

<b>Form 5500</b>  Department of the Treasury Internal Revenue Service  Department of Labor Employee Benefits Security Administration  Pension Benefit Guaranty Corporation	<b>Annual Return/Report of Employee Benefit Plan</b> This form is required to be filed for employee benefit plans under sections 104 and 4065 of the Employee Retirement Income Security Act of 1974 (ERISA) and sections 6057(b) and 6058(a) of the Internal Revenue Code (the Code).  <p style="text-align: center;">▶ <b>Complete all entries in accordance with the instructions to the Form 5500.</b></p>	OMB Nos. 1210-0110 1210-0089  <b>2021</b>  <b>This Form is Open to Public Inspection</b>
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<b>Part I</b>	<b>Annual Report Identification Information</b>
For calendar plan year 2021 or fiscal plan year beginning <u>01/01/2021</u> and ending <u>12/31/2021</u>	
<b>A</b> This return/report is for:	<input type="checkbox"/> a multiemployer plan <input type="checkbox"/> a multiple-employer plan (Filers checking this box must attach a list of participating employer information in accordance with the form instructions.) <input checked="" type="checkbox"/> a single-employer plan <input type="checkbox"/> a DFE (specify) _____
<b>B</b> This return/report is:	<input checked="" type="checkbox"/> the first return/report <input type="checkbox"/> the final return/report <input type="checkbox"/> an amended return/report <input type="checkbox"/> a short plan year return/report (less than 12 months)
<b>C</b> If the plan is a collectively-bargained plan, check here. . . . .	<input type="checkbox"/>
<b>D</b> Check box if filing under:	<input type="checkbox"/> Form 5558 <input type="checkbox"/> automatic extension <input type="checkbox"/> the DFVC program <input type="checkbox"/> special extension (enter description)
<b>E</b> If this is a retroactively adopted plan permitted by SECURE Act section 201, check here. . . . .	<input type="checkbox"/>

<b>Part II</b>	<b>Basic Plan Information—enter all requested information</b>				
<b>1a</b> Name of plan <u>MARY'S PLACE HEALTH PLAN</u>	<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 80%;"><b>1b</b> Three-digit plan number (PN) ▶</td> <td style="width: 20%; text-align: center;"><u>501</u></td> </tr> <tr> <td colspan="2"><b>1c</b> Effective date of plan <u>12/01/2020</u></td> </tr> </table>	<b>1b</b> Three-digit plan number (PN) ▶	<u>501</u>	<b>1c</b> Effective date of plan <u>12/01/2020</u>	
<b>1b</b> Three-digit plan number (PN) ▶	<u>501</u>				
<b>1c</b> Effective date of plan <u>12/01/2020</u>					
<b>2a</b> Plan sponsor's name (employer, if for a single-employer plan) Mailing address (include room, apt., suite no. and street, or P.O. Box) City or town, state or province, country, and ZIP or foreign postal code (if foreign, see instructions) <u>MARY'S PLACE</u>  <u>PO BOX 1711</u> <u>113 DEXTER AVE N</u> <u>SEATTLE, WA 98111-1711</u> <u>SEATTLE, WA 98109</u>	<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td><b>2b</b> Employer Identification Number (EIN) <u>27-2087950</u></td> </tr> <tr> <td><b>2c</b> Plan Sponsor's telephone number <u>206-621-8474</u></td> </tr> <tr> <td><b>2d</b> Business code (see instructions) <u>624200</u></td> </tr> </table>	<b>2b</b> Employer Identification Number (EIN) <u>27-2087950</u>	<b>2c</b> Plan Sponsor's telephone number <u>206-621-8474</u>	<b>2d</b> Business code (see instructions) <u>624200</u>	
<b>2b</b> Employer Identification Number (EIN) <u>27-2087950</u>					
<b>2c</b> Plan Sponsor's telephone number <u>206-621-8474</u>					
<b>2d</b> Business code (see instructions) <u>624200</u>					

**Caution: A penalty for the late or incomplete filing of this return/report will be assessed unless reasonable cause is established.**

Under penalties of perjury and other penalties set forth in the instructions, I declare that I have examined this return/report, including accompanying schedules, statements and attachments, as well as the electronic version of this return/report, and to the best of my knowledge and belief, it is true, correct, and complete.

<b>SIGN HERE</b>	Filed with authorized/valid electronic signature.	06/30/2022	MIKE KOMOLA
	Signature of plan administrator	Date	Enter name of individual signing as plan administrator
<b>SIGN HERE</b>	Filed with authorized/valid electronic signature.	06/30/2022	MIKE KOMOLA
	Signature of employer/plan sponsor	Date	Enter name of individual signing as employer or plan sponsor
<b>SIGN HERE</b>			
	Signature of DFE	Date	Enter name of individual signing as DFE

For Paperwork Reduction Act Notice, see the Instructions for Form 5500.

Form 5500 (2021)  
v. 210624

<b>3a</b> Plan administrator's name and address <input checked="" type="checkbox"/> Same as Plan Sponsor	<b>3b</b> Administrator's EIN  <b>3c</b> Administrator's telephone number  <div style="background-color: #cccccc; height: 40px; width: 100%;"></div>
<b>4</b> If the name and/or EIN of the plan sponsor or the plan name has changed since the last return/report filed for this plan, enter the plan sponsor's name, EIN, the plan name and the plan number from the last return/report: <b>a</b> Sponsor's name <b>c</b> Plan Name	<b>4b</b> EIN  <b>4d</b> PN
<b>5</b> Total number of participants at the beginning of the plan year	<b>5</b> 80
<b>6</b> Number of participants as of the end of the plan year unless otherwise stated (welfare plans complete only lines <b>6a(1)</b> , <b>6a(2)</b> , <b>6b</b> , <b>6c</b> , and <b>6d</b> ).  <b>a(1)</b> Total number of active participants at the beginning of the plan year..... <b>a(2)</b> Total number of active participants at the end of the plan year .....  <b>b</b> Retired or separated participants receiving benefits..... <b>c</b> Other retired or separated participants entitled to future benefits ..... <b>d</b> Subtotal. Add lines <b>6a(2)</b> , <b>6b</b> , and <b>6c</b> ..... <b>e</b> Deceased participants whose beneficiaries are receiving or are entitled to receive benefits. .... <b>f</b> Total. Add lines <b>6d</b> and <b>6e</b> .....  <b>g</b> Number of participants with account balances as of the end of the plan year (only defined contribution plans complete this item) .....  <b>h</b> Number of participants who terminated employment during the plan year with accrued benefits that were less than 100% vested .....	<b>6a(1)</b> 80 <b>6a(2)</b> 80 <b>6b</b> <b>6c</b> <b>6d</b> 80 <b>6e</b> <b>6f</b> 80 <b>6g</b> <b>6h</b>
<b>7</b> Enter the total number of employers obligated to contribute to the plan (only multiemployer plans complete this item).....	<b>7</b>
<b>8a</b> If the plan provides pension benefits, enter the applicable pension feature codes from the List of Plan Characteristics Codes in the instructions:  <b>b</b> If the plan provides welfare benefits, enter the applicable welfare feature codes from the List of Plan Characteristics Codes in the instructions:  4A	

<b>9a</b> Plan funding arrangement (check all that apply) <b>(1)</b> <input checked="" type="checkbox"/> Insurance <b>(2)</b> <input type="checkbox"/> Code section 412(e)(3) insurance contracts <b>(3)</b> <input type="checkbox"/> Trust <b>(4)</b> <input type="checkbox"/> General assets of the sponsor	<b>9b</b> Plan benefit arrangement (check all that apply) <b>(1)</b> <input checked="" type="checkbox"/> Insurance <b>(2)</b> <input type="checkbox"/> Code section 412(e)(3) insurance contracts <b>(3)</b> <input type="checkbox"/> Trust <b>(4)</b> <input type="checkbox"/> General assets of the sponsor
<b>10</b> Check all applicable boxes in 10a and 10b to indicate which schedules are attached, and, where indicated, enter the number attached. (See instructions)	
<b>a Pension Schedules</b> <b>(1)</b> <input type="checkbox"/> <b>R</b> (Retirement Plan Information)  <b>(2)</b> <input type="checkbox"/> <b>MB</b> (Multiemployer Defined Benefit Plan and Certain Money Purchase Plan Actuarial Information) - signed by the plan actuary  <b>(3)</b> <input type="checkbox"/> <b>SB</b> (Single-Employer Defined Benefit Plan Actuarial Information) - signed by the plan actuary	<b>b General Schedules</b> <b>(1)</b> <input type="checkbox"/> <b>H</b> (Financial Information) <b>(2)</b> <input type="checkbox"/> <b>I</b> (Financial Information – Small Plan) <b>(3)</b> <input checked="" type="checkbox"/> <u>1</u> <b>A</b> (Insurance Information) <b>(4)</b> <input type="checkbox"/> <b>C</b> (Service Provider Information) <b>(5)</b> <input type="checkbox"/> <b>D</b> (DFE/Participating Plan Information) <b>(6)</b> <input type="checkbox"/> <b>G</b> (Financial Transaction Schedules)

**Part III Form M-1 Compliance Information (to be completed by welfare benefit plans)**

**11a** If the plan provides welfare benefits, was the plan subject to the Form M-1 filing requirements during the plan year? (See instructions and 29 CFR 2520.101-2.) ..... ☐ Yes ☒ No

If "Yes" is checked, complete lines 11b and 11c.

**11b** Is the plan currently in compliance with the Form M-1 filing requirements? (See instructions and 29 CFR 2520.101-2.) ..... ☐ Yes ☐ No

**11c** Enter the Receipt Confirmation Code for the 2021 Form M-1 annual report. If the plan was not required to file the 2021 Form M-1 annual report, enter the Receipt Confirmation Code for the most recent Form M-1 that was required to be filed under the Form M-1 filing requirements. (Failure to enter a valid Receipt Confirmation Code will subject the Form 5500 filing to rejection as incomplete.)

Receipt Confirmation Code \_\_\_\_\_

<div><div><b>SCHEDULE A</b></div><div><b>(Form 5500)</b></div><div>Department of the Treasury Internal Revenue Service</div><div>Department of Labor Employee Benefits Security Administration</div><div>Pension Benefit Guaranty Corporation</div></div>	<div><b>Insurance Information</b></div> <div>This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA).</div> <div>▶ <b>File as an attachment to Form 5500.</b></div> <div>▶ Insurance companies are required to provide the information pursuant to ERISA section 103(a)(2).</div>	<div>OMB No. 1210-0110</div> <div><b>2021</b></div> <div><b>This Form is Open to Public Inspection</b></div>
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For calendar plan year 2021 or fiscal plan year beginning 12/01/2020 and ending 11/30/2021	
<b>A</b> Name of plan MARY'S PLACE HEALTH PLAN	<b>B</b> Three-digit plan number (PN) ▶ 501
<b>C</b> Plan sponsor's name as shown on line 2a of Form 5500 MARY'S PLACE	<b>D</b> Employer Identification Number (EIN) 27-2087950

<b>Part I</b>	<b>Information Concerning Insurance Contract Coverage, Fees, and Commissions</b> Provide information for each contract on a separate Schedule A. Individual contracts grouped as a unit in Parts II and III can be reported on a single Schedule A.
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**1** Coverage Information:

**(a)** Name of insurance carrier  
KAISER FOUNDATION HEALTH PLAN OF WASHINGTON

(b) EIN	(c) NAIC code	(d) Contract or identification number	(e) Approximate number of persons covered at end of policy or contract year	Policy or contract year	
				(f) From	(g) To
91-0511770	95672	1476700	80	12/01/2020	11/30/2021

**2** Insurance fee and commission information. Enter the total fees and total commissions paid. List in line 3 the agents, brokers, and other persons in descending order of the amount paid.

<b>(a)</b> Total amount of commissions paid 11702	<b>(b)</b> Total amount of fees paid 0
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**3** Persons receiving commissions and fees. (Complete as many entries as needed to report all persons).

**(a)** Name and address of the agent, broker, or other person to whom commissions or fees were paid

(b) Amount of sales and base commissions paid	Fees and other commissions paid		(e) Organization code
	(c) Amount	(d) Purpose	

**(a)** Name and address of the agent, broker, or other person to whom commissions or fees were paid

(b) Amount of sales and base commissions paid	Fees and other commissions paid		(e) Organization code
	(c) Amount	(d) Purpose	

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**(a)** Name and address of the agent, broker, or other person to whom commissions or fees were paid

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<b>(b)</b> Amount of sales and base commissions paid	Fees and other commissions paid		<b>(e)</b> Organization code
	<b>(c)</b> Amount	<b>(d)</b> Purpose	

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**(a)** Name and address of the agent, broker, or other person to whom commissions or fees were paid

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<b>(b)</b> Amount of sales and base commissions paid	Fees and other commissions paid		<b>(e)</b> Organization code
	<b>(c)</b> Amount	<b>(d)</b> Purpose	

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**(a)** Name and address of the agent, broker, or other person to whom commissions or fees were paid

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<b>(b)</b> Amount of sales and base commissions paid	Fees and other commissions paid		<b>(e)</b> Organization code
	<b>(c)</b> Amount	<b>(d)</b> Purpose	

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**(a)** Name and address of the agent, broker, or other person to whom commissions or fees were paid

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<b>(b)</b> Amount of sales and base commissions paid	Fees and other commissions paid		<b>(e)</b> Organization code
	<b>(c)</b> Amount	<b>(d)</b> Purpose	

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**(a)** Name and address of the agent, broker, or other person to whom commissions or fees were paid

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<b>(b)</b> Amount of sales and base commissions paid	Fees and other commissions paid		<b>(e)</b> Organization code
	<b>(c)</b> Amount	<b>(d)</b> Purpose	

**Part II Investment and Annuity Contract Information**

Where individual contracts are provided, the entire group of such individual contracts with each carrier may be treated as a unit for purposes of this report.

**4** Current value of plan's interest under this contract in the general account at year end ..... **4****5** Current value of plan's interest under this contract in separate accounts at year end..... **5****6** Contracts With Allocated Funds:**a** State the basis of premium rates ▶**b** Premiums paid to carrier ..... **6b****c** Premiums due but unpaid at the end of the year ..... **6c****d** If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or retention of the contract or policy, enter amount. .... **6d**  
Specify nature of costs ▶**e** Type of contract: (1) ☐ individual policies (2) ☐ group deferred annuity(3) ☐ other (specify) ▶**f** If contract purchased, in whole or in part, to distribute benefits from a terminating plan, check here ☐**7** Contracts With Unallocated Funds (Do not include portions of these contracts maintained in separate accounts)**a** Type of contract: (1) ☐ deposit administration (2) ☐ immediate participation guarantee(3) ☐ guaranteed investment (4) ☐ other ▶**b** Balance at the end of the previous year ..... **7b****c** Additions: (1) Contributions deposited during the year ..... **7c(1)**(2) Dividends and credits..... **7c(2)**(3) Interest credited during the year..... **7c(3)**(4) Transferred from separate account..... **7c(4)**(5) Other (specify below) ..... **7c(5)**

▶

(6) Total additions ..... **7c(6)****d** Total of balance and additions (add lines **7b** and **7c(6)**) ..... **7d****e** Deductions:(1) Disbursed from fund to pay benefits or purchase annuities during year ..... **7e(1)**(2) Administration charge made by carrier..... **7e(2)**(3) Transferred to separate account..... **7e(3)**(4) Other (specify below) ..... **7e(4)**

▶

(5) Total deductions ..... **7e(5)****f** Balance at the end of the current year (subtract line **7e(5)** from line **7d**) ..... **7f**

**Part III Welfare Benefit Contract Information**

If more than one contract covers the same group of employees of the same employer(s) or members of the same employee organizations(s), the information may be combined for reporting purposes if such contracts are experience-rated as a unit. Where contracts cover individual employees, the entire group of such individual contracts with each carrier may be treated as a unit for purposes of this report.

**8** Benefit and contract type (check all applicable boxes)

- a** ☐ Health (other than dental or vision)     
**b** ☐ Dental     
**c** ☐ Vision     
**d** ☐ Life insurance  
**e** ☐ Temporary disability (accident and sickness)     
**f** ☐ Long-term disability     
**g** ☐ Supplemental unemployment     
**h** ☐ Prescription drug  
**i** ☐ Stop loss (large deductible)     
**j** ☐ HMO contract     
**k** ☐ PPO contract     
**l** ☐ Indemnity contract  
**m** ☐ Other (specify) ▶

**9** Experience-rated contracts:

<b>a</b> Premiums: (1) Amount received .....	<b>9a(1)</b>		
(2) Increase (decrease) in amount due but unpaid .....	<b>9a(2)</b>		
(3) Increase (decrease) in unearned premium reserve .....	<b>9a(3)</b>		
(4) Earned ((1) + (2) - (3)) .....		<b>9a(4)</b>	
<b>b</b> Benefit charges (1) Claims paid .....	<b>9b(1)</b>		
(2) Increase (decrease) in claim reserves .....	<b>9b(2)</b>		
(3) Incurred claims (add (1) and (2)) .....		<b>9b(3)</b>	
(4) Claims charged .....		<b>9b(4)</b>	
<b>c</b> Remainder of premium: (1) Retention charges (on an accrual basis) --			
(A) Commissions .....	<b>9c(1)(A)</b>		
(B) Administrative service or other fees .....	<b>9c(1)(B)</b>		
(C) Other specific acquisition costs .....	<b>9c(1)(C)</b>		
(D) Other expenses .....	<b>9c(1)(D)</b>		
(E) Taxes .....	<b>9c(1)(E)</b>		
(F) Charges for risks or other contingencies .....	<b>9c(1)(F)</b>		
(G) Other retention charges .....	<b>9c(1)(G)</b>		
(H) Total retention .....		<b>9c(1)(H)</b>	
(2) Dividends or retroactive rate refunds. (These amounts were <input type="checkbox"/> paid in cash, or <input type="checkbox"/> credited.) .....		<b>9c(2)</b>	
<b>d</b> Status of policyholder reserves at end of year: (1) Amount held to provide benefits after retirement .....		<b>9d(1)</b>	
(2) Claim reserves .....		<b>9d(2)</b>	
(3) Other reserves .....		<b>9d(3)</b>	
<b>e</b> Dividends or retroactive rate refunds due. (Do not include amount entered in line 9c(2).) .....		<b>9e</b>	

**10** Nonexperience-rated contracts:

<b>a</b> Total premiums or subscription charges paid to carrier .....	<b>10a</b>	
<b>b</b> If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or retention of the contract or policy, other than reported in Part I, line 2 above, report amount. .... Specify nature of costs.	<b>10b</b>	

**Part IV Provision of Information**

**11** Did the insurance company fail to provide any information necessary to complete Schedule A? ..... ☐ Yes ☐ No

**12** If the answer to line 11 is "Yes," specify the information not provided. ▶

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Name of Plan: Core  
Name of Insurance Carrier: Kaiser Foundation Health Plan of Washington  
Employer Identification Number (EIN): 91-0511770  
NAIC #: 95672

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KRISTI TOLLNER  
MARY'S PLACE SEATTLE  
113 DEXTER AVE N  
SEATTLE, WA 98109

RE: Schedule A/Form 5500 information regarding the group(s) referenced below:

**Name of Plan Sponsor:**  
MARY'S PLACE SEATTLE

**Contract or Identification Number:**  
1476700

**Approximate number of persons covered  
at beginning of policy or contract year  
(List employees and dependents)**

88 employees and 4 dependents

**Approximate number of persons covered  
at ending of policy or contract year (List  
employees and dependents)**

80 employees and 3 dependents

**Policy or contract year:**  
12/1/2020 - 11/30/2021

**Type of benefit:**  
Medical Insurance

**Premiums due and unpaid at end of plan  
year:**

**Non-Experience Rated contract. Total  
premiums paid to carrier:**  
\$466,094.07

**Name and address of agent(s) or broker(s)  
to whom commissions or fees were paid:**  
CUMMINGS FRASER & ASSOCIATES  
LLC  
3201 FIRST AVE S  
STE 108  
SEATTLE, WA 98134

**Amount of commissions paid:**  
\$11,702.44

**Amount of non-monetary compensation paid:**  
\$0.00

For questions regarding this information, please contact Membership Operations Support  
at (855) 397-9599.

Sincerely,



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Name of Plan: Options  
Name of Insurance Carrier: Kaiser Foundation Health Plan of Washington  
Options, Inc.  
Employer Identification Number (EIN): 91-1467158  
NAIC #: 47055

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KRISTI TOLLNER  
MARY'S PLACE SEATTLE  
113 DEXTER AVE N  
SEATTLE, WA 98109

RE: Schedule A/Form 5500 information regarding the group(s) referenced below:

**Name of Plan Sponsor:**  
MARY'S PLACE SEATTLE

**Contract or Identification Number:**  
8153600

**Approximate number of persons covered  
at beginning of policy or contract year  
(List employees and dependents)**

36 employees and 9 dependents

**Approximate number of persons covered  
at ending of policy or contract year (List  
employees and dependents)**

41 employees and 11 dependents

**Policy or contract year:**  
12/1/2020 - 11/30/2021

**Type of benefit:**  
Medical Insurance

**Premiums due and unpaid at end of plan  
year:**

**Non-Experience Rated contract. Total  
premiums paid to carrier:**  
\$280,585.46

**Name and address of agent(s) or broker(s)  
to whom commissions or fees were paid:**

CUMMINGS FRASER & ASSOCIATES  
LLC  
3201 FIRST AVE S  
STE 108  
SEATTLE, WA 98134

**Amount of commissions paid:**  
\$6,469.48

**Amount of non-monetary compensation paid:**  
\$0.00

For questions regarding this information, please contact Membership Operations Support  
at (855) 397-9599.

Sincerely,