

OPEN ENROLLMENT BENEFITS GUIDE Must Enroll by February 28, 2023

BENEFIT PLAN YEAR APRIL 1, 2023 – MARCH 31, 2024

TABLE of CONTENTS

Pages 3

Clearing Browser History Accessing LAWSON

Page 4

Resources & Contacts

Page 5

Your Enrollment Process WELCOME Screen

Pages 6-8

Dependent Maintenance Upload Documents Add New Dependents

Pages 9

Address Review Smoker Status Order of Enrollment (FT & PPT)

Page 10

Order of Enrollment (PRNs/PT & Benefits ALT)

Page 11

Review Current Benefits

Page 12

Selecting Plans to change for Open Enrollment

Page 13-15

Options for Making Selections

Pages 16-18

Spousal Privilege Premium Waiver Application

Pages 19-20

Selecting High Deductible Plan HSA Information

Pages 21

Declining Health Coverage

Page 22-30

Examples of Benefit Selections

Page 31

Review Confirmation Page

Pages 32

Making Changes

Pages 33-34

Review Confirmation Page with Changes & Finish Enrollment

Page 35

Printing Benefits Summary Statement of Health Information

Page 36

Final Confirmation Page

Page 37

Adding or Uplifting Life Insurance Beneficiary

Pages 38-45

Clearing your browser history in Google Chrome or Microsoft Edge

PLEASE CLEAR BROWSER HISTORY BEFORE YOU BEGIN

Instructions on clearing **Microsoft Edge** (PREFERRED) & Google CHROME start on page 46.

Online benefits enrollment can be accessed through Lawson Employee Self Service using the following methods:

YOUR DESKTOP WORKSTATION

Using the Virginia Hospital Center **EMPLOYEE PORTAL**, click on **Lawson** under the **VHC Applications/External Links** section.

HOME ACCESS

Set up Dual Factor Authentication using the **Imprivata App** on your mobile device & refer to the DFA Tip Sheet.

Go to <u>https://myapps.virginiahospitalcenter.com</u> and sign in with your network username and password

For issues, create a **ServiceNow** Incident or contact the Help Desk at 703.558.6566 for assistance.

Know Your Resources and Contact Information:

For questions regarding your employee benefits – 1st Visit the <u>BENEFITS CORNER</u> 2nd Contact the <u>BENEFIT COUNSELORS</u> Phone: 1.855.874.0205 Website: <u>BenefitsGo.com/VHC</u> 3rd Contact the Benefits Department Email: <u>Benefits_Department@VHChealth.org</u> Phone: 703.558.6711 (ext. 6711)

For technical issues with Employee Self Service, contact the Help Desk

1st Open a ticket using the Service Now Icon on your Desktop 2nd Phone: 703-558-6566 (ext. 6566) 3rd Email: <u>HelpDesk@VHChealth.org</u>

YOUR BENEFIT ENROLLMENT PROCESS

Follow these easy steps to add, drop or make changes to your benefits

Virginia Hospital Center Login to Infor Lawson ESS Sign in with your organizational account The system will display the Lawson portal login vhc) Password screen. Enter vhc\ & your network login ID and password, and then click the Login button. Lawson VIRGINIA HOSPITAL CENTER Bookmarks Favorites/Shortcuts Go To Employee Self-Service Bookmark ➢Click "Benefits Links" Bookmarks Employee Self-Service Click on "Benefits Open Enrollment" to start your HELP benefits enrollment. 👻 📂 Benefit Links Benefits Open Enrollment New Hire Enrollment

Review and Continue

Review the welcome message for important information about your enrollment process

Pelcome to the VHC 2023-2024 Benefits Open Enrollment Process tring our Annual Benefits Open Enrollment Period of February 14, 2023 through February 28, 2023, u will make all changes to your benefits using online *LAWSON Employee Self-Service*.

FORE YOU BEGIN The second secon

are adding a spouse

DOING A DEPENSION sponse of dependents of dependents of sponsent status by clicking on the UPLOSH thin the Status are listed in the Annual Ben process company will not be notified of their dents to your health and/or dental plans for the first time, you will be required to submit *Proof of* **UPCOAD** button on the Dependent Naintenance screen **2**. **Documents must be submitted Interpretation** and Benefits Enrollment Guide. Your dependent(s) will be placed in a pending status and the d of their enrollment until the documents are received.

SAL PRIVILEGE PREMIUM WAIVER I have a spouse on a medical plan option: you will be subject to a <u>Spousal Privilege Premium</u> of \$300 a th (\$138.46 per pay period). You will complete the Spousal Privilege Premium Waiver Affidavit during the ment process and submit supporting documentation for this fee to be waived. You must upload your mentation online in the Dependent Maintenance Screen no later than Tuesday, February 28, 2023. If y the waiver criteria, you will be notified by the Benefits Department with an email. If you do not get approved, a, you will be notified by the Benefits Department with an email. If you do not get approved, al Privilege Premium (SPP).
e Premium stays in effect through the benefit plan year unless you have a qualifying r spouse from your VHC health insurance plan.

i wish to enroll in Disability or Additional Life Insurance for yourself and/or your spouse, you will be required to it a <u>Statement of Health</u> for each person to MetLife Statement of Health Medical Underwriting for review and wal. You will receive an email with instructions on completing your Statement of Health with MetLife. Your tions will be placed in a pending status until the Benefits Department has been notified of your approval ife. Your Statement of Health should be submitted to MetLife by email, fax, or USPS no later than day, *February 28, 2023*.

EXIBLE SPENDING

Parking -Higible for this benefit. If you commute to tax by payroll deduction up to \$300/mo

or technical issues with Employee Self Service or if you have a question for the Counselors during off-hours? Open an incident using the Service Now shortcut on your desktop or type https://yhc.serv

your Google Chrome

Click the continue button to begin your enrollment

Dependent Maintenance / Existing Dependents – Add / Review

> You will see a list of your existing dependents.

Dependent Maintenance					
Click the Add/Change Dependent button to add any new dependent(s) who should be covered under your benefit plans and/or if you want to upload any required documentation. Dependent's coverage will not be provided until required documents have been reviewed and approved.					
Please note that if you are removing any dependents from your benefit plans, they will be updated to inactive status when your benefit elections are processed following the review of any required documentation related to your life event.					
Name	Relation	Birthdate			
MODEL_EMPLOYEE25781, RUTHIE	SPOUSE OF EMPLOYEE	04/08/1996			
MODEL_EMPLOYEE25781, MONICA	CHILDREN OF EMPLOYEE	04/04/2018			
Continue Add/Change Upload Documents Previous					

If you don't need to add dependents, click Continue to move forward in the enrollment process
 Your existing dependents will be listed with an option to view information. If corrections are needed, please send an email to <u>Benefits_Department@VirginiaHospitalCenter.com</u> with information on what needs to be corrected. PLEASE do not enter that dependent again
 Click on <u>UPLOAD DOCUMENTS</u> to submit Dependent Verification Documentation

Upload Dependent Documents

Employee Dependents Update

Please type your dependent information in the form below. Please note * means required field. After adding or changing information for each dependent, click save. Click continue after all dependent updates are complete to proceed to the next screen.

Please note that if you are removing a dependent due to a life event they will become inactive and removed from viewing following receipt of the required documentation. You will not have the ability to delete their record(s) below but should update their address, if applicable, that will be used for required COBRA notification purposes.

Existing Dependent(s) List				
Name	Relation	Birthdate		
MODEL_EMPLOYEE25781, RUTHIE	SPOUSE OF EMPLOYEE	04/08/1996	View	
MODEL_EMPLOYEE25781, MONICA	CHILDREN OF EMPLOYEE	04/04/2018	View	

uick on the upload Documents button to upload your required supporting documents (EX: social security card, marnage license).	
Dependent's coverage will not be provided until required documents have been reviewed and approved.	
	Upload Document

Proof of Dependent Status is required when adding a dependent to your medical or dental insurance.

Upload your documents by clicking the **UPLOAD DOCUMENTS** button.

Add New Dependents

- > To add a new dependent complete the New Dependent Form
- Required fields are noted with an * symbol

If corrections are needed, please contact the Benefits Department by sending an email to benefits_department@virginiahospitalcenter.com with information that needs to be corrected. PLEASE do not enter that dependent again

Click on the 'Upload Documents' button to upload your required supporting documents (Ex: social security card, marriage license).						
Dependent's coverage will not be provided until required documents have been reviewed and approved.						
	Upload Documents					
New Dependent(s) Form						
* First Name	MILLICENT					
Middle Initial	T					
* Last Name	MODEL_EMPLOYEE25781					
Suffix						
* Birthdate (mm/dd/yyyy)	09/27/2019					
(If adopted): Adoption Date (mm/dd/yyyy)						
* Social Security Number	281 -08 -9217					
* Relationship	CHILD CHILDREN OF EMPLOYEE					
* Gender	O Male Female					
Disabled	⊖Yes ●No					
*Does this dependent reside with you?	● Yes ○ No-resides at different address					
Continue Previous Save						

Upload Dependent Documents

Proof of Dependent Status is required when adding a dependent to your medical or dental plans. You may upload your documents by clicking the <u>UPLOAD DOCUMENTS</u> button on the add new dependent form.

Acceptable documents proving dependent status include:

- a. <u>For All Dependents (Spouse & Child/ren)</u> Copy of page 1 of your current Federal 1040 Tax Return, showing Married Filing Jointly or Separately to add your spouse & listing your claimed dependents (confidential financial information may be hidden) AND
- b. For Spouse/Same Sex Spouse Copy of marriage or civil union certificate/license & social security card AND
- c. <u>For Children/Adult Children</u> Copy of birth certificate, adoption agreement or placement for adoption, court custody or guardianship document, divorce decree or other court documents requiring you to provide medical coverage & social security card.

Proof of Dependent (Spouse & Child/ren) verification documents must be uploaded to LAWSON Employee Self-Service by the last day of Open Enrollment.

Documents needed only if adding new dependents (Spouse & Child/ren) to any of your benefit plans.

<u>Important Note:</u> If all dependent verification documents are not submitted prior to end of open enrollment, Monday, February 28, 2023, your benefit elections may be changed to reflect the level of coverage equal to the documents received.

When you select Upload Documents, the following pop-up screen will appear -

🕤 File U	pload - Google Chrome		
â s3t	est.virginiahospitalcenter.com/lawson/xbnnetvhc/popupFile	Upload	I Q
You may : each docu size is 204	File Upload select the files to upload by selecting the browse button. You are required ument. Acceptable file types are doc,docx,txt,jpg,pdf,csv,tif,png. Maximum 48 KB. Required fields are denoted by *. Save Back	to give n accepta	a title of able file
Upload File:	Choose File No file chosen		
Title:			
File 1:			View
Upload File:	Choose File No file chosen		
Title:			
File 2:		*	View
Upload File:	Choose File No file chosen		
Title:			
File 3:		×	View
Upload File:	Choose File No file chosen		
Title:			
File 4:		×	View

After all documents have been uploaded, don't forget to **Select Save**.

Address Update

> Please take the time to verify & update your address if necessary

Smoker Status

You must elect smoker status for yourself & as well as your dependent(s) if you added any.



Enrollment Order for PRNs & Part-Time working less than 20 hours

Enrollment Order
You will enroll in benefits in the following order:
Plan Type
HEALTH
SPOUSAL PRIV PREMIUM
CAFE PAYROLL
VHC FOUNDATION GIFTS
Continue Exit

Enrollment Order for Benefits Alternative Status

Enrollment Order

You will enroll in benefits in the following order:

Plan Type	
HEALTH	
SPOUSAL PRIV PREMIUM	
HEALTH SAVINGS ACCT	
FLEX SPEND MEDICAL	
FLEX SPEND DAYCARE	
CAFE PAYROLL	
VHC FOUNDATION GIFTS	

Continue E

Review your Current Benefits

- To make changes, click in the box next to that plan
- The system may select additional plans that need to be updated
 - If you cover a spouse on your plan, you will go through your medical plan, Spousal Privilege Premium status as well as any Flexible Spending Accounts (FSA), Health Saving Account (HSA), Limited Purpose Flexible Spending Account (LPFSA) or Dependent Care Flexible Spending Account (DCFSA) elections
 - If you choose to make changes to your Supplemental Life Insurance, you must also update your Supplemental AD&D Life Insurance as well as Life & AD&D Insurance for your spouse &/or Child(ren)

Current Benefits

Listed below are the benefits in which you are currently enrolled. Check the boxes of those plans you wish to change for 2022. If you need to add or change dependents for a particular plan, you MUST check the box for that plan. Key:

A blank box means your current benefit elections will remain in place for 2022.

A checked box 🗹 means you want to change your benefits for 2022.

A shaded 🗹 check box means the system automatically requires you to make a plan choice for 2022.

An asterisk (*)means this is a company paid benefit, no action necessary.

Some plans are linked together, so if you make a change to one, the other plan will require review.

To find out more information about the benefits offered, review the Benefits Enrollment Guide.

		~	a. 15 (¥ 6.
Select		Han	Start Date	Coverage	Your Cost
0	VHC PPO HEALTH PLAN		02/01/2022	FAM	LY 429.09 Pretax
		RUTHIE L MODEL_EMPLOYEE25781 MONICA T. MODEL_EMPLOYEE25781			
	WAIVE SP PRIV PREMIUM		02/01/2022	Wa	ve
	DECLINE HSA ACCOUNT		02/01/2022		
D	VHC DENTAL PLAN		02/01/2022	FAM	LY 69.90 Pretax
		RUTHIE L MODEL_EMPLOYEE25781 MONICA T. MODEL_EMPLOYEE25781			
	SHORT TERM DISABILITY		02/01/2022	60% of sa 29,839	ary 20.39 Aftertax
0	LONG TERM DISABILITY		02/01/2022	60% of sa 29,839	ary 4.13 Aftertax
	METLIFE GROUP ACCIDENT INSURAN		02/01/2022	FAMILY (EE SPOUSE CHIL	D) 9.01 Aftertax
		RUTHIE L MODEL_EMPLOYEE25781 MONICA T. MODEL_EMPLOYEE25781			
D	METLIFE GROUP CRIT IL		02/01/2022	Family 20k 1	Ok 10.25 Aftertax
		RUTHIE L MODEL_EMPLOYEE25781 MONICA T. MODEL_EMPLOYEE25781			
	METLIFE GRP HOSPITAL INDEMNITY		02/01/2022	FAMILY (EE SPOUSE CHIL	D) 30.76 Aftertax
		RUTHIE L MODEL_EMPLOYEE25781 MONICA T. MODEL_EMPLOYEE25781			
	SUPPLEMENTAL EMPLOYEE LIFE INSURANCE		02/01/2022	150,000	00 4.15 Pretax
D	SUPPLEMENTAL EMPLOYEE LIFE INSURANCE AD&D		02/01/2022	150,000	00 1.73 Pretax
	SUPPLEMENTAL SPOUSE LIFE INSURANCE		02/01/2022	150,000	00 4.15 Pretax
		RUTHIE L. MODEL_EMPLOYEE25781			
D	SUPPLEMENTAL SPOUSE LIFE INSURANCE AD&D		02/01/2022	150,000	00 1.73 Pretax
		RUTHIE L. MODEL_EMPLOYEE25781			
D	CHILDREN LIFE INSURANCE		02/01/2022	10,000	00 0.92 Pretax
		MONICA T. MODEL_EMPLOYEE25781			
	CHILDREN LIFE INSURANCE - AD&D		02/01/2022	10,000	00 0.12 Pretax
		MONICA T. MODEL_EMPLOYEE25781			
	MEDICAL FLEXIBLE SPENDING ACCT		02/01/2022	570.00 per y	ar 142.50 Pretax
	DAYCARE FLEXIBLE SPENDING ACCT		02/01/2022	400.00 per y	ar 100.00 Pretax
D	HYATT LEGAL BENEFIT PLAN		02/01/2022		8.31 Aftertax
		Pay Period S	lummany		Your Pay Period Cost
		Total pretax cont	Inbutions		754.30
		Total aftertax cont	Inbutions		82.85
					Your deductions may differ slightly due to rounding.

Continue Previous Exit

- Select all plans you wish to change.
- If you make a change to your medical plan, the spousal privilege premium plan or waive will also be selected.
- You may also receive pop ups to ensure the HSA or FSA/LPFSA accounts are selected.

elect	
	VHC PPO HEALTH PLAN
-	WAIVE SP PRIV PREMIUM
63	DECLINE HSA ACCOUNT
	VHC DENTAL PLAN
0	SHORT TERM DISABILITY
0	LONG TERM DISABILITY
2	METLIFE GROUP ACCIDENT INSURAN
•	METLIFE GROUP CRIT IL
2	METLIFE GRP HOSPITAL INDEMNITY
2	SUPPLEMENTAL EMPLOYEE LIFE INSURANCE
	SUPPLEMENTAL SPOUSE LIFE INSURANCE
2	CHILDREN LIFE INSURANCE

152	MEDICAL FLEXIBLE SPENDING ACCT	
	DAYCARE FLEXIBLE SPENDING ACCT	
0	HYATT LEGAL BENEFIT PLAN	

Enrollment Elections - HEALTH

	As Of	Coverage Type	Your	Cost
03	3/31/2022	FAMILY	429.09	Pretax
04	4/01/2022	FAMILY	441.96	Pretax
	C	Covered Dependents As Of 03	/31/2022	
RUTHI	E L. MODEL_E	EMPLOYEE25781 MONICAT	. MODEL_EMP	LOYEE25781
Select	Option			
0	Keep the same coverage			
0	Keep the same option; add or change dependent coverage			
0	O Change the coverage			
	O Select a different plan			

Your Options

Your options may include the following when you make a change to your current elections:

Keep the same coverage – Allows you to keep the same benefit plan and coverage level

Keep the same option; add or change dependent coverage - Allows you to add additional dependent(s) or exclude dependent(s) but keep the same plan & level of coverage

Change your coverage – Allows you to change your coverage level for the existing plan (Example: Employee Only to Family).

Select a different plan – Allows you to view all available plans & coverage levels, including an option to WAIVE the plan.

Keep the same option; add or change dependent coverage

Enroll	Enrollment Elections - HEALTH						
	As Of Coverage Type Your Cost				You are surrently any link in MUC DDO US ALTHING AND Costs are not Day Baried		
03	3/31/2022	FAMILY	429.09	Pretax	Tou are currently enrolled in VHC PPO HEALTH PLAN. Costs are per Pay Period.		
04	4/01/2022	FAMILY	441.96	Pretax			
	C	overed Dependents As Of 03	/31/2022				
RUTHIE L. MODEL_EMPLOYEE25781 MONICA T. MODEL_EMPLOYEE25781				LOYEE25781			
Select Option							
O Keep the same coverage							
Keep the same option; add or change dependent coverage							
0	Change the co	verage					
Select a different plan							
Contin	ue Exit						

Benefit Elections - HEALTH

You have selected VHC PPO HEALTH PLAN. This plan may cover a spouse and your dependents. This plan covers 2 to 99 dependents. Select dependents to include for plan coverage.

Select	Dependent	Status
	RUTHIE L. MODEL_EMPLOYEE25781	Eligible
	MONICA T. MODEL_EMPLOYEE25781	Eligible
	MILLICENT T. MODEL_EMPLOYEE25781	Eligible

A new dependent was added in Dependent Maintenance & this is where you add that dependent to your plan.

Benefit Elections - HEALTH

You have selected VHC PPO HEALTH PLAN. This plan may cover a spouse and your dependents. This plan covers 2 to 99 dependents. Select dependents to include for plan coverage

Select	Dependent	Status
	RUTHIE L. MODEL_EMPLOYEE25781	Eligible
	MONICA T. MODEL_EMPLOYEE25781	Eligible
	MILLICENT T. MODEL_EMPLOYEE25781	Eligible

Changing Your Level of Coverage -

Enrol	Iment Electior	ns - HEALTH			
	As Of	Coverage Type	Your	Cost	
C	03/31/2022	FAMILY	429.09	Pretax	You are currently enrolled in VHC PPO HEALTH PLAN. Costs are per Pay Period.
0	04/01/2022	FAMILY	441.96	Pretax	
	C	Covered Dependents As Of 03/	/31/2022		
RUTH	HE L. MODEL_E	EMPLOYEE25781 MONICA T	MODEL_EMP	LOYEE25781	
Select	Option				
0	Keep the same	e coverage			
0	Keep the same	e option; add or change depen	ident coverage		
۲	Change the co	overage			
0	Select a differe	ent plan			
Conti	nue Exit				

Benefit Elections - HEALTH

You have selected VHC PPO HEALTH PLAN. Your contribution will be pretax. Costs are per Pay Period. Select one coverage option.

Select	Coverage	Your Pay Period Cost
0	EMPLOYEE ONLY	126.43
0	EMP/CHILD(REN)	268.34
0	EMPLOYEE/SPOUSE	312.36
0	FAMILY	441.96



The dependents you are able to select, depends on who you added into the system in the Dependent Maintenance screen as well as the level of coverage you selected.

Selecting a Different Plan -

Enrollment Elections - HEALTH

As Of	Coverage Type	Your Cost	You are surrently aprelled in VUC DDO UEALTH DLAN. Casts are per Day Deried
03/31/2022	FAMILY	429.09 Pretax	Tou are currently enrolled in VHC FFO HEALTH FLAN. Costs are per Pay Period.
04/01/2022	FAMILY	441.96 Pretax	

Covered Dependents As Of 03/31/2022

RUTHIE L. MODEL_EMPLOYEE25781 MONICA T. MODEL_EMPLOYEE25781

Select	Option
0	Keep the same coverage
0	Keep the same option; add or change dependent coverage
0	Change the coverage
٥	Select a different plan

Continue Exi

Benefits Enrollment

Benefit Elections - HEALTH

Select the plan in which you would like to enroll.

Select	Plan	Coverage	Your Pay Period Cost
0	VHC HIGH DEDUCTIBLE PLAN	EMPLOYEE ONLY	50.90
0	VHC HIGH DEDUCTIBLE PLAN	EMPLOYEE CHILD(REN)	76.00
0	VHC HIGH DEDUCTIBLE PLAN	EMPLOYEE/SPOUSE	90.00
0	VHC HIGH DEDUCTIBLE PLAN	FAMILY	118.00
0	KAISER HMO	EMPLOYEE ONLY	115.25
0	KAISER HMO	EMPLOYEE CHILD(REN)	244.57
0	KAISER HMO	EMPLOYEE/SPOUSE	284.68
0	KAISER HMO	FAMILY	402.83
0	DECLINE ALL HEALTH PLANS	MEDICAL WAIVE	
0	VHC PPO2 HEALTH PLAN	EMPLOYEE ONLY	71.02
0	VHC PPO2 HEALTH PLAN	EMP/CHILD(REN)	194.12
0	VHC PPO2 HEALTH PLAN	EMPLOYEE/SPOUSE	215.42
0	VHC PPO2 HEALTH PLAN	FAMILY	310.12
0	VHC PPO HEALTH PLAN	EMPLOYEE ONLY	130.22
0	VHC PPO HEALTH PLAN	EMP/CHILD(REN)	276.39
\circ	VHC PPO HEALTH PLAN	EMPLOYEE/SPOUSE	321.73
0	VHC PPO HEALTH PLAN	FAMILY	455.22

You have selected VHC PPO2 HEALTH PLAN. This plan may cover a spouse and your dependents. This plan covers 2 to 99 dependents. Select dependents to include for plan coverage.

Select	Dependent	Status
	RUTHIE L. MODEL_EMPLOYEE25781	Eligible
	MONICA T. MODEL_EMPLOYEE25781	Eligible
	MILLICENT T. MODEL_EMPLOYEE25781	Eligible

Continue Previous

Spousal Privilege Premium Waiver Application -

Benefit Elections - HEALTH

You have selected VHC PPO2 HEALTH PLAN. Costs are per Pay Period. Changes will be effective 04/01/2022. Review and confirm your election choices for this benefit.

Plan	Coverage	Your Pay Period Cost
VHC PPO2 HEALTH PLAN	FAMILY	301.09 Pretax
Cove	red Dependents As Of 04/01/2022	
RUTHIE L MODEL_EMPLOYEE25781	MONICA T. MODEL_EMPLOYEE25781	
MILLICENT T. MODEL_EMPLOYEE23781		
SPOUSAL PRI	VILEGE PREMIUM WAIVER APPLICATION	
Effective as of January 1, 2015, VHC implemented an exclusion for an employee's working spouse when medical coverage i	is available through their employer.	
If your spouse is enrolled in a Virninia Hospital Center Health Insurance Plan (VHC DDO, VHC DDO), VHC HDD, or Kaiser HM	O you will be subject to a monthly spousal privilege premium of \$300 (\$138.	46 per nav period) upless you are eligible for the spousal privilege
premium waiver. To determine your eligibility for the spousal privilege premium waiver, please check the appropriate box t	pelow that applies to you.	to per pay periody amess you are engine for the spousar privilege
If you have your documents ready to upload, you may upload them using the Upload Document link below on the left. You	are required to upload supporting documents before the end of your enrolln	ient window to be considered for the SPP Waiver.

If you don't have your documents ready to upload, you can return later and use the Upload Documents link on the Dependent Maintenance Screen. The Dependent Maintenance screen is immediately following the Welcome Message. After uploading your documents, you can close out of Open Enrollment. It is not necessary to go through the enrollment process again if you have already finalized/submitted your enrollment by agreeing to the terms and clicking the Finish button and you have your Confirmation Email. However, you can return anytime before the enrollment period closes, if you need to make any changes.

Spousal Privilege Premium Waiver Application (cont'd) -

My Spouse is (Select One):

Benefit Elections - HEALTH Spouse is SELF-EMPLOYED My spouse is self-employed and is not covered or eligible under any other employer group health benefits. Click here to see if you are eligible for Waiver of Spousal Privilege Premium when Spouse is Self-Employed and find out about the documents you'll need to upload in order to be considered for this waiver. Spouse is currently UNEMPLOYED My spouse is not currently employed and not eligible for employer group health plan.benefits. Click here to see if you are eligible for Waiver of Spousal Privilege Premium when Spouse Not Working and find out about the documents you'll need to upload in order to be considered for this waiver. Spouse is currently RETIRED My spouse is retired and not eligible for employer group health plan benefits. Click here to see if you are eligible for Waiver of Spousal Privilege Premium when Spouse is Retired and find out about the documents you'll need to upload in order to be considered for this waiver. My Shouse is (check one) Spouse is currently EMPLOYED by VHC My spouse is currently employed by Virginia Hospital Center. Click here to learn more about the Waiver of Spousal Privilege Premium when Spouse employed by VHC and find out more about the simple process to insure that your the SPP is waived. Spouse NOT ELIGIBLE for Insurance My spouse is employed but not eligible or not offer group health benefits through his/her employer. Click here to see if you are eligible for Waiver of Spousal Privilege Premium when Spouse Not Eligible for Insurance through an employer and find out about the documents you'll need to upload in order to be considered for this waiver. Enroll spouse who is ELIGIBLE for ANOTHER Group Health plan My spouse is currently employed and is eligible for another group health plan, but I wish to enroll them in a VHC plan. Click here to learn more about Enrolling your spouse in a VHC Group Health Insurance Plan and find out more about the Spousal Privilege Premium. Employer Name:

Employer Address:	
City	
State	v
Zip	

Does Employer Offer Health Insurance? O Yes

Spousal Privilege Premium Waiver Application (cont'd)-

Remember: You are subject to the Spousal Privilege Premium unless you upload all required documentation through LAWSON Employee Self-Service by Monday, **February 28, 2023**. Benefit Elections - SPOUSAL PRIV PREMIUM

This spouse premium will be waived once we have received the appropriate documentation.

You have selected SPOUSE PRIV PREMIUM. Your contribution will be pretax.

Your Cost

138.46

Continue

SPOUSAL PRIVILEGE PREMIUM WAIVER REQUIRED DOCUMENTATION

SPOUSE STATUS	DESCRIPTION	REQUIRED DOCUMENTATION
Spouse is NOT ELIGIBLE for Insurance	My spouse is employed, but is not eligible, or not offered, group health benefits through his/her employer.	A copy of the most recent State or 1040 Federal Tax Return & a letter from your spouse's Human Resource Department, on company letterhead [with a contact person's name and telephone number other than your spouse], that states your spouse is not offered employer group health benefits.
Spouse is UNEMPLOYED or RETIRED	My spouse is unemployed or retired and not covered or eligible for any other employer group health benefits.	A copy of the most recent State or 1040 Federal Tax Return verifying your spouse & their employment status. Including the portion of the return which shows the name of the member and the member's spouse as well as the signature block that contains the employee's spousal signature and occupation. All other information on the tax return can be redacted (blacked out). On Federal Form 1040, that information is found at the top of page 1 (member's name and spouse's name) and the bottom of page 2 (employee's & spouse's signatures and occupations). If the unemployed spouse files a MARRIED FILING SEPARATE 1040 Tax Return, they must submit their return showing the same information as stated above. If your spouse became unemployed or retired after the most recent federal tax return was filed, the Employee must submit that return and a signed statement from the employee that states the spouse is currently unemployed or retired and not covered or eligible under any other employer group health benefits and any applicable supporting documentation of unemployment or retirement (Separation Agreement, COBRA Notice or Letter of Retirement from employer)
Spouse is SELF-EMPLOYED	My spouse is self-employed and is not covered or eligible under any other employer group health benefits.	 A copy of the most recent State or 1040 Federal Tax Return & one of the following: Schedule SE (Self-Employment Tax) Sole Proprietor – Schedule C or Form 1040-ES Partnership – Form 1065 Corporations – Form 1120 or Form 1120-S Form 941 (Employer's Quarterly Federal Tax Return) Form 940 (Employer's Annual Federal Unemployment Tax Return) If your spouse became self-employed after the most recent state or federal tax return was filed, please submit a copy of Form W-9 which verifies the Business Name and Federal Tax Classification. Taxes will be required when filed.
Spouse Is Employed with VHC	Spouse is currently employed through VHC Health	Email your spouse's first and last name as well as their VHC employee ID # to Benefits_Department@VHCHEALTH.Org.

If your spouse is enrolled in a Virginia Hospital Center Health Insurance Plan (VHC PPO, VHC HDP or Kaiser HMO) you will be subject to a monthly spousal privilege premium of \$300 (\$138.46 per pay period). The spousal privilege premium stays in effect through the benefit plan year unless you have a qualifying event to remove your spouse from your VHC Health Insurance Plan.

To be eligible for the Spousal Privilege Premium Waiver, one of the categories above must apply. You are required to upload all documents to your Dependent Maintenance screen in the LAWSON Employee Self-Service Annual Benefits Enrollment system no later than Sunday, February 28, 2023. Once you are approved for the waiver, you will be notified by the Benefits Department with an email. If you do not get approved you will pay the Spousal Privilege Premium.

Selecting the High Deductible Medical Plan -

The High Deductible Medical Plan

- Available to all employees
- The only Medical Option for PRNs, Part Time Employees (<20 hours/week) & Benefits Alternative status Employees
- May be eligible for the Health Savings Account (HSA) & the Limited Purpose Flexible Spending Account (LPFSA)
- Answer Yes or No to the HSA Certification of Eligibility to proceed
- > You will be given an option to elect or waive enrollment in the HSA & the LPFSA

HSA Certification of Eligibility

I understand that in order for the Company to contribute to a health savings account (HSA) on my behalf, I must meet all of the following HSA eligibility conditions

- 1. I am electing self-only coverage OR family coverage under the high deductible health plan (HDHP) under Code § 223(c)(2)
 - 2. I am new to the plan and am establishing or I am not new to the plan, have already established an HSA through OPTUM Bank and am enrolling in the HSA plan for next year.

3. I understand that my HSA can be used to pay for qualified medical expenses incurred by my eligible tax dependents.

- 4. I cannot be claimed as another person's tax dependent.
- 5. I am not entitled to Medicare and/or Tricare benefits.
- 6. If I have any health coverage other than my coverage under the high deductible health plan (HDHP), that coverage is either (a) HDHP coverage or (b) permitted non-HDHP insurance or coverage.
- 7. If I am married, my spouse either does not have any non-HDHP family coverage or has excluded me from any non-HDHP family coverage

Account Authorization Acknowledgement to Open a Health Savings Account (HSA)

If I choose to enroll in the HSA, plan, I appoint my employer ("Employer") as my agent for the purpose of opening and administering / maintaining an Optum Bank, Inc. ("Bank") Health Savings Account ("HSA") on my behalf and authorize Employer to send and receive information to and from the Bank on my behalf (including account number) in order to accomplish this purpose. I authorize the Bank to make any inquiries that it considers appropriate to determine if it should open and maintain my HSA, and I acknowledge that I have received the Bank's USA PATRIOT Act Notice provided below:

IMPORTANT INFORMATION ABOUT PROCEDURES FOR OPENING A NEW ACCOUNT

To help the government fight the funding of terrorism and money laundering activities, federal law requires all financial institutions to obtain, verify, and record information that identifies each person who opens an account. What this means for you: When you open an account, we will ask for your name, address, date of birth, and other information that will allow us to identify you. We may also ask to see your driver's license or other identifying documents.

I certify that I am eligible to contribute to an HSA under Internal Revenue Code Section 223. I authorize and direct the Bank to issue a Debit MasterCard® to me. I certify that I have received or viewed the Bank's statement of the hardware and software requirements for access to and relention of electronic records and that I have the ability to access the Bank's website where electronic statements and other documentation are stored. I instruct the Bank, unless otherwise notified and instructed by me, to provide the Custodial and Deposit Agreement and all other HSA notices, disclosures and information related to and governing my HSA to me online at www.optumbank.com. I understand that monthly account statements and other documentation and notices will be delivered or made available electronically. If I want HSA statements mailed to my home, I must notify the Bank directly.

I agree that Employer will remain my agent unless and until Employer and the Bank receive notice that the appointment of Employer as my agent has been terminated, that I am no longer employed by Employer, or that I am no longer an HSA eligible individual; or I receive a notice from the Bank that my application for an HSA has been declined.

Optum Bank - Access to and Retention of Electronic HSA Records

To view the Bank's hardware and software requirements, instructions for viewing and downloading copies of electronic documents, and instruction for updating an email address, follow the link below.

https://www.optumbank.com/content/dam/optumbank/resources/ns/238-Hardware-and-Software-Requirements.pdf

- YES, I certify that all of the statements above are true. I understand that I am not eligible for HSA contributions during any month in which I do not meet all of the above HSA eligibility conditions and I agree that I will notify the Employer immediately in writing, if I cease to meet or yr of these conditions. I also understand that the Employer will make contributions to an HSA I establish with OPTUM Bank on my behalf on the basis of my certification and that the Employer's HSA contributions (if any) are subject to certain agreeate limits under federal tax law.
- NO, Icertify that I do NOT meet some of the statements listed above at this time, therefore I am not eligible to establish a qualified HSA. I understand that I am not eligible for employer contributions and may not make HSA contributions through payroll deductions. If my eligibility status changes after January 1st of the plan year, I will notify the Employer immediately in writing; I also understand that I may be eligible to recieve a prorated HSA employer contribution during the year that I may make personal prorated contributions to the HSA.
- subject to the limits under federal law

Benefit Elections - HEALTH SAVINGS ACCT

Select the plan in which you would like to enroll.

Select	Plan	
0	HEALTH SAVINGS ACCOUNT FAMILY	
0	DECLINE HSA ACCOUNT	
Continu	ue Previous Start Over Exit	
Benefit I	Elections - HEALTH SAVINGS ACCT	
You have s	selected HEALTH SAVINGS ACCOUNT FAMILY. Your contri	ution will be pretax.
Pay Period	d Minimum	Pay Period Maximum
	5.00	0.00
Annual Mir	5.00	0.00 Annual Maximum
Annual Mir	5.00 nimum 130.00	0.00 Annual Maximum 7,300
Annual Mi Enter the a 100.00 26 periods or	5.00 nimum 130.00 amount you want to contribute. per pay period remaining from benefit start date per year	0.00 Annual Maximum 7,300.

The Annual Maximum depends on the Coverage Level you select as well as your age

Whether you enroll in or opt-out of the Health Savings Account, you will still have the opportunity to enroll in or opt-out of the Limited Purpose FSA later in the enrollment process.

Declining Health Coverage -

Benefit Elections - HEALTH

Select the plan in which you would like to enroll.

Select	Plan	Coverage	Your Pay Period Cost
0	VHC HIGH DEDUCTIBLE PLAN	EMPLOYEE ONLY	50.90
0	VHC HIGH DEDUCTIBLE PLAN	EMPLOYEE CHILD(REN)	76.00
0	VHC HIGH DEDUCTIBLE PLAN	EMPLOYEE/SPOUSE	90.00
0	VHC HIGH DEDUCTIBLE PLAN	FAMILY	118.00
0	KAISER HMO	EMPLOYEE ONLY	115.25
0	KAISER HMO	EMPLOYEE CHILD(REN)	244.57
0	KAISER HMO	EMPLOYEE/SPOUSE	284.68
0	KAISER HMO	FAMILY	402.83
۲	DECLINE ALL HEALTH PLANS	MEDICAL WAIVE	
0	VHC PPO2 HEALTH PLAN	EMPLOYEE ONLY	71.02
0	VHC PPO2 HEALTH PLAN	EMP/CHILD(REN)	194.12
0	VHC PPO2 HEALTH PLAN	EMPLOYEE/SPOUSE	215.42
0	VHC PPO2 HEALTH PLAN	FAMILY	310.12
0	VHC PPO HEALTH PLAN	EMPLOYEE ONLY	130.22
0	VHC PPO HEALTH PLAN	EMP/CHILD(REN)	276.39
0	VHC PPO HEALTH PLAN	EMPLOYEE/SPOUSE	321.73
0	VHC PPO HEALTH PLAN	FAMILY	455.22

Select DECLINE ALL HEALTH PLANS

righta respitar senter 7 annual Senente Enrennent	Virginia Hos	pital Center - A	Annual Benefits	Enrollment
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- X

Benefit Elections - HEALTH

You have selected DECLINE ALL HEALTH PLANS. Changes will be effective 04/01/2019. Review and confirm your election choices for this benefit.

Plan	Coverage
DECLINE ALL HEALTH PLANS	Waive
Waive Coverage Confirmation	
Please answer the questions below regarding your waive of Medical coverage. (NOTE: policy number and carrier name fields a	re restricted to 10 characters)
Please select the reason you are waiving your medical insurance below.	
Have other medical insurance outside VHC	
O I currently have Medicare	
No current insurance and do not want insurance.	
Other Reason	

Continue Previous

This information is used for Affordable Care Act Reporting

Enrollment Elections - DENTAL

As Of	Coverage Type	Your Cost
03/31/2022	FAMILY	69.90 Pretax
04/01/2022	FAMILY	69.90 Pretax

You are currently enrolled in VHC DENTAL PLAN. Costs are per Pay Period.

Covered Dependents As Of 03/31/2022

RUTHIE L. MODEL_EMPLOYEE25781 MONICA T. MODEL_EMPLOYEE25781

Select	Option
0	Keep the same coverage
۲	Keep the same option; add or change dependent coverage
0	Change the coverage
0	Select a different plan

Continue E:

Benefit Elections - DENTAL

You have selected VHC DENTAL PLAN. This plan may cover a spouse and your dependents. This plan covers 2 to 99 dependents. Select dependents to include for plan coverage.

Select	Dependent	Status
	RUTHIE L. MODEL_EMPLOYEE25781	Eligible
✓	MONICA T. MODEL_EMPLOYEE25781	Eligible
	MILLICENT T. MODEL_EMPLOYEE25781	Eligible

Continue Previous

Benefit Elections - DENTAL

You have selected VHC DENTAL PLAN. This plan may cover a spouse and your dependents. This plan covers 2 to 99 dependents. Select dependents to include for plan coverage.

Select	Dependent	Status
	RUTHIE L. MODEL_EMPLOYEE25781	Eligible
	MONICA T. MODEL_EMPLOYEE25781	Eligible
	MILLICENT T. MODEL_EMPLOYEE25781	Eligible

12	D
Infinite	Previous
munuc	TICYIUUS

As Of	Percent of Salary	Monthly Benefit	You	r Cost
03/31/2022	60%	2,486.64	20.39	Aftertax
04/01/2022	60%	2,486.64	20.39	Aftertax
Select		Option		
Kee	p the same coverage	;		
O Mak	ce Changes			

Continue

Enrollment Elections - LONG TERM DISABILITY

As	Df	Percent of Salary	Monthl	y Benefit	Υοι	ır Cost
03/31/2022		60%	60% 2,486.64		4.13	Aftertax
04/01/2022		60%		2,486.64	4.13	Aftertax
Select			Option			
۲	Keep the same coverage					
0	Mak	e Changes				

You are currently enrolled in LONG TERM DISABILITY. Costs are per Pay Period.

Continue

Enrollment Elections - ACCIDENT INSURANCE

A	As Of	Coverage Type	Yo	our Cost
03/3	31/2022	FAMILY (EE SPOUSE CHILD)	9.01	Aftertax
04/0	01/2022	FAMILY (EE SPOUSE CHILD)	9.01	Aftertax
		Covered Dependents As Of 03/31/2022		
RUTH	HE L. MODE	EL_EMPLOYEE25781 MONICA T. MODEL	_EMPL	OYEE25781
Select	Option			
0	Keep the	same coverage		
۲	Keep the	same option; add or change dependent cov	erage	
0	Change th	le coverage	2	
0	O Select a different plan			



You have selected METLIFE GROUP ACCIDENT INSURAN. This plan may cover a spouse and your dependents. This plan covers 2 to 99 dependents. Select dependents to include for plan coverage.

Select	Dependent	Status
✓	RUTHIE L. MODEL_EMPLOYEE25781	Eligible
~	MONICA T. MODEL_EMPLOYEE25781	Eligible
	MILLICENT T. MODEL_EMPLOYEE25781	Eligible

Continue Previous

Benefit Elections - ACCIDENT INSURANCE

You have selected METLIFE GROUP ACCIDENT INSURAN. This plan may cover a spouse and your dependents. This plan covers 2 to 99 dependents. Select dependents to include for plan coverage.

Select	Dependent	Status
	RUTHIE L. MODEL_EMPLOYEE25781	Eligible
	MONICA T. MODEL_EMPLOYEE25781	Eligible
~	MILLICENT T. MODEL_EMPLOYEE25781	Eligible

Continue Previous

Enrollment Elections - CRITICAL ILLNESS INS

As Of	Coverage Type	Your Cost	You are surroutly encoded in METHER COOLD COLT II. Costs are not Day Deried
03/31/2022	Family 20k 10k	10.25 Aftertax	Tou are currently enrolled in METLIFE GROUP CRITIC. Costs are per Pay Period.
04/01/2022	Family 20k 10k	10.25 Aftertax	

Covered Dependents As Of 03/31/2022

RUTHIE L. MODEL_EMPLOYEE25781 MONICA T. MODEL_EMPLOYEE25781

- Keep the same coverage
- Keep the same option; add or change dependent coverage
- Change the coverage
- O Select a different plan

Continue Ex

You have selected METLIFE GROUP CRIT IL. This plan may cover a spouse and your dependents. This plan covers 2 to 99 dependents. Select dependents to include for plan coverage.

Select	Dependent	Status
	RUTHIE L. MODEL_EMPLOYEE25781	Eligible
~	MONICA T. MODEL_EMPLOYEE25781	Eligible
	MILLICENT T. MODEL_EMPLOYEE25781	Eligible

Continue Previous

Benefit Elections - CRITICAL ILLNESS INS

You have selected METLIFE GROUP CRIT IL. This plan may cover a spouse and your dependents. This plan covers 2 to 99 dependents. Select dependents to include for plan coverage.

Select	Dependent	Status
✓	RUTHIE L. MODEL_EMPLOYEE25781	Eligible
\checkmark	MONICA T. MODEL_EMPLOYEE25781	Eligible
	MILLICENT T. MODEL_EMPLOYEE25781	Eligible

Continue Previous

Enrollment Elections - HOSPITAL INDEMNITY

As	Of	Coverage Type	Υοι	ır Cost
03/31	/2022	FAMILY (EE SPOUSE CHILD)	30.76	Aftertax
04/01	/2022	FAMILY (EE SPOUSE CHILD)	30.76	Aftertax
		Covered Dependents As Of 03/31/2022	2	
RUTHIE	e L. Mode	EL_EMPLOYEE25781 MONICA T. MODE	L_EMPLC	OYEE25781
Select	Option			
0	Keep the	same coverage		
O	Keep the	same option; add or change dependent co	verage	
0	Change th	ne coverage		
0	Select a d	ifferent plan		
		_		
Continu	ie Exi	t		

You have selected METLIFE GRP HOSPITAL INDEMNITY. This plan may cover a spouse and your dependents. This plan covers 2 to 99 dependents. Select dependents to include for plan coverage.

Select	Dependent	Status
	RUTHIE L. MODEL_EMPLOYEE25781	Eligible
	MONICA T. MODEL_EMPLOYEE25781	Eligible
	MILLICENT T. MODEL_EMPLOYEE25781	Eligible

Continue Previous

Benefit Elections - HOSPITAL INDEMNITY

You have selected METLIFE GRP HOSPITAL INDEMNITY. This plan may cover a spouse and your dependents. This plan covers 2 to 99 dependents. Select dependents to include for plan coverage.

Select	Dependent	Status
	RUTHIE L. MODEL_EMPLOYEE25781	Eligible
	MONICA T. MODEL_EMPLOYEE25781	Eligible
	MILLICENT T. MODEL_EMPLOYEE25781	Eligible

Continue Previous

Enrollment Elections - EMPLOYEE LIFE

03/31/20	22 150.000.00	/ 15	-	Tou are currently enforced in SOFFLEMENTAL EMPLOTEE LIFE INSORANCE. Costs are per ray i
		4.15	Pretax	
04/01/20	22 150,000.00	4.15	Pretax	
Select	Option			
۲	Keep the same o	overage		
0	Change the cove	erage		
0	Select a different	plan		

Enrollment Elections - SPOUSE LIFE

As	s Of	Coverage	Your Pa	y Period Cost
03/31	1/2022	150,000.00	4.15	Pretax
04/01	1/2022	150,000.00	4.15	Pretax
	Cov	vered Dependents As	s Of 04/01/2	2022
RUTHI	E L. MOD	EL EMPLOYEE257	81	
Select	Option	-		
Select	Option			
\odot	Keep the	same coverage		
0	Change t	he coverage		
0	Keep the	same option; add or	change de	pendent coverage
0	Select a d	different plan		
Continu	ue Ex	it		

Enrollment Elections - CHILD LIFE

۵	s Of	Coverage	Your Pa	v Period Cost
00/0	4/2022	10.000.00	0.02	Preterio Obst
03/3	1/2022	10,000.00	0.92	Pretax
04/01	1/2022	10,000.00	0.92	Pretax
	Cov	vered Dependents A	s Of 04/01/	2022
MONIC		DEL EMPLOYEE25	781	
Calaat	Ontine			
Select	Option			
0	Keep the	same coverage		
0	Change t	the coverage		
0	Keep the	same option; add o	or change de	ependent coverage
0	Select a	different plan		
<u> </u>	00.001 4			
Contin	ue E>	cit		

Current Contrib	ution: 142.50 Pretax per pay period 570.00 Pretax per year	You are currently enrolled in MEDICAL FLEXIBLE SPENDING ACCT. Contributions are per Pay Period.
Select Option		
O Keep th	ne same coverage	
O Change	e the coverage	
O Select a	a different plan	

Continue

If employee selected the High Deductible Medical Plan, the option here would be the Limited Purpose FSA

Benefit Elections - FLEX SPEND MEDICAL

You have selected MEDICAL FLEXIBLE SPENDING ACCT. Your contribution	will be pretax.		
Pay Period Minimum		Pay Period Maximum	
5.00			0.00
Annual Minimum		Annual Maximum	
130.00			2,850.00
Enter the amount you want to contribute. per pay period 26 periods remaining from benefit start date or 2850.00 per year Continue Previous Exit Enrollment Elections - ELEX SPEND DAYCAR	F		
Current Contribution: 100.00 Pretax per pay period 400.00 Pretax per year	You are currently enrolled in DAYCARE FI	LEXIBLE SPENDING ACCT. Co	ntributions are per Pay Period.
Select Option			
O Keep the same coverage			
O Change the coverage			
 Select a different plan 			
Continue Benefit Elections - FLEX SPI	END DAYCARE		

Select the plan in which you would like to enroll.

Select	Plan
\circ	DAYCARE FLEXIBLE SPENDING ACCT
۲	DECLINE DAY FLEX SPENDING PLAN
Continu	e Previous Start Over Exit

Enrollment Elections - LEGAL

As	s Of	Yo	ur Cost	Very and supported in LIVATE LEGAL DENIERT DUAN. Costs and and David
03/3	1/2022	8.31	Aftertax	You are currently enrolled in HYATT LEGAL BENEFIT PLAN. Costs are per Pay Period.
04/0	1/2022	8.31	Aftertax	
Select	Option			
۲	Keep tl	ne sam	e coverage	
0	Select	a differe	ent plan	
Contir	nue			

Benefit Elections - CAFE PAYROLL

Select the plan in which you would like to enroll.

Select	Plan
\circ	CAFE PAYROLL DEDUCTION PLAN
\circ	WAIVE CAFE PAYROLL DEDUCTION

Continue Start Over Exit

Benefit Elections - CAFE PAYROLL

You have selected CAFE PAYROLL DEDUCTION PLAN.

Continue Previous
Benefit Elections - CAFE PAYROLL
You have selected CAFE PAYROLL DEDUCTION PLAN. Changes will be effective 04/01/2022. Review and confirm your election choices for this benefit.
Plan
CAFE PAYROLL DEDUCTION PLAN
Employee Cafeteria Charge Enrollment Authorization I hereby voluntarily authorize Virginia Hospital Center Arlington Health System (VHCAHS, including any of its subsidiary or affiliated entities), which is my employer, to deduct from my bi-weekly payroll check any balance for purchases that I make using my Employee Badge in the VHCAHS cafeteria. Accordingly, I
specifically acknowledge and agree as follows:
I am responsible for paying the full balance of all purchases made using my Employee Badge in the VHCAHS cafeteria.
Employees on leave of absence may not use this payment method.
• All purchases made during a pay period will be deducted from the following pay period ., and balances will not be spread out over several pay periods. I understand that such deductions will be taken out of my net (after-tax) pay.
• No cash refunds will be made for charges. I will receive a refund to my account unless the pay period has closed, at that time I will be issued a meal ticket(s) for the amount in dispute.
I will not allow anyone else to use my Employee Badge to make purchases.
This payroll doduction authorization will remain in effect until it is discontinued by me in writing and the balance for all purchases made using my Employee Badge have been reduced to zero.
• If the purchases exceed my wages or any legally allowable deduction in a given pay period, the balance of such purchases will be deducted from my next paycheck(s) until the balance is reduced to zero.
 Upon termination of my employment, any balance due and owing for purchases I have made will be deducted from my final paycheck and I specifically authorize VHCAHS to deduct any such balance due from my final paycheck. If there is a remaining balance due from me which exceeds my final paycheck, I agree to remit immediately to VHCAHS the full amount due.
YES, I agree to the terms and conditions above.
Continue Previous

Benefit Elections - VHC FOUNDATION GIFTS

Select the plan in which you would like to enroll.

Select	Plan		
0	Foundation Employee Giving		
0	Decline Foundation Giving		
Continue			
Pay Period Minimu	roundation Employee Giving, rour contribution will be altertax.	Pay Period Maximum	
	1.00		0.00
Annual Minimum		Annual Maximum	
	26.00		0.00
Enter the amount y 50.00 per pa 26 periods remainin or per ye	rou want to contribute. Iy period ng from benefit start date ar		
Continue Previo	ous Exit		
Benefit Elections - VHC FC	OUNDATION GIFTS		

You have selected Foundation Employee Giving. Costs are per Pay Period. Changes will be effective 04/01/2022. Review and confirm your election choices for this benefit.

Plan	Coverage	Your Pay Period Cost
Foundation Employee Giving	1,300.00 per year	50.00 Aftertax

Payroll Deduction Contribution Authorization.

I authorize Virginia Hospital Center Arlington Health System (VHCAHS including any of its subsidiaries or affiliated entities) which is my employer, to deduct the amount I have specified as a charitable contribution to the VHC Foundation. I further agree to and acknowledge that:

- Contributions to the Foundation are 100% tax-deductible as no goods or services will be provided to me in consideration of this contribution.
- Contributions made through this process will be designated to support the "Hospital's Greatest Need." If I wish to change that designation I must contact the Foundation directly.
- Charitable contributions authorized through this process are considered "benefit-controlled" deductions, and they are separate and distinct from other gift deductions I may already have arranged with the Foundation, including gifts of accrued PTO.
- Once authorized, I acknowledge that I will not be able to change the authorized deduction amount until the next Open Enrollment period.
- If my net pay does not provide for sufficient funds to cover my authorized contribution in its entirety, then no deduction will be made for that particular pay period.
- The contribution deduction totals shown on my pay stubs is not an official receipt for tax preparation purposes. The VHC Foundation will provide me a letter in January summarizing all contributions made in the
 previous calendar year.

Please contact the Foundation directly with additional questions or concerns.

Yes, I agree to the terms and conditions above.

Review Your Confirmation Page -

- Your benefit elections are tracked as you complete each screen. Once all screens are completed, you will view the Benefit Elections screen with your election choices. Review Carefully.
- You have the opportunity to make changes before saving your final elections, by clicking "Make Changes".

Benefit Elections As Of 04/01/2022

Verify that your 2022 elections are listed correctly below.

Click Make Changes if you would like to make changes to any of the information below.

Click Finish if the information below is correct. A Dialog box will ask you to print your elections. Be sure to click Continue to print and keep your elections for future reference.

To find out more information about each benefit offered, click on the benefit plan name.

Plan	Coverage	Your Cost
VHC PPO HEALTH PLAN	FAMILY	441.96 Pretax
WAIVE SP PRIV PREMIUM		
DECLINE HSA ACCOUNT		
VHC DENTAL PLAN	FAMILY	69.90 Pretax
SHORT TERM DISABILITY	60% of salary 29,839.68	20.39 Aftertax
LONG TERM DISABILITY	60% of salary 29,839.68	4.13 Aftertax
METLIFE GROUP ACCIDENT INSURAN	FAMILY (EE SPOUSE CHILD)	9.01 Aftertax
METLIFE GROUP CRIT IL	Family 20k 10k	10.25 Aftertax
METLIFE GRP HOSPITAL INDEMNITY	FAMILY (EE SPOUSE CHILD)	30.76 Aftertax
SUPPLEMENTAL EMPLOYEE LIFE INSURANCE	150,000.00	4.15 Pretax
SUPPLEMENTAL EMPLOYEE LIFE INSURANCE AD&D	150,000.00	1.73 Pretax
SUPPLEMENTAL SPOUSE LIFE INSURANCE	150,000.00	4.15 Pretax
SUPPLEMENTAL SPOUSE LIFE INSURANCE AD&D	150,000.00	1.73 Pretax
CHILDREN LIFE INSURANCE	10,000.00	0.92 Pretax
CHILDREN LIFE INSURANCE - AD&D	10,000.00	0.12 Pretax
MEDICAL FLEXIBLE SPENDING ACCT	2,850.00 per year	109.62 Pretax
DECLINE DAY FLEX. SPENDING PLAN		
HYATT LEGAL BENEFIT PLAN		8.31 Aftertax
CAFE PAVROLL DEDUCTION PLAN		
Foundation Employee Giving	1,300.00 per year	50.00 Aftertax
Pending Plans		
SPOUSE PRIV PREMIUM Pending DOCUMENTATION		138.46
Dependent Information		
Dependent HEALTH Depts Secure Life Child Life		

 Image: A second s	×	×	×
× .	×	×	×
×	×	×	Pending
	✓ ✓ ×	V V V V X X	✓ ✓ ✓ ✓ ✓ X X X X

Dependents with a checkmark 🗹 are enrolled in the chosen plans for the upcoming year unless shown as pending for dependent eligibility verification as indicated above.

Dependents with a 📕 are not enrolled in the plan shown above

Dependents with a Pending means their enrollment is pending until supporting documentation is provided and reviewed by Human Capital. For acceptable document to verify your dependents review the enrollment guide

Your Pay Period Cost	Pay Period Summary
634.28	Total pretax contributions
132.85	Total aftertax contributions

Please check the box. By checking the box I hereby agree that I have read and agree to the following:

1 General Announcedgement – I am applying to enroll in the benefit opticated by me pursuant to this Lawon celf-service benefits optime enrollment system. I have read and understand this enrollment from and decise that life information given is true and complete to the benefit optical (system has provided or made available documentation related to the benefit optical system has provided and that my and my eligible dependents' receipt of benefits or benefits coverage pursuant to this enrollment from shall be subject in all respects to the term, conditions, and equivalents' and equivalent and my eligible dependents' receipt of benefits or benefits coverage pursuant to the benefit optical (sected by me pursuant to this enrollment from shall be subject in all respects to the term, conditions, and equivalents' and optical benefits op

2 Deduction Automation & Reminusment - Lambraice Virginia Restriction Center Health System to take any and all applicable deductions from my person or there are present that I or my eligible degendents receive benefits or benefits contraries for which have not paid the applicable deductions from the applicable applicable. Center Health System for its or any of its area present or applicable deductions from the applicable explores paid control (spectra do the applicable deductions from the applicable explores paid conts, largee to remburse Virginia Hospital Center Health System for its or any of its area present or applicable deductions from the applicable explores paid conts, largee to remburse Virginia Hospital Center Health System for its or any of its area present or applicable applicable deductions from the applicable explores paid conts, largee to remburse Virginia Hospital Center Health System for its or any of its area present or applicable applicable explores paid conts, largee to remburse Virginia Hospital Center Health System for its or any of its area present or applicable applicable explores paid conts, largee to not head to applicable deductions from the present paid contex integrity applicable deductions from the present paid contex integrity applicable deductions from the present paid contex integrity applicable deductions from the present or applicable applicable explores paid contex integrity applicable explores paid contex integrity applicable applicable applicable applicable explores paid contex integrity applicable applicable explores paid conte

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5. Enrolment Period – Lundestand that I must timely complete this enrollment form to enroll in one or more of the benefit options subject to this enrollment form. Lacknowledge that the only time I can enroll, add dependents, and/or change plans pursuant to this enrollment form is during the open enrollment period each year, unless I experience an earlier "qualifying event" and timely make and submit such change to Vignia Hospital Center Health System.

6. Fraud Warnings – Any person who knowingly and with intent to defraud any insurance company or other person files an application for benefits or statement of claim containing any materially false information, or concests for the purpose of misleading, information concerning any material fact thereto commits a fraudulent insurance act, which is a crime and could subject such person to criminal and civil penalties.

7. Spousal Philege Premium - If you have a spouse enrolled in one of Virginia Hospital Center Health System's health plan options, you will be subject to an additional Spousal Philege Premium fee monthly, unless notified you have been approved to waive the fee. This will be reviewed upon initial enrollment or eligibility and annually during Virginia Hospital Center Health System been for each option of the fee. This will be reviewed upon initial enrollment or eligibility and annually during Virginia Hospital Center Health System been for each option of the fee. This will be reviewed upon initial enrollment or eligibility and annually during Virginia Hospital Center Health System been for each option of the fee. This will be reviewed upon initial enrollment or eligibility and annually during Virginia Hospital Center Health System been for each option of the fee. This will be reviewed upon initial enrollment or eligibility and annually during Virginia Hospital Center Health System been for each option of the fee. This will be reviewed upon initial enrollment or eligibility and annually during Virginia Hospital Center Health System been for each option of the fee. This will be reviewed upon initial enrollment or eligibility and annually during Virginia Hospital Center Health System been for each option option option option option.

<u> Making Changes -</u>

- When making changes to your Health or Life Insurance Benefits, you will need to elect other plans that coincide with those plans.
- Changing Health Plans In addition to selecting HEATLH, you must select SPOUSAL PRIV PREMIUM & HEALTH SAVINGS ACCT. If there's a change to your health plan, it could affect the other plans as well.
- Changing Life Insurance Plans In addition to selecting EMPLOYEE LIFE you must select SPOUSE LIFE & CHILD LIFE. If there's a change to your life insurance plan, it could affect the other plans as well.

Enrollment Change

Select the plan type(s) you would like to change. You will re-enroll for benefits within the type(s) selected.

Select	Plan Type
	HEALTH
	SPOUSAL PRIV PREMIUM
	HEALTH SAVINGS ACCT
	DENTAL
	SHORT TERM DISABLTY
	LONG TERM DISABILITY
	ACCIDENT INSURANCE
	CRITICAL ILLNESS INS
	HOSPITAL INDEMNITY
	EMPLOYEE LIFE
	SPOUSE LIFE
	CHILD LIFE
	FLEX SPEND MEDICAL
	FLEX SPEND DAYCARE
	LEGAL
	CAFE PAYROLL
~	VHC FOUNDATION GIFTS
Contin	ue Previous

Once you've made those changes, you will see another Benefit Elections screen with an asterisk (*) by the plans you made a change.

Benefit Elections As Of 04/01/2022

Verify that your 2022 elections are listed correctly below.

Pending benefits will not go into effect until they are approved. There could be two reasons you have pending benefits

- 1. You have dependents that need to go through the "dependent verification" process. Dependents will not be covered unless they have gone through the dependent verification process. It is your responsibility to confirm the Benefits department has the needed documentation for verification.
- 2. You have elected a benefit that requires Evidence of Insurability (EOI). These benefits will go into effect after you have completed and submitted the EOI Form and the Carrier has approved your coverage.

Click Make Changes if you would like to make changes to any of the information below.

Click Finish if the information below is correct. A Dialog box will ask you to print your elections. Be sure to click Continue to print and keep your elections for future reference.

To find out more information about each benefit offered, click on the benefit plan name.

Benefit Elections As Of 04/01/2022							
Plan					Coverage	Your	Cost
VHC PPO HEALTH PLAN					FAMILY	441.96	Pretax
WAIVE SP PRIV PREMIUM							
DECLINE HSA ACCOUNT							
VHC DENTAL PLAN					FAMILY	69.90	Pretax
SHORT TERM DISABILITY					60% of salary 29,839.68	20.39	Aftertax
LONG TERM DISABILITY					60% of salary 29,839.68	4.13	Aftertax
METLIFE GROUP ACCIDENT INSURAN					FAMILY (EE SPOUSE CHILD)	9.01	Aftertax
METLIFE GROUP CRIT IL					Family 20k 10k	10.25	Aftertax
METLIFE GRP HOSPITAL INDEMNITY					FAMILY (EE SPOUSE CHILD)	30.76	Aftertax
* SUPPLEMENTAL EMPLOYEE LIFE INSURANCE					150,000.00	4.16	Pretax
* SUPPLEMENTAL EMPLOYEE LIFE INSURANCE AD&D					150,000.00	1.73	Pretax
* SUPPLEMENTAL SPOUSE LIFE INSURANCE					150,000.00	4.16	Pretax
* SUPPLEMENTAL SPOUSE LIFE INSURANCE AD&D					150,000.00	1.73	Pretax
* CHILDREN LIFE INSURANCE					10,000.00	0.92	Pretax
* CHILDREN LIFE INSURANCE - AD&D					10,000.00	0.12	Pretax
MEDICAL FLEXIBLE SPENDING ACCT					2,850.00 per year	109.62	Pretax
DECLINE DAY FLEX SPENDING PLAN							
HYATT LEGAL BENEFIT PLAN						8.31	Aftertax
CAFE PAYROLL DEDUCTION PLAN							
Foundation Employee Giving					260.00 per year	10.00	Aftertax
Pending Plans							
SPOUSE PRIV PREMIUM Pending DOCUMENTATION						138.46	
* SUPPLEMENTAL EMPLOYEE LIFE INSURANCE - Pending B	EOI				300,000.00	8.31	Pretax
* SUPPLEMENTAL EMPLOYEE LIFE INSURANCE AD&D - Pe	nding EOI				250,000.00	2.89	Pretax
* SUPPLEMENTAL SPOUSE LIFE INSURANCE - Pending EO	I				300,000.00	8.31	Pretax
* SUPPLEMENTAL SPOUSE LIFE INSURANCE AD&D - Pendi	ing EOI				250,000.00	2.89	Pretax
* Election changed							
Dependent Information Dependent	HEALTH	Dental	Spouse Life	Child Life			
RUTHIE L MODEL EMPLOYEE25781	~			*			
MONICA T. MODEL EMPLOYEE25781	~	~	×	~			
MILLICENT T. MODEL_EMPLOYEE25781 - Requires Verification	Pending	Pending	×	Pending			
Dependents with a checkmark ✔ are enrolled in the chosen plans for the upcoming year unless shown as pending for dependent eligibility verification as indicated above.							
Dependents with a X are not enrolled in the plan shown above. Dependents with a Pending means their enrollment is pending un dependents review the enrollment guide.	til supporting do	cumentation is p	rovided and revie	wed by Human C	apital. For acceptable document t	o verify your	
	Pay Period	d Summary			,	Your Pay Perio	d Cost

Total pretax contributions	634.30
Total aftertax contributions	92.85
	Notes and the provide state of the state of

Your deductions may differ slightly due to rounding

🗷 lease check the box. By checking the box I hereby agree that I have read and agree to the following:

- 1. General Acknowledgment I am applying to enroll in the benefit option(s) selected by me pursuant to this Lawson self-service benefits online enrollment system. I have read and understand this enrollment form and declare that all the information given is true and complete to the best of my knowledge and belief. Virginia Hospital Center Health System has provided or made available documentation related to the benefit options subject to this enrollment. I have read and understand the plan documents and/or plan related materials, and I understand that my and my eligible dependents' receipt of benefits or benefits coverage pursuant to the benefit option(s) selected by me pursuant to this enrollment form shall be subject in all respects to the terms, conditions, and requirements of the plan documents applicable to such benefit option.
- 2. Deduction Authorization & Premium Reimbursement I authorize Virginia Hospital Center Health System to take any and all applicable deductions from my paychecks, on a pretax or after-tax basis as appropriate, and to pay such sums as are due to the applicable carriers or providers for the benefit option(s) selected by me pursuant to this enrollment form. To the extent that I or my eligible dependents receive benefits or benefits coverage for which I have not paid the applicable premiums or other applicable employee-paid costs, I agree to reimburse Virginia Hospital Center Health System for its or any of its affiliates' payment of such premiums and other employee-paid costs and acknowledge that Virginia Hospital Center Health System shall have the right to and shall be authorized to require me to tender a cash payment for such reimbursement or to deduct such reimbursement from payments of any kind otherwise due to me from Virginia Hospital Center Health System. In addition, if you are a part-time (less than 20 hours per week) or PRN employee or terminate employment with Virginia Hospital Center Health System and premiums are unable to be collected from your paycheck due to a lack of hours worked; you understand benefits will be terminated on the last day of the month and you will be responsible for payment of any missed premiums.
- 3. Employee Eligibility I currently meet the applicable eligibility requirements of each benefit option selected by me pursuant to this enrollment form.
- 4. Employee Responsibility I understand that it is my responsibility, and not the responsibility of Virginia Hospital Center Health System, to check my paychecks or paystubs to ensure that proper deductions are being applied accurately for my requested benefit option(s) and to ensure that I am enrolled in the proper benefit option(s).
- 5. Enrollment Period I understand that I must timely complete this enrollment form to enroll in one or more of the benefit options subject to this enrollment form. I acknowledge that the only time I can enroll, add dependents, drop dependents, and/or change plans pursuant to this enrollment form is during the open enrollment period each year, unless I experience an earlier "qualifying event" and I timely make and submit such change to Virginia Hospital Center Health System.
- 6. Fraud Warnings Any person who knowingly and with intent to defraud any insurance company or other person files an application for benefits or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any material fact thereto commits a fraudulent insurance act, which is a crime and could subject such person to criminal and civil penalties.
- 7. Spousal Privilege Premium If you have a spouse enrolled in one of Virginia Hospital Center Health System's health plan options, you will be subject to an additional Spousal Privilege Premium fee monthly, unless notified you have been approved to waive the fee. This will be reviewed upon initial enrollment or eligibility and annually during Virginia Hospital Center Health System benefits open enrollment.



When you are done with your elections, read the information at the bottom of the page & check the box so the Finish button appears for you to select.

Print Your Benefits Summary & Statement of Health -

- You will be prompted to print your elections. Please select "Yes" to print a copy of your benefit election changes for your records.
- If you are electing Short or Long Term Disability for the first time or making changes to Employee or Dependent Life Insurance options, you will receive a Statement of Health Form to complete.

Dialog ×	Enrollment Elections
Do you want to print these elections for your reference?	Print Statement of Health Form ** 2023 Annual Enrollment Confirmation/Summary Effective Date: 04/01/2023 Printed: 02/06/2023 Time: 17:30:16 Employee Number: 25781
Continue	VHC J. MODEL_EMPLOYEE25781 1701 N GEORGE MASON DR ARLINGTON, VA 22205

Statement of Health Form (Evidence of Insurability – EOI)

Print from confirmation page, complete & send directly to MetLife by Monday, February 28, 2023. Instruction on the 1st page of the form gives you information to mail, fax or email your information. If you are not able to print the form from your confirmation page, please go to **GROUP 6** of the Benefits Corner to download a blank copy of the *MetLife Statement of Health* form.

You have successfully completed the New Hire Benefits Enrollment. Your elections will be reviewed by the Benefits Department and you will be contacted <u>ONLY</u> if you have not submitted the proper documentation or election clarification is needed.

Benefits Enrollment

Enrollment Elections

Elections

Plan		Coverage		Pre Ta	x Cost A	After Tax Cost
VHC PPO HEALTH PLAN			FAMIL	(441.96	
WAIVE SP PRIV PREMIUM						
DECLINE HSA ACCOUNT						
VHC DENTAL PLAN			FAMIL	0	69.90	
SHORT TERM DISABILITY		60	0% of salar 29,839.68	y i		20.39
LONG TERM DISABILITY		60	0% of salar) 29,839.68	Y .		4.13
METLIFE GROUP ACCIDENT INSURAN		FAMILY (EE SPOU	JSE CHILD)		9.01
METLIFE GROUP CRIT IL		Far	nily 20k 10l	k		10.25
METLIFE GRP HOSPITAL INDEMNITY		FAMILY (EE SPOU	JSE CHILD)		30.76
MEDICAL FLEXIBLE SPENDING ACCT		2,850	.00 per yea	r	109.62	
DECLINE DAY FLEX SPENDING PLAN						
HYATT LEGAL BENEFIT PLAN						8.31
CAFE PAYROLL DEDUCTION PLAN						
* SUPPLEMENTAL EMPLOYEE LIFE INSURANCE			150,000.00	D	4.16	
* SUPPLEMENTAL EMPLOYEE LIFE INSURANCE AD&D			150,000.00	D	1.73	
* SUPPLEMENTAL SPOUSE LIFE INSURANCE			150,000.00	D	4.16	
* SUPPLEMENTAL SPOUSE LIFE INSURANCE AD&D			150,000.00	D	1.73	
* CHILDREN LIFE INSURANCE			10,000.00	D	0.92	
* CHILDREN LIFE INSURANCE - AD&D			10,000.00	D	0.12	
* Foundation Employee Giving		260	.00 per yea	r		10.00
Your Per Pay Period Summary					634.30	92.85
Pending Plans Under Review**						
SPOUSE PRIV PREMIUM Pending DOCUMENTATION						138.46
* SUPPLEMENTAL EMPLOYEE LIFE INSURANCE - Pending EC	ы		300,000.00	D	8.31	
* SUPPLEMENTAL EMPLOYEE LIFE INSURANCE AD&D - Pend	ling EOI		250,000.00	D	2.89	
* SUPPLEMENTAL SPOUSE LIFE INSURANCE - Pending EOI			300,000.00	D	8.31	
* SUPPLEMENTAL SPOUSE LIFE INSURANCE AD&D - Pending) EOI		250,000.00	D	2.89	
Dependent Information						
Dependent	Birth Date	Relationship	HEALTH	Dental	Spouse L	ife Child Life
RUTHIE L. MODEL_EMPLOYEE25781	04/08/1996	SPOUSE OF EMPLOYEE	× .	× .	 Image: A second s	×
MONICA T. MODEL_EMPLOYEE25781	04/04/2018	CHILDREN OF EMPLOYEE	× .	× .	×	×
MILLICENT T. MODEL_EMPLOYEE25781 - Requires Verification	09/27/2019	CHILDREN OF EMPLOYEE	Pending	Pending	×	Pending

Dependents with a checkmark 🗸 are enrolled in the chosen plans for the upcoming year unless shown as pending for dependent eligibility verification as indicated above.

Dependents with a 🔻 are not enrolled in the plan shown above.

Dependents with a Pending means their enrollment is pending until supporting documentation is provided and reviewed by Human Capital. For acceptable document to verify your dependents review the enrollment guide.

Adding or Updating Life Insurance Beneficiary -



Sign out once your enrollment & beneficiary updates are done

Clear Browser History in Google Chrome



Clear Browser History (Google Chrome)

Procedure

1. Click on the Settings button as shown.

Googl	e	
Q. Search Google or type a URL		
۲		

2. Click Settings



3. Click Security and Privacy as shown.







4. Click Clear browsing data as shown.



5. Verify that you have selected the four options shown here.





6. After verifying that you have selected the options shown, click **Cleardata** to clear your browser history.

		Basic	Advanced
Time r	ange	All time	-
	Browsin	g history	
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	Cookies	and other site data	
× .	Signs yo	ou out of most sites.	
-	Cached	images and files	
~	Frees ur	2.9 MB. Some sites ma	v load more slowly on your next visit

data

7. Click here to close your browser window completely.

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8. Launch Google Chrome and try accessing the site again.

Clear Browser History in Microsoft Edge







How to Clear Browser History in Microsoft Edge.

Procedure

1. Click on the three dots in the upper righthand corner of your browser as shown.



2. Click **History**.

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3. Click on the three dots as shown here.

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4. Click Clear browsing data.

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5. Make sure that you have these item selected. You can unselect anyother items if you do not wish to clear them.

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6. Click here to clear your browser history.

Clearing Browser History in Microsoft Edge

cking prevention 💿	
sites use trackers to collect info about your brow onalized ads. Some trackers collect and send you	vsing. Websites may use this info to improve sites and show you content like ur info to sites you haven't visited.
Allows most trackers across all sites Content and ads will likely be personalized Sites will work as expected Blocks known harmful trackers Blocks known ha	Bal Clear browsing data Inter range Time range Isota training and the story will we
ocked trackers ew the sites that we've blocked from tracking you	Cookies and other site data From 5 sites. Signs you out of most sites.
	Cached images and files

7. Close Browser down by clicking on the 'X' as shown

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Strict Blocks a majority of trackers from all sites Content and ads will likely have minimal personalization Parts of sites might not work	Clearing Browser History in Microsoft Edge
Strict Blocks a majority of trackers from all sites Content and ads will likely have minimal personalization Parts of sites might not work Blocks known harmful trackers	Clearing Browses History in Microsoft Edge
Strict Bocks a majority of trackers from all site: Content and ads will likely have minmal personalization Parts of sites might not work Blocks known harmful trackers	Clearing Browses History in Microsoft Edge

8. Relaunch Microsoft Edge and try accessing the site again.