month (PTR employees are not eligible for long term disability benefits).

You may purchase additional coverage equal to:

- 10% of your monthly income (for a total of 60%), up to $7,500 per month
- 20% of your monthly income (for a total of 70%), up to $12,000 per month

NOTE: YOUR LONG TERM DISABILITY BENEFITS WILL BE REDUCED BY ANY SOCIAL SECURITY INCOME YOU ARE ELIGIBLE TO RECEIVE.

When you first become eligible to enroll for coverage, you may enroll for any coverage level you wish. In future years, you may keep your coverage level the same or increase your coverage. However, if you choose to increase your coverage level, you must provide evidence of good health and be approved by the insurance carrier before your coverage becomes effective.

Travel Assistance: If you are covered by the LTD plan, you may be eligible to receive special assistance while traveling. This assistance includes three kinds of services: Pre-Trip Information, Emergency Medical Assistance, and Emergency Personal Services. Contact the benefits staff for more information.

Ability Assist: If you are covered by the LTD plan, you may receive services to help deal with emotional and work-life issues, legal concerns, or financial planning. Contact the benefits staff for more information.

Flexible Spending Accounts

Dimensions offers two Flexible Spending Accounts (FSAs) – the Health Care FSA and Dependent Care FSA. These accounts are designed to help you save on taxes by allowing you to set aside money, up to certain limits, on a pre-tax basis to pay for eligible health care or dependent care expenses.

You decide how much to contribute each year (up to certain limits) and your contributions are automatically deducted from your paycheck each pay period before certain taxes are taken out. When you have an eligible expense, you file a claim for reimbursement and are paid from your account with pre-tax money. Both accounts can be reimbursed through easy direct deposit.

The accounts are outlined below.

Health Care FSA

You can contribute up to $2,600 each year and use this account to pay for eligible health, dental, and vision expenses, such as copays, deductibles, and other expenses not covered by your health insurance. The Health Care FSA also features a debit card that makes it easier to access funds. Debit card charges other than office and prescription drug copays will require you to provide substantiation (proof of eligibility such as an insurance carrier's Explanation of Benefits (EOB)) or a detailed invoice. *Beginning January 1, 2011, your debit card can no longer be used to purchase over-the-counter drugs, even if you have a prescription. However, you may still receive reimbursement through faxing or mailing in your receipt with the applicable form.*

Dependent Care FSA

You can contribute up to $5,000 each year and use this account to pay for eligible day care expenses for your children up to age 13, or your dependents of any age who are physically or mentally unable to care for themselves and for whom you contribute more than half of their financial support.

BECAUSE OF THE TAX ADVANTAGES OF THE FSAs, THE INTERNAL REVENUE SERVICE (IRS), PLACES SEVERAL RESTRICTIONS ON THEIR USE:

- **YOU FORFEIT ANY UNUSED MONEY LEFT IN YOUR FSA AT THE END OF THE PLAN YEAR (YOU HAVE UNTIL DECEMBER 31 TO INCUR EXPENSES, AND YOU HAVE UNTIL MARCH 31 TO FILE YOUR CLAIM FOR REIMBURSEMENT).**
- **YOU MAY ONLY USE YOUR FSA TO PAY FOR GOODS AND SERVICES THAT ARE CONSIDERED BY THE IRS TO BE ELIGIBLE EXPENSES. REFER TO WWW.IRS.GOV FOR MORE INFORMATION.**
- **YOU MAY ONLY USE MONEY IN YOUR HEALTH CARE FSA TO BE REIMBURSED FOR ELIGIBLE HEALTH CARE EXPENSES, AND YOU MAY ONLY USE MONEY IN YOUR DEPENDENT CARE FSA TO BE REIMBURSED FOR DEPENDENT CARE EXPENSES.**
- **YOU MAY NOT TRANSFER MONEY FROM ONE ACCOUNT TO ANOTHER.**
- **YOU MAY ONLY CHANGE YOUR FSA CONTRIBUTIONS DURING THE YEAR IF YOU EXPERIENCE A QUALIFYING LIFE EVENT.***
- **YOU MAY ONLY RECEIVE REIMBURSEMENT FROM YOUR DEPENDENT CARE FSA AS FUNDS ARE DEPOSITED IN YOUR ACCOUNT.**
- **YOU MUST PROVIDE YOUR DEPENDENT CARE PROVIDER'S TAX ID NUMBER OR SOCIAL SECURITY NUMBER FOR REIMBURSEMENT FROM YOUR DEPENDENT CARE FSA.**

* Special rules apply to FSAs. Contact the benefits staff to determine what qualifying life events permit you to make changes to your FSA contributions.

Dimensions Health Corporation Retirement Savings Plan

As an eligible employee, you will receive a DHS base contribution equal to 2% of your pay, added to your defined contribution retirement savings plan account each paycheck. This plan is also known as a 403(b) plan and allows you to save toward your retirement through pre-tax contributions. You automatically receive this contribution whether you contribute to the 403(b) plan or not.

Dimensions offers all employees the opportunity to participate in the defined contribution retirement savings plan. You decide what percentage of your pay you would like to contribute on an annual basis and your contributions are deducted from each paycheck before certain taxes are taken out. By participating in the Dimensions Retirement Savings Plan, you will be able to defer paying federal income taxes on your contributions and your investment earnings. You may elect to contribute to the plan at any time. Enroll and make changes online at www.massmutual.com and clicking on "The Journey."

As an eligible employee, if you contribute to the 403(b) plan, you are also eligible to receive matching contributions from Dimensions equal to 50% of your contribution, up to 2% of your pay. That means you could receive up to 4% of your pay – plus whatever you choose to contribute – each year from Dimensions in your 403(b) plan account. And this is calculated on your total bi-weekly compensation, including any overtime amount you may receive.

You must be budgeted to work 1,000 hours of service during the calendar year to be eligible to receive both employer contributions on a bi-weekly basis. Employees who are not budgeted to work at least 1,000 hours a year but actually do, will receive employer contribution(s) in the beginning of the following year.

You will become fully vested for the DHS base contributions and matching contributions upon completion of three years of credited vested service. There is no partial vesting prior to that time. You are immediately vested in your personal deferrals and any rollover amount you contribute to the plan.

For example, let's assume you make $25,000 per year. Refer to the chart below to see how much money could be set aside in your 403(b) account toward your retirement savings in one year if you choose to save 0%, 2%, 4%, or 6% of your pay.

Your Pay	Your Contribution	DHS Contributions		Total Contributions
		DHS Base Contribution (2% of your pay)	**DHS Matching Contribution** (50%, up to 2% of your pay)	
$25,000	$0 (0%)	$500 (2%)	$0 (0%)	**$500 (2%)**
$25,000	$500 (2%)	$500 (2%)	$250 (1%)	**$1,250 (5%)**
$25,000	$1,000 (4%)	$500 (2%)	$500 (2%)	**$2,000 (8%)**
$25,000	$1,500 (6%)	$500 (2%)	$500 (2%)	**$2,500 (10%)**

BENEFITS FOR BALANCING YOUR WORK AND LIFE

Juggling the demands of your professional life and personal life can be difficult. Dimensions provides our employees with several programs and services to help you better balance those demands.

Paid Leave

Paid Time Off (PTO)

It's important for our employees to be on the job, but it's also important to refresh and recharge from time to time. That is why we provide all employees with Paid Time Off (PTO). PTO combines vacation and sick leave into one type of leave so that you have more freedom to use your leave the way you see fit.

You earn PTO hours each pay period, based on the number of years you have been employed by Dimensions. Increases in PTO accrual occur automatically on the pay period following employment anniversaries. The PTO schedule is outlined below:

Years	Days/Year	Hours/Pay
0 to 3	23	7.07
4 to 9	27	8.30
10 to 15	30	9.23
16 to 20	33	10.15
21 or more	36	11.07

PTR employees earn PTO on a pro-rated basis. Managers earn PTO as outlined above, except for years 0 to 3; for the first three years, they will earn 7.69 hours per pay. WEA employees earn 2.77 hours per pay (EWEA earn 1.38 hours per pay). Employees are eligible to use PTO after successfully completing their Initial Review Period. Requests for exceptions are to be referred to the Vice President, Human Resources.

PTO Carryover

You may accumulate up to 400 hours of PTO. Any hours over 400 will roll over into a long term sick (LTS) leave bank each February. After three days of extended absence, you can request to use LTS for your or your dependents' illness in lieu of PTO, or substitute LTS for PTO in case of illness of yourself or your family.

PTO CASH-IN: DURING OPEN ENROLLMENT, YOU MAY ELECT TO CASH-IN UP TO 40 HOURS OF PTO TO BE PAID IN JANUARY. TO BE ELIGIBLE, YOU MUST MAINTAIN A MINIMUM OF 80 HOURS OF PTO (OR 40 HOURS, IF YOU ARE A 1199 SEIU RN).

PTO OFFSET: DURING OPEN ENROLLMENT, YOU MAY ELECT TO OFFSET THE BI-WEEKLY COST OF YOUR BENEFIT ELECTIONS WITH UP TO 80 HOURS OF PTO FOR THE FOLLOWING PLAN YEAR.

Holidays

Dimensions provides all FT and PTR employees with six paid holiday each year:

- New Year's Day
- Memorial Day
- Independence Day
- Labor Day
- Thanksgiving Day
- Christmas Day

FT employees receive eight hours of leave; PTR employees receive four hours of leave. If you work on a holiday, special compensation and rules apply.

Jury And Witness Duty

If you are required to serve as a juror or are subpoenaed as a witness in court, Dimensions provides unlimited paid time off from work to do so.

Tuition Reimbursement

Dimensions encourages you to reach your professional goals, so we offer tuition reimbursement to FT and PTR employees after six continuous months of employment. Reimbursement is equal to:

- FT employees: $3,000 per year
- PTR employees: $1,500 per year

To be eligible for reimbursement, courses must be from an accredited college or university and either:

- Leading to a degree; or
- A course that directly relates to your job and whose purpose is to increase your job knowledge and skills.

If you receive reimbursement from Dimensions for tuition expenses, you must remain in benefits-eligible employment with the company for at least one year following the completion of the reimbursed course.

VOLUNTARY BENEFITS

In addition to the other benefit options listed in this guide, Dimensions offers you the opportunity to participate in several voluntary benefits. You pay for the cost of these voluntary benefits in full, but may benefit from lower group rates than if you were to purchase the coverage on your own.

Short Term Disability (UNUM)

If you are unable to work due to an illness or injury, short term disability may provide you with a portion of your income while you are out. If you purchase coverage through UNUM and you suffer a qualifying disability, the plan will pay a monthly benefit after you have been out of work for seven days. You may purchase short term disability coverage equal to an amount up to 60% of your monthly income. You choose how much coverage to purchase. Benefits are payable for up to three months, as long as you remain disabled. You are eligible for STD benefits up to age 69.

IF YOU DO NOT ELECT SHORT TERM DISABILITY COVERAGE WHEN YOU ARE FIRST ELIGIBLE, BUT DO ELECT COVERAGE DURING OPEN ENROLLMENT, YOUR COVERAGE IS SUBJECT TO A PRE-EXISTING CONDITION CLAUSE FOR 12 MONTHS, INCLUDING PREGNANCY.

THE ENROLLMENT WINDOW IS TYPICALLY BETWEEN THE FIRST AND 15TH OF EACH MONTH. NEW HIRES HAVE 45 DAYS TO ENROLL AND YOU HAVE 60 DAYS TO ENROLL DUE TO QUALIFYING LIFE EVENTS.

Critical Illness Insurance (UNUM)

Dimensions offers this coverage through UNUM. If you, your spouse, or your children are diagnosed with a certain critical illness, such as heart attack, stroke, cancer, renal failure, and major organ transplants, this coverage pays a lump sum benefit up to $50,000. This benefit is paid in addition to any other health coverage you may have.

Because early detection is often the best defense against critical illnesses, this coverage also pays a wellness benefit for an annual health screening, up to $50 each calendar year. Pre-existing conditions may apply.

Accident Insurance (UNUM)

Dimensions offers this coverage through UNUM. You may choose to purchase accident coverage that pays a lump sum for certain covered injuries, such as broken bones, burns, cuts, paralysis, eye injuries, and accidental death.

TO LEARN MORE ABOUT THE VOLUNTARY PLANS, THE PREMIUMS, OR TO ENROLL, CALL 1-888-9ENROLL.

TO MAKE CHANGES IN YOUR VOLUNTARY PLAN ELECTIONS, CONTACT:

UNUM AT: 1-800-635-5597

OR

BOSTON MUTUAL AT: 1-800-669-2668

Whole Life Insurance (Boston Mutual)

You have the option to purchase whole life insurance for yourself and your spouse and children through this voluntary plan with Boston Mutual Life Insurance. This plan provides a variety of coverage levels and costs at group rates. You may enroll for whole life insurance at any time during the year if you experience a qualifying life event listed on page 4, as long as it falls within the enrollment window as defined by Boston Mutual Life Insurance.

OTHER BENEFITS

Credit Union/Banking Services

As a Dimensions employee, you have access to Money One credit union services and banking services through Bank of America. Membership is based on application approval.

Parking

Free parking is available at all Dimensions locations. Employees working evening and night shifts at PGHC are eligible for free inside parking.

Cafeteria Discount

Employees at PGHC and LRH receive an employee discount in the hospital cafeteria.

TERM LIFE INSURANCE VS. WHOLE LIFE INSURANCE

DIMENSIONS PROVIDES YOU WITH BASIC LIFE INSURANCE COVERAGE, AND THE OPTION TO PURCHASE SUPPLEMENTAL LIFE INSURANCE COVERAGE, AS DESCRIBED EARLIER. THAT COVERAGE IS KNOWN AS "TERM LIFE INSURANCE." THE VOLUNTARY COVERAGE OFFERED THROUGH BOSTON MUTUAL LIFE INSURANCE IS KNOWN AS "WHOLE LIFE INSURANCE."

HERE ARE SOME OF THE DIFFERENCES BETWEEN THESE TWO TYPES OF COVERAGE:

THE WHOLE LIFE INSURANCE COVERAGE IS PORTABLE, WHICH MEANS YOU CAN CONTINUE YOUR COVERAGE AT THE SAME RATES EVEN IF YOU LEAVE DIMENSIONS. THE REGULAR TERM LIFE INSURANCE BENEFIT MAY ALSO BE PORTABLE & CONVERTIBLE; CHECK WITH THE BENEFITS OFFICE FOR MORE INFORMATION.

THE WHOLE LIFE INSURANCE COVERAGE ACCUMULATES CASH VALUE BY EARNING INTEREST AT CURRENT INTEREST RATES. THE TERM LIFE INSURANCE COVERAGE PAYS A BENEFIT ONLY IN THE EVENT OF YOUR DEATH.

THE TERM LIFE INSURANCE COVERAGE RATES WILL INCREASE AS YOUR AGE INCREASES; THE WHOLE LIFE INSURANCE COVERAGE RATES WILL NOT INCREASE.

THIS IS ONLY A BRIEF LOOK AT THE DIFFERENCES BETWEEN TERM AND WHOLE LIFE INSURANCE. YOU SHOULD CONSULT WITH A FINANCIAL ADVISOR WHEN DECIDING IF YOU WANT ADDITIONAL COVERAGE THROUGH WHOLE LIFE INSURANCE.

YOUR COST FOR COVERAGE

Below are your 2011 costs for coverage on a semi-monthly (twice a month) basis for medical, dental, and vision coverage. Your cost for coverage for supplemental life insurance, supplemental long term disability coverage, and voluntary coverage (short term disability insurance, whole life insurance, critical illness insurance, accident insurance, travel assistance, and ability assist), is based on your age, gender, and salary. To find out your cost for these coverages, log on to employee self-service on the DHS intranet.

Medical Plan	2011 Semi-Monthly Premiums								
	FT Employees			PTR Employees			On-Call Float Pool Employees		
	Employee	Employee + 1	Family	Employee	Employee + 1	Family	Employee	Employee + 1	Family
UHC Choice HMO	$57.70	$109.63	$201.96	$115.40	$219.26	$403.91	$230.81	$438.53	$807.83
UHC Choice Plus POS	$58.91	$111.92	$206.17	$117.81	$223.84	$412.35	$235.62	$447.68	$824.70
UHC Options PPO	$73.72	$140.06	$258.00	$147.43	$280.12	$516.00	$294.86	$560.23	$1,032.00
CareFirst PPO (1199 SEIU RNs only)	$84.20	$159.98	$294.70	$168.40	$319.96	$589.40	$336.80	$639.92	$1,178.80
Opt-out Credit (must provide proof of other coverage)	$32.50			$16.25			N/A		

Dental Plan	2011 Semi-Monthly Premiums								
	FT Employees			PTR Employees			On-Call Float Pool Employees		
	Employee	Employee + 1	Family	Employee	Employee + 1	Family	Employee	Employee + 1	Family
MetLife PDP	$2.62	$5.25	$9.49	$5.25	$10.49	$18.98	$10.49	$20.98	$37.96
DentaQuest ePPO	$2.06	$4.13	$5.38	$4.13	$8.25	$10.75	$8.25	$16.50	$21.50
DentaQuest Orthodontia Program*	$49 per person *(enrolled with DentaQuest)* $99 per person *(not enrolled with DentaQuest)*			$49 per person *(enrolled with DentaQuest)* $99 per person *(not enrolled with DentaQuest)*			$49 per person *(enrolled with DentaQuest)* $99 per person *(not enrolled with DentaQuest)*		
Opt-out Credit (must provide proof of other coverage)	$4.50			$2.25			N/A		

Vision Plan	2011 Semi-Monthly Premiums								
	FT Employees			PTR Employees			On-Call Float Pool Employees		
	Employee	Employee + 1	Family	Employee	Employee + 1	Family	Employee	Employee + 1	Family
NVA	$0.27	$0.55	$1.09	$0.55	$1.10	$2.19	$1.10	$2.20	$4.37
Opt-out Credit (must provide proof of other coverage)	$0.50			$0.25			N/A		

IMPORTANT NOTICES

Following are federally-required notices related to your Dimensions Benefit Program.

Women's Health And Cancer Rights Act

Federal law requires a group health plan to provide coverage for the following services to an individual receiving plan benefits in connection with a mastectomy:

- Reconstruction of the breast on which the mastectomy has been performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance; and
- Prosthesis and physical complications for all stages of a mastectomy, including lymphedemas (swelling associated with the removal of lymph nodes).

The group health plan must determine the manner of coverage in consultation with the attending physician and patient. Coverage for breast reconstruction and related services will be subject to deductibles and coinsurance amounts that are consistent with those that apply to other benefits under the plan.

Maternity And Newborn Length Of Stay

Under federal law, group health plans and health coverage issuers offering group coverage generally may not restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to:

- Less than 48 hours following a normal vaginal delivery; or
- Less than 96 hours following a cesarean section.

They may also not require that a provider obtain authorization from the plan or coverage issuer for prescribing a length of stay not in excess of those periods. The law generally does not prohibit an attending provider of the mother or newborn (in consultation with the mother) from discharging the mother or newborn earlier than 48 hours or 96 hours, as applicable.

Special Enrollment Rights Under HIPAA

The Health Insurance Portability and Accountability Act (HIPAA) of 1996 provides the following special enrollment rights. If you do not enroll for medical coverage for yourself and your dependents (including your spouse) because of other health insurance coverage, you may be able to enroll yourself or you dependents in this plan, as long as you request enrollment within 31 days after your other coverage ends. You will need to provide proof that your other coverage has ended.

In addition, if you have a new dependent as the result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents as long as you request enrollment within 31 days after the marriage, birth, adoption, or placement for adoption.

Notice Of Health Information Privacy Practices (HIPAA)

The privacy of your medical information is important to us. As a participant in a medical plan sponsored by Dimensions Healthcare System, you may receive a HIPAA Privacy Notice. The HIPAA Notice describes how medical information about you may be used and disclosed and how you can get access to this information.

You may access a copy of the HIPAA Privacy Notice at any time by visiting: https://sss2.ceridian.com/dimensionshealth

For more information about our privacy practices or for additional copies of the HIPAA Privacy Notice, please contact us using the information provided.

Contact Position/Office:	Human Resources Department, Director of Benefits
Address:	3001 Hospital Drive, Cheverly, MD
Phone Number:	301-583-4000

Consolidated Omnibus Budget Reconciliation Act (COBRA)

The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to you when you would otherwise lose your group health coverage. It can also become available to other members of your family who are covered under the plan when they would otherwise lose their group health coverage. For additional information about your rights and obligations under the plan and under federal law, you should review the plan's summary plan description or contact the plan administrator.

COBRA continuation coverage is a continuation of plan coverage when coverage would otherwise end because of a life event known as a qualifying event, as listed below. After a qualifying event, COBRA continuation coverage must be offered to each person who is a qualified beneficiary. You, your spouse, and your dependent children could become qualified beneficiaries if coverage under the plan is lost because of the qualifying event. Under the plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

If you are an employee, you will become a qualified beneficiary if you lose your coverage under the plan because your hours of employment are reduced or your employment ends for any reason other than your gross misconduct.

If you are the spouse or dependent child of an employee, you will become a qualified beneficiary if you lose your coverage under the plan because any of the following qualifying events happens:

- The employee dies;
- The employee's hours of employment are reduced;
- The employee's employment ends for any reason other than his or her gross misconduct;
- The employee becomes entitled to Medicare benefits (under Part A, Part B, or both);
- The employee becomes divorced or legally separated; or
- If you are a dependent child, you stop being eligible for coverage under the plan as a "dependent child."

Sometimes, filing a proceeding in bankruptcy under title 11 of the United States Code can be a qualifying event. If a proceeding in bankruptcy is filed with respect to Dimensions, and that bankruptcy results in the loss of coverage of any retired employee covered under the plan, the retired employee will become a qualified beneficiary with respect to the bankruptcy. The retired employee's spouse, surviving spouse, and dependent children will also become qualified beneficiaries if bankruptcy results in the loss of their coverage under the plan.

The plan will offer COBRA continuation coverage to qualified beneficiaries only after the plan administrator has been notified that a qualifying event has occurred. When the qualifying event is the end of employment or reduction of hours of employment, death of the employee, commencement of a proceeding in bankruptcy with respect to the employer, or the employee's becoming entitled to Medicare benefits (under Part A, Part B, or both), the employer must notify the plan administrator of the qualifying event.

For the other qualifying events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), you must notify the plan administrator within 60 days after the qualifying event occurs. You must provide this notice to the benefits staff.

Once the plan administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered employees may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation coverage on behalf of their children.

COBRA continuation coverage is a temporary continuation of coverage. When the qualifying event is death of the employee, the employee's becoming entitled to Medicare benefits (under Part A, Part B, or both), your divorce or legal separation, or a dependent child's losing eligibility as a dependent child, COBRA continuation coverage lasts for up to a total of 36 months. When the qualifying event is the end of employment or reduction of the employee's hours of employment, and the employee became entitled to Medicare benefits less than 18 months before the qualifying event, COBRA continuation coverage for qualified beneficiaries other than the employee lasts until 36 months after the date of Medicare entitlement. Otherwise, when the qualifying event is the end of employment or reduction of the employee's hours of employment, COBRA continuation coverage generally lasts for only up to a total of 18 months. There are two ways in which this 18-month period of COBRA continuation coverage can be extended.

If you or anyone in your family covered under the plan is determined by the Social Security Administration to be disabled and you notify the plan administrator in a timely fashion, you and your entire family may be entitled to receive up to an additional 11 months of COBRA continuation coverage, for a total maximum of 29 months. The disability would have to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of continuation coverage.

If your family experiences another qualifying event while receiving 18 months of continuation coverage, your spouse and dependent children can get up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if notice of the second qualifying event is properly given to the plan. This extension may be available to your spouse and any dependent children receiving continuation coverage if the employee or former employee dies, becomes entitled to Medicare benefits (under Part A, Part B, or both), or gets divorced or legally separated, or if the dependent child stops being eligible under the plan as a dependent child, but only if the event would have caused the spouse or dependent child to lose coverage under the plan had the first qualifying event not occurred.

If you have questions about your plan or your COBRA continuation coverage rights, refer to the contact listed below. For more information about your rights under ERISA, including COBRA, the Health Insurance Portability and Accountability Act (HIPAA), and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit the EBSA website

at www.dol.gov/ebsa. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.)

In order to protect your family's rights, you should keep the plan administrator informed of any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the plan administrator.

Contact Position/Office:	Human Resources Department, Director of Benefits
Address:	3001 Hospital Drive, Cheverly, MD
Phone Number:	301-583-4000

IMPORTANT NOTICE FROM DIMENSIONS HEALTHCARE SYSTEM ABOUT YOUR PRESCRIPTION DRUG COVERAGE AND MEDICARE

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with Dimensions Healthcare System and prescription drug coverage available for people with Medicare. It also explains the options you have under Medicare prescription drug coverage and can help you decide whether or not you want to enroll. At the end of this notice is information about where you can get help to make decisions about your prescription drug coverage.

- Medicare prescription drug coverage became available in 2006 to everyone with Medicare through Medicare prescription drug plans and Medicare Advantage Plans that offer prescription drug coverage. All Medicare prescription drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.
- Dimensions Healthcare System has determined that the prescription drug coverage which is a part of our medical plans underwritten by UnitedHealthcare and CareFirst are, on average for all plan participants, expected to pay out as much as the standard Medicare prescription drug coverage will pay and is considered Creditable Coverage.

For those employee enrolled in medical coverage with DHS, your existing coverage is on average at least as good as standard Medicare prescription drug coverage, you can keep this coverage and not pay extra if you later decide to enroll in Medicare prescription drug coverage.

Individuals can enroll in a Medicare prescription drug plan when they first become eligible for Medicare and each year from November 15 through December 31. Beneficiaries leaving employer/union coverage may be eligible for a Special Enrollment Period to sign up for a Medicare prescription drug plan.

You should compare your current coverage, including which drugs are covered, with the coverage and cost of the plans offering Medicare prescription drug coverage in your area.

If you do decide to enroll in a Medicare prescription drug plan and drop your Dimensions Healthcare System medical/prescription drug coverage, be aware that you and your dependents will only be able to re-enroll in the DHS plans if a life change event occurs or during the next Open Enrollment period. Please contact us for more information about what happens to your coverage if you enroll in a Medicare prescription drug plan.

You should also know that if you drop or lose your coverage with Dimensions Healthcare System and don't enroll in Medicare prescription drug coverage after your current coverage ends, you may pay more (a penalty) to enroll in Medicare prescription drug coverage later.

If you go 63 days or longer without prescription drug coverage that's at least as good as Medicare's prescription drug coverage, your monthly premium will go up at least 1% per month for every month that you did not have that coverage. For example, if you go 19 months without coverage, your premium will always be 19% higher than what many other people pay. You'll have to pay this higher premium as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following November to enroll.

For more information about the DHS prescription drug coverage…

Contact the benefits staff (x82260 or x72941) or review the medical summary online at https://sss2.ceridian.com/dimensionshealth. NOTE: You will receive this notice annually and at other times in the future such as before the next period you can enroll in Medicare prescription drug coverage, and if this coverage through UnitedHealthcare or CareFirst changes. You also may request a copy.

For more information about your options under Medicare prescription drug coverage…

More detailed information about Medicare plans that offer prescription drug coverage is in the "Medicare & You" handbook. You'll get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare prescription drug plans.

For more information about Medicare prescription drug plans:

- Visit www.medicare.gov.
- Call your State Health Insurance Assistance Program (see your copy of the Medicare & You handbook for their telephone number) for personalized help.
- Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

For people with limited income and resources, extra help paying for Medicare prescription drug coverage is available. Information about this extra help is available from the Social Security Administration (SSA) online at www.socialsecurity.gov, or you can call them at 1-800-772-1213 (TTY 1-800-325-0778).

Remember: Keep this notice. If you enroll in one of the plans approved by Medicare which offer prescription drug coverage, you may be required to provide a copy of this notice when you join to show that you are not required to pay a higher premium amount.

Date:	October 2010
Name of Entity/Sender:	Dimensions Healthcare System
Contact Position/Office:	Human Resources Department, Director of Benefits
Address:	3001 Hospital Drive, Cheverly, MD
Phone Number:	301-583-4000

Dimensions Health Corporation Retirement Savings Plan Default Investment Notice

If you have made an investment election with respect to your own account, the following information may not apply to you.

Right to direct investment. This notice advises you that as a participant (including a beneficiary of a deceased participant) in the plan, you have the right to direct the investment of all of your plan account assets.

Default investment. You may invest your account(s) (your "directed account(s)") in any of the investment choices offered in the plan. If you do *not* make an election as to how the plan should invest any of your future directed account(s) (e.g. rollover contribution, employee, or employer contribution) by returning the election form to the plan administrator, the plan trustee will invest your future directed account(s) in the "default" investment that the plan officials have selected. The default investments are the T. Rowe Price Retirement Income Funds (listed below).

- T. Rowe Price Retirement 2010 Fund
- T. Rowe Price Retirement 2020 Fund
- T. Rowe Price Retirement 2030 Fund
- T. Rowe Price Retirement 2040 Fund
- T. Rowe Price Retirement 2050 Fund

Contact human resources for information regarding these investment options.

Description of default investment. The description of the default investment options including investment strategy, risk and return characteristics, and fees and expenses are available in human resources.

Right to alternative investment. Even if the plan trustee invests some or all of your directed account(s) in the default investment, you have the continuing right to direct the investment of your directed account(s) in one or more of the other investment choices available to you under the plan. You may change your investments at any time. You are entitled to invest in any of the alternative investment choices without incurring a financial penalty.

Where to go for further investment information. You can obtain further investment information about the plan's investment alternatives other than the default investment by contacting the Plan Administrator, Human Resources, 3001 Hospital Drive, Cheverly, MD 20785 or by calling (301) 618-2260.

Notice of Opportunity to Enroll in Connection with Extension of Dependent Coverage to Age 26

Individuals whose coverage ended, or who were denied coverage (or were not eligible for coverage), because the availability of dependent coverage of children ended before attainment of age 26 are eligible to enroll in a DHS medical plan. Individuals may request enrollment for such children for 30 days from the date of notice. Enrollment will be effective January 1, 2011. For more information contact the benefits staff.

Notice of Grandfathered Status for CareFirst Preferred Provider Organization (PPO) Plan

This group health plan believes this plan (CareFirst PPO) is a "grandfathered health plan" under the Patient Protection and Affordable Care Act (the Affordable Care Act). As permitted by the Affordable Care Act, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted. Being a grandfathered health plan means that your plan may not include certain consumer protections of the Affordable Care Act that apply to other plans, for example, the requirement for the provision of preventive health services without any cost sharing. However, grandfathered health plans must comply with certain other consumer protections in the Affordable Care Act, for example, the elimination of lifetime limits on benefits.

Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to Plan Administrator, Human Resources, 3001 Hospital Drive, Cheverly, MD 20785 or by calling (301) 618-2260. You may also contact the Employee Benefits Security Administration, U.S. Department of Labor at 1-866-444-3272 or www.dol.gov/ebsa/healthreform. This website has a table summarizing which protections do and do not apply to grandfathered health plans.

Removal of Lifetime Limits for United Healthcare Choice (HMO) and Choice Plus (POS) Plans

The lifetime limit on the dollar value of benefits under the United Healthcare Choice HMO and Choice Plus POS plans no longer applies. Individuals whose coverage ended by reason of reaching a lifetime limit under the plan are eligible to enroll in the plan. Individuals have 30 days from the date of this notice to request enrollment. For more information contact Plan Administrator, Human Resources, 3001 Hospital Drive, Cheverly, MD 20785 or by calling (301) 618-2260.

DIMENSIONS HEALTHCARE SYSTEM RESERVES THE RIGHT TO MODIFY, AMEND, SUSPEND, OR TERMINATE ANY PLAN AT ANY TIME, AND FOR ANY REASON WITHOUT PRIOR NOTIFICATION, UNLESS COVERAGE IS PROVIDED UNDER A COLLECTIVE BARGAINING AGREEMENT. THIS DOCUMENT IS ONLY MEANT TO HIGHLIGHT THE BENEFIT PLANS AT DIMENSIONS HEALTHCARE SYSTEM. THE BENEFIT PLANS ARE GOVERNED BY INSURANCE CONTRACTS AND PLAN DOCUMENTS, WHICH ARE AVAILABLE ON THE DHS SELF SERVICE SITE OR THROUGH THE HUMAN RESOURCES DEPARTMENT. SHOULD THERE BE A DISCREPANCY BETWEEN THIS DOCUMENT AND THE PROVISIONS OF THE INSURANCE CONTRACTS OR PLAN DOCUMENTS, THE PROVISIONS OF THE INSURANCE CONTRACTS OR PLAN DOCUMENTS WILL GOVERN.