



PLAN YEAR | APRIL 1, 2011 – MARCH 31, 2012

WORKING FOR YOU

EMPLOYEE BENEFITS GUIDE



www.virginiahospitalcenter.com

AT VIRGINIA HOSPITAL CENTER WE ARE STRIVING TO BE THE BEST

You see, to **Be The Best** is our mission. It's really that simple. And, we know that your time and expertise are valuable, which is why we offer one of the best benefits packages in the area. Virginia Hospital Center is a community-based hospital with the luxury of being located within a large and culturally-diverse metropolitan area, providing you with the convenience of national museums, public transportation, shopping, nightlife, and more.

To help you be at your best and make the most of your employment experience, we offer a comprehensive and generous benefits package. We want to recognize your needs and the needs of your family so that you can provide your best at the workplace. Your Hospital programs and plans will help you meet the challenges of everyday living, from high-quality medical and dental care benefits that help you and your family be at your healthiest to retirement benefits that will help you build wealth for the future.

Human Resources at Virginia Hospital Center is dedicated to customer service and you are our customer. We have an open door policy and encourage your feedback, ideas, and/or comments regarding your employment with us.

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HOW YOUR EMPLOYEE BENEFITS PACKAGE WORKS

Provided that you enroll within 30 days of your eligibility date, your benefits will begin on the first day of the month following your eligibility date. If you do not enroll for benefits within the 30-day eligibility period, you will have to wait for annual open enrollment to apply for benefits. No exceptions can be made to this provision. If your status changes and you become a benefits-eligible employee, your benefits will begin on the first of the month following your status change. You will have 30 days to apply. No exceptions can be made to this provision. Eligible employees are full-time employees who work at least 32 hours per week, and permanent part-time employees who work at least 20 hours per week.

ELIGIBLE DEPENDENTS FOR BENEFITS

If you choose to enroll dependents in your medical plan and/or other benefits, your dependents must meet the criteria defined in the PPO Health Plan Summary Plan Description booklet located on the Employee Portal. Proper documentation will be required for your spouse and/or dependents enrolled in your health and dental plan. For enrollment of eligible dependents who are adult children (age 19-25), an affidavit is also required.

FAMILY STATUS CHANGE

Since life has a way of changing, and some of these changes may affect your need for benefits, you may make a coverage change during the year if you experience a qualified event such as marriage, birth or adoption of a baby, divorce, or change of status of employment by you or your spouse. *You have 30 days after the change in status event to make a benefit change. Contact Human Resources to see if you are eligible for a change. Newborn children must be added to the health plan within 30 days from the date of birth.*

EMPLOYEE STATUS CHANGE

If you have an employment status change from PRN or part-time to permanent part-time or full-time, you have 30 days from your status change effective date to enroll in Hospital benefits. No exceptions can be made to this provision. Your benefits will begin on the first of the month following your employment status change. If you do not enroll in Hospital benefits during this 30-day window, next year's annual open enrollment period or a family-status change event will be your next opportunity to add coverage.

YOUR PRE-TAX BENEFITS

Our benefits program is tax-effective in ways you may not even realize. For example, the premiums you pay for certain benefits (such as medical coverage) are deducted from your pay on a pre-tax basis. Because of this favorable tax treatment, IRS rules limit changes to your coverage during the year.

ANNUAL OPEN ENROLLMENT TIME

This is the one time each year that you are allowed to add or change your benefits, a rule established by government regulations, because you pay for the benefits with pre-tax dollars. Careful attention to this summary will help ensure that your benefits meet your needs. During annual open enrollment, you may add or drop coverage or add or drop dependents. Your Medical and Dependent Care Flexible Spending Account elections do not automatically carry over each year. If you want to participate in the Flexible Spending Account programs, you must re-enroll each year, even if you want your Flexible Spending Account levels to stay the same.

SUMMARY OF VIRGINIA HOSPITAL CENTER BENEFITS

	STATUS BASED ON HOURS WORKED PER WEEK		
	FULL-TIME: 32-40 HOURS	PERMANENT PART-TIME: 20-31 HOURS	PRN (ON CALL) PART-TIME: UNDER 20 HOURS PER WEEK
Arlington Transit	•	•	•
Arlington Community Federal Credit Union	•	•	•
Childcare & Education at Virginia Hospital Center	•	•	•
Core Pension Plan & 401(k)/403(b)	•	•	•
Direct Deposit	•	•	•
Employee Assistance Program (EAP)	•	•	•
For Eyes	•	•	•
Jury Duty	•	•	
Life Insurance	•	•	
Long-Term Disability (LTD)	•	•	
Medical/Dependent Care Flexible Spending Accounts	•	•	
Medical/Dental Insurance	•	•	
NPEP – Apartment Discount Program	•	•	•
Paid Family Leave Program	•	•	
Paid Time Off (PTO)	•	•	• (PT Only)
Sick Time (EIB or SCK Bank)	•	•	• (PT Only)
Short-Term Disability (STD)	•	•	
Sport and Health	•	•	•
Sprint/Nextel	•	•	•
Tuition Reimbursement	•	•	
Verizon Wireless	•	•	•
Wells Fargo Bank at Work Services	•	•	•
Worker's Compensation	•	•	•
YMCA	•	•	•
1-800-FLOWERS	•	•	•

YOUR MEDICAL CHOICES

You have a choice of two options: Virginia Hospital Center PPO or Kaiser Permanente Signature HMO. To help you understand the difference between the two health plan options and evaluate which is best for you, carefully review each plan's basic overview and summary plan descriptions. *Deduction cost per pay period is located on page 7.*

GRANDFATHERED STATUS

Virginia Hospital Center believes its medical plan options are “grandfathered health plans” 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 certain “essential health services.”

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 the benefit department at 703-558-6572. 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.



KEY FEATURES OF VIRGINIA HOSPITAL CENTER PPO

Virginia Hospital Center offers a *Preferred Provider Organization (PPO)* medical plan that is administered through a national network: *CareFirst Administrators – BlueCard* for your health care needs. This makes good sense from a medical perspective because the network helps assure that every physician is qualified with the appropriate credentials. It also makes sense from a cost perspective because when you use a network physician, you receive the service at a discounted rate. In addition, when you use Virginia Hospital Center services, you receive a 100% benefit. For a list of network providers, visit the CareFirst Administrators website: www.CFABlue.com or call the Customer Service number: 1-866-942-7859.

INFORMED CARE MANAGEMENT

Members in the Virginia Hospital Center PPO plan will have a health condition management program included in your health benefit. This program is a confidential service that is voluntary to you and your covered dependents to help manage your health care conditions. For more Information, visit www.myactivehealth.com or call 1-800-660-8280.

SERVICES	IN-NETWORK BENEFITS	OUT-OF-NETWORK BENEFITS *
Annual deductible (applies to inpatient care only)	None	\$2,000 per person
Pre-existing condition limits	None	None
Annual out-of-pocket limit	\$2,500 per person \$5,000 per family	\$5,000 per person \$10,000 per family
Primary care physician visits	\$15 co-pay	50%*
OB/GYN visits	\$15 co-pay	50%*
Maternity care	\$15 co-pay	50%*
Well baby care	\$15 co-pay	50%*
Specialist visits	\$30 co-pay	50%*
Outpatient mental and nervous/alcohol and drug abuse	\$30 co-pay	50%*
Outpatient surgery	100% at Virginia Hospital Center 70% In-network	50%*
Inpatient room and board	100% at Virginia Hospital Center 70% In-network	50%*
Inpatient diagnostic lab and X-ray	100% at Virginia Hospital Center 70% In-network	50%*
Outpatient diagnostic lab and X-ray	100% at Virginia Hospital Center 70% In-network	50%*
Inpatient mental and nervous/alcohol and drug abuse	100% at Virginia Hospital Center 70% In-network	50%*
Emergency room	100% at Virginia Hospital Center 70% In-network	70%*
Urgent care	100% at Virginia Hospital Center \$15 co-pay In-Network	50%*
Vision care	Plan pays up to \$200 per person per plan year	
Retail prescription drugs	After the \$50 per person/\$150 per family prescription deductible: Generic – \$4 co-pay Preferred brand – \$25 co-pay Non-preferred brand – \$45 co-pay	
Mail order prescription drugs (up to 90-day supply; no prescription deductible)	Generic – \$8 co-pay Preferred brand – \$50 co-pay Non-preferred brand – \$90 co-pay	

*Subject to deductible

KEY FEATURES OF KAISER PERMANENTE HMO

As a Signature HMO plan member, you would have the ability to choose a primary care physician and receive care at any one of the 30 Kaiser Permanente medical centers or from affiliated physicians. Many of the medical centers also offer pharmacy, lab, X-ray, urgent care and vision services, allowing you the convenience of being able to access all these services in one trip.

SERVICES	IN-NETWORK BENEFITS
Annual deductible	None
Annual out-of pocket limit	\$3,500 per person / \$9,400 per family
Pre-existing condition limit	None
Primary care physician visits	\$20 co-pay
Specialist visits	\$30 co-pay (No charge for children up to age 5)
OB/GYN visits	\$30 co-pay
Maternity care	No co-pay
Well baby care	No co-pay up to age 5 (No charge after initial diagnosis)
Outpatient surgery	No charge
In-patient room and board	No \$250 per admission
In-patient diagnostic lab and X-ray	No co-pay
Outpatient diagnostic lab and X-ray	No co-pay
In-patient behavioral and chemical	\$250 per admission
Outpatient behavioral and chemical	\$20 group therapy / \$30 individual therapy
Preventative care	No co-pay
Urgent care	\$30 co-pay
Emergency room	\$100 co-pay (waived if admitted)
Prescription plan	Generic - \$10 Kaiser Permanente / \$20 contracted pharmacy Preferred brand - \$20 Kaiser Permanente / \$40 contracted pharmacy
Mail order prescription plan	Generic - \$8 (2x for a 90 day supply) Brand - \$18 (2x for a 90 day supply) Non-preferred - \$33 (2x for a 90 day supply)
Vision care	Routine eye refractions \$20 co-pay 25% discount on eyeglass frames and lenses at Kaiser Permanente optical departments



DENTAL CARE BENEFITS

Dental coverage is provided through the *Delta Dental PPO* plan. Delta Dental offers a large nationwide network of providers and you will be able to take advantage of lower out-of-pocket expenses because of the preferred pricing the network has established. Your benefits are based on levels of treatment: Diagnostic & Preventive, Basic, Major, and Orthodontic. Please refer to the Dental Plan Summary Plan Description available on the Employee Portal for specific details. To contact Delta Dental for providers or customer service, you can visit the website at: www.deltadentalva.com or by phone at 1-800-237-6060.

SERVICES	IN-NETWORK PPO/PREMIER	OUT-OF-NETWORK
Annual deductible	\$75 per person/\$150 per family	
Annual benefit maximum	\$1,500 per person, per plan year	
Oral exams	100%	100%
Periodontal/Regular cleanings	100%	100%
Fluoride applications	100%	100%
Bitewing X-rays	100%	100%
Full mouth/panelpipse X-rays	100%	100%
Space maintainers	100%	100%
Sealants	100%	100%
Palliative treatment	100%	100%
Amalgam and composite fillings	80%*	80%*
Stainless steel crowns	80%*	80%*
Oral surgery	80%*	80%*
Denture repair and recementation of crowns, bridges and dentures	80%*	80%*
Endodontic services/root canal therapy	80%*	80%*
Periodontic services	80%*	80%*
Therapeutic drug injections	80%*	80%*
Prosthodontics/dentures/bridges	50%*	50%*
Crowns	50%*	50%*
Implants	50%*	50%*
Orthodontic	50%**	50%**

*Subject to deductible

**\$1,500 lifetime maximum applies



EMPLOYEE COST: MEDICAL AND DENTAL PLANS

Your per pay period deductions for medical coverage and dental coverage, from April 1, 2011 through March 31, 2012, are shown below.

MEDICAL DEDUCTIONS PER PAY PERIOD: VIRGINIA HOSPITAL CENTER PPO		
COVERAGE LEVEL	FULL-TIME	PERMANENT PART-TIME
Employee only	\$56.57	\$113.14
Employee and child(ren)	\$120.06	\$240.12
Employee and spouse	\$139.76	\$279.52
Family	\$197.74	\$395.48

MEDICAL DEDUCTIONS PER PAY PERIOD: KAISER PERMANENTE SIGNATURE HMO PLAN		
COVERAGE LEVEL	FULL-TIME	PERMANENT PART-TIME
Employee only	\$56.57	\$113.14
Employee and child(ren)	\$120.06	\$240.12
Employee and spouse	\$139.76	\$279.52
Family	\$197.74	\$395.48

DENTAL DEDUCTIONS PER PAY PERIOD: DELTA DENTAL PPO PLAN	
COVERAGE LEVEL	FULL-TIME AND PERMANENT PART-TIME
Employee only	\$15.33
Employee and child(ren)	\$29.28
Employee and spouse	\$32.23
Family	\$54.14



INCOME PROTECTION BENEFITS

Short-Term Disability, Long-Term Disability, Life Insurance, and Accidental Death and Dismemberment are insured through the Standard Insurance Company.

SHORT-TERM DISABILITY

A very real concern among people who work for a living is the need to protect their income during periods of disability. Short-Term Disability (STD) insurance helps to safeguard your income in the event that you experience a prolonged sickness or injury. This insurance coverage is available to benefit-eligible employees only. Employees pay the full cost with after-tax premiums for this benefit. There is a 15-day elimination period and you must deplete your accrued sick time (EIB/SCK) accruals before STD payments go into effect. Refer to the STD Plan Summary booklet for more information about this benefit.

LONG-TERM DISABILITY

What if you have an extended illness and can't work? How would the mortgage or other debts get paid? How would you take care of your family? In fact, you are more likely to become disabled during your working career than to die. That's why we offer you Long-Term Disability (LTD) coverage. Monthly LTD benefits are paid after you've been certified as partially or totally disabled and unable to work for 90 days. Employees pay the full cost with after-tax premiums. The plan works together with other disability benefits that you may receive – such as Social Security, Worker's Compensation, STD, and/or your sick bank. Refer to the LTD Plan Summary booklet for more information about this benefit.

LIFE/ACCIDENTAL DEATH & DISMEMBERMENT (AD&D) INSURANCE

Term Life Insurance pays benefits to your beneficiary if you die. The Hospital pays the premium for this coverage.

EMPLOYEE STATUS	LIFE/AD&D BENEFITS
Full-time employee	1 x annual salary
Permanent part-time employee	½ x annual salary

DESIGNATE A BENEFICIARY

When you enroll, you must name a beneficiary (or beneficiaries) to receive your life insurance. You may name anyone you wish, and you may change your designation at any time. To request a beneficiary form or to change your beneficiary, contact the Benefits Department in Human Resources.

PORTABLE TERM LIFE

You are eligible to buy additional term life insurance for yourself, your spouse, and your children. You may purchase additional life insurance for yourself and your spouse in \$10,000 increments up to \$500,000. You may also purchase additional AD&D coverage for yourself and your spouse up to \$250,000. The coverage amount you elect for your spouse may not exceed 100 percent of your additional life coverage. If you wish to purchase additional term life insurance for your children for a policy of \$5,000 or \$10,000 coverage, you must also purchase additional term life insurance.

You pay for this portable life insurance on a pre-tax basis, and you can continue it when you retire or leave the Hospital. You must inform the Benefits Department in Human Resources if you wish to continue this insurance.

FLEXIBLE SPENDING ACCOUNTS (FSA)

Everyone wants to save money and use it wisely. That's what Flexible Spending Accounts do – they offer a way for you to pay for certain expenses with pre-tax dollars. The kinds of expenses you can pay through FSAs are generally important and necessary costs. Through the benefit plan, you have the option of two separate accounts – one for *medical* and one for *daycare* expenses. You must be a benefits eligible employee to participate in the FSAs and re-enroll every plan year.

- **Medical FSA** – You may contribute up to \$5,000 each plan year to pay for eligible medical, dental, vision, and prescription drug expenses and that are not covered by another source, such as insurance.
- **Dependent Care FSA** – You may contribute up to \$5,000 each plan year (or \$2,500 if you are married, but file separate income tax returns) to pay for eligible daycare expenses while you are at work. Highly Compensated Employees (HCEs) can contribute up to a maximum of \$2,200 each plan year.

FSA CONTRIBUTION MINIMUMS AND MAXIMUMS

Minimum contribution: \$5 per pay

Maximum contribution: \$192.30 per pay

Your FSAs are administered by ConnectYourCare. You may access balance information and submit your claims online through the ConnectYourCare website: www.connectyourcare.com. Please see the Employee Portal for FSA set up and login instructions. To contact ConnectYourCare, call 1-888-870-7929.

HOW FSAs WORK

It's simple to use these accounts – and it's easy to enroll in this benefit plan:

- Estimate the eligible expenses that you and your family will have during the plan year (refer to the Flex Plan Summary Plan Description for a list of eligible expenses). *Under the Medical FSA, you may be reimbursed for over-the-counter (OTC) medicines, such as eye care, first aid dressings/supplies and diabetes testing kits/aids. Some OTC medicines require a physician's note.*
- For annual enrollment, divide this amount by the number of pay periods in the plan year. This amount is put into your Medical FSA and/or Dependent Care FSA each pay period through pre-tax deductions from your paycheck.
- Reimbursement checks are mailed to your home address or you can enroll in direct deposit online through www.connectyourcare.com.

IMPORTANT REGULATORY CHANGES TO MEDICAL FSAs FOR 2011

Due to Patient Protection and Affordable Care Act (PPACA) regulations, some OTC drugs and medications will no longer be eligible for reimbursement after December 31, 2010, unless accompanied by a prescription. This list is subject to change. Please visit www.connectyourcare.com/otc for updated information.

Also as a result of changes associated with health care reform, you may submit eligible expenses incurred by your children up to age 26 (through the last day of the calendar year in which the adult child turned 26) for reimbursement under your Medical FSA. Your dependent may be married and is not required to live with you, attend school or be a tax dependent.

EXAMPLES OF ELIGIBLE FSA EXPENSES

Medical FSA:

- Your share of medical and dental care expenses, such as co-payments and deductibles
- Prescription drug co-payments
- Non-covered vision care expenses such as eye exams, eye glasses, contact lenses, or laser vision correction
- Non-covered hearing exams and hearing aids

Dependent Care FSA:

- Care for children up to age 13 at a licensed nursery school, day camp, or childcare center that provides day care
- Services from individuals who provide child care in or outside your home while you work
- Household services (related to the care of the elderly or disabled adults or children who live with you) provided by a housekeeper, maid, cook, etc., as long as the individual is partly responsible for the well-being and care of your qualified dependents
- Care by a nurse or home health care agency for care for your spouse or legal dependent that is physically or mentally incapable of self-care

FOR MORE INFORMATION ABOUT ELIGIBLE EXPENSES, REFER TO:

- The Flexible Spending Account Summary Plan Description on the Employee Portal
- The ConnectYourCare website: www.connectyourcare.com
- IRS publications 503(Dependent Care FSA), 502 and 969 (Medical FSA); available via the IRS website: www.irs.gov

IRS FORFEITURE RULES

Be sure to estimate your expenses carefully. Government regulations require that you forfeit any unused dollars in your FSAs at the plan year's end. *Bottom Line: if you don't use it, you lose it.* If your employment ends, the deposits you make to the Dependent Care FSA may be used for expenses you have up until the end of the plan year that your coverage ends. Deposits that you make to the Medical FSA only cover expenses you incur through the day that your coverage ends. For more information, please visit the IRS website at www.irs.gov and view IRS publications: 503 (Dependent Care FSA), 502 and 969 (Medical FSA).



WORK/LIFE BENEFITS

ARLINGTON TRANSIT

Hospital employees can ride the ART 51 and ART 52 buses for free by showing their Hospital ID badge upon boarding. The ART 51 bus serves customers who travel between Ballston Metro and Virginia Hospital Center. The ART 52 bus serves customers who travel between East Falls Church Metro and Virginia Hospital Center. The commuterpage.com website offers a large variety of commuter friendly options and information in the metropolitan area. Take advantage of the free Guaranteed Ride Home program which dispatches a taxi to pick you up at work and drive you home. Sign up for text message alerts regarding severe weather service and how it may impact your ART route. View schedules of transportation throughout the Arlington area and neighboring jurisdictions. Purchase ART and other transit fares online. For more information on these benefits and many others visit www.commuterpage.com/art or call 703-228-RIDE.

ARLINGTON COMMUNITY FEDERAL CREDIT UNION

As a Hospital employee, you and your family members are eligible for membership at Arlington Community Federal Credit Union (ACFCU). A member-owned, not-for-profit financial cooperative, ACFCU pledges to provide its members with personalized, professional and courteous service while acting as responsible stewards of the funds invested with them. Joining ACFCU is simple – just open a Share Savings Account with a \$5 deposit, and you're a member. To sign up with ACFCU, go online at www.arlingtoncu.org and click the "Online Account Opening" button on their homepage. You may visit one of their three locations at 2130 N. Glebe Road, Arlington, VA or 1435 N. Courthouse Road, Arlington, VA or 5666 Columbia Pike, Baileys Crossroads, VA or call 703-526-0200.

CHILD CARE AND EDUCATION AT VIRGINIA HOSPITAL CENTER

Child Care and Education at Virginia Hospital Center serves 123 children ages 6 weeks through 5 years on a full-time and part-time basis including drop-in care. The teacher to child ratio meets widely recognized national standards of quality as defined by the National Association for the Education of Young Children and the Arlington Virginia Department of Human Services. The center is conveniently located at 601 S. Carlin Springs Road, just off Route 50. The center is complimented by age appropriate outdoor playgrounds and is open for 13½ hours per day for Virginia Hospital Center employees. For more information, contact 703-717-7200, email vahospital@brighthorizons.com or visit the Bright Horizons website at www.brighthorizons.com/vahospital.

FOR EYES VISION DISCOUNT

For Eyes Optical Company will provide you with comprehensive eye care services including eyeglasses, contact lenses and eye examinations at preferred pricing discounts for you and your immediate family. A 10% discount on eyeglass frames, lenses and eye exams, a 20% discount on a complete pair of eyeglasses or contact lenses. For a location near you, call 1-800-FOR-EYES or www.foreyes.com.

INSIGHT PROGRAM – EMPLOYEE ASSISTANCE PROGRAM (EAP)

The Insight Program is an assessment and referral service for employees. It provides free, confidential, professional assistance to help employees resolve problems that affect their personal lives or job performance. To contact Insight, dial 703-558-6EAP.

NPEP - APARTMENT DISCOUNT PROGRAM

As an employee of Virginia Hospital Center, you are eligible for great discounts on a new lease at participating communities throughout the Metro DC area. Visit www.npep.com, email info@npep.com, or call 1-877-629-6082 for more information and to get the latest participating community listings.

SPORT AND HEALTH

Sport and Health provides discounted membership options to employees and accompanying members of their immediate family (restrictions apply). All Virginia Hospital Center employees receive a 15% discount and discounted enrollment fees. To enroll, visit the website www.sportandhealth.com and enter the pin number: 01537, or call direct at 703-816-8800.

SPRINT/NEXTEL

All Virginia Hospital Center employees are entitled to receive a discount on their monthly charges on either Sprint or Nextel phone service with a two-year service agreement. Sprint users receive 23% and Nextel users receive 13% off their monthly service. Begin using your benefit now by visiting www.sprint.com/vhc or by calling 1-800-927-2199. You may also visit your local retail store with your employee ID or a recent pay stub. When calling or visiting a location, mention the Corporate ID **HHPI_VAH_ZZZ**.

TUITION REIMBURSEMENT PROGRAM

The Hospital provides assistance to employees for pre-approved, clinical only, coursework at an accredited college, university, or professional school. Courses are approved by select criteria (refer to tuition policy for criteria). Full-time employees can use, on an annual basis, an unlimited amount to attend a college or university listed in the tuition policy, and permanent part-time employees can use \$2,500 annually to attend a college or university listed in the tuition policy. If a full-time employee wishes to attend a college or university not on the specified list, there is a \$5,000 yearly maximum (\$2,500 for permanent part-time employees). You must complete your 90-day probationary period, then you can apply for coursework in the following semester. You must apply before the start of coursework each semester.

VERIZON WIRELESS

Virginia Hospital Center employees can take advantage of special pricing on wireless service, equipment, and accessory purchases. Employees receive 22% off their monthly access fee on plans \$39.99 and higher, 25% off accessories, and low equipment prices. To place an order, or to register your line, please go to www.verizonwireless.com/getdiscount. For questions that are not answered online, contact Verizon Wireless at 1-800-922-0204.

WELLS FARGO AT WORK

Wells Fargo Bank offers you discounts on checking, savings, borrowing needs and planning for your future. To find the nearest Wells Fargo Banking Financial Center, call 1-888-353-7375 or www.wachovia.com/wachoviaatwork. (This website may redirect you in the future due to rebranding.)

YMCA

Virginia Hospital Center employees get a special discounted rate on membership at the YMCA Arlington, located at 3422 13th Street North, Arlington, VA 22201. They offer a variety of activities and amenities for members, including cardio equipment, LifeFitness strength circuit, free-weight area, racquetball/handball courts, outdoor swimming pool, saunas, towel service, free aerobic classes, free babysitting, and the AWAY program for traveling members. The YMCA also has a metropolitan membership program for people who live outside the Arlington area. For more information, check the website at www.ymcadc.org or call at 703-525-5420.

1-800-FLOWERS

1-800-FLOWERS offers an employee discount program for Virginia Hospital Center employees to use anytime throughout the year for personal purchases. You may take advantage of this discount by visiting www.1800flowers.com or by contacting their business gift services dedicated line at 1-800-755-7474 and using promotional code: VHCenter to receive a 10% discount off your entire purchase.

OTHER ADDITIONAL BENEFITS

As an employee with Virginia Hospital Center, you are also entitled to other additional benefits:

- ATM money machines on campus
- Cafeteria discount
- Employee parking
- Employee recognition program "Stars"
- Gift shops on campus
- Health promotion fitness and health education class discounts
- Hospital discount for employee and family members
- On-site employee health nurse
- Retirement education sessions
- Smoke/drug free campus
- Arlington Urgent Care Center - Open 24 hours a day, 7 days a week

PAID TIME OFF (PTO)

Paid Time Off (PTO) is an employee benefit that combines traditional vacation, holiday, and sick leave programs into one plan with two components, which provides you a flexible method of scheduling time off with pay.

The first component, PTO, includes hours that may be used at your discretion with the approval of your department manager. The second component, sick time (EIB or SCK), is restricted to use for personal illness/injury only. For absences due to illness or injury, this is intended to enable you to accrue sufficient time to bridge the waiting period between the onset of Short-Term Disability (STD) and/or Long-Term Disability (LTD).

All employees must use their PTO time for Hospital-recognized holidays when their department is closed. Those employees who work on a recognized holiday are paid time and one-half. Those whose day off falls on a holiday, do not have to use PTO. If a supervisor allows an employee to work on a holiday when their department is closed, the employee does not use PTO.

FULL-TIME STAFF PTO SCALE		
	YEARS OF SERVICE	ACCRUAL
STAFF	5 years or less	0.08460 per hour
	More than 5 years	0.10385 per hour
DEPARTMENT HEAD	3 years or less	0.10385 per hour
	More than 3 years	0.12308 per hour

(For example, a full-time staff member worked 80 hours per pay period and three years of service.) To calculate his/her PTO: $80 \text{ hours} \times 0.0846 = 6.77$ (time accrued each pay period). 6.77×26 pay periods per year = 22 days per year.

PART-TIME STAFF PTO SCALE		
	YEARS OF SERVICE	ACCRUAL
STAFF	5 years or less	0.0500 per hour
	More than 5 years	0.0692 per hour

(For example, a part-time staff member worked 40 hours per pay period and three years of service.) To calculate his/her PTO: $40 \text{ hours} \times 0.05 = 2.0$ (time accrued each pay period). 2.0×26 pay periods per year = 13 days per year.

ACCUMULATION

The maximum of accrued hours that can be carried over from one calendar year to another is 120 hours for staff and department heads.

Upon resignation or termination from the Hospital, employees will receive 75% payment for PTO balances.

SICK TIME

A staff member may be paid accrued extended illness bank leave/sick leave (EIB/SCK) pay if the absence is due to:

- A hospital (inpatient) admission.
- An outpatient surgical procedure, including dental surgery.
- A work-related illness or injury sustained on the job that qualifies for workers compensation.
- A re-occurrence of an illness when the re-occurrence appears prior to the completion of five consecutive shifts from the date of return, or the first 24 hours of illness.
- Absences that exceed 24 hours of normally worked time.
- When a staff member is absent due to an illness for which he/she subsequently (1) is admitted to a hospital as an in-patient) or (2) undergoes an outpatient surgical procedure (including dental surgery), the first three days of that illness are paid from accrued EIB/SCK leave. The previously charged PTO time is then credited to the staff member.
- If an employee has a continuous service date of five years or more he/she may use his/her sick time (SCK) leave on the first sick day.
- Physician certification may be requested before EIB/SCK hours are used.

FULL-TIME SICK TIME (EIB OR SCK) ACCRUAL SCALE

	YEARS OF SERVICE	ACCRUAL
STAFF	5 years or less More than 5 years	0.02690 per hour 0.03846 per hour
DEPARTMENT HEAD	All years of service	0.03846 per hour

PART-TIME SICK TIME (EIB OR SCK) ACCRUAL SCALE

	YEARS OF SERVICE	ACCRUAL
STAFF	All years of service	0.02690 per hour

FAMILY LEAVE PROGRAM

Virginia Hospital Center recognizes the need for employees to be responsible for family matters. All full-time (work 32 hours or more per week) and permanent part-time employees (work 20 hours or more per week) become participants in the family leave program upon hire. To begin using the accrued time in this program, you must have a continuous service date of five years or more. Full-time employees will earn FVL ACC and accrue up to four days per year; permanent part-time employees will earn FVL ACC and accrue up to two days per year. The maximum accrual is 20 days for full-time employees and 10 days for permanent part-time employees.

USE OF FAMILY LEAVE ACCRUAL (FVL ACC)

When an employee has a qualified family medical leave situation (as defined by the Federal government) and has reached the five year service requirement, he/she is eligible to use the days accrued in their family leave bank. You must complete a request form and turn it in to Human Resources along with required medical certification. Your timekeeper will record your time as SCK, PTO, or leave without pay. Human Resources and Payroll will credit back your hours. Once an employee has exhausted the family leave bank he/she will once again begin to accrue days for future family leave purposes. Human Resources must approve family leave pay before it is credited back to your used hours, and you must provide proper medical certification.

VIRGINIA HOSPITAL CENTER RETIREMENT PROGRAM

There are three parts to the savings and retirement program for eligible employees of Virginia Hospital Center:

- Core Pension Plan paid by Virginia Hospital Center
- Your 401(k) or 403(b)* contributions
- Hospital-paid match - 60¢ on the dollar up to 8% of your salary

CORE PENSION PLAN

Virginia Hospital Center will make contributions to the Core Pension Plan, ranging from 0.25% to 3.5% of eligible compensation, following the end of each calendar year is determined as follows: You must have completed one year of service, be an active employee on December 31, and work 1,000 hours in the plan year to be eligible for the core contribution. (See the chart on the following page for the percentage of contribution based on these criteria).

*SALARY DEFERRAL PLAN 401(k)/403(b)**

Through the salary deferral plan 401(k) or 403(b)*, you can elect to save from 1% to 50% of your eligible compensation – not to exceed \$16,500 (plan year 2011) – with pre-tax dollars. Virginia Hospital Center will match your contribution .60¢ on every \$1 you save, up to the first 8% of your contribution. To receive the match, you must have completed one year of service, be an active employee on December 31, and work 1,000 hours in the plan year. This match is determined following the end of each calendar year.

MORE ABOUT THE 401(K) OR 403(B) PLAN*

The 401(k) or 403(b)* plan offers an easy way to save for retirement. Because your 401(k) or 403(b)* savings are tax-deferred, you pay no taxes on your contributions or their earnings until you take a distribution. It also offers flexibility for today with loans that provide access to your money in case you need it before you retire. If you're eligible for a distribution from another retirement plan, you may be able to roll it over to the Hospital plan. For more information about the plan and your investment choices, contact Wells Fargo Retirement at 1-800-377-9188 (press "0" for Operator).



VESTING

You'll earn ownership rights to Hospital contributions to the Core Pension Plan and ownership of the Hospital's matching funds to your 401(k) or 403(b) after three years of service and working 1,000 hours per year. Of course, your own 401(k) or 403(b)* contributions are always 100% vested.

CATCH-UP PROVISION

The government has allowed certain employees to contribute additional compensation towards retirement after reaching the 401(k) or 403(b)* deferral maximum. If you are age 50 or older or turn age 50 during the plan year, you may contribute an additional \$5,500 (Plan year 2011) to your 401(k) or 403(b)* plan. *You must contact a Human Resources Benefits Representative to notify them of your eligibility so you can be set up in the program for this provision.*

OVERVIEW OF THE SAVINGS AND RETIREMENT PROGRAMS

PLAN FEATURE	CORE PLAN	401(K) PLAN	
You are eligible	The first of the month following 12 months of service	Starting on your date of hire	
Action you must take	None – you are automatically enrolled when eligible	You must enroll via the Wells Fargo website: www.wellsfargo.com/401k or via the voice response system at 1-800-377-9188 (press “0” for Operator)	
You contribute	Nothing – Virginia Hospital Center pays the full cost	From 1% - 50% of your eligible pay before taxes; maximum of \$16,500 (Plan year 2011)	
Virginia Hospital Center contributes	Based on service:	60¢ on every \$1 you contribute, up to the first 8% of your contribution; you must have completed one year of service, be an active employee on December 31, and work at least 1,000 hours in the Plan year to be eligible for the match.	
	YEARS OF SERVICE		% OF ELIGIBLE PAY**
	Less than 5		0.25%
	5-9		1.00%
	10-14		2.00%
	15-19		3.00%
	20 or more		3.50%
	Vesting requirements must be met for ownership of Core Pension contributions**		Vesting requirements must be met for ownership of match contributions**
Funds invested in	Your choice of professionally-managed funds	Your choice of professionally-managed funds	
For more information	See Summary Plan Description on the Employee Portal	See Summary Plan Description on the Employee Portal	

Note: Plan year for Retirement refers to calendar year.

**Highly compensated employees are directed to a 403(b) plan annually based on prior year's total eligible compensation earned at Virginia Hospital Center and meet the IRS compensation limits per year.*

***Plan provisions and maximums apply.*

CONTACT INFORMATION

Arlington Community Federal Credit Union

703-526-0200

www.arlingtoncu.org

Arlington Transit

703-228-RIDE

www.commuterpage.com/art

CareFirst Administrators – BlueCard

Virginia Hospital Center's Medical and COBRA administrators

1-866-942-7859

www.CFABlue.com

Caremark/CVS

Prescription drug administrators

1-800-966-5772

www.caremark.com or www.druglist.com to view the medication directory

Child Care & Education at Virginia Hospital Center

703-717-7200

www.brighthorizons.com/vahospital

ConnectYourCare

Flexible Spending Account administrators

1-888-870-7929

www.connectyourcare.com

Delta Dental

Virginia Hospital Center Dental Plan

1-800-237-6060

www.deltadentalva.com

For Eyes

1-800-FOR-EYES

www.foreyes.com

Insight Program (EAP)

703-558-6EAP

Kaiser Permanente Signature HMO

703-359-7878 (Washington Metro Area)

1-800-777-7904 (Outside Washington Metro Area)

www.kp.org

NPEP – Apartment Discount Program

1-877-629-6082

www.npep.com

Sport and Health

703-816-8800

www.sportandhealth.com/enroll

Sprint/Nextel

1-888-457-6294

www.sprint.com/vhc

The Standard Insurance Company

Short-Term Disability/Long-Term Disability/Life and AD&D Insurance

1-888-937-4783

www.standard.com

Verizon Wireless

1-800-922-0204

www.verizonwireless.com/getdiscount

Virginia Hospital Center – Benefits Department

703-558-6572

www.virginiahospitalcenter.com/content/benefits.asp

Wells Fargo at Work

1-888-353-7375

www.wachovia.com/Wachoviaatwork

(This website may redirect you in the future due to rebranding.)

Wells Fargo Retirement Services

Virginia Hospital Center Retirement Plan

1-800-377-9188

www.wellsfargo.com/401k

YMCA – Arlington

703-525-5420

www.ymcadc.org

1-800-FLOWERS

1-800-FLOWERS

www.1800flowers.com

BENEFITS NOTICES

The following are notices and certifications relating to the Virginia Hospital Center benefit plans. Some of these notices are required by the federal government.

- WOMEN'S HEALTH NOTICE
- FAMILY AND MEDICAL LEAVE ACT OF 1993
- YOUR CONTINUATION COVERAGE RIGHTS UNDER COBRA
- YOUR RIGHTS UNDER ERISA
- MEDICARE PART D CREDITABLE COVERAGE NOTICE
- HIPPA NOTICE OF PRIVACY PRACTICES
- MEDICAID AND THE CHILDREN'S HEALTH INSURANCE PROGRAM – CHIP

WOMEN'S HEALTH AND CANCER RIGHTS ACT OF 1998

A group health plan, and a health insurance issuer providing health insurance coverage in connection with a group health plan, that provides medical and surgical benefits with respect to a mastectomy shall provide, in a case of a participant or beneficiary who is receiving benefits in connection with a mastectomy and who elects breast reconstruction in connection with such mastectomy, coverage for:

1. All stages of reconstruction of the breast on which the mastectomy has been performed;
2. Surgery and reconstruction of the other breast to produce a symmetrical appearance; and
3. Prosthesis and physical complications all stages of mastectomy, including lymphedemas; in a manner determined in consultation with the attending physician and the patient.

Such coverage may be subject to annual deductibles and coinsurance provisions as may be deemed appropriate and as are consistent with those established for other benefits under the plan or coverage. Written notice of the availability of such coverage shall be delivered to the participant upon enrollment and annually thereafter.

YOUR RIGHTS UNDER THE FAMILY AND MEDICAL LEAVE ACT OF 1993 (FMLA)

FMLA requires covered employers to provide up to 12 weeks of unpaid, job-protected leave to "eligible" employees for certain family and medical reasons. Employees are eligible if they have worked for a covered employer (one with at least 50 employees within 75 miles) for at least one year, and for 1,250 hours over the previous 12 months.

REASONS FOR TAKING LEAVE

Unpaid leave must be granted for any of the following reasons:

- to care for the employee's child after birth, or placement for adoption or foster care;

- to care for the employee's spouse, son or daughter, or parent, who has a serious health condition; or
- for a serious health condition that makes the employee unable to perform the employee's job.

At the employee's or employer's option, certain kinds of paid leave may be substituted for unpaid leave.

ADVANCE NOTICE AND MEDICAL CERTIFICATION

The employee may be required to provide advance leave notice and medical certification. Taking of leave may be denied if requirements are not met.

- The employee ordinarily must provide 30 days advance notice when the leave is "foreseeable."
- An employer may require medical certification to support a request for leave because of a serious health condition, and may require second or third opinions (at the employer's expense) and a fitness for duty report to return to work.

JOB BENEFITS AND PROTECTION

For the duration of FMLA leave, the employer must maintain:

- The employee's health coverage under any "group health plan."
- Upon return from FMLA leave, most employees must be restored to their original or equivalent positions with equivalent pay, benefits, and other employment terms.
- The use of FMLA leave cannot result in the loss of any employment benefit that accrued prior to the start of an employee's leave. FMLA cannot exceed 12 weeks in total.

UNLAWFUL ACTS BY EMPLOYERS

FMLA makes it unlawful for any employer to:

- Interfere with, restrain, or deny the exercise of any right provided under FMLA; or
- Discharge or discriminate against any person for opposing any practice made unlawful by FMLA or for involvement in any proceeding under or relating to FMLA.

ENFORCEMENT

- The U.S. Department of Labor is authorized to investigate and resolve complaints of violations.
- An eligible employee may bring a civil action against an employer for violations.

FMLA does not affect any federal or state law prohibiting discrimination, or supersede any state or local law or collective bargaining agreement which provides greater family or medical leave rights.

FOR ADDITIONAL INFORMATION

Contact the nearest office of the Wage and Hour Division, listed in most telephone directories under U.S. Government, Department of Labor.

U.S. Department of Labor
Employment Standards Administration
Wage and Hour Division
Washington, D.C. 20210

COBRA

The Consolidated Omnibus Budget Reconciliation Act (COBRA), as amended by the Tax Reform Act of 1986 and the Omnibus Budget Reconciliation Act of 1989, requires the continuation of health benefits in certain situations where coverage would otherwise be lost.

ELIGIBLE EMPLOYEES

If you are an employee of Virginia Hospital Center and are covered under the Virginia Hospital Center's health and/or dental benefit plans, you may have a right to choose COBRA if you lose your group health/dental coverage because of a reduction in your hours of employment or the termination of your employment (for reasons other than gross misconduct).

ELIGIBLE DEPENDENTS

If you are covered under Virginia Hospital Center's benefit plan, you may choose COBRA for yourself if you lose your coverage because of:

- The death of the employee.
- A reduction in the employee's work hours or termination of the employee's employment (for reason other than gross misconduct).
- Divorce or legal separation.
- The employee becoming entitled to Medicare.

In addition, a dependent child who stops being eligible as a dependent under Virginia Hospital Center's benefit plan is eligible for COBRA coverage. A child born to, or placed for adoption with, the covered employee during a period of continuation coverage is also a qualified beneficiary eligible for COBRA coverage.

It is your (or your family member's) responsibility to inform

Human Resources of a divorce, legal separation or a child losing dependent status under Virginia Hospital Center's Benefit plan within 30 days of the date of the event. You have at least 60 days from the date you would lose coverage to notify the COBRA administrator that you want to continue coverage under COBRA. If you don't choose to continue coverage within this time period, your medical coverage will end. Your coverage under COBRA will be identical to the coverage provided under the plan to similarly situated employees or their covered dependents. This also means that if the coverage changes for similarly situated employees or their covered dependents, your coverage under COBRA will also be modified. See plan description for more information.

YOUR RIGHTS UNDER ERISA

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

- Examine, without charge, at the plan administrator's office and at other specified locations, all plan documents, including insurance contracts, and copies of all documents filed by the plans with the U.S. Department of Labor, such as detailed annual reports and plan descriptions.
- Obtain copies of all plan documents and other plan information upon written request to the plan administrator. The administrator may make a reasonable charge for the copies.
- Receive a summary of the plan's annual financial report. The plan administrator is required by law to furnish each participant with a copy of this summary annual report.

CONTINUE GROUP HEALTH PLAN COVERAGE

You are entitled to continue health care coverage for yourself, your spouse, or your dependents if there is a loss of coverage under the plan as a result of a qualifying event. You or your dependents may have to pay for such coverage. It is important to review the documents governing the plan regarding the rules for exercising your COBRA continuation coverage rights. You also are entitled to reduce or eliminate exclusionary periods of coverage for pre-existing conditions under your group health plan, provided that you have creditable coverage from another plan. You should be provided a certificate of creditable coverage, free of charge, from your group health plan or health insurance issuer:

- When you lose coverage under the plan;
- When you become entitled to elect COBRA continuation coverage;
- When your COBRA continuation coverage ceases (if you request it before losing coverage); or
- When you request it anytime up to 24 months after losing coverage.

Without evidence of creditable coverage, you may be subject to a pre-existing condition exclusion for up to 12 months (18 months

for late enrollees) after the date you enroll in the plan. In addition to creating rights for plan participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plans. The people who operate your plans have a duty to do so prudently, and in the interest of you and other plan participants and beneficiaries.

No one, including your employer or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA.

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

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request materials from the plan and do not receive them within 30 days, you may file suit in a federal court. In such 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 those who operate the plan 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 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 claims frivolous.

CLAIM REVIEW

Claim processing usually takes from 5 to 10 business days, exclusive of mailing time. In special situations, we may need additional time to make a final decision on your claim.

CLAIM APPEAL PROCEDURE

If a claim is denied or partially denied, the plan supervisor will furnish notice to the participant which will specify the reason or describe the additional information required. Upon written request by the participant within 60 days after notice is received, the plan supervisor will review the claim in question and give final written decision. If such decision is not received within 90 days, the participant may assume that the claim has been denied, unless he/she has been notified of the special circumstances necessitating an extension of time for consideration of the claim (up to 90 additional days).

Within 60 days after an appealed claim has been denied by the plan supervisor, the participant may appeal the denial by filing a written request for a review by the plan administrator. The

participant may have access to pertinent plan documents, which will be made available during normal business hours or any other reasonable times designated by the employer. He/she also has the right to provide the plan administrator with written statements relating to the merits of his/her claim. As soon as it is possible (but in no event longer than 120 days), the plan administrator will render a written, final and binding decision. This decision will also be delivered in writing setting forth-specific reasons for the decision and specific references to the pertinent plan provisions upon which the decision is based. If the decision to review is not furnished within the prescribed time, the claim shall be denied on review.

If you have any questions about this statement or your rights under ERISA, you should contact the plan administrator, Rita Jensen-Jaouhari at 703-558-6572 or the nearest Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory, or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue, N.W., Washington, DC 20210.

IMPORTANT NOTICE FROM VIRGINIA HOSPITAL CENTER 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 Virginia Hospital Center and new prescription drug coverage that will become available January 1, 2006 for people with Medicare. It also tells you where to find more information to help you make decisions about your prescription drug coverage.

1. Starting January 1, 2006, new Medicare prescription drug coverage will be available to everyone with Medicare.
2. Virginia Hospital Center has determined that the prescription drug coverage offered in the Virginia Hospital Center PPO plan is, on average for all plan participants, expected to pay out as much as the standard Medicare prescription drug coverage will pay.
3. Read this notice carefully – it explains the options you have under Medicare prescription drug coverage and can help you decide whether or not you want to enroll.

You may have heard about Medicare's new prescription drug coverage, and wondered how it would affect you. Virginia Hospital Center has determined that your prescription drug coverage with Virginia Hospital Center PPO plan is, on average for all plan participants, expected to pay out as much as the standard Medicare prescription drug coverage will pay. Starting January 1, 2006, prescription drug coverage will be available to everyone with Medicare through Medicare prescription drug plans. All Medicare prescription drug plans will provide at least a standard level of coverage set by Medicare. Some plans might offer more coverage for a higher monthly premium.

Because your existing coverage is, on average, as good as standard Medicare prescription drug coverage, you can keep your Virginia Hospital Center coverage and not pay extra if you later decide to enroll in Medicare coverage.

People with Medicare can enroll in a Medicare prescription drug plan from November 15, 2005 through May 15, 2006 (the initial enrollment period). However, because you have existing prescription drug coverage that, on average, is as good as the Medicare coverage, you can choose to join a Medicare prescription drug plan later. Each year after the initial enrollment period, you will have the opportunity to enroll in a Medicare prescription drug plan between November 15th and December 31st.

If you do decide to enroll in a Medicare prescription drug plan and drop your Virginia Hospital Center prescription drug coverage, be aware that you may not be able to get your Virginia Hospital Center coverage back until the next annual open enrollment period.

If you drop your coverage with Virginia Hospital Center and enroll in a Medicare prescription drug plan, you may not be able to get your Virginia Hospital Center coverage back until the next annual open enrollment period. 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.

You should also know that if you drop or lose your coverage with Virginia Hospital Center and don't enroll in Medicare prescription drug coverage after your current coverage ends, you may pay more to enroll in Medicare prescription drug coverage later. If, after May 15, 2006, 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 after May 15, 2006 that you did not have that coverage. For example, if you go 19 months without coverage, your premium will always be at least 19% higher than what most other people pay. You'll have to pay this higher premium as long as you have Medicare coverage. In addition, you may have to wait until the next open enrollment period to enroll.

For more information about this notice or your current prescription drug coverage:

For more information about your current Virginia Hospital Center prescription drug coverage, you may contact Human Resources at 703-558-6572 and speak to a benefits representative. You may receive this notice at other times in the future, such as before the next period you can enroll in Medicare prescription drug coverage, and if this coverage 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 included in the "Medicare & You 2006" handbook. You should have received a copy of the

handbook in the mail from Medicare (October 2005). You may also be contacted directly by Medicare prescription drug plans. You can also get more information about Medicare prescription drug plans from these places:

- Visit www.medicare.gov.
- Call your State Health Insurance Assistance Program (see your copy of the "Medicare & You 2006" handbook for their telephone number).
- 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 a Medicare prescription drug plan is available. Information about this extra help is available from the Social Security Administration (SSA). For more information about this extra help, visit SSA online at www.socialsecurity.gov, or call them at 1-800-772-1213 (TTY users should call 1-800-325-0778).

Remember: Keep this notice. If you enroll in one of the new plans approved by Medicare that offer prescription drug coverage after May 15, 2006, you may need to give a copy of this notice when you join to show that you are not required to pay a higher premium amount.

Virginia Hospital Center
Benefits Department
1701 N George Mason Drive
Arlington, VA 22205
703-558-6572

Rita Jensen-Jaouhari
Director of Benefits
Assistant Director, Human Resources

HIPPA NOTICE OF PRIVACY PRACTICES

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully. The Privacy of your Medical information is important to us.

Virginia Hospital Center Arlington Health System Health Care Plan
Virginia Hospital Center Arlington Health System Dental Care Plan
Virginia Hospital Center Arlington Flexible Spending Account

OUR LEGAL DUTY

This Notice describes our privacy practices, which include how we might use, disclose (share or give out), collect, handle, and protect our members' protected health information. We are required by certain federal and state laws to maintain the privacy of your protected health information. We are also required to give you this notice about our privacy practices, our legal duties, and your rights concerning your protected health information. We must follow the privacy practices that are described in this notice while

it is in effect. This notice takes effect April 14, 2003, and is not intended to amend any prior notice of Virginia Hospital Center Health Plans privacy practices. We reserve the right to change our privacy practices and the terms of this notice at any time, as long as law permits the changes. We reserve the right to make the changes in our privacy practices and the new terms of our notice effective for all protected health information that we maintain, including protected health information we created or received before we made the changes. If we make a significant change in our privacy practices, we will change this notice and send the new notice to our health plan subscribers within sixty days of the effective date of the change. You may request a copy of our notice at any time. For more information about our privacy practices, or for additional copies of this notice, please contact us using the information listed at the end of this notice.

USES AND DISCLOSURES OF MEDICAL INFORMATION

Primary Uses and Disclosures of Protected Health Information

We use and disclose protected health information about you for payment and health care operations. The federal health care Privacy Regulations generally do not “preempt” (or take precedence over) state privacy or other applicable laws that provide individuals greater privacy protections. As a result, to the extent state law applies, the privacy laws of a particular state, or other federal laws, rather than the HIPAA Privacy Regulations, might impose a privacy standard under which we will be required to operate. For example, where such laws have been enacted, we will follow more stringent state privacy laws that relate to uses and disclosures of the protected health information concerning HIV or AIDS, mental health, substance abuse/chemical dependency, genetic testing, and reproductive rights. In addition to these state law requirements, we also may use or disclose protected health information in the following situations:

Payment: We might use and disclose your protected health information for all activities that are included within the definition of “payment” as written in the Federal Privacy Regulations. For example, we might use and disclose your protected health information to pay claims for services provided to you by doctors, hospitals, pharmacies and others for services delivered to you that are covered by your health plan. We might also use your information to determine your eligibility for benefits, to coordinate benefits, to examine medical necessity, to obtain premiums, and to issue explanations of benefits to the person who subscribes to the health plan in which you participate.

Health Care Operations: We might use and disclose your protected health information for all activities that are included within the definition of “health care operations” as defined in the Federal Privacy Regulations. For example, we might use and disclose your protected health information to determine our premiums for your health plan, to conduct quality assessment and improvement activities, to engage in care coordination or case management, and to manage our business.

Business Associates: In connection with our payment and health care operations activities, we contract with individuals and entities (called “business associates”) to perform various functions on our behalf or to provide certain types of services (such as member service support, utilization management, subrogation, or pharmacy benefit management). To perform these functions or to provide the services, our business associates will receive, create, maintain, use, or disclose protected health information, but only after we require the business associates to agree in writing to contract terms designed to appropriately safeguard your information.

Other Covered Entities: In addition, we might use or disclose your protected health information to assist health care providers in connection with their treatment or payment activities, or to assist other covered entities in connection with certain of their health care operations. For example, we might disclose your protected health information to a health care provider when needed by the provider to render treatment to you, and we might disclose protected health information to another covered entity to conduct health care operations in the areas of quality assurance and improvement activities, or accreditation, certification, licensing or credentialing.

OTHER POSSIBLE USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION

The following is a description of other possible ways in which we might (and are permitted to) use and/or disclose your protected health information.

To you or with Your Authorization: We must disclose your protected health information to you, as described in the Individual Rights section of this notice. You may give us written authorization to use your protected health information or to disclose it to anyone for any purpose not listed on this notice. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures that we made as permitted by your authorization while it was in effect. Without your written authorization, we might not use or disclose your protected health information for any reason except those described in this notice.

Disclosures to the Secretary of the U.S. Department of Health and Human Services: We are required to disclose your protected health information to the Secretary of the U.S. Department of Health and Human Services when the Secretary is investigating or determining our compliance with the federal Privacy Regulations.

To Plan Sponsors. Where permitted by law, we may disclose your protected health information to the plan sponsor of your group health plan to permit the plan sponsor to perform plan administration functions. For example, a plan sponsor may contact us seeking information to evaluate future changes to your benefit plan. We may also disclose summary health information (this type of information is defined in the Federal Privacy Regulations) about the enrollees in your group health plan to the plan sponsor to obtain premium bids for the health insurance coverage offered through your group health plan or to decide whether to modify, amend or terminate your group health plan.

To Family and Friends: If you agree (or, if you are unavailable to agree), such as in a medical emergency situation we might disclose your protected health information to a family member, friend or other person to the extent necessary to help with your health care or with payment for your health care.

Underwriting: We might receive your protected health information for underwriting, premium rating or other activities relating to the creation, renewal or replacement of a contract of health insurance or health benefits. We will not use or further disclose this protected health information received under these circumstances for any other purpose, except as required by law, unless and until you enter into a contract of health insurance or health benefits with us.

Health Oversight Activities: We might disclose your protected health information to a health oversight agency for activities authorized by law, such as: audits; investigations; inspections; licensure or disciplinary actions; or civil, administrative, or criminal proceedings or actions. Oversight agencies seeking this information include government agencies that oversee: (i) the health care system; (ii) government benefit programs; (iii) other government regulatory programs; and (iv) compliance with civil rights laws.

Abuse or Neglect: We might disclose your protected health information to appropriate authorities if we reasonably believe that you might be a possible victim of abuse, neglect, domestic violence or other crimes.

To Prevent a Serious Threat to Health or Safety: Consistent with certain federal and state laws, we might disclose your protected health information if we believe that the disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public.

Coroners, Medical Examiners, Funeral Directors, and Organ Donation: We might disclose protected health information to a coroner or medical examiner for purposes of identifying you after you die, determining your cause of death or for the coroner or medical examiner to perform other duties authorized by law. We also might disclose, as authorized by law, information to funeral directors so that they may carry out their duties on your behalf. Further, we might disclose protected health information to organizations that handle organ, eye, or tissue donation and transplantation.

Research: We might disclose your protected health information to researchers when an institutional review board or privacy board has: (1) reviewed the research proposal and established protocols to ensure the privacy of the information; and (2) approved the research.

Inmates: If you are an inmate of a correctional institution, we might disclose your protected health information to the correctional institution or to a law enforcement official for: (1) the institution to provide health care to you; (2) your health and safety and the health and safety of others; or (3) the safety and security of the correctional institution.

Workers' Compensation: We might disclose your protected health information to comply with workers' compensation laws and other similar programs that provide benefits for work-related injuries or illnesses.

Public Health and Safety: We might disclose your protected health information to the extent necessary to avert a serious and imminent threat to your health or safety or the health or safety of others.

Required by Law: We might use or disclose your protected health information when we are required to do so by law. For example, we must disclose your protected health information to the U.S. Department of Health and Human Services upon their request for purposes of determining whether we are in compliance with federal privacy laws.

Legal Process and Proceedings: We might disclose your protected health information in response to a court or administrative order, subpoena, discovery request, or other lawful process, under certain circumstances. Under limited circumstances, such as a court order, warrant, or grand jury subpoena, we might disclose your protected health information to law enforcement officials.

Law Enforcement: We might disclose to a law enforcement official limited protected health information of a suspect, fugitive, material witness, crime victim, or missing person. We might disclose protected health information where necessary to assist law enforcement officials to capture an individual who has admitted to participation in a crime or has escaped from lawful custody.

Military and National Security: We might disclose to military authorities the protected health information of Armed Forces personnel under certain circumstances. We might disclose to federal officials protected health information required for lawful intelligence, counterintelligence, and other national security activities.

Other Uses and Disclosures of Your Protected Health Information: Other uses and disclosures of your protected health information that are not described above will be made only with your written authorization. If you provide us with such an authorization, you may revoke the authorization in writing, and this revocation will be effective for future uses and disclosures of protected health information. However, the revocation will not be effective for information that we already have used or disclosed in reliance on your authorization.

INDIVIDUAL RIGHTS

Access: You have the right to look at or get copies of the protected health information contained in a designated record set, with limited exceptions. You may request that we provide copies in a format other than photocopies. We will use the format you request unless we cannot reasonably do so. You must make a request in writing to obtain access to your protected health information. You may obtain a form to request access by using the contact information listed at the end of this notice. You may also request access by sending a letter

to the address at the end of this notice. If you request copies, we might charge you a reasonable fee for each page, and postage if you want the copies mailed to you. If you request an alternative format, we might charge a cost-based fee for providing your protected health information in that format. If you prefer, we will prepare a summary or an explanation of your protected health information, but we might charge a fee to do so.

We might deny your request to inspect and copy your protected health information in certain limited circumstances. Under certain conditions, our denial will not be reviewable. If this event occurs, we will inform you in our denial that the decision is not reviewable. If you are denied access to your information and the denial is subject to review, you may request that the denial be reviewed. A licensed health care professional chosen by us will review your request and the denial. The person performing this review will not be the same person who denied your initial request.

Disclosure Accounting: You have the right to receive a list of instances in which we or our business associates disclosed your protected health information for purposes other than treatment, payment, health care operations and certain other activities, after April 14, 2003. We will provide you with the date on which we made the disclosure, the name of the person or entity to which we disclosed your protected health information, a description of the protected health information we disclosed, the reason for the disclosure, and certain other information. If you request this list more than once in a 12-month period, we might charge you a reasonable, cost-based fee for responding to these additional requests. You may request an accounting by submitting your request in writing using the information listed at the end of this notice. Your request may be for disclosures made up to 6 years before the date of your request, but in no event, for disclosures made before April 14, 2003.

Restriction Requests: You have the right to request that we place additional restrictions on our use or disclosure of your protected health information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in an emergency). Any agreement that we might make to a request for additional restrictions must be in writing and signed by a person authorized to make such an agreement on our behalf. We will not be liable for uses and disclosures made outside of the requested restriction unless our agreement to restrict is in writing. We are permitted to end our agreement to the requested restriction by notifying you in writing. You may request a restriction by writing to us using the information listed at the end of this notice. In your request tell us: (1) the information of which you want to limit our use and disclosure; and (2) how you want to limit our use and/or disclosure of the information.

Confidential Communication: If you believe that a disclosure of all or part of your protected health information may endanger you, you have the right to request that we communicate with you in confidence about your protected health information. This means that

you may request that we send you information by alternative means, or to an alternate location. We must accommodate your request if: it is reasonable, specifies the alternative means or alternate location, and specifies how payment issues (premiums and claims) will be handled. You may request a Confidential Communication by writing to us using the information listed at the end of this notice.

Amendment: You have the right to request that we amend your protected health information. Your request must be in writing, and it must explain why the information should be amended. We may deny your request if we did not create the information you want amended or for certain other reasons. If we deny your request, we will provide you with a written explanation. You may respond with a statement of disagreement to be appended to the information you wanted amended. If we accept your request to amend the information, we will make reasonable efforts to inform others, including people you name, of the amendment and to include the changes in any future disclosures of that information.

Electronic Notice: Even if you agree to receive this notice on our web site, or by electronic mail (e-mail), you are entitled to receive a paper copy as well. Please contact us using the information listed at the end of this notice to obtain this notice in written form. If the e-mail transmission has failed, and the Virginia Hospital Center Health Plan is aware of the failure, then we will provide a paper copy of the notice to you.

QUESTIONS AND COMPLAINTS

Information on Virginia Hospital Center Health Plans Privacy

Practices: If you want more information about our privacy practices, or have questions or concerns, please contact the member services number on the back of your card.

Filing a Complaint: If you are concerned that we might have violated your privacy rights, or you disagree with a decision we made about your individual rights, you may use the contact information listed at the end of this notice to complain to us. You also may submit a written complaint to the U.S. Department of Health and Human Services (DHHS). We will provide you with the contact information for DHHS upon request. We support your right to protect the privacy of your protected health and financial information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

Virginia Hospital Center Health Plans Contact Information:

Contact Office:

Virginia Hospital Center Health Plans HIPAA Privacy Office
Human Resources Department – Attn: Rita Jensen-Jaouhari
Virginia Hospital Center
1701 N. George Mason Drive
Arlington, VA 22205
Telephone: 703-558-6494 Fax: 703-558-6553
E-mail: rjensen@virginiahospitalcenter.com

MEDICAID AND THE CHILDREN'S HEALTH INSURANCE PROGRAM (CHIP) OFFER FREE OR LOW-COST HEALTH COVERAGE TO CHILDREN AND FAMILIES

If you are eligible for health coverage from your employer, but are unable to afford the premiums, some States have premium assistance programs that can help pay for coverage. These States use funds from their Medicaid or CHIP programs to help people who are eligible for employer-sponsored health coverage, but need assistance in paying their health premiums.

If you or your dependents are already enrolled in Medicaid or CHIP and you live in a State listed below, you can contact your State Medicaid or CHIP office to find out if premium assistance is available.

If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, you can contact your State Medicaid or CHIP office or dial 1-877-KIDS NOW or www.insurekidsnow.gov to find out how to apply. If you qualify, you can ask the State if it has a program that might help you pay the premiums for an employer-sponsored plan.

Once it is determined that you or your dependents are eligible for premium assistance under Medicaid or CHIP, your employer's health plan is required to permit you and your dependents to enroll in the plan – as long as you and your dependents are eligible, but not already enrolled in the employer's plan. This is called a "special enrollment" opportunity, and you must request coverage within 60 days of being determined eligible for premium assistance.

If you live in one of the following States, you may be eligible for assistance paying your employer health plan premiums. The following list of States is current as of March 3, 2010. You should contact your State for further information on eligibility.

ALABAMA – Medicaid

Website: <http://www.medicaid.alabama.gov>
Phone: 1-800-362-1504

ALASKA – Medicaid

Website: <http://health.hss.state.ak.us/dpa/programs/medicaid/>
Phone (Outside of Anchorage): 1-888-318-8890
Phone (Anchorage): 907-269-6529

ARIZONA – CHIP

Website: <http://www.azahcccs.gov/applicants/default.asp>
Phone: 602-417-5422

ARKANSAS – CHIP

Website: <http://www.arkidsfirst.com/>
Phone: 1-888-474-8275

GEORGIA – Medicaid

Website: <http://dch.georgia.gov/>
Click on Programs, then Medicaid
Phone: 1-800-869-1150

IDAHO – Medicaid and CHIP

Medicaid Website: www.accesstohealthinsurance.idaho.gov
Medicaid Phone: 208-334-5747
CHIP Website: www.medicaid.idaho.gov
CHIP Phone: 1-800-926-2588

INDIANA – Medicaid

Website: <http://www.in.gov/fssa/2408.htm>
Phone: 1-877-438-4479

IOWA – Medicaid

Website: www.dhs.state.ia.us/hipp/
Phone: 1-888-346-9562

KANSAS – Medicaid

Website: <https://www.khpa.ks.gov>
Phone: 800-766-9012

KENTUCKY – Medicaid

Website: <http://chfs.ky.gov/dms/default.htm>
Phone: 1-800-635-2570

LOUISIANA – Medicaid

Website: www.dhh.louisiana.gov/offices/?ID=92
Phone: 1-888-342-6207

MAINE – Medicaid

Website: <http://www.maine.gov/dhhs/oms/>
Phone: 1-800-321-5557

MASSACHUSETTS – Medicaid and CHIP

Medicaid & CHIP Website: <http://www.mass.gov/MassHealth>
Medicaid & CHIP Phone: 1-800-462-1120

MINNESOTA – Medicaid

Website: <http://www.dhs.state.mn.us/>
Click on Health Care, then Medical Assistance
Phone: 800-657-3739

MISSOURI – Medicaid

Website: <http://www.dss.mo.gov/mhd/index.htm>
Phone: 573-751-6944

NORTH DAKOTA – Medicaid

Website: <http://www.nd.gov/dhs/services/medicalserv/medicaid/>
Phone: 1-800-755-2604

OKLAHOMA – Medicaid

Website: <http://www.insureoklahoma.org>
Phone: 1-888-365-3742

OREGON – Medicaid and CHIP

Medicaid Website:
<http://www.oregon.gov/DHS/healthplan/index.shtml>
 Medicaid Phone: 1-800-359-9517
 CHIP Website:
http://www.oregon.gov/DHS/healthplan/app_benefits/ohp4u.shtml
 CHIP Phone: 1-800-359-9517

PENNSYLVANIA – Medicaid

Website:
<http://www.dpw.state.pa.us/partnersproviders/medicalassistance/doingbusiness/003670053.htm>
 Phone: 1-800-644-7730

RHODE ISLAND – Medicaid

Website: www.dhs.ri.gov
 Phone: 401-462-5300

CALIFORNIA – Medicaid

Website:
http://www.dhcs.ca.gov/services/Pages/TPLRD_CAU_cont.aspx
 Phone: 1-866-298-8443

COLORADO – Medicaid and CHIP

Medicaid Website: <http://www.colorado.gov/>
 Medicaid Phone: 1-800-866-3513
 CHIP Website: [http:// www.CHPplus.org](http://www.CHPplus.org)
 CHIP Phone: 303-866-3243

FLORIDA – Medicaid

Website: <http://www.fdhc.state.fl.us/Medicaid/index.shtml>
 Phone: 1-866-762-2237

MONTANA – Medicaid

Website:
<http://medicaidprovider.hhs.mt.gov/clientpages/clientindex.shtml>
 Telephone: 1-800-694-3084

NEBRASKA – Medicaid

Website: <http://www.dhhs.ne.gov/med/medindex.htm>
 Phone: 1-877-255-3092

NEVADA – Medicaid and CHIP

Medicaid Website: <http://dwss.nv.gov/>
 Medicaid Phone: 1-800-992-0900
 CHIP Website: <http://www.nevadacheckup.nv.org/>
 CHIP Phone: 1-877-543-7669

NEW HAMPSHIRE – Medicaid

Website: <http://www.dhhs.state.nh.us/DHHS/MEDICAIDPROGRAM/default.html>
 Phone: 1-800-852-3345 x 5254

NEW JERSEY – Medicaid and CHIP

Medicaid Website: <http://www.state.nj.us/humanservices/dmahs/clients/medicaid/>
 Medicaid Phone: 1-800-356-1561
 CHIP Website: <http://www.njfamilycare.org/index.html>
 CHIP Phone: 1-800-701-0710

NEW MEXICO – Medicaid and CHIP

Medicaid Website: <http://www.hsd.state.nm.us/mad/index.html>
 Medicaid Phone: 1-888-997-2583
 CHIP Website: <http://www.hsd.state.nm.us/mad/index.html>
 Click on Insure New Mexico
 CHIP Phone: 1-888-997-2583

NEW YORK – Medicaid

Website: http://www.nyhealth.gov/health_care/medicaid/
 Phone: 1-800-541-2831

NORTH CAROLINA – Medicaid

Website: <http://www.nc.gov>
 Phone: 919-855-4100

UTAH – Medicaid

Website: <http://health.utah.gov/medicaid/>
 Phone: 1-866-435-7414

VERMONT– Medicaid

Website: <http://ovha.vermont.gov/>
 Telephone: 1-800-250-8427

VIRGINIA – Medicaid and CHIP

Medicaid Website: <http://www.dmas.virginia.gov/rcp-HIPP.htm>
 Medicaid Phone: 1-800-432-5924
 CHIP Website: <http://www.famis.org/>
 CHIP Phone: 1-866-873-2647

WASHINGTON – Medicaid

Website: <http://hrsa.dshs.wa.gov/premiumpymt/Apply.shtm>
 Phone: 1-877-543-7669

WEST VIRGINIA – Medicaid

Website: <http://www.wvrecovery.com/hipp.htm>
 Phone: 304-342-1604

WISCONSIN – Medicaid

Website:
<http://dhs.wisconsin.gov/medicaid/publications/p-10095.htm>
 Phone: 1-800-362-3002

WYOMING – Medicaid

Website: <http://www.health.wyo.gov/healthcarefin/index.html>
 Telephone: 307-777-7531

SOUTH CAROLINA – Medicaid

Website: <http://www.scdhhs.gov>
 Phone: 1-888-549-0820

TEXAS – Medicaid

Website: <https://www.gethipptexas.com/>

Phone: 1-800-440-0493

To see if any more States have added a premium assistance program since March 3, 2010, or for more information on special enrollment rights, you can contact either:

U.S. Department of Labor Employee Benefits Security Administration

www.dol.gov/ebsa

1-866-444-EBSA (3272)

U.S. Department of Health and Human Services Centers for Medicare & Medicaid Services

www.cms.hhs.gov

1-877-267-2323, Ext. 61565

OMB Control Number 1210-0137 (expires 07/31/2010)

PLEASE NOTE: This booklet is meant to provide you with an overview of the benefits of working at Virginia Hospital Center. The Hospital reserves the right to make any changes to any of the benefit plans.

We have made every effort to make the information in this booklet as accurate and easy for you to understand as possible. However, this booklet and any oral statements are not a substitute for the official plan documents. If there is a difference between what is in this booklet or told to you orally, and the official plan documents, the official plan documents will govern.

Summary Plan Descriptions (available on the Employee Portal) provide you with specific information about specific plans. Virginia Hospital Center policies and procedures are written in the Personnel Policy Manual and accessible to you through your supervisor, department manager, or Human Resources. The Human Resources Department encourages you to review all plan materials in detail before making any benefit or employment decisions.

Please feel free to contact us.





HUMAN RESOURCES DEPARTMENT

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Arlington, VA 22205

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703.558.6553 fax

www.virginiahospitalcenter.com