

Collective Bargaining Agreement (CBA)
Benefit Highlight Summary

All regular full- & part-time employees covered under a CBA are eligible for the following benefits.

Healthcare Plan

The healthcare plan through Sound Health & Wellness Trust (SHWT) begins on the 1st day of the 4th month of employment (dental insurance begins on the 5th month). Coverage includes:

- Medical Insurance
- Dental Insurance
- Prescription (Rx) Insurance
- Vision Insurance
- Short-Term Disability Pay
- \$15,000 Life/AD&D Insurance

Bi-Weekly Premium Cost

- Employee Only - \$84.41 per pay
- Employee + Spouse - \$86.76 per pay
- Employee + Child(ren) - \$85.16 per pay
- Employee + Family - \$88.87 per pay

Enhanced Medical Benefit Program

Employees/dependents enrolled in the SHWT healthcare plan are eligible for the Enhanced Medical Benefit Program. Medical services covered by SHWT medical insurance plan performed at JH facilities are eligible to be written off by JH eliminating out-of-pocket expenses for deductibles, co-pays, or co-insurance.

Retirement Plans

Employees are eligible to participate in the *457-deferral plan* the first day of the month following date of hire. Employees may defer up to a maximum limit of \$20,500 (\$27,000 if over age 50) of pre-tax earnings to a retirement account maintained by Nationwide. All deferred funds are 100% fully vested.

Employees are eligible for the *Employee Retirement Plan* after two (2) years and 832 hours (per year) of employment. Employees will receive a contribution of five percent (5%) of pre-tax earnings to a retirement account maintained by Nationwide. All contributions are made by Jefferson Healthcare and are 100% fully vested.

**Life/Accidental Death & Dismemberment
(AD&D) Insurance**

Employees that enroll in the SHWT healthcare plan receive a \$15,000 Life/AD&D insurance policy through SHWT.

Leave Benefits

Paid Time Off (PTO) and Paid Sick Leave (PSL) begin accruing on your first day of employment. Utilize PTO upon completion of your 90th day of employment.

Disability Plans

SHWT will contribute up to \$300 per week for up to 26 weeks if you are unable to work due to an illness or injury. The benefit begins on the 4th day of continuous disability.

Employee Assistance Program (EAP)

Employees and their dependents are eligible for the EAP on the first day of employment. The EAP is 100% confidential and provides resources for work/life situations.

Supplemental/Voluntary Benefits

Employees are eligible to enroll in voluntary benefits through American Fidelity after 90 days of employment. American Fidelity administers our flexible spending accounts as well as provides additional life insurance, critical illness, critical accident, and many more benefit products.

Discounted Services & Products

Employees are eligible for "around-the-town" discounted services and products inclusive of, but not limited to:

- Reduced Gym Membership at Port Townsend Athletic Club & Evergreen Fitness
- PT Cyclery
- Airlift Northwest Air Transport

PTO Accrual Rate: Non-Exempt

Completion of:	Hrs	Accrual Rate	8-Hr Days	10-Hr Days	12-Hr Days
<1 year	91.94	0.0442	11	9	8
1 year	147.89	0.0711	18	15	12
2 years	155.79	0.0749	19	16	13
3 years	163.90	0.0788	20	16	14
4 years	171.81	0.0826	21	17	14
5 years	187.82	0.0903	23	19	16
6 years	195.94	0.0942	24	20	16
7 years	204.05	0.0981	26	20	17
8 years	211.95	0.1019	26	21	18
9 years	219.86	0.1057	27	22	18
10 years	227.97	0.1096	28	23	19
11 years	235.87	0.1134	29	24	20
12 years	243.98	0.1173	30	24	20
13 years	251.89	0.1211	31	25	21
16 years	259.79	0.1249	32	26	22
17 years	267.90	0.1288	33	27	22
20 years	275.81	0.1326	34	28	23
23 years	283.92	0.1365	35	28	24

A one-time allotment of 56 hours will be deposited into your PTO bank following the completion of 2080 worked hours.

Welcome to the Jefferson Healthcare Employee Assistance Program (EAP)

Our program is confidential and covers employees, spouses, domestic partners, and children up to age 18. Jefferson Healthcare provides your EAP services free of charge (no co-pay, deductible, or premium).

You can use EAP services to solve a wide range of concerns and problems:

- ✓ Marital and family issues
- ✓ Depression and anxiety
- ✓ Problems with substance abuse
- ✓ Problems with gambling
- ✓ Balancing work and home
- ✓ Personal/family concerns

Your EAP is available 24 hours a day, 7 days a week. Simply call (800) 777-4114 and a Customer Service Representative will assist you. The EAP provides **up to 6 face-to-face assessment and referral sessions** with a Licensed Behavioral Health Provider who is skilled in assessing your concerns. If preferred, you may request an online appointment at www.FirstChoiceEAP.com.

■ e Invite You to Explore Our Online Tools and Resources

Go to www.FirstChoiceEAP.com and click on the **Login** button.

username:
Jeffersonhealth

You can search a vast electronic library for information, tools, and resources including legal forms, financial information, pet care, parenting solutions, health and wellness, family matters, daycare information, eldercare, and much more.

Enhanced ■ or ■ Life Services

Legal Services: You can speak with an attorney for up to 30 minutes at no charge. Should you decide to retain the attorney, you will receive a 25% discount off the attorney's standard hourly fees (work-related issues are not covered).

Financial Services: You can speak with a financial professional by phone for up to 30 minutes at no charge. Issues may include debt management, credit card education/consultation, and budgeting advice (investment advice is not provided).

ID Theft and Fraud Resolution: This benefit can help protect you from theft and fraud or assist you should you become a victim of a fraud-related crime.

Childcare and Eldercare Consultation: You will be connected with a childcare or eldercare specialist who can assist in arranging care or resources for your child or older parent regardless of their location in the U.S.

Home Ownership Consultation: Save thousands if you are buying, selling, refinancing, or remodeling a home.

First Choice Health™

Healthy Employees. Healthy Companies.™





New Health Insurance Marketplace Coverage Options and Your Health Coverage

Form Approved
OMB No. 1210-0149
(expires 5-31-2020)

PART A: General Information

When key parts of the health care law take effect in 2014, there will be a new way to buy health insurance: the Health Insurance Marketplace. To assist you as you evaluate options for you and your family, this notice provides some basic information about the new Marketplace and employment-based health coverage offered by your employer.

What is the Health Insurance Marketplace?

The Marketplace is designed to help you find health insurance that meets your needs and fits your budget. The Marketplace offers "one-stop shopping" to find and compare private health insurance options. You may also be eligible for a new kind of tax credit that lowers your monthly premium right away. Open enrollment for health insurance coverage through the Marketplace begins in October 2013 for coverage starting as early as January 1, 2014.

Can I Save Money on my Health Insurance Premiums in the Marketplace?

You may qualify to save money and lower your monthly premium, but only if your employer does not offer coverage, or offers coverage that doesn't meet certain standards. The savings on your premium that you're eligible for depends on your household income.

Does Employer Health Coverage Affect Eligibility for Premium Savings through the Marketplace?

Yes. If you have an offer of health coverage from your employer that meets certain standards, you will not be eligible for a tax credit through the Marketplace and may wish to enroll in your employer's health plan. However, you may be eligible for a tax credit that lowers your monthly premium, or a reduction in certain cost-sharing if your employer does not offer coverage to you at all or does not offer coverage that meets certain standards. If the cost of a plan from your employer that would cover you (and not any other members of your family) is more than 9.5% of your household income for the year, or if the coverage your employer provides does not meet the "minimum value" standard set by the Affordable Care Act, you may be eligible for a tax credit.¹

Note: If you purchase a health plan through the Marketplace instead of accepting health coverage offered by your employer, then you may lose the employer contribution (if any) to the employer-offered coverage. Also, this employer contribution—as well as your employee contribution to employer-offered coverage—is often excluded from income for Federal and State income tax purposes. Your payments for coverage through the Marketplace are made on an after-tax basis.

How Can I Get More Information?

For more information about your coverage offered by your employer, please check your summary plan description or Benefits@jeffersonhealthcare.org

The Marketplace can help you evaluate your coverage options, including your eligibility for coverage through the Marketplace and its cost. Please visit HealthCare.gov for more information, including an online application for health insurance coverage and contact information for a Health Insurance Marketplace in your area.

¹ An employer-sponsored health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs.

PART B: Information About Health Coverage Offered by Your Employer

This section contains information about any health coverage offered by your employer. If you decide to complete an application for coverage in the Marketplace, you will be asked to provide this information. This information is numbered to correspond to the Marketplace application.

3. Employer name Jefferson County Public District Hospital #2 (dba Jefferson Healthcare)		4. Employer Identification Number (EIN) 91-0928081	
5. Employer address 834 Sheridan St		6. Employer phone number 360-385-2200	
7. City Port Townsend		8. State WA	9. ZIP code 98368
10. Who can we contact about employee health coverage at this job? Human Resources			
11. Phone number (if different from above)		12. Email address benefits@jeffersonhealthcare.org	

Here is some basic information about health coverage offered by this employer:

- As your employer, we offer a health plan to:

☐ All employees. Eligible employees are:

☐ Some employees. Eligible employees are:

Regular Full-Time, Part-Time Employees

- With respect to dependents:

☒ We do offer coverage. Eligible dependents are:

--Your spouse, if you're not divorced or legally separated. --Your same sex domestic partner, provided you or your partner is at least age 62 at the time such domestic partnership is established. --Your children under age 26 who are your natural children, stepchildren, adopted children, children placed with you for adoption, or foster children.

☐ We do not offer coverage.

☒ If checked, this coverage meets the minimum value standard, and the cost of this coverage to you is intended to be affordable, based on employee wages.

** Even if your employer intends your coverage to be affordable, you may still be eligible for a premium discount through the Marketplace. The Marketplace will use your household income, along with other factors, to determine whether you may be eligible for a premium discount. If, for example, your wages vary from week to week (perhaps you are an hourly employee or you work on a commission basis), if you are newly employed mid-year, or if you have other income losses, you may still qualify for a premium discount.

If you decide to shop for coverage in the Marketplace, [HealthCare.gov](https://www.healthcare.gov) will guide you through the process. Here's the employer information you'll enter when you visit [HealthCare.gov](https://www.healthcare.gov) to find out if you can get a tax credit to lower your monthly premiums.

SOUND HEALTH & WELLNESS TRUST

DENTAL OPTIONS

FOR

SOUNDPLUS PLAN

2021 ENROLLMENT

	Delta Dental PPO #09135	DeltaCare #00404	Schedule Plan #09392
How it Works	<p>This option requires you to choose from a list of dentists in a managed care network.</p> <ul style="list-style-type: none"> • <u>DDWA/Delta Dental Preferred (PPO) Providers</u>: Seeing a Preferred Dentist will provide the highest level of benefits and may provide the lowest out of pocket costs. • <u>DDWA/Delta Dental Participating Providers</u>: These Dentists provide a discount, but your benefits percentage is lower and may result in higher out of pocket costs vs. a Preferred Dentist. • <u>Non-DDWA Dentist</u>: If your Dentist is not Preferred or Participating, your benefits will be lower, and you may have higher out of pocket costs. Reimbursement is made based on maximum allowable fees, which may leave you with a higher patient responsibility. 	<p>DeltaCare is a dental HMO plan. This option requires you to choose from a list of approved dentists and clinics.</p> <p>You MUST choose a DeltaCare primary care dentist who coordinates all of your care, including any referrals to specialists. Under this plan you cannot just see any licensed dentist for treatment.</p> <p>A list of DeltaCare providers can be found at www.deltadentalwa.com. Make sure you have a DeltaCare provider in your area before enrolling in this option.</p>	<p>This option allows you to see any licensed dental provider.</p> <p>Your reimbursement will depend on which network the provider belongs to.</p> <p>Benefits will be paid according to the schedule of allowances. If treatment is performed by a participating dentist, the dentist may not charge more than their allowable fee. If treatment is performed by a non-participating dentist, dental charges in excess of the schedule will be your responsibility.</p>
Annual Deductible (per calendar year)	Individual: \$10 Family: \$30	Individual: None Family: None	Individual: \$10 Family: \$30
Annual Maximum (per calendar year)	\$2,500 per person	None	\$2,500 per person

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This Plan comparison provides a general overview of Plan benefits. Please refer to your Summary Plan Description for specifics about covered expenses as well as exclusions and limitations.

	Delta Dental PPO #09135	DeltaCare #00404	Schedule Plan #09392
Coinsurance Class I Procedures: <ul style="list-style-type: none"> • Diagnostic • Preventative 	<u>DDWA/Delta Dental Participating Dentist</u> 100% of charges for preferred providers 75% of charges for non-preferred providers <u>Non-DDWA Participating Dentist</u> 75% of allowable fees	Covered procedures are provided with no co-payment when performed by an assigned DeltaCare Dentist.	Paid per Plan's Schedule of Allowances.
Class II Procedures: <ul style="list-style-type: none"> • Restorations • Oral Surgery • Periodontics • Endodontics • General Anesthesia • Intravenous Sedation • Palliative Care 	<u>DDWA/Delta Dental Participating Dentist</u> 85% of charges for preferred providers 75% of charges for non-preferred providers <u>Non-DDWA Participating Dentist</u> 75% of allowable fees	Covered procedures are provided with copays.	Paid per Plan's Schedule of Allowances.
Class III Procedures: <ul style="list-style-type: none"> • Crowns • Dentures • Bridges • Partial 	<u>DDWA/Delta Dental Participating Dentist</u> 50% of charges for preferred providers 40% of charges for non-preferred providers <u>Non-DDWA Participating Dentist</u> 40% of allowable fees	Covered procedures are provided with copays.	Paid per Plan's Schedule of Allowances.
Orthodontia	50% \$2,000 lifetime maximum benefit	\$1,200 copay – dependent children to age 19 \$1,600 copay – dependent children age 19+ and adults	50% \$2,000 lifetime maximum benefit
Implants	Not Covered	Not Covered	Paid per Plan's Schedule of Allowances.

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FURTHER QUESTIONS?

Eligibility, Enrollment Process
(206) 282-4500 or (800) 225-7620

Delta Dental PPO Plan or Schedule Plan
(800) 554-1907

DeltaCare
(800) 650-1583

SOUND HEALTH & WELLNESS TRUST

MEDICAL, PRESCRIPTION DRUG AND VISION OPTIONS

FOR

SOUNDPLUS PLAN

2021 ENROLLMENT

Sound Health & Wellness Trust

Comparison of Medical/Prescription Drug/Vision Benefits Effective January 1, 2021

	SoundPlus PPO Plan	SoundPlus Kaiser Permanente Plan	SoundPlus ACO Plan
Definition and Service Area	The PPO Plan's Preferred Provider Network is the Aetna Choice POS II Network. When you use Preferred Providers for medical services, your benefits will be greater. All services provided by non-preferred providers are paid at the lower out of Network level and are subject to Usual, Customary and Reasonable (UCR) charges.	When you choose In-Network care, you get access to all Kaiser Permanente providers. In addition, you have access to a number of contracted community physicians in the area. If you choose Out of Network care, you can see First Choice Health Network or First Health providers at a discounted rate. Or you can see any licensed provider you want for most covered services. Your out of pocket costs will be higher than if you choose care inside the Kaiser network.	The ACO Plan uses a Network of providers and facilities that are part of or affiliated with the Providence-Swedish health care system. You will receive the highest level of benefits when you use an ACO provider or facility. If you use a Preferred Provider from the Aetna Choice POS II Network for medical services, your benefits may be paid at the lower out of Network level if those services are available through the ACO unless your ACO provider refers you. All services provided by non-preferred providers are subject to Usual, Customary and Reasonable (UCR) charges.
Weekly Employee Premium Deductions	Employee only - \$9 Employee & spouse - \$21 Employee & child(ren) - \$15 Family - \$23	Employee only - \$5 Employee & spouse - \$15 Employee & child(ren) - \$9 Family - \$19	Employee only - \$5 Employee & spouse - \$15 Employee & child(ren) - \$9 Family - \$19

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Sound Health & Wellness Trust

Comparison of Medical/Prescription Drug/Vision Benefits Effective January 1, 2021

	SoundPlus PPO Plan	SoundPlus Kaiser Permanente Plan	SoundPlus ACO Plan
<p>Annual net deductible (per calendar year)</p> <ul style="list-style-type: none"> Employee Only Family 	<p>\$250 for Preferred Providers \$500 for non-preferred providers</p> <p>\$500 for Preferred Providers \$1,000 for non-preferred providers</p> <p>For family coverage, the deductible applies to the family as a whole.</p> <p>Note: If you (and your enrolled spouse) do not update your contact information, take your Personal Health Assessment (PHA), choose a Primary Care Physician (PCP) and complete health actions during the available time period, your deductible will be higher.</p>	<p>\$250 for Kaiser (In-Network) Providers \$500 for Out of Network Providers</p> <p>\$500 for Kaiser (In-Network) Providers \$1,000 for Out of Network Providers</p> <p>For family coverage, the deductible applies to the family as a whole.</p> <p>Note: If you (and your enrolled spouse) do not update your contact information, take your Health Profile, choose a Primary Care Physician (PCP) and complete health actions during the available time period, your deductible will be higher.</p>	<p>\$250 for ACO Providers and Aetna Network Providers when services are not available through an ACO Provider \$500 for non-ACO Providers, Aetna Network Providers when services are available through the ACO and Out of Network Providers</p> <p>\$500 for ACO Providers and Aetna Network Providers when services are not available through an ACO Provider \$1,000 for non-ACO Providers, Aetna Network Providers when services are available through the ACO and Out of Network Providers</p> <p>For family coverage, the deductible applies to the family as a whole.</p> <p>Note: If you (and your enrolled spouse) do not update your contact information, take your Personal Health Assessment (PHA), choose a Primary Care Physician (PCP) and complete health actions during the available time period, your deductible will be higher.</p>
<p>Annual Out of Pocket (OOP) Maximum (per calendar year)</p> <ul style="list-style-type: none"> Employee Only 	<p>\$2,250 for Preferred Providers \$4,500 for non-preferred providers</p>	<p>\$2,250 for Kaiser (In-Network) Providers \$4,500 for Out of Network Providers</p>	<p>\$2,250 for ACO Providers and Aetna Network Providers when services are not available through an ACO Provider \$4,500 for non-ACO Providers, Aetna Network Providers when services are available through the ACO and Out of Network Providers</p>

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Sound Health & Wellness Trust

Comparison of Medical/Prescription Drug/Vision Benefits Effective January 1, 2021

	SoundPlus PPO Plan	SoundPlus Kaiser Permanente Plan	SoundPlus ACO Plan
<ul style="list-style-type: none"> Family <p>Deductible and co-insurance apply to the OOP maximum.</p>	<p>\$4,500 for Preferred Providers \$9,000 for non-preferred providers</p> <p>Overall in-network out-of-pocket limit on Essential Health Benefits: \$8,550 person / \$17,100 family</p> <p>For employees with Family coverage, the "Employee Only coverage" maximum will apply to each covered individual until the "Family coverage" maximum is met.</p> <p>Note: If you (and your enrolled spouse) do not update your contact information, take your Personal Health Assessment (PHA), choose a Primary Care Physician (PCP) and complete health actions during the available time period, your out of pocket will be higher.</p>	<p>\$4,500 for Kaiser (In-Network) Providers \$9,000 for Out of Network Providers</p> <p>Overall in-network out-of-pocket limit on Essential Health Benefits: \$8,550 person / \$17,100 family</p> <p>For employees with Family coverage, the "Employee Only coverage" maximum will apply to each covered individual until the "Family coverage" maximum is met.</p> <p>Note: If you (and your enrolled spouse) do not update your contact information, take your Health Profile, choose a Primary Care Physician (PCP) and complete health actions during the available time period, your deductible will be higher.</p>	<p>\$4,500 for ACO Providers and Aetna Network Providers when services are not available through an ACO Provider \$9,000 for non-ACO Providers, Aetna Network Providers when services are available through the ACO and Out of Network Providers</p> <p>Overall in-network out-of-pocket limit on Essential Health Benefits: \$8,550 person / \$17,100 family</p> <p>For employees with Family coverage, the "Employee Only coverage" maximum will apply to each covered individual until the "Family coverage" maximum is met.</p> <p>Note: If you (and your enrolled spouse) do not update your contact information, take your Personal Health Assessment (PHA), choose a Primary Care Physician (PCP) and complete health actions during the available time period, your out of pocket will be higher.</p>
	All benefits described below are paid at the percentage indicated after satisfaction of the annual deductible unless otherwise noted.	All benefits described below are paid at the percentage indicated after satisfaction of the annual deductible unless otherwise noted.	All benefits described below are paid at the percentage indicated after satisfaction of the annual deductible unless otherwise noted.
<p>Hospital</p> <ul style="list-style-type: none"> Inpatient and Outpatient <p>Emergency Room (Copoly applies only to the Essential Health Benefits OOP maximum)</p>	<p>85% for preferred hospitals 60% for non-preferred hospitals</p> <p>(\$250 penalty if hospitalization is not pre-certified – does not apply to OOP maximums.)</p> <p>\$100 copay, waived if admitted. 85% for preferred hospitals 60% for non-preferred hospitals Life endangering medical emergency at non-preferred hospital covered as if preferred hospital</p>	<p>85% for Kaiser (In-Network) Providers 60% for Out of Network Providers</p> <p>\$100 copay at Kaiser and non-designated facilities, waived if admitted. Worldwide emergency care is covered.</p>	<p>85% for ACO hospitals 60% for Aetna Network (unless referred by an ACO provider) or Out of Network hospitals</p> <p>(\$250 penalty if hospitalization is not pre-certified – does not apply to OOP maximums.)</p> <p>\$100 copay, waived if admitted. 85% for ACO or Aetna Network hospitals 60% for Out of Network hospitals Life endangering medical emergency at non-preferred hospital covered as if preferred hospital (subject to</p>

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Sound Health & Wellness Trust

Comparison of Medical/Prescription Drug/Vision Benefits Effective January 1, 2021

	SoundPlus PPO Plan	SoundPlus Kaiser Permanente Plan	SoundPlus ACO Plan
	(subject to UCR).		UCR).
Ambulance (air/ground)	85% for preferred providers 60% for non-preferred providers	85% for preferred providers 60% for non-preferred providers	85% for ACO or Aetna Network Providers 60% for Out of Network Providers
Surgical Services (PCP, non-PCP, inpatient or outpatient)	85% for preferred providers 60% for non-preferred providers	85% for Kaiser (In-Network) Providers 60% for Out of Network Providers	85% for ACO providers 60% for Aetna Network (unless referred by an ACO provider) or Out of Network providers
Anesthesia (including supplies)	85% for preferred providers 60% for non-preferred providers	85% for Kaiser (In-Network) Providers 60% for Out of Network Providers	85% for ACO providers 60% for Aetna Network (unless referred by an ACO provider) or Out of Network providers
Second Surgical Opinion	85% for preferred providers 60% for non-preferred providers	85% for Kaiser (In-Network) Providers 60% for Out of Network Providers	85% for ACO or Aetna Network Providers 60% for Out of Network Providers
Ambulatory Surgical Center	85% for preferred providers 60% for non-preferred providers	85% for Kaiser (In-Network) Providers 60% for Out of Network Providers	85% for ACO providers 60% for Aetna Network (unless referred by an ACO provider) or Out of Network providers
Physician Inpatient Visits	85% for preferred providers 60% for non-preferred providers	85% for Kaiser (In-Network) Providers 60% for Out of Network Providers	85% for ACO or Aetna Network Providers 60% for Out of Network Providers
Physician Office Visits <ul style="list-style-type: none"> primary care services by PCP non-preventive or non-primary care services 	85% for preferred providers 60% for non-preferred providers 85% for preferred providers 60% for non-preferred providers	85% for Kaiser (In-Network) Providers 60% for Out of Network Providers 85% for Kaiser (In-Network) Providers 60% for Out of Network Providers	100% ACO Network PCP- no deductibles or coinsurance 60% Aetna Network PCP 60% Aetna Network provider 60% non-ACO/non-Aetna Network provider 85% ACO Network PCP 85% other ACO Network provider 85% Referred by ACO provider to Aetna Network

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Sound Health & Wellness Trust

Comparison of Medical/Prescription Drug/Vision Benefits Effective January 1, 2021

	SoundPlus PPO Plan	SoundPlus Kaiser Permanente Plan	SoundPlus ACO Plan
			provider 60% Aetna Network PCP 60% Aetna Network provider 60% non-ACO/non-Aetna Network provider
Preventive Care: <ul style="list-style-type: none"> Physical Exam Preventive Screenings, Lab Tests Immunizations and Flu Shots 	All covered preventive services covered in accordance with the Plan's preventive care schedule (refer to the Summary Plan Description booklet): 100% for preferred providers - no deductibles or coinsurance 60% for non-preferred providers - after deductible	All preventive services covered in accordance with Kaiser well care schedule: 100% for Kaiser (In-Network) Providers (no deductible) 60% for Out of Network Providers (after deductible)	All covered preventive services covered in accordance with the Plan's preventive care schedule (refer to the Summary Plan Description booklet): 100% ACO Network PCP - no deductible 100% other ACO Network provider - no deductible 60% Aetna Network PCP 60% Aetna Network provider 60% non-ACO/non-Aetna Network provider
Diagnostic X-ray and Lab <ul style="list-style-type: none"> primary care services through your PCP non-preventive or non-primary care services 	85% for preferred providers 60% for non-preferred providers 85% for preferred providers 60% for non-preferred providers	85% for Kaiser (In-Network) Providers 60% for Out of Network Providers 85% for Kaiser (In-Network) Providers 60% for Out of Network Providers	100% ACO Network - no deductible 85% Referred by ACO provider to Aetna Network provider 60% Aetna Network PCP for primary care services 85% ACO Network provider 85% Aetna Network provider 60% non-ACO/non-Aetna Network provider
Imaging	85% for preferred providers 60% for non-preferred providers	85% for Kaiser (In-Network) Providers 60% for Out of Network Providers	85% ACO Network provider 85% Aetna Network provider 60% non-ACO/non-Aetna Network provider
Dental Treatment	85% for preferred providers 60% for non-preferred providers	85% for Kaiser (In-Network) Providers 60% for Out of Network Providers for treatment for	85% Aetna Network provider 60% non-Aetna Network provider

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Comparison of Medical/Prescription Drug/Vision Benefits Effective January 1, 2021

	SoundPlus PPO Plan	SoundPlus Kaiser Permanente Plan	SoundPlus ACO Plan
	for treatment for accidental injuries to natural teeth or fractured jaw if treatment is performed within six months from the date of accident. Routine dental treatment is not covered.	accidental injuries to natural teeth or fractured jaw if treatment is performed within six months from the date of accident. Routine dental treatment is not covered.	for treatment for accidental injuries to natural teeth or fractured jaw if treatment is performed within six months from the date of accident. Routine dental treatment is not covered.
Medical Supplies, Equipment and Prosthetic Devices	85% for preferred providers 60% for non-preferred providers	85% for Kaiser (In-Network) Providers 60% for Out of Network Providers	85% Aetna Network provider 60% non-Aetna Network provider
Mental and Nervous Disorder <ul style="list-style-type: none"> Inpatient Outpatient 	85% for preferred providers 60% for non-preferred providers 85% for preferred providers 60% for non-preferred providers	85% at Kaiser approved facility 60% for Out of Network facilities <ul style="list-style-type: none"> Excess does not apply to OOP maximum 85% for Kaiser (In-Network) Providers 60% for Out of Network Providers <ul style="list-style-type: none"> Excess does not apply to OOP maximum 	85% ACO Network facility 85% Aetna Network facility 85% Referred by ACO provider to Aetna Network facility 60% non-ACO/non-Aetna Network facility 85% ACO Network provider 85% Aetna Network provider 60% non-ACO/non-Aetna Network provider
Chiropractic Care (Excess of the \$30 per visit applies only to the Essential Health Benefits OOP maximum. Excess of the 20 visits per calendar year does not apply to the OOP maximums-PPO/ACO.)	85% for preferred providers 60% for non-preferred providers <ul style="list-style-type: none"> Benefit limited to \$30 per visit PPO providers provide a discount Maximum of 20 visits per calendar year Chiropractic x-rays limited to one set from one chiropractic visit, per calendar year	85% for Kaiser (In-Network) Providers 60% for Out of Network Providers <ul style="list-style-type: none"> Maximum of 10 self-referral visits for manipulative therapy of the spine and extremities per calendar year; additional visits available when approved by Kaiser (In-Network) 	85% Aetna Network provider 60% non-Aetna Network provider <ul style="list-style-type: none"> Benefit limited to \$30 per visit PPO providers provide a discount Maximum of 20 visits per calendar year Chiropractic x-rays limited to one set from one chiropractic visit, per calendar year
Podiatry (Excess of the \$20 per visit and 12 visits per calendar year applies only to the Essential Health Benefits OOP maximum-)	85% for preferred providers 60% for non-preferred providers <ul style="list-style-type: none"> Benefit limited to \$20 per visit Maximum of 12 visits per calendar year 	85% for Kaiser (In-Network) Providers 60% for Out of Network Providers <ul style="list-style-type: none"> Routine foot care not covered, except in the presence of a non-related medical condition affecting the lower limbs 	85% Aetna Network provider 60% non-Aetna Network provider <ul style="list-style-type: none"> Benefit limited to \$20 per visit Maximum of 12 visits per calendar year

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Sound Health & Wellness Trust

Comparison of Medical/Prescription Drug/Vision Benefits Effective January 1, 2021

	SoundPlus PPO Plan	SoundPlus Kaiser Permanente Plan	SoundPlus ACO Plan
PPO/ACO.)			
Acupuncture (9 th through the 12 th non-covered visit applies only to the Essential Health Benefits OOP maximum.)	85% for preferred providers 60% for non-preferred providers <ul style="list-style-type: none"> Maximum of 8 visits per calendar year 	85% for Kaiser (In-Network) Providers 60% for Out of Network Providers <ul style="list-style-type: none"> Maximum of 8 self-referral visits per calendar year; additional visits available when approved by Kaiser (In-Network) 	85% Aetna Network provider 60% non-Aetna Network provider <ul style="list-style-type: none"> Maximum of 8 visits per calendar year
Naturopaths (Excess does not apply to OOP maximum)	85% for preferred providers 60% for non-preferred providers <ul style="list-style-type: none"> Maximum of 5 visits per calendar year 	85% for Kaiser (In-Network) Providers 60% for Out of Network Providers Maximum of 5 self-referral visits per calendar year; additional visits available when approved by Kaiser (in Network)	85% Aetna Network provider 60% non-Aetna Network provider <ul style="list-style-type: none"> Maximum of 5 visits per calendar year
Hearing Aid (Excess does not apply to OOP maximum)	85% for preferred providers 60% for non-preferred providers <ul style="list-style-type: none"> Maximum of \$2,000 in any 3 consecutive calendar years for exam and hearing aid Rental charges covered for up to 30 days 	85% for Kaiser (In-Network) Providers 60% for Out of Network Providers for exams to determine hearing loss <ul style="list-style-type: none"> Hearing aids, including hearing aid exams, are covered up to a maximum of \$1,000 per ear, limited to one aid per ear during any 3-year period when authorized by a Kaiser physician (In-Network) or with a physician prescription (Out of Network) 	85% Aetna Network provider 60% non-Aetna Network provider <ul style="list-style-type: none"> Maximum of \$2,000 in any 3 consecutive calendar years for exam and hearing aid Rental charges covered for up to 30 days
Skilled Nursing Facility	85% for preferred providers 60% for non-preferred providers	85% for Kaiser (In-Network) Providers 60% for Out of Network Providers <ul style="list-style-type: none"> Maximum of 60 days per calendar year 	85% ACO Network facility 85% Aetna Network facility 60% non-ACO/non-Aetna Network facility
Home Health Care	100% for preferred providers (no deductible) 60% for non-preferred providers <ul style="list-style-type: none"> Must be in lieu of confinement in hospital or skilled nursing facility 	Covered in full (Out of Network subject to UCR) <ul style="list-style-type: none"> Must be in lieu of confinement in hospital or skilled nursing facility 	100% ACO Network provider (no deductible) 100% Aetna Network provider (no deductible) 60% non-ACO/non-Aetna Network provider <ul style="list-style-type: none"> Must be in lieu of confinement in hospital or skilled nursing facility

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Sound Health & Wellness Trust

Comparison of Medical/Prescription Drug/Vision Benefits Effective January 1, 2021

Hospice	100% for preferred providers (no deductible) 60% for non-preferred providers	Covered in full (Out of Network subject to UCR)	100% ACO Network provider (no deductible) 100% Aetna Network provider (no deductible) 60% non-ACO/non-Aetna Network provider
Transplant Benefit	85% for preferred providers 60% for non-preferred providers Covers only listed procedures	85% for Kaiser (In-Network) Providers 60% for Out of Network Providers	85% ACO Network provider 85% Aetna Network provider 60% non-ACO/non-Aetna Network provider Covers only listed procedures
Rehabilitation			
<ul style="list-style-type: none"> ▪ Outpatient Services 	85% for preferred providers 60% for non-preferred providers Maximum of 45 visits per condition per calendar year for physical, occupational, restorative speech, hand and cardiac therapy combined, including services for neurodevelopmentally disabled children age 6 and under	85% for Kaiser (In-Network) Providers 60% for Out of Network Providers Maximum of 45 visits per condition per calendar year for physical, occupational and restorative speech therapy combined, including services for neurodevelopmentally disabled children age 6 and under	85% ACO Network provider 85% Aetna Network provider 60% non-ACO/non-Aetna Network provider Maximum of 45 visits per condition per calendar year for physical, occupational and restorative speech therapy combined, including services for neurodevelopmentally disabled children age 6 and under
<ul style="list-style-type: none"> ▪ Inpatient Services 	85% for preferred providers 60% for non-preferred providers Maximum of 30 days per condition per calendar year for physical, occupational, restorative speech, hand and cardiac therapy combined, including services for neurodevelopmentally disabled children age 6 and under	85% for Kaiser (In-Network) Providers 60% for Out of Network Providers Maximum of 30 days per condition per calendar year for physical, occupational and restorative speech therapy combined, including services for neurodevelopmentally disabled children age 6 and under	85% ACO Network provider 85% Aetna Network provider 60% non-ACO/non-Aetna Network provider Maximum of 30 days per condition per calendar year for physical, occupational and restorative speech therapy combined, including services for neurodevelopmentally disabled children age 6 and under
Substance Abuse Treatment			
<ul style="list-style-type: none"> ▪ Inpatient 	85% for preferred providers 60% for non-preferred providers	85% for Kaiser (In-Network) Providers 60% for Out of Network Providers 85% for Kaiser (In-Network) Providers	85% Aetna Network provider 60% non-Aetna Network provider

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Sound Health & Wellness Trust

Comparison of Medical/Prescription Drug/Vision Benefits Effective January 1, 2021

	SoundPlus PPO Plan	SoundPlus Kaiser Permanente Plan	SoundPlus ACO Plan
▪ Outpatient	85% for preferred providers 60% for non-preferred providers	60% for Out of Network Providers	85% Aetna Network provider 60% non-Aetna Network provider

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Sound Health & Wellness Trust

Comparison of Medical/Prescription Drug/Vision Benefits Effective January 1, 2021

	SoundPlus PPO Plan	SoundPlus Kaiser Permanente Plan	SoundPlus ACO Plan
Prescription Drug Benefits			
Copays and all prescription drug benefit requirements are the same for both the PPO Plan and the ACO Plan. If you do not identify yourself or dependents as a member of the Sound Health & Wellness Trust to the pharmacist when your prescription is filled, you will be assessed a processing fee in addition to the co-pay. The processing fee for generic is \$10; the processing fee for Brand is \$20. Copays apply only to the Essential Health Benefits OOP maximum. Processing fees do not apply to the OOP maximums.			
Retail (30 day supply)	Purchased at a "Trust Network" Pharmacy – copay per 30-day supply:	Copay per 30-day supply (no deductible):	Purchased at a "Trust Network" Pharmacy – copay per 30-day supply:
Tier 0: Some highly cost-effective medications	\$0 copay	\$0 copay	\$0 copay
<ul style="list-style-type: none"> ▪ Cholesterol Lowering Medications (Simvastatin) ▪ Proton Pump Inhibitors (Omeprazole – generic of Prilosec OTC, with physician Rx) ▪ Non-sedating Antihistamines (Loratadine - generic of Claritin OTC, with physician RX) ▪ Diabetes products (Metformin and lancets) 			
Tier 1: Current Generics, some future generics	\$6 copay	\$6 copay for Generics if on Kaiser formulary	\$6 copay
Tier 2: Most brand drugs, and more costly or less desirable future generics	\$22 copay	\$22 copay for Brand if on Kaiser formulary	\$22 copay
Tier 3: Non-Preferred brand drugs and some undesirable future generics	\$35 copay	\$35 copay if not on Kaiser formulary (Brand or Generic)	\$35 copay
Brand Name Drug with Generic Available: If you fill a prescription for a brand name drug when there is a generic	Generic copay plus the actual difference in cost between the generic and the brand name drug	Generic copay plus the actual difference in cost between the generic and the brand name drug.	Generic copay plus the actual difference in cost between the generic and the brand name drug.

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Sound Health & Wellness Trust

Comparison of Medical/Prescription Drug/Vision Benefits Effective January 1, 2021


	SoundPlus PPO Plan	SoundPlus Kaiser Permanente Plan	SoundPlus ACO Plan
Maintenance “Mail” at Retail ▪ Tier 3 maintenance drugs	Purchased at certain “Trust Network” pharmacies: \$66 for a 90 day supply	Not available	Purchased at certain “Trust Network” pharmacies: \$66 for a 90 day supply
Mail Order ▪ Tier 0 ▪ Tier 1 ▪ Tier 2 ▪ Tier 3 Brand Name Drug with Generic Available	Optional (up to 90 day supply) (copays listed are for a 90 day supply) \$0 copay \$18 copay \$66 copay \$70 copay Generic copay plus the actual difference in cost between the generic and the brand name drug	Optional (90 day supply) (copays listed are for a 90 day supply) ▪ Must use Kaiser Mail Order Program \$0 copay \$18 copay for Generic if on Kaiser formulary \$66 copay for Brand if on Kaiser formulary \$105 copay if not on Kaiser formulary (brand or generic) Generic copay plus the actual difference in cost between the generic and the brand name drug	Optional (90 day supply) (copays listed are for a 90 day supply) \$0 copay \$18 copay \$66 copay \$70 copay Generic copay plus the actual difference in cost between the generic and the brand name drug

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Sound Health & Wellness Trust

Comparison of Medical/Prescription Drug/Vision Benefits Effective January 1, 2021

	SoundPlus PPO Plan	SoundPlus Kaiser Permanente Plan	ACO Plan
Exam	100% at a VSP provider, up to \$50 at a non-VSP provider after a \$10 copay, once each 12 months from last date of service	85% for Kaiser (In-Network) Providers 60% for Out of Network Providers (no deductible), once each 12 consecutive months	100% at a VSP provider, up to \$50 at a non-VSP provider after a \$10 copay, once each 12 months from last date of service
Vision Hardware			100% at a VSP provider, from \$50 to \$125 at a non-VSP provider; depending on the lenses, once each 12 months from last date of service
▪ Lenses	100% at a VSP provider, from \$50 to \$125 at a non-VSP provider; depending on the lenses, once each 12 months from last date of service	 <p>Up to \$200 (no deductible); once each 12 consecutive months</p> <p>(Amounts over \$200 apply to the Essential health Benefits OOP maximum)</p>	
▪ Frames	Up to \$150 allowance at a VSP provider, up to \$70 at a non-VSP provider; once each 24 months from last date of service		Up to \$150 allowance at a VSP provider, up to \$70 at a non-VSP provider; once each 24 months from last date of service
▪ Contact lenses	Up to \$60 copay for contact lens exam (fitting and evaluation) \$130 allowance contact lenses at a VSP provider, up to \$105 at a non-VSP provider; once each 12 months from last date of service (contacts are in lieu of lenses)		Up to \$60 copay for contact lens exam (fitting and evaluation) \$130 allowance contact lenses at a VSP provider, up to \$105 at a non-VSP provider; once each 12 months from last date of service (contacts are in lieu of lenses)

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FURTHER QUESTIONS?

**SoundPlus PPO or ACO Plan
206-282-4500 or 800-225-7620
(Choose member, then option 1)**

**SoundPlus Kaiser Permanente Plan
888-901-4636**

**JEFFERSON HEALTHCARE
EMPLOYEE'S RETIREMENT PLAN
SUMMARY PLAN DESCRIPTION**

October 1, 2017

Prepared by:
Panagiotu Pension Advisors, Inc.

JEFFERSON HEALTHCARE
EMPLOYEE'S RETIREMENT PLAN
SUMMARY PLAN DESCRIPTION

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INTRODUCTION

Jefferson Healthcare (the "Employer") established the Jefferson Healthcare Employee's Retirement Plan (the "Plan") effective October 1, 1991. The Plan was restated effective January 1, 2014. This Summary Plan Description describes the Plan as amended effective September 29, 2017.

This revised Summary Plan Description supersedes all previous Summary Plan Descriptions. Although the purpose of this document is to summarize the more significant provisions of the Plan, the Plan document will prevail in the event of any inconsistency. In addition, the terms of the Plan cannot be modified by written or oral statements made to you by the Plan Administrator or other personnel.

ELIGIBILITY FOR PARTICIPATIONEligible Employee

You are an "Eligible Employee" if you are employed by Jefferson Healthcare or any affiliate who has adopted the Plan. However, you are not an "Eligible Employee" if you are a member of any of the following classes of employees:

For purposes of Nonelective Contributions, any leased employee.

The term "Eligible Employee" will not include: Per Diem and Temporary Employees for all contribution types.

Nonelective Contributions

You will become a Participant with respect to Nonelective Contributions on the a) first day of the first month of the Plan Year or b) first day of the seventh month of the Plan Year coincident with or next following the date you attain age 18 and you complete two (2) Years of Eligibility Service, provided that you are an Eligible Employee on that date.

Computing Service

With respect to eligibility to receive Nonelective Contributions, "Year of Eligibility Service" means an Eligibility Computation Period during which you complete at least 832 hours of service.

"Eligibility Computation Period" means a 12-consecutive month period beginning with your first day of employment. Any succeeding Eligibility Computation Period will then switch to the Plan Year, beginning with the Plan Year that includes your first anniversary of employment. You will generally earn an hour of service for each hour you are paid for the performance of duties for the Employer (however, numerous exceptions and special rules apply).

All eligibility service with the Employer is taken into account.

CONTRIBUTIONS TO THE PLANAccount

"Account" means all of the contributions, of whatever type, made to the Plan for a Participant, including the earnings and losses on those contributions.

Nonelective Contributions

The Employer may, in its sole discretion, make a Nonelective Contribution to the Plan on your behalf. You will be eligible to receive an allocation if you have completed at least one (1) hour of service during the Plan Year.

Nonelective Contributions will be allocated to the Nonelective Contribution Accounts of each Participant eligible to share in such allocations as soon as administratively feasible after the end of each pay period. Any service requirements will be applied pro rata and any last day rule will be applied as of the end of each period selected in the preceding sentence. Such contributions will be allocated in an amount designated by the Employer to be allocated to each eligible Participant.

Rollovers

The Plan may accept a Rollover Contribution made on behalf of any Eligible Employee, regardless of whether such employee has met the age and service requirements of the Plan. An Eligible Employee who has not yet met any of the eligibility requirements of the Plan will be deemed a Participant only with respect to amounts, if any, in his Rollover Contribution Account. In general, any eligible rollover distribution will be accepted by the Plan; however, the Plan Administrator may establish procedures that regulate the method by which Rollover Contributions will be accepted.

Military Service

If you serve in the United States armed forces and must miss work as a result of such service, you may be eligible to receive contributions, benefits and service credit with respect to any qualified military service. In addition, you or your survivors may be eligible to receive contributions, benefits and service credit if you die or become disabled while performing qualified military service.

Limits on Contributions

The amount that may be contributed to the Plan on your behalf in any year is limited to a fixed dollar amount (\$54,000 in 2017). In addition, contributions cannot exceed 100% of your total Compensation.

Compensation

"Compensation" means wages that are shown as taxable wages on your IRS Form W-2. For any self-employed individual, Compensation will mean earned income. Compensation will include wages paid during any period in which you are performing service in the uniformed services while on active duty for a period of more than 30 days that represents all or a portion of the wages you would have received if you were performing service for the Employer. For purposes of Nonelective Contributions, Compensation will also include any amount you elect to defer on a tax-preferred basis to any Employer benefit plan. For purposes of Nonelective Contributions, Compensation will include only that compensation which is actually paid to you by the Employer during that part of the Plan Year that you are eligible to participate in the Plan. Compensation will exclude group term life insurance for all contribution types.

No more than \$270,000 (in 2017) of Compensation may be taken into account in determining your benefits under the Plan.

For purposes of Nonelective Contributions, Compensation will include payments of unused accrued bona fide sick, vacation, or certain other leave that are paid to you after you terminate employment.

VESTING

Rollover Contribution Account and Nonelective Contribution Account

You are always fully (100%) vested in your Rollover Contribution Account and Nonelective Contribution Account.

DISTRIBUTIONS

Commencement of Distributions

Termination of Employment. You are entitled to receive a distribution from your Account after you terminate employment. This includes termination due to Disability. The distribution will start at the time specified in the section titled "Timing and Form of Payment" below.

Late Retirement. If you continue working for the Employer after your Normal Retirement Age, your participation under the Plan will continue, and your benefits will begin following the date you terminate employment. You generally may not begin distributions until the time specified in the section titled "Timing and Form of Payment" below.

Death. If you die, your beneficiary will become entitled to receive your vested Account balance. The distribution will start at the time specified in the section titled "Timing and Form of Payment" below.

Normal Retirement Age

"Normal Retirement Age" means the date you reach age 65.

Timing and Form of Payment

Distribution for Reasons Other Than Death. If you become entitled to receive your benefit for any reason other than death your Account will be distributed in a lump sum payment. This is your normal form of payment. Payment of your vested Account may start as soon as administratively feasible with a final payment made consisting of any allocations occurring after your termination of employment. Your Account is payable in cash or as an in-kind distribution. If you do not choose a form of payment, the payment will be made in the form of a lump sum distribution.

Distribution on Account of Death. If you die before distribution of your Account begins, distribution of your entire Account must be completed by December 31 of the calendar year containing the fifth anniversary of your death.

If the Qualified Preretirement Survivor Annuity has been waived or is not required, as specified below, your beneficiary will be entitled to a distribution in any form that is available to you prior to your death.

If you die after distribution of your Account has begun, the remaining portion of your Account will continue to be distributed under the method of distribution being used prior to your death. If your Account was not being distributed in the form of an annuity at the time of your death, the remaining balance must be distributed by December 31 of the calendar year containing the fifth anniversary of your death.

Beneficiary

You have the right to designate, in a written form acceptable to the Plan Administrator, one or more primary and one or more secondary beneficiaries to receive any benefit becoming payable upon your death. Your spouse must be your sole beneficiary unless he or she consents to the designation of another beneficiary. You may change your beneficiaries at any time and from time to time by filing written notice of such change with the Plan Administrator.

If you fail to designate a beneficiary, or in the event that all designated primary and secondary beneficiaries die before you, the death benefit will be payable to your spouse, or if there is no spouse, to your children in equal shares, or if there are no children to your estate.

IN-SERVICE DISTRIBUTIONS

Hardship Withdrawals

General Rule. You may receive a distribution on account of hardship from the vested portion of all of your Accounts.

Immediate and Heavy Financial Need. You may receive a hardship distribution only if the Plan Administrator finds that you have an immediate and heavy financial need where you lack other available resources. Whether you have an immediate and heavy financial need is to be determined based on all relevant facts and circumstances. The need to pay the funeral expenses of a family member would constitute an immediate and heavy financial need and a distribution to you for the purchase of a boat or television would not constitute a distribution made on account of an immediate and heavy financial need. A financial need may be immediate and heavy even if it was reasonably foreseeable or voluntarily incurred by you.

Amount Necessary to Satisfy Need. A distribution is not treated as necessary to satisfy an immediate and heavy financial need to the extent the amount of the distribution is in excess of the amount required to relieve the financial need or to the extent the need may be satisfied from other resources that are reasonably available to you. This determination generally is to be made on the basis of all relevant facts and circumstances. Your resources are deemed to include those assets of your spouse and minor children that are reasonably available to you. The amount of an immediate and heavy financial need may

include any amounts necessary to pay any federal, state, or local income taxes or penalties reasonably anticipated to result from the distribution. A distribution generally may be treated as necessary to satisfy a financial need if the Plan Administrator relies upon your written representation, unless the Plan Administrator has actual knowledge to the contrary, that the need cannot reasonably be relieved:

- (1) Through reimbursement or compensation by insurance or otherwise;
- (2) By liquidation of your assets;
- (3) By cessation of all your contributions under the Plan; or
- (4) By other distributions or nontaxable (at the time of the loan) loans from plans maintained by the Employer or by any other employer, or by borrowing from commercial sources on reasonable commercial terms, in an amount sufficient to satisfy the need.

Withdrawals at Any Time

You may receive a distribution from your Rollover Contribution Account at any time.

Disability Distributions

If you become Disabled (defined below) while still employed, you may receive a distribution from your Accounts.

Rules Regarding In-service Distributions

The Plan Administrator may establish uniform procedures that include, but are not limited to, prescribing limitations on the frequency and minimum amount of withdrawals. All distributions will be made in the form of a single sum as soon as practicable following the valuation date as of which such withdrawal is made. Such distributions will be paid in cash or in kind. Only Employees are eligible to receive in-service distributions.

Loans

Loans are not permitted.

INVESTMENTS

Participant Self Direction

In General. The Plan Administrator allows you to direct the investment of all of your Accounts. The Plan Administrator may establish uniform guidelines and procedures relating to Participant self-direction.

Investment Elections. You may direct the percentage of your Accounts to be invested in one or more of the available investment funds. Your elections will be subject to such rules and limitations as the Plan Administrator may prescribe. After your death, your beneficiary may make investment elections as if the beneficiary were the Participant. However, the Plan Administrator may restrict investment transfers to the extent required to comply with applicable law.

Investment Decisions. The Plan is intended to constitute a plan described in section 404(c) of ERISA. This means that Plan fiduciaries may be relieved of liability for any of your losses that are the result of your investment elections.

Qualifying Employer Securities

The Trustee may not invest the assets of the trust fund in "qualifying employer securities" or "qualifying employer real property".

Voting Rights

You may not direct the Trustee as to the exercise of voting rights with respect to any Trust Fund Investment.

Valuation Dates

Accounts are valued each business day.

SPECIAL TOP-HEAVY RULES

Minimum Allocations

If the Plan is Top-Heavy, the Employer will generally allocate a minimum of 3% of your Compensation to the Plan if you are a Participant who is (i) employed by the Employer on the last day of the Plan Year and (ii) not a key employee.

Note that if you are covered by a collective bargaining agreement you will not share in Top-Heavy minimum allocations, provided retirement benefits were the subject of good faith bargaining.

Minimum Vesting

If you complete an hour of service while this Plan is Top-Heavy, all of your Accounts will be 100% vested and nonforfeitable.

CLAIM PROCEDURES

Application for Benefits. You or any other person entitled to benefits from the Plan (a "Claimant") may apply for such benefits by completing and filing a claim with the Plan Administrator. Any such claim must be in writing and must include all information and evidence that the Plan Administrator deems necessary to properly evaluate the merit of and to make any necessary determinations on a claim for benefits. The Plan Administrator may request any additional information necessary to evaluate the claim.

Timing of Notice of Denied Claim. The Plan Administrator will notify the Claimant of any adverse benefit determination within a reasonable period of time, but not later than 90 days (45 days if the claim relates to a disability determination) after receipt of the claim. This period may be extended one time by the Plan for up to 90 days (30 additional days if the claim relates to a disability determination), provided that the Plan Administrator both determines that such an extension is necessary due to matters beyond the control of the Plan and notifies the Claimant, prior to the expiration of the initial review period, of the circumstances requiring the extension of time and the date by which the Plan expects to render a decision. If the claim relates to a disability determination, the period for making the determination may be extended for up to an additional 30 days if the Plan Administrator notifies the Claimant prior to the expiration of the first 30-day extension period.

Content of Notice of Denied Claim. If a claim is wholly or partially denied, the Plan Administrator will provide the Claimant with a written notice identifying (1) the reason or reasons for such denial, (2) the pertinent Plan provisions on which the denial is based, (3) any material or information needed to grant the claim and an explanation of why the additional information is necessary, and (4) an explanation of the steps that the Claimant must take if he wishes to appeal the denial including a statement that the Claimant may bring a civil action.

Appeals of Denied Claim. If a Claimant wishes to appeal the denial of a claim, he must file a written appeal with the Plan Administrator on or before the 60th day (180th day if the claim relates to a disability determination) after he receives the Plan Administrator's written notice that the claim has been wholly or partially denied. The written appeal must identify both the grounds and specific Plan provisions upon which the appeal is based. The Claimant will be provided, upon request and free of charge, documents and other information relevant to his claim. A written appeal may also include any comments, statements or documents that the Claimant may desire to provide. The Plan Administrator will consider the merits of the Claimant's written presentations, the merits of any facts or evidence in support of the denial of benefits, and such other facts and circumstances as the Plan Administrator may deem relevant. The Claimant will lose the right to appeal if the appeal is not timely made. The Plan Administrator will ordinarily rule on an appeal within 60 days (45 days if the claim relates to a disability determination). However, if special circumstances require an extension and the Plan Administrator furnishes the

Claimant with a written extension notice during the initial period, the Plan Administrator may take up to 120 days (90 days if the claim relates to a disability determination) to rule on an appeal.

Denial of Appeal. If an appeal is wholly or partially denied, the Plan Administrator will provide the Claimant with a notice identifying (1) the reason or reasons for such denial, (2) the pertinent Plan provisions on which the denial is based, (3) a statement that the Claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the Claimant's claim for benefits, and (4) a statement describing the Claimant's right to bring action. The determination rendered by the Plan Administrator will be binding upon all parties.

Determinations of Disability. If the claim relates to a disability determination, determinations of the Plan Administrator will include the information required under applicable United States Department of Labor regulations.

MISCELLANEOUS

Domestic Relations Orders

Under certain circumstances, a court may issue a domestic relations order assigning a portion of your benefits under the Plan to a spouse, former spouse, child or other dependent. The Plan Administrator will determine whether the order is a qualified domestic relations order ("QDRO"). If the Plan Administrator determines that the order is a QDRO, it will implement the terms of the QDRO and divide your Account accordingly. You may obtain, without charge, a copy of the Plan's QDRO procedures from the Plan Administrator.

Disability

Under this Plan, you are disabled if you have been determined disabled by the Social Security Administration and you are eligible to receive disability benefits under the Social Security Act.

Assignment and Alienation of Benefits

Except as provided below, your Account is held in trust and cannot be assigned and, to the extent permitted by law, is not subject to any form of attachment, garnishment, sequestration or other actions of collection. You may not alienate, anticipate, commute, pledge, encumber or assign any of the benefits or payments which you may expect to receive, contingently or otherwise, under the Plan, except that you may designate a beneficiary.

However, you may lose all or part of your balance:

- pursuant to the terms of a QDRO;
- to comply with any federal tax levy; or
- to comply with the provisions and conditions of a judgment, order, decree or settlement agreement between you and the Secretary of Labor or the Pension Benefit Guaranty Corporation relating to your violation (or alleged violation) of fiduciary responsibilities.

Amendment and Termination

Although the Employer intends to maintain the Plan indefinitely, the Employer may amend or terminate the Plan at any time in its sole discretion. If any of these actions is taken, you will be notified. However, no such action may permit any part of Plan assets to be used for any purpose other than the exclusive benefit of participants and beneficiaries or cause any reduction in your vested Account balance as of the date of the amendment or termination. If the Plan is terminated, all amounts credited to your Account will become 100% vested.

Insurance

The Plan is not insured by the Pension Benefit Guaranty Corporation (PBGC) because it is not a defined benefit pension plan.

Administrator Discretion

The Plan Administrator has the authority to make factual determinations, to construe and interpret the provisions of the Plan, to correct defects and resolve ambiguities in the Plan and to supply omissions to the Plan. Any construction, interpretation or application of the Plan by the Plan Administrator is final, conclusive and binding.

Plan Not a Contract of Employment

The Plan does not constitute, and is not to be deemed to constitute, an employment contract between the Employer and any employee or an inducement or condition of employment of any employee. Nothing in the Plan is to be deemed to give any employee the right to be retained in the Employer's service or to interfere with the Employer's right to discharge any employee at any time.

Waiver

Any failure by the Plan or the Plan Administrator to insist upon compliance with any of the Plan's provisions at any time or under any set of circumstances does not operate to waive or modify the provision or in any other manner render it unenforceable as to any other time or as to any other occurrence, whether the circumstances are the same or different. No waiver of any term or condition of the Plan is valid or of any force or effect unless it is expressed in writing and signed by a person authorized by the Plan Administrator to grant a waiver.

Errors

Any clerical or similar error by the Plan Administrator cannot give coverage under the Plan to any individual who otherwise does not qualify for coverage under the Plan. An error cannot give a benefit to an individual who is not actually entitled to the benefit.

ADMINISTRATIVE INFORMATION

1. The Plan Sponsor and Plan Administrator is Jefferson Healthcare.

Address: 834 Sheridan Street, Port Townsend, Washington 98368-2443
Phone number: 360-385-2200
Employer Identification Number: 91-0928081
2. The Plan is a profit-sharing plan. The Plan number is 002.
3. The Plan's designated agent for service of legal process is the head of the agency named in item 1. Any legal papers should be delivered to such person at the address listed in item 1. However, service may also be made upon the Plan Administrator or a Trustee.
4. The Plan's assets are held in a trust created under the terms of the Plan. The Trustees are Caitlin Harrison, Lawrence Michael Glenn and Hilary Whittington. Their principal place of business is the address listed in item 1.
5. The Employer's fiscal year and the Plan Year end on December 31.
6. If the Plan is established or maintained by two or more employers, you can obtain a complete list of the employers sponsoring the Plan upon written request to the Plan Administrator (this list is also available for examination by participants and beneficiaries); you may also receive from the Plan Administrator, upon written request, information as to whether a particular employer is a sponsor of the Plan and, if the employer is a plan sponsor, the sponsor's address.

Fees Addendum

Your Account may be charged for some or all of the costs and expenses of operating the Plan. Such expenses include the following:

The Plan may charge all Participants for the expenses of receiving a distribution following termination of employment (if applicable to the Participant) in the following manner: \$0 - \$85 per distribution.

The Plan may charge all Participants for the expenses of determining required minimum distributions (if applicable to the Participant) in the following manner: \$0 - \$250 per distribution.

The Plan may charge all Participants for the expenses of receiving a hardship withdrawal (if applicable to the Participant) in the following manner: \$0 - \$150 per distribution.

The Plan may charge all Participants for the expenses of receiving an in-service withdrawal other than hardship (if applicable to the Participant) in the following manner: \$0 - \$150 per distribution.

The Plan may charge all Participants for the expenses of processing a domestic relations order (if applicable to the Participant) in the following manner: \$250 per occurrence.

Fees listed above are subject to change. Please check with the Plan Administrator to be sure you have a current fee listing.

JEFFERSON HEALTHCARE
§457 DEFERRED COMPENSATION PLAN

SUMMARY PLAN DESCRIPTION

OCTOBER 1, 2017

**SUMMARY PLAN DESCRIPTION
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SUMMARY PLAN DESCRIPTION

(1) General. The legal name, address and Federal Employer Identification Number of the Employer are:

Jefferson Healthcare
834 Sheridan Street
Port Townsend, WA 98368-2443

EIN: 91-0928081

The Employer has established a retirement plan (“Plan”) to supplement your income upon retirement. In addition to retirement benefits, the Plan may provide benefits in the event of your death or disability or in the event of your termination of employment prior to normal retirement. If after reading the summary you have any questions, please ask the person identified under Section (4) as the Plan Administrator. We emphasize this summary is a highlight of the more important provisions of the Plan. If there is conflict between a statement in this summary plan description and in the Plan, *the terms of the Plan shall control*.

(2) Identification of Plan.

The Plan is known as **Jefferson Healthcare §457 Deferred Compensation Plan**

The plan year is the period on which the Plan maintains its records: **January 1 through December 31**

(3) Type of Plan.

The Plan is commonly known as a §457 Plan.

Under this Plan, there is no fixed dollar amount of retirement benefits. Your actual retirement benefit will depend on the amount of your account balances at the time of retirement. Your account balances will reflect your own deferral contributions, the period of time you participate in the Plan, and your success in investing and re-investing the assets of your accounts. Furthermore, a governmental agency known as the Pension Benefit Guaranty Corporation (PBGC) insures the benefits payable under plans which provide for fixed and determinable retirement benefits. Because this Plan does not provide a fixed and determinable retirement benefit, the PBGC does not include this Plan within its insurance program.

(4) Plan Administrator. The Employer is the Plan Administrator. You may contact the Employer at the address and phone number listed below.

The Plan Administrator is responsible for providing you and other participants information regarding your rights and benefits under the Plan. The Plan Administrator also has the primary authority for filing the various reports, forms and returns with the Department of Labor and the Internal Revenue Service.

The agent for service of legal process and the address where a processor may serve legal process upon the Plan is:

Jefferson Healthcare
834 Sheridan Street
Port Townsend, WA 98368-2443
Phone: 360-385-2200

A legal processor also may serve the Trustees of the Plan or the Plan Administrator. The Plan Administrator has the responsibility for making all discretionary determinations under the Plan and for giving distribution directions to the Trustees.

(5) Trustee/Trust Fund. The names and address of the Plan's Trustees are:

**L. Michael Glenn
Tyler Freeman
834 Sheridan Street
Port Townsend, WA 98368-2443**

The Trustees are responsible for the administration, management and, subject to participant direction of investment, the investment of this trust fund. The Trustees, upon the direction of the Plan Administrator, will make all distribution and benefit payments from the trust fund to participants and to beneficiaries. The Trustees will maintain trust fund records on a plan year basis: January 1 through December 31.

(6) Eligibility to Participate. If you are a member of a class of employees identified below, you are an excluded employee, and you are not entitled to participate in the Plan. The excluded employees are:

- Per Diem Employees
- Temporary Employees

If you are not an excluded employee, you will become eligible to participate in the Plan once you have completed three (3) months of continuous service, and have attained age 18. However, you will actually enter the Plan on the January 1, April 1, July 1 or October 1 immediately following your satisfaction of the eligibility conditions. In order to make deferral contributions under the Plan, you must complete a salary reduction agreement.

(7) Employee (Deferral) Contributions. As a participant in the §457 arrangement, you may enter into a salary reduction agreement with the Employer. The Plan Administrator will give you a salary reduction agreement form, which will explain your salary reduction options and the effect of your salary reduction agreement. The Employer will withhold from your compensation, in accordance with your salary reduction agreement, the amount you have agreed to have the Employer contribute to the Plan. The Plan refers to the contributions the Employer makes on your behalf, pursuant to your salary reduction agreement, as deferral contributions. The Plan Administrator will allocate the deferral contributions the Employer makes on your behalf to your Deferral Contributions Account.

Your deferral contributions may not exceed, for any calendar year, a specific dollar amount determined by law and published by the Internal Revenue Service as of each January 1. The Plan refers to this specific dollar amount as the 402(g) limitation. The 2017 402(g) limit is \$18,000. If you have attained age 50 by the last day of the calendar year, you may make additional deferral contributions, called “catch-up contributions.” Catch-up contributions are deferral contributions that exceed the 402(g) limitation or another limitation on your deferral contributions for the plan year. The 2017 catch-up contribution limit is \$6,000. These limits may be changed after 2017 for cost-of-living adjustments. Upon your request, the Plan Administrator will provide you the 402(g) dollar limitation and the catch-up limitation in effect for a particular calendar year. If your deferral contributions for a particular calendar year exceed the 402(g) limitation, plus the catch-up limitation if applicable, in effect for that calendar year, the Trustee will refund the excess amount, plus any earnings (or loss) allocated to that excess amount. If you participate in another “401(k) arrangement” or in similar arrangements under which you elect to have an employer contribute on your behalf, your total deferral contributions may not exceed the 402(g) limitation, plus the catch-up limitation if applicable, in effect for that calendar year. The Form W-2 you receive from each employer for the calendar year will report the amount of your deferral contributions for that calendar year under that employer’s plan. If your total exceeds the 402(g) limitation, plus the catch-up limitation, if applicable, in effect for that calendar year you should decide which plan you wish to designate as the plan with the excess amount. If you designate this Plan as holding the excess amount for a calendar year, you must notify the Plan Administrator of that designation by March 1 of the following calendar year. The Trustees then will distribute the excess amount to you, plus earnings (or loss)

allocated to that excess amount.

Compensation. The Plan defines compensation as the total amounts paid to the employee for services rendered to the Employer. With limited exceptions, the Plan includes an employee's compensation only for the part of the plan year in which she/he actually is a participant.

Trust Fund Allocations. The Plan Administrator, in general, will allocate trust fund earnings for the valuation period and trust fund gains and losses to all participants' separate accounts on the basis of each participant's opening account balance for the valuation period less distributions and charges to each participant's account during the valuation period with special accounting for the portion of the trust fund subject to participant direction of investment and for deferral contributions made during the valuation period.

Limitations. The law limits the amount of "additions" (other than trust earnings) which the Plan may allocate to your Accounts under the Plan. Your additions may never exceed 100% of your compensation for a particular plan year, but may be less if 100% of your compensation exceeds a dollar amount announced by the Internal Revenue Service each year. The Plan may need to reduce this limitation if you participate (or have participated) in any other plans maintained by the Employer.

(8) Payment of Benefits after Termination of Employment. After you terminate employment with the Employer, the Trustees will commence distribution to you. If you receive a distribution from the Plan prior to your attaining age 59½, the law, with limited exceptions, imposes a 10% penalty on the amount of the distribution you receive to the extent you must include the distribution in your gross income. You should consult a tax advisor regarding this 10% penalty.

The Plan permits you to elect distribution as of any date following your termination of employment with the Employer. No later than 30 days prior to the date the Trustees expect to make distribution to you, the Plan Administrator will provide you with a notice explaining your right to elect distribution from the Plan and the forms necessary to make your election. If you fail to elect commencement of payment of your vested account balances, the Plan Administrator will direct the Trustees to commence distribution to you no later than the 60th day following the close of the plan year in which the latest of three events occurs:

- (1) Attainment of normal retirement age;
- (2) Your attainment of age 62; or
- (3) Your termination of employment with the Employer.

If you already have attained the later of age 62 or normal retirement age when you terminate employment, the Trustees must make this distribution no later than the 60th day following the close of the plan year in which you terminate employment with the Employer. Normal retirement age under the Plan is age 60.

If you terminate employment with the Employer prior to attaining age 70½, you must commence distribution of your vested account balance by April 1 of the calendar year following the year in which you attain age 70½. These required distribution dates override any contrary distribution dates described in this summary.

Form of Benefit Payment. The Plan will distribute your vested portion, in lump sum, as soon as administratively practicable following your termination of employment.

(9) Payment of Benefits Prior to Termination of Employment. Prior to your termination of employment with the Employer, you may elect to withdraw all or any portion of your Accounts under the Plan if you incur an unforeseeable emergency. An unforeseeable emergency is a severe financial hardship of a Participant or

Beneficiary resulting from:

- (1) Illness or accident of the Participant, the Beneficiary, or the Participant's or Beneficiary's spouse or dependent (as defined in Code §152(a));
- (2) Loss of the Participant's or Beneficiary's property due to casualty;
- (3) The need to pay for the funeral expenses of the Participant's or Beneficiary's spouse or dependent (as defined in Code §152(a)); or
- (4) Other similar extraordinary and unforeseeable circumstances arising from events beyond the Participant's or Beneficiary's control.

The Plan Administrator will not pay the Participant or the Beneficiary more than the amount reasonably necessary to satisfy the emergency need, which may include amounts necessary to pay taxes or penalties on the distribution. The Plan Administrator will not make payment to the extent the Participant or Beneficiary may relieve the financial hardship by cessation of deferrals under the Plan, through insurance or other reimbursement, or by liquidation of the individual's assets to the extent such liquidation would not cause severe financial hardship.

(10) Disability Benefits. If you terminate employment because of disability, the Trustee will pay your vested account balances to you in the same manner as if you had terminated employment without disability, subject to the election, consent and mandatory distribution requirements. In general, disability under the Plan means because of a physical or mental disability you are unable to perform the duties of your customary position of employment for an indefinite period which, in the opinion of the Plan Administrator, will be of long continued duration. The Plan Administrator also will consider you disabled if you terminate employment because of a permanent loss or loss of use of a member or function of your body or a permanent disfigurement. The Plan Administrator may require a physical examination in order to confirm the disability.

(11) Payment of Benefits upon Death. If you die prior to receiving all of your benefits under the Plan, the Trustees will pay the balance of your accounts to your beneficiary. If the Employer permits the Trustees to purchase life insurance on your life with a portion of your account balances, your account balances also will receive any life insurance proceeds payable by reason of your death.

The Trustees will pay your vested account balances remaining in the Plan at the time of your death to your designated beneficiary. The Plan Administrator will provide you with an appropriate form for naming a beneficiary. If you are married, your spouse must consent to the designation of any nonspouse beneficiary. If the vested portion of your account balances does not exceed \$5,000 (disregarding any rollover contributions), the Trustees will pay the benefit, in lump sum, to your designated beneficiary as soon as administratively practicable after your death. If the vested portion of your account exceeds \$5,000 (disregarding any rollover contributions), the Trustees will pay the benefit to your designated beneficiary, in the form and at the time elected by the beneficiary, unless you made a distribution election prior to your death. The benefit payment election generally must complete distribution of your vested account balances within five years of your death, unless distribution commences within one year of your death to your designated beneficiary or unless benefits had commenced prior to your death.

(12) Qualified Domestic Relations Order (“QDRO”) Procedure. Under some circumstances, a qualified domestic relations order (“QDRO”) entered pursuant to a state domestic relations law may direct the Plan Administrator to pay some or all of your vested account balances to a spouse, former spouse, child or other dependent for child support, alimony payments or marital property rights. The Plan has established a procedure for processing QDROs. You may obtain, without charge, a copy of the QDRO procedure from the Plan Administrator.

(13) Claims Procedure. You need not file a formal claim with the Plan Administrator in order to receive

your benefits under the Plan. When an event occurs which entitles you to a distribution of your benefits under the Plan, the Plan Administrator automatically will notify you regarding the distribution of your benefits. However, if you disagree with the Plan Administrator's determination of the amount of your benefits under the Plan or with respect to any other decision the Plan Administrator may make regarding your interest in the Plan, the Plan contains the appeal procedure you should follow. In brief, if the Plan Administrator of the Plan determines it should deny benefits to you or to your beneficiary making a claim for benefits, the Plan Administrator will give you or your beneficiary adequate notice in writing setting forth specific reasons for the denial and referring you or your beneficiary to the pertinent provisions of the Plan supporting the Plan Administrator's decision. If you or your beneficiary disagrees with the Plan Administrator, you or your beneficiary, or a duly authorized representative, must appeal the adverse determination in writing to the Plan Administrator within 75 days after the receipt of the notice of denial of benefits, except that if your entitlement to or amount of benefits involves a claim of your disability, you must appeal the adverse determination in writing to the Plan Administrator within 180 days (rather than 75 days) after the receipt of the notice of denial of benefits. If you or your beneficiary fails to appeal a denial within the 75-day period (180-days period in case of a disability benefit claim), the Plan Administrator's determination will be final and binding.

If you or your beneficiary appeals to the Plan Administrator, you, or your duly authorized representative, must submit the issues and comments you feel are pertinent to permit the Plan Administrator to re-examine all facts and make a final determination with respect to the denial. The Plan Administrator, in most cases, will make a decision within 60 days of a request on appeal unless special circumstances would make the rendering of a decision within the 60-day period unfeasible, except that if your entitlement to or amount of benefits involves a claim of your disability, the 60-day period becomes a 45-day period. In any event, the Plan Administrator must render a decision within 120 days (90 days in case of a disability benefit claim) after its receipt of a request for review.

(14) Retired Participant, Separated Participant with Vested Benefit, Beneficiary Receiving Benefits.

If you are a retired participant or beneficiary receiving benefits, the benefits you presently are receiving will continue in the same amount and for the same period provided in the mode of settlement selected at retirement. If you are a separated participant with a vested benefit, you may obtain a statement of the dollar amount of your vested benefit upon request to the Plan Administrator. There is no Plan provision which reduces, changes, terminates, forfeits, or suspends the benefits of a retired participant, a beneficiary receiving benefits or a separated participant's vested benefit amount.

(15) Federal Income Taxation of Benefits Paid. Existing Federal income tax laws do not require you to report currently as income amounts the Employer contributes to the Plan and which the Plan Administrator allocates to your accounts. When the Trustee ultimately distributes your account balances to you, such as upon your retirement, you must report as income the Plan distributions you receive. However, it may be possible for you to defer Federal income taxation of a distribution by making a "rollover" contribution to your own individual retirement account ("IRA") or to another retirement plan.

Mandatory income tax withholding rules apply to some distributions you do not rollover directly to an individual retirement account or to another qualified plan. At the time you receive a distribution, you also will receive a notice explaining the withholding requirements and the options available to you. We emphasize you should consult your own tax adviser with respect to the proper method of reporting any distribution you receive from the Plan.

(16) Participant Direction of Investment. The Plan permits every participant to direct the investment of his/her account balances under the Plan. For this purpose, the Plan Administrator will provide you a form for making your investment direction. The investment direction form explains your investment direction options and explains the frequency with which you may change your investment direction. The Trustees will invest your account balances under the Plan in accordance with your written direction.



Origination 01/2014
Last Approved 12/2021
Last Revised 12/2021
Next Review 12/2022

Owner [Heather Bailey:
Interim Chief of
Human
Resources](#)
Policy Area [Human
Resources
Policies](#)

Employee Benefits

PURPOSE:

To provide employees a competitive total compensation and benefit package.

POLICY:

Benefit participation is subject to plan requirements. Some benefits are available to all employees; others are available only to regular part time and full time employees.

PROCEDURE:

Regular Full-Time and Part-Time (.4FTE and above) employees are eligible for the following benefits:

- Employee Assistance Program
- Cafeteria Discount of 10%
- Free Use of Rehab Exercise Equipment
- Workers Compensation
- Wage Differential in Lieu of Full Benefit Package

Per Diem, Temporary, and Part-Time (below .4FTE) employees are eligible for the following benefits:

- Employee Assistance Program
- Cafeteria Discount of 10%
- Free Use of Rehab Exercise Equipment
- Workers Compensation
- Wage Differential in Lieu of Full Benefit Package

457 RETIREMENT PROGRAM: Eligible full time and regular part time employees are eligible to participate in the deferred compensation program **the first day of the month following date of hire.** You select from multiple fund choices how you want your contribution invested. You can defer up to **19,500** per year; if you are 50 or older during the calendar year, you can defer **26,000**. If you plan to contribute the maximum amount to your 457, you may opt to contribute to the 457(f) plan. When you are age 57 or older, you may be able to defer up to twice the allowable amount under the 3-year rule.

EMPLOYER SPONSORED RETIREMENT PROGRAM (ERPS): After two years of employment, if you are over 18 and have worked at least 832 hours during two consecutive years of employment, you will begin participation in the employer-sponsored retirement program. Participation begins in January or July following two years of employment. The hospital contributes the equivalent of 5% of your earnings into your account. You select from multiple fund choices how you want your contribution invested. This plan is 100% vested upon opening.

ENROLLMENT:

At time of hire, or when transferring to a benefit eligible position, the Human Resources Department provides employees with the appropriate benefit packet of information.

Eligible (regular full-time and part-time) employees are auto-enrolled into the default SoundPlus Healthcare plan by Sound Health & Wellness Trust on the 1st of the 4th month of service. Eligible dependents may only be added on during the initial enrollment, the annual open enrollment, or during a qualifying life event. See plan document for full details.

For healthcare, Sound Health & Wellness Trust will mail enrollment forms to the employee's address on file. The enrollment forms and supporting documentation must be completed and returned to Sound Health & Wellness Trust by the due date provided by Sound Health & Wellness Trust.

Benefits for regular full-time and part-time employees generally include:

- Medical
- Dental
- Vision
- Prescription
- Life Insurance
- Short Term Disability
- Pension Program for hospital bargaining unit RNs funded payroll deductions
- 457-Deferred Retirement Plan
- 401a Hospital Funded Retirement Plan
- Paid Time Off
- Paid Sick Leave
- Flexible Spending Accounts offered through American Fidelity
- Additional self-pay insurance benefits offered through American Fidelity (Life, cancer, accident,

disability & critical illness)

- Enhanced Benefit Program for medical coverage while using Jefferson Healthcare services and providers

Official Plan Documents control benefits and eligibility for benefits. Specific benefit questions should be addressed directly with the appropriate plan provider. Booklets and contact information is available in Human Resources. Contact information is also available on the Intranet at the HR Home Page.

OTHER BENEFITS AVAILABLE TO JEFFERSON HEALTHCARE EMPLOYEES:

- Payroll deduction for purchases of over \$20 offered at Gift Shop.
- Longevity Recognition Program begins at 5 years of employment and employees are recognized every five years at a recognition ceremony. Recognized employees receive a pin and Jefferson Healthcare commemorative certificate. Employees who've achieved the 10 and 15 year milestone will receive a \$50 bonus, and employees with 20+ years in service will receive a \$100 cash bonus in their paycheck.
- Referral Bonus Program when you refer an applicant we hire and they successfully complete their probationary period you are eligible for a referral bonus as per the referral program documents. See Referral Bonus Policy for additional details.

EXTERNAL DISCOUNTS:

The below local businesses offer discounted services and products when showing your employee ID.

- Evergreen Fitness and Port Townsend Athletic Club - reduced monthly membership
- The Car Wash - discounted services
- PT Cyclery - 10% off bikes, 20% accessory or parts
- Howell's Sandwich Company offers 10% off
- Courtyard Cafe offers 10% off

REFERENCED DOCUMENTS:

None.

Reference Type	Title	Notes
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Approval Signatures

Step Description

Approver

Date

Caitlin Harrison: CHRO

12/2021

2023 PAYROLL CALENDAR

January							February							March							April						
S	M	T	W	T	F	S	S	M	T	W	T	F	S	S	M	T	W	T	F	S	S	M	T	W	T	F	S
1	2	3	4	5	6	7				1	2	3	4				1	2	3	4							1
8	9	10	11	12	13	14	5	6	7	8	9	10	11	5	6	7	8	9	10	11	2	3	4	5	6	7	8
15	16	17	18	19	20	21	12	13	14	15	16	17	18	12	13	14	15	16	17	18	9	10	11	12	13	14	15
22	23	24	25	26	27	28	19	20	21	22	23	24	25	19	20	21	22	23	24	25	16	17	18	19	20	21	22
29	30	31					26	27	28					26	27	28	29	30	31		23	24	25	26	27	28	29
																					30						

May							June							July							August						
S	M	T	W	T	F	S	S	M	T	W	T	F	S	S	M	T	W	T	F	S	S	M	T	W	T	F	S
	1	2	3	4	5	6					1	2	3							1			1	2	3	4	5
7	8	9	10	11	12	13	4	5	6	7	8	9	10	2	3	4	5	6	7	8	6	7	8	9	10	11	12
14	15	16	17	18	19	20	11	12	13	14	15	16	17	9	10	11	12	13	14	15	13	14	15	16	17	18	19
21	22	23	24	25	26	27	18	19	20	21	22	23	24	16	17	18	19	20	21	22	20	21	22	23	24	25	26
28	29	30	31				25	26	27	28	29	30		23	24	25	26	27	28	29	27	28	29	30	31		
														30	31												

September							October							November							December						
S	M	T	W	T	F	S	S	M	T	W	T	F	S	S	M	T	W	T	F	S	S	M	T	W	T	F	S
					1	2	1	2	3	4	5	6	7				1	2	3	4						1	2
3	4	5	6	7	8	9	8	9	10	11	12	13	14	5	6	7	8	9	10	11	3	4	5	6	7	8	9
10	11	12	13	14	15	16	15	16	17	18	19	20	21	12	13	14	15	16	17	18	10	11	12	13	14	15	16
17	18	19	20	21	22	23	22	23	24	25	26	27	28	19	20	21	22	23	24	25	17	18	19	20	21	22	23
24	25	26	27	28	29	30	29	30	31					26	27	28	29	30			24	25	26	27	28	29	30
																					31						

Pay Dates are in GREEN
 Beginning of Pay Period are in BLUE
 End of Pay Period are in RED