WHITMAN COLLEGE
RETIREE-ONLY
HEALTH REIMBURSEMENT
ARRANGEMENT

January 1, 2023

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WHITMAN COLLEGE
RETIREE-ONLY HEALTH REIMBURSEMENT ARRANGEMENT

ARTICLE I INTRODUCTION

1.1 Establishment of Plan. Whitman College (the "Plan Sponsor") has established the Whitman College Retiree-Only Health Reimbursement Arrangement (the "Plan"). Effective as of January 1, 2023, this document shall govern the Plan. Capitalized terms used in this Plan that are not otherwise defined shall have the meanings set forth in Article II.

This Plan is intended to permit a Participant to obtain reimbursement of Medical Care Expenses on a nontaxable basis from his or her HRA Account.

1.2 Legal Status. The Plan Sponsor intends the Plan to:

(a) Qualify as a "health reimbursement arrangement" as that term is defined under IRS Notice 2002-45, and a medical reimbursement plan under Sections 105 and 106 of the Internal Revenue Code of 1986 ("Code"), as amended;

(b) Be exempt from the Affordable Care Act as a separate "retiree-only" plan under ERISA Section 732(a) and Code Section 9831(a)(2); and

(c) Provide for reimbursed Medical Care Expenses under the Plan to be excluded from Participants' gross income under Code Section 105(b).

This Plan will be interpreted at all times in a manner consistent with these intentions.

ARTICLE II DEFINITIONS

2.1 Definitions. When used in this Plan, the following capitalized terms shall have the meaning set forth in this Section 2.1.

"Benefits" means the reimbursement benefits for Medical Care Expenses under this Plan.

"Code" means the Internal Revenue Code of 1986, as amended.

"Effective Date" means January 1, 2023.

"**ERISA**" means the Employee Retirement Income Security Act of 1974, as amended from time to time.

"**Medical Care Expense**" means an expense incurred by a Participant for private supplemental Medicare policy premiums, including those for supplemental Medicare prescription drug policies, which qualify as "medical care" as defined in Code Section 213(d) and the rules, regulations and Internal Revenue Service interpretations thereunder.

"**Participant**" means any former employee who has satisfied the eligibility requirements described in Article III.

"**Plan**" means this Whitman College Retiree-Only Health Reimbursement Arrangement set forth herein, as may be amended from time to time.

"**Plan Administrator**" means the Plan Sponsor or third-party administrator selected by the Plan Sponsor.

"**Plan Sponsor**" means Whitman College.

"**Plan Year**" means the 12 month period beginning on July 1 and ending on June 30.

ARTICLE III ELIGIBILITY AND PARTICIPATION

3.1 Eligibility to Participate. The following individuals are eligible to participate in this Plan:

(a) Category I Participants. Employees of the Plan Sponsor who have retired and (i) had completed the equivalent of at least 10 years of full-time service with the Plan Sponsor on June 30, 1992; (ii) who had attained at least age 60 on June 30, 1992.

(b) Category II Participants. Employees of the Plan Sponsor who have retired and (i) were hired prior to July 1, 1992; and (ii) had completed the equivalent of at least 10 years of full-time service with the Plan Sponsor and had attained at least age 65 at the time of retirement.

Employees of the Plan Sponsor who were hired on or after July 1, 1992 are not eligible for any benefits under the Plan.

ARTICLE IV BENEFITS

4.1 Amount of Reimbursement.

(a) Category I Participants. Participants who are described as Category I Participants in Section 3.1(a) above are eligible for reimbursement of the cost of private Medicare supplemental coverage.

(b) Category II Participants. Participants who are described as Category II Participants in Section 3.1(b) above are eligible for reimbursement of the cost of private Medicare supplemental coverage, up to a monthly maximum amount, as determined by the Plan Sponsor for each fiscal year. The monthly maximum as of July 1, 2023, is $280.79, and the maximum monthly amount may be increased by a maximum of 5% each fiscal year. The cap for Benefits shall be communicated to Participants annually by the Plan Administrator.

4.2 Maximum Benefits. No Participant shall receive a reimbursement in excess of the Benefits described in this Plan for any Plan Year.

4.3 Reimbursement Procedure. Participants shall submit requests for the reimbursement of Medical Care Expenses in accordance with this Section 4.3.

(a) Submitting a Claim for Reimbursement. All Participants must submit proof of payment of Medical Care Expenses based on the procedures proscribed by the Plan Administrator, but in no event sixty (60) days later than the end of the Plan Year in which they are incurred. In order to receive reimbursement from the Plan, a Participant must submit: (i) a written bill or other statement evidencing the Medical Care Expense from the supplemental Medicare carrier evidencing the date and amount of such expense incurred by the Participant; (ii) at the discretion of the Plan Administrator, a receipt showing payment has been made; and (iii) any additional documentation the Plan Administrator may request.

(b) Timing of Reimbursement. The Plan Administrator shall review all requests for reimbursement within thirty (30) days of receipt. If the Plan Administrator determines that additional time is needed due to matters beyond its control and the control of the Plan, the Plan Administrator will notify the Participant within the initial thirty (30)-day period that the Plan Administrator needs up to an additional fifteen (15) days to review the claim. If such an extension is necessary because the Participant failed to provide the information necessary to evaluate the claim, the notice of extension will describe the information that the Participant will need to provide to the Plan Administrator. The Participant will have no less than forty-five (45) days from the date he or she receives the notice to provide the requested information. The Plan Administrator shall provide to every Participant who is denied a claim for benefits (in whole or in part) written or electronic notice setting forth in a manner calculated to be understood by the Participant:

(i) the specific reason or reasons for the denial;

(ii) specific reference to pertinent Plan provisions on which denial is based;

(iii) a description of any additional material or information necessary for the Participant to perfect the claim and an explanation of why such material or information is necessary;

(iv) a copy of any internal rule, guideline, protocol, or other similar criterion relied upon in making the initial determination or a statement that such a rule, guideline, protocol, or other criterion was relied upon in making the appeal determination and that a copy of such rule will be provided to claimant free of charge upon request; and

(v) a description of the Plan's appeal procedures and the time limits applicable to such procedures, including a statement of the Participant's right to bring a civil action under ERISA Section 502(a) to appeal any adverse benefit determination on review.

(c) Denied Requests for Reimbursement. Requests for reimbursement that are partially or wholly denied may be appealed to the Plan Administrator as provided herein.

4.4 Carryover of Benefits. A Participant's Benefits available for a Plan Year shall not carry over for use in any subsequent Plan Years.

4.5 Death. If the Participant dies, his or her estate or representatives may submit claims for Medical Care Expenses incurred by the Participant prior to his or her death, as long as such claims are submitted no later than one-hundred eighty (180) days after the date of death.

4.6 Nondiscrimination. The Plan Administrator may limit, reallocate or deny any benefit to any Participant who was a highly compensated individual (as defined in Code Section 105(h)) to the extent necessary to avoid discrimination under Code Section 105(h). Any action of the Plan Administrator under this Section shall be carried out in a uniform and non-discriminatory manner.

ARTICLE V FUNDING

5.1 Funding. The Benefits under the Plan shall be provided by the Plan Sponsor out of its general assets, and no assets shall be segregated or earmarked for the purpose of providing Benefits under the Plan, nor shall any person have any right, title or claim to such assets prior to their payment under the Plan. In no event may any Benefits under the Plan be funded with Participant contributions.

ARTICLE VI HIPAA PROVISIONS

6.1 General. The Plan is subject to the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") shall comply with the standards for privacy of protected health information as set forth in the Privacy Rule, the security standards for the protection of Electronic PHI as set forth in the Security Rule, and the notification requirements for Breaches of Unsecured PHI under the Breach Notification Rule.

6.2 Definitions. For purposes of this Article, the following definitions shall apply:

(a) "Breach" shall mean the acquisition, access, use, or disclosure of an individual's PHI in a manner not permitted under the Privacy Rule. A Breach shall be presumed unless the Plan determines there is a low probability that the PHI has been compromised. A Breach does not include: (1) an unintentional acquisition, access, or use of PHI by a workforce member or person acting under the authority of a covered entity or business associate, if such acquisition, access, or use was in good faith and within the scope of authority and does not result in a further impermissible use or disclosure; (2) an inadvertent disclosure by a person who is authorized to access PHI to another person authorized to access PHI at the same covered entity or business associate or organized health care arrangement and the information received is not further used or disclosed in a manner not permitted under the Privacy Rule; or (3) a disclosure of PHI where a covered entity or business associate has a good faith belief that an unauthorized person to whom the disclosure was made would not reasonably have been able to retain such information.

(b) "Breach Notification Rule" means the regulations issued under HIPAA set forth in subpart D of 45 CFR Part 164.

(c) "Electronic Protected Health Information" or "Electronic PHI" means PHI that is transmitted by or maintained in electronic media.

(d) "Health Care Operations" is as defined under 45 CFR §164.501.

(e) "HIPAA Health Plan," as defined under 45 CFR §160.103, means an individual or group plan that provides, or pays the cost of, medical care, and includes those plans and arrangements listed in 45 CFR §160.103.

(f) "Payment" is as defined under 45 CFR §164.501, and means activities undertaken by a HIPAA Health Plan to obtain contributions or to determine or fulfill its responsibility for coverage and provision of benefits, or to obtain or provide reimbursement for the provision of health care.

(g) "Privacy Policy" means the Employer HIPAA Privacy Policy.

(h) "Privacy Rule" means the regulations issued under HIPAA set forth in subpart E of 45 CFR Part 164.

(i) "Protected Health Information" or "PHI" means individually identifiable health information that (1) relates to the past, present, or future physical or mental condition of a current or former Participant, Spouse, or Dependent, provision of health care to a Participant, Spouse, or Dependent, or payment for such health care; (2) can either identify the Participant, Spouse, or Dependent, or there is a reasonable basis to believe the information can be used to identify the Participant, Spouse, or Dependent; and (3) is received or created by or on behalf of the Plan.

(j) "Responsible Employee" means an employee (including a contract, temporary, or leased employee) of the Plan Administrator whose duties (1) require that the employee have access to PHI for purposes of Payment or Health Care Operations; or (2) make it likely that the employee will receive or have access to PHI (e.g., the Plan's privacy officer and security officer).

(k) "Security Incident," as defined under 45 CFR §164.304, means the attempted or successful unauthorized access, use, disclosure, modification, or destruction of information or interference with system operations in an information system.

(l) "Security Rule" means the regulations issued under HIPAA set forth in subpart C of 45 CFR Part 164.

6.3 Responsible Employees. Only Responsible Employees shall be permitted to use, disclose, create, receive, access, maintain, or transmit PHI or Electronic PHI on behalf of the Plan. The use or disclosure of PHI or Electronic PHI by Responsible Employees shall be restricted to the Plan administration functions that the Employer performs on behalf of the Plan pursuant to Section 6.4.

6.4 Permitted Uses and Disclosures. Responsible Employees may access, request, receive, use, disclose, create, and/or transmit PHI only to perform certain permitted and required functions on behalf of the Plan, consistent with the Privacy Policy. This includes:

(a) uses and disclosures for the Plan's own Payment and Health Care Operations functions;

(b) uses and disclosures for another HIPAA Health Plan's Payment and Health Care Operations functions;

(c) disclosures to a health care provider, as defined under 45 CFR §160.103, for the health care provider's treatment activities;

(d) disclosures to the Plan Sponsor, acting in its role as Plan Sponsor, of (1) summary health information for purposes of obtaining health insurance coverage or premium bids for HIPAA Health Plans or for making decisions to modify, amend, or terminate a HIPAA Health Plan; or (2) enrollment or disenrollment information;

(e) disclosures of a Participant's, Spouse's, or Dependent's PHI to the Participant or the Dependent or his or her personal representative, as defined under 45 CFR §164.502(g);

(f) disclosures to a Participant's, Spouse's, or Dependent's family members or friends involved in the Participant's, Spouse's, or Dependent's health care or payment for the Participant's, Spouse's, or Dependent's health care, or to notify a Participant's, Spouse's, or Dependent's family in the event of an emergency or disaster relief situation;

(g) uses and disclosures to comply with workers' compensation laws;

(h) uses and disclosures for legal and law-enforcement purposes, such as to comply with a court order;

(i) disclosures to the Secretary of Health and Human Services to demonstrate the Plan's compliance with the Privacy Rule, Security Rule, or Breach Notification Rule;

(j) uses and disclosures for other governmental purposes, such as for national security purposes;

(k) uses and disclosures for certain health and safety purposes, such as to prevent or lessen a threat to public health, to report suspected cases of abuse, neglect, or domestic violence, or relating to a claim for public benefits or services;

(l) uses and disclosures to identify a decedent or cause of death, or for tissue donation purposes;

(m) uses and disclosures required by other applicable laws; and

(n) uses and disclosures pursuant to the Participant's authorization that satisfies the requirements of 45 CFR §164.508.

6.5 Prohibited Uses and Disclosures. Notwithstanding anything in the Plan to the contrary, use or disclosure of Protected Health Information is prohibited in the following situations.

(a) Genetic Information. Use or disclosure of Protected Health Information that is Genetic Information about an individual for underwriting purposes shall not be a permitted use or disclosure. The term "underwriting purposes" includes determining eligibility for benefits, computation of premium or contribution amounts, or the creation, renewal, or replacement of a contract of health insurance.

(b) Employment-Related Actions. Use or disclosure of Protected Health Information for the purpose of employment-related actions or decisions shall not be a permitted use or disclosure.

(c) Other Benefits. Use or disclosure of Protected Health Information in connection with any other benefit or employee benefit plan of the Employer, except as expressly permitted in Section 6.4, shall not be a permitted use or disclosure.

6.6 Mitigation. In the event of noncompliance with any of the provisions set forth in this Article:

(a) The HIPAA privacy official or security official, as appropriate, shall address any complaint promptly and confidentially. The HIPAA privacy official or security official, as appropriate, first will investigate the complaint and document the investigation efforts and findings.

(b) If PHI, including Electronic PHI, has been used or disclosed in violation of the Privacy Policy or inconsistent with this Article, the HIPAA privacy official and/or the security official, as appropriate, shall take immediate steps to mitigate any harm caused by the violation and to minimize the possibility that such a violation will recur.

(c) If a Responsible Employee or other Employer employee is found to have violated the Privacy Policy and/or policy developed under the Security Rule, such personnel shall be subject to disciplinary action up to and including termination.

6.7 Breach Notification. Following the discovery of a Breach of unsecured PHI, the Plan shall notify each individual whose unsecured PHI has been, or is reasonably believed to have been, accessed, acquired, or disclosed as a result of a Breach, in accordance with 45 CFR §164.404, and shall notify the Secretary of Health and Human Services in accordance with 45 CFR §164.408. For a breach of unsecured PHI involving more than 500 residents of a State or jurisdiction, the Plan shall notify the media in accordance with 45 CFR §164.406. "Unsecured PHI" means PHI that is not secured through the use of a technology or methodology specified in regulations or other guidance issued by the Secretary of Health and Human Services.

ARTICLE VII CONTINUATION COVERAGE

The Benefits provided under the Plan do not give rise to continuation coverage under the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended ("COBRA").

ARTICLE VIII ADMINISTRATION

8.1 Plan Administrator. The Plan Administrator shall be responsible for the performance of all reporting and disclosure obligations under ERISA, and all other obligations required to be performed by the plan administrator under ERISA or the Code, except such obligations and responsibilities as may be delegated under the Plan to such person or entity as the Plan Administrator designates. The Plan Administrator shall be the designated agent for service of legal process with respect to the Plan.

8.2 Duties of the Plan Administrator.

(a) The Plan Administrator shall have the sole discretion and authority to control and manage the operation and administration of the Plan.

(b) The Plan Administrator shall have complete discretion to interpret the provisions of the Plan, make findings of fact, correct errors, supply omissions, and determine the benefits payable under this Plan. All decisions and interpretations of the Plan Administrator made in good faith pursuant to the Plan shall be final, conclusive and binding on all persons, subject only to the claims procedure, and may not be overturned unless found by a court to be arbitrary and capricious.

(c) The Plan Administrator shall have all other powers necessary or desirable to administer the Plan, including, but not limited to, the following:

(i) To prescribe procedures to be followed by Participants in making elections under the Plan and in filing claims under the Plan;

(ii) To prepare and distribute information explaining the Plan to Participants;

(iii) To receive from Participants such information as shall be necessary for the proper administration of the Plan;

(iv) To keep records of elections, claims, and disbursements for claims under the Plan, and any other information required by ERISA or the Code;

(v) To appoint individuals or committees to assist in the administration of the Plan and to engage any other agents as it deems advisable;

(vi) To accept, modify or reject Participant elections under the Plan;

(vii) To promulgate election forms and claims forms to be used by Participants, which may be electronic in nature;

(viii) To determine and enforce any limits on benefit elections hereunder; and

(ix) To correct errors and make equitable adjustments for mistakes made in the administration of the Plan, specifically, and without limitation, to recover erroneous overpayments made by the Plan to a Participant, in whatever manner the Plan Administrator deems appropriate, including suspensions or recoupment of, or offsets against, future payments due that Participant.

8.3 Allocation and Delegation of Duties.

(a) The Plan Administrator shall have the authority to allocate, from time to time, by instrument in writing filed in its records, all or any part of its responsibilities under the Plan to one or more of its employees, officers or members as may be deemed advisable, and in the same manner to revoke such allocation of responsibilities. In the exercise of such allocated responsibilities, any action of the employee, officer, or member to whom responsibilities are allocated shall have the same force and effect for all purposes hereunder as if such action had been taken by the Plan Administrator. The Plan Administrator shall not be liable for any acts or omissions of such employee, officer, or member. The employee, officer, or member to whom responsibilities have been allocated shall periodically report to the Plan Administrator concerning the discharge of the allocated responsibilities.

(b) The Plan Administrator shall have the authority to delegate, from time to time, by written instrument filed in its records, all or any part of its responsibilities under the Plan to such person or persons as it may deem advisable (and may authorize such person to delegate such responsibilities to such other person or persons as the Plan Administrator shall authorize) and in the same manner to revoke any such delegation of responsibility. Any action of the delegate in the exercise of such delegated responsibilities shall have the same force and effect for all purposes hereunder as if such action had been taken by the Plan Administrator. The Plan Administrator shall not be liable for any acts or omissions of any such delegate. The delegate shall periodically report to the Plan Administrator concerning the discharge of the delegated responsibilities.

(c) The Plan Administrator may employ such legal counsel, accountants, consultants, actuaries, and other agents as it shall deem advisable. The compensation of such legal counsel, accountants, consultants, actuaries and other agents and any other expenses incurred by the Plan Administrator in the administration or management of the Plan or in furtherance of its duties hereunder shall be paid by the Plan.

8.4 Bonding. The Plan Administrator, each person who is a fiduciary under the Plan and each person who handles funds of the Plan, shall be bonded in an amount no less than the amounts required by ERISA Section 412 and the regulations issued thereunder, to the extent that this requirement applies to the Plan.

8.5 Information to be Supplied by Plan Sponsor. The Plan Sponsor shall provide the Plan Administrator or its delegate with such information as it shall from time to time need in the discharge of its duties. The Plan Administrator may rely conclusively on the information certified to it by the Plan Sponsor.

8.6 Claims Procedure.

(a) Within one hundred and eighty (180) days of receipt by a claimant of a notice under Section 4.3 denying a claim in whole or in part, the claimant or his or her duly authorized representative may request in writing a full and fair review of the claim by the Plan Administrator. In connection with such review, the claimant or his or her duly authorized representative may, upon request and free of charge, have reasonable access to, and copies of, all documents, records and other information relevant to the claim for benefits, and may submit issues and comments in writing. The Plan Administrator shall make a decision promptly, but not later than sixty (60) days after the Plan Administrator's receipt of a request for review. The decision on review shall be in writing, in a manner calculated to be understood by the claimant, and shall include:

(i) specific reasons for the decision;

(ii) specific references to the pertinent plan provisions on which the decision is based;

(iii) 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 claim for benefits;

(iv) a copy of any internal rule, guideline, protocol, or other similar criterion relied upon in making the initial determination or a statement that such a rule, guideline, protocol, or other criterion was relied upon in making the appeal determination and that a copy of such rule will be provided to claimant free of charge upon request; and

(v) a statement of the Participant's right to bring a civil action under ERISA Section 502(a) to appeal any adverse benefit determination on review.

(b) The decision of the Plan Administrator shall be final and conclusive on all persons claiming benefits under the Plan, subject to applicable law. If claimant challenges the decision of the Plan Administrator within one year after the date of the decision, a review by a court of law will be limited to the facts, evidence and issues presented during the claims procedure set forth above. The appeal process described herein must be exhausted before a claimant can pursue the claim in federal court. Facts

and evidence that become known after having exhausted the appeals procedure may be submitted for reconsideration of the appeal in accordance with the time limits established above. Issues not raised during the appeal will be deemed waived.

7.7 Nondiscriminatory Operation. All rules, decisions, interpretations and designations by the Plan Administrator under the Plan shall be made in a nondiscriminatory manner, and persons similarly situated shall be treated alike.

ARTICLE IX GENERAL PROVISIONS

9.1 Amendment and Termination. Although the Plan Sponsor intends to maintain the Plan for an indefinite period, the Plan Sponsor reserves the right to amend, modify, or terminate this Plan at any time, including but not limited to the right to modify persons eligible for participation and benefits paid by the Plan.

9.2 Plan Sponsor Liability. Benefits under the Plan are paid by the Plan Sponsor out of its general assets.

9.3 Alienation of Benefits. No benefit under this Plan may be voluntarily or involuntarily assigned or alienated and any attempt to do so shall be void and unenforceable.

9.4 Facility of Payment. If the Plan Administrator deems any person incapable of receiving benefits to which he or she is entitled by reason of illness, infirmity, or other incapacity, it may direct that payment be made directly for the benefit of such person or to any person selected by the Plan Administrator to disburse it, whose receipt shall be complete acquittance therefor. Such payments shall, to the extent thereof, discharge all liability of the Plan Administrator and the Plan Sponsor.

9.5 Status of Benefits. The Plan Administrator does not make any commitment or guarantee that any amounts paid to or for the benefit of a Participant under this Plan will be excludable from the Participant's gross income for federal, state, or local income tax purposes. It shall be the obligation of each Participant to determine whether each payment under this Plan is excludable from the Participant's gross income for federal, state, and local income tax purposes and to notify the Plan Administrator if the Participant has any reason to believe that such payment is not so excludable. Any Participant, by accepting a benefit under this Plan, agrees to be liable for any tax that may be imposed with respect to those benefits, plus any interest as may be imposed.

9.6 Applicable Law. The Plan shall be construed and enforced according to the laws of the state of Washington, to the extent not preempted by any Federal law.

9.7 Severability. If any provision of this Plan shall be held invalid or unenforceable, such invalidity or unenforceability shall not affect any other provision, and this Plan shall be construed and enforced as if such provision had not been included.

IN WITNESS WHEREOF, the Chief Financial Officer of Whitman College has caused this Plan to be executed this 2nd day of May, 2023.

Whitman College

By: _____
Its: Chief Financial Officer