

SUMMARY PLAN DESCRIPTION

FOR

**HANFORD EMPLOYEE WELFARE
TRUST (HEWT)
RETIREE HEALTH REIMBURSEMENT
ARRANGEMENT**

April 1, 2015

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INTRODUCTION

The Hanford Employee Welfare Trust has established this Retiree Health Reimbursement Arrangement (the “Plan”) for the benefit of its eligible retirees and eligible dependents. The purpose of the Plan is to reimburse eligible retirees and eligible dependents for certain medical expenses which are not otherwise reimbursed. The Plan is intended to qualify as a self-insured medical reimbursement plan for purposes of Sections 105 and 106 of the Internal Revenue Code, as amended (“Code”), as well as a health reimbursement arrangement as defined in IRS Notice 2002-45.

The material provisions of the Plan as of the Effective Date are summarized below, but this summary plan description (“SPD”) is qualified in its entirety by reference to the full text of the formal plan document, a copy of which is available for inspection at the Sponsor’s offices. In the event of any conflict between the terms of this SPD and the terms of the plan document, the terms of the plan document will control. Participants seeking to obtain additional information about the Plan should contact the Plan Administrator.

Note that capitalized terms used in this SPD are defined the first time they are used. Please note that “you,” “your” and “my” when used in this SPD refer to you, the retiree.

PART I GENERAL INFORMATION ABOUT THE PLAN

Q-1. What is the purpose of the Plan?

The purpose of the Plan is to reimburse Participants (as defined in Q-2 and Q-3) for Eligible Medical Expenses (as defined in Q-6) which are not otherwise reimbursed by any other plan or program. Reimbursements for Eligible Medical Expenses paid by the Plan generally are excludable from the Participant’s taxable income.

Q-2. Who can participate in the Plan?

Retired employees of a Sponsor are eligible to participate in the Plan if they meet all requirements to be an Eligible Retiree as defined in the Administrative Wrapper for the Hanford Retiree Welfare Benefit Plans. Eligible Retirees who become covered under the Plan, as explained in Q-4, are called “Participants.”

Q-3. Can my dependents participate in the Plan?

Your Eligible Dependents may also become Participants in the Plan.

Your Eligible Dependents generally include your legal spouse and your covered children at the time of your retirement. Eligible Dependents are defined in the Administrative Wrapper for the Hanford Retiree Welfare Benefit Plans. You are required to provide proof of dependent status upon request by the Plan Administrator (or its designee). Failure to provide such proof may result in a delay in benefits provided under the Plan. In addition, the Plan will allow reimbursement of Eligible Medical Expenses for a child of yours (as defined by applicable state law) in accordance with a Qualified Medical

Child Support Order (“QMCSO”) to the extent the QMCSO does not require coverage not otherwise offered under this Plan. The Plan Administrator will make a determination as to whether the order is a QMCSO in accordance with the Plan’s QMCSO procedures. The Plan Administrator will notify both you and the affected child once a determination has been made. You may request a copy of the Plan’s QMCSO procedures, free of charge, by contacting the Plan Administrator.

Q-4. When do I actually become a Participant in the Plan?

An Eligible Retiree or an Eligible Dependent actually becomes a Participant in the Plan on the later of the Effective Date of the Plan or the date that he or she has satisfied all of the following requirements:

- He or she has become eligible for Medicare;
- He or she has obtained an individual health insurance policy (including TRICARE or health care benefits from Veterans Health Administration) through OneExchange (or any of its affiliates); and
- He or she has completed any enrollment forms or procedures required by the Plan Administrator.

Q-5. How does the Plan work?

One HRA Account will be established for all Participants in your family. Benefit Credits for all Participants in your family will be credited to that HRA Account.

Benefit Credits will be credited to HRA Accounts by the Sponsors in the amount of \$1800 per eligible Participant on the first day of the Plan Year and will be reduced from time to time by the amount of any Eligible Medical Expenses for which the Participant is reimbursed under the Plan. At any time, the Participant may receive reimbursement for Eligible Medical Expenses up to the amount in his or her HRA Account. Note that the law does not permit Participants to make any contributions to their HRA Accounts.

An HRA Account is merely a bookkeeping account on the Sponsors’ records; it is not funded and does not bear interest or accrue earnings of any kind. All benefits under the Plan are paid entirely from the Sponsors’ general assets.

Q-6. What is an “Eligible Medical Expense”?

An Eligible Medical Expense is an expense incurred by you or any Eligible Dependent for medical care, as that term is defined in Code Section 213(d) (generally, expenses related to the diagnosis, care, mitigation, treatment or prevention of disease). Some common examples of Eligible Medical Expenses include:

- Prescription and over-the-counter medications (in reasonable quantities);
- Dental expenses;

- Dermatology;
- Physical therapy;
- Contact lenses or glasses used to correct a vision impairment;
- Birth control pills;
- Chiropractor treatments;
- Hearing aids;
- Wheelchairs; and
- Premiums for medical, prescription drug, dental, vision or long-term care insurance.

Some examples of common items that are not Eligible Medical Expenses include:

- Baby-sitting and child care;
- Long-term care services;
- Cosmetic surgery or similar procedures (unless the surgery is necessary to correct a deformity arising from a congenital abnormality, accident or disfiguring disease);
- Funeral and burial expenses;
- Household and domestic help;
- Massage therapy;
- Custodial care;
- Health club or fitness program dues; and
- Cosmetics, toiletries, toothpaste, etc.

For more information about what items are and are not Eligible Medical Expenses, consult IRS Publication 502, "Medical and Dental Expenses," under the headings "What Medical Expenses Are Includible" and "What Expenses Are Not Includible." (Be careful in relying on this Publication, however, as it is specifically designed to address what medical expenses are deductible on Form 1040, Schedule A, not what is reimbursable under a health reimbursement account.) If you need more information regarding whether an expense is an Eligible Medical Expense under the Plan, contact the Third Party Administrator.

Only Eligible Medical Expenses incurred while you are a Participant in the Plan may be reimbursed from your HRA Account. Similarly, only Eligible Medical Expenses incurred while your Eligible Dependent is a Participant in the Plan may be reimbursed from his or her HRA Account. Eligible Medical Expenses are “incurred” when the medical care is provided, not when you or your Eligible Dependent are billed, charged or pay for the expense. Thus, an expense that has been paid but not incurred (e.g., pre-payment to a physician) will not be reimbursed until the services or treatment giving rise to the expense has been provided.

The following expenses may not be reimbursed from an HRA Account:

- expenses incurred for qualified long term care services;
- expenses incurred prior to the date that you became a Participant in the HRA;
- expenses incurred after the date that you cease to be a Participant in the HRA; and
- expenses that have been reimbursed by another plan or for which you plan to seek reimbursement under another health plan.

Q-7. When do I cease participation in the Plan?

If you are an Eligible Retiree, you will cease being a Participant in the Plan on the earlier of:

- the date you cease to be an Eligible Retiree for any reason;
- the date you are rehired by a Sponsor as an active employee;
- the date you cease to be eligible for Medicare;
- your date of death;
- the effective date of any amendment terminating your eligibility under the Plan;
or
- the date the Plan is terminated.

If you are an Eligible Dependent, you will cease being a Participant in the Plan on the earlier of:

- the date you cease to be an Eligible Dependent for any reason;
- the date you cease to be eligible for Medicare;
- in the case of an Eligible Dependent spouse, the date you divorce the Eligible Retiree;

- the effective date of any amendment terminating your eligibility under the Plan; or
- the date the Plan is terminated.

You may not obtain reimbursement of any Eligible Medical Expenses incurred after the date your eligibility ceases. (For the definition of “incurred,” see Q-6.) You have 180 days after your eligibility ceases, however, to request reimbursement of Eligible Medical Expenses you incurred before your eligibility ceased.

In addition, your Eligible Dependents may be eligible to continue coverage under the Plan beyond the date that their coverage would otherwise end if coverage is lost for certain reasons. Their continuation of coverage rights and responsibilities are described in Q-16 below.

Q-8. What happens if I do not use all of the credits allocated to my HRA Account during the Plan Year?

If you do not use all of the amounts credited to your HRA Account during a Plan Year, those amounts will carry over to the following Plan Year.

Q-9. How do I receive reimbursement under the Plan?

You must complete a reimbursement form and mail or fax it to the Claims Submission Agent as provided in the Plan Information Appendix, along with a copy of your insurance premium bill, an “explanation of benefits” or “EOB,” or, if no EOB is provided, a written statement from the service provider. The written statement from the service provider must contain the following: (a) the name of the patient, (b) the date service or treatment was provided, (c) a description of the service or treatment; and (d) the amount incurred. You can obtain a reimbursement form from the Third Party Administrator. Your claim is deemed filed when it is received by the Claims Submission Agent. (Do not mail your form to the Third Party Administrator as this may result in a delay in processing.)

You must submit requests for reimbursement of Eligible Medical Expenses by March 31 following the Plan Year in which the expense is incurred.

If your claim for reimbursement is approved, you will be provided reimbursement as soon as reasonably possible following the determination. Claims are paid in the order in which they are received by the Claims Submission Agent.

Q-10. What happens if my claim for benefits is denied?

If your claim for reimbursement is wholly or partially denied, you will be notified in writing within 30 days after the Claims Submission Agent receives your claim. If the Claims Submission Agent determines that an extension of this time period is necessary due to matters beyond the control of the Plan, the Claims Submission Agent will notify you within the initial 30-day period that an extension of up to an additional 15 days will be required. If the extension is necessary because you failed to provide sufficient

information to allow the claim to be decided, you will be notified and you will have at least 45 days to provide the additional information. The notice of denial will contain:

- the reason(s) for the denial and the Plan provisions on which the denial is based;
- a description of any additional information necessary for you to perfect your claim, why the information is necessary, and your time limit for submitting the information;
- a description of the Plan's appeal procedures and the time limits applicable to such procedures; and
- a description of your right to request all documentation relevant to your claim.

If your request for reimbursement under the Plan is denied in whole or in part and you do not agree with the decision of the Claims Submission Agent, you may file a written appeal. You should file your appeal with the Plan Administrator no later than 180 days after receipt of the denial notice. You should submit all information identified in the notice of denial, as necessary, to perfect your claim and any additional information that you believe would support your claim.

You will be notified in writing of the decision on appeal no later than 60 days after the Plan Administrator receives your request for appeal. The notice will contain the same type of information provided in the first notice of denial provided by the Claims Submission Agent.

Note that you cannot file suit in federal court until you have exhausted these appeals procedures.

Q-11. What happens if I die?

If the Eligible Retiree dies with no Eligible Dependents who are Participants in the Plan, his or her HRA Account is immediately forfeited upon death, but the deceased Eligible Retiree's estate or representatives may submit claims for Eligible Medical Expenses incurred by the Eligible Retiree and his or her Eligible Dependents before his or her death. Claims must be submitted within 180 days of his or her death.

If the Eligible Retiree dies with one or more Eligible Dependents who are Participants that share the account, his or her HRA Account shall continue and the Eligible Dependents who are Participants can continue to submit Eligible Medical Expenses for reimbursement. No contributions for the Eligible Retiree will be made to the HRA Account after the Eligible Retiree dies.

Q-12. Are my benefits taxable?

The Plan is intended to meet certain requirements of existing federal tax laws, under which the benefits you receive under the Plan generally are not taxable to you. However, the Sponsors cannot guarantee the tax treatment to any given Participant, as individual

circumstances may produce different results. If there is any doubt, you should consult your own tax advisor.

Q-13. What happens if I receive an overpayment under the Plan or a reimbursement is made in error from my HRA Account?

If it is later determined that you or your Eligible Dependent received an overpayment or a payment was made in error (e.g., you were reimbursed from your HRA Account for an expense that is later paid by another medical plan), you or your Eligible Dependent will be required to refund the overpayment or erroneous reimbursement to the Sponsors.

If you do not refund the overpayment or erroneous payment, the Sponsors reserve the right to offset future reimbursements equal to the overpayment or erroneous payment or, if that is not feasible, to withhold such funds from any amounts due to you from the Sponsor. If all other attempts to recoup the overpayment/erroneous payment are unsuccessful, the Plan Administrator may treat the overpayment as a bad debt, which may have tax implications for you.

Q-14. How long will the Plan remain in effect?

Although the Sponsor expects to maintain the Plan indefinitely, it has the right to amend, modify or terminate the program at any time for any reason, including the right to change the classes of persons eligible for participation, the amount credited to HRA Accounts or to reduce or eliminate any amounts currently credited to a Participant's HRA Account.

Q-15. How does the Plan interact with other medical plans?

Only medical care expenses that have not been or will not be reimbursed by any other source may be Eligible Medical Expenses (to the extent all other conditions for Eligible Medical Expenses have been satisfied). You must first submit any claims for medical expenses to the other plan or plans before submitting the expenses to this Plan for reimbursement.

If you are also a participant in a health flexible spending account sponsored by a Sponsor, the expenses covered both by this Plan and the health flexible spending account must be submitted first to the health flexible spending account.

Q-16. What is "continuation coverage" and how does it work?

Under a federal law called "COBRA," Eligible Dependents under the Plan who are the spouse, former spouse or dependent child of a Participant may elect to continue coverage under the Plan for a limited time after the date they would otherwise lose coverage because of a divorce or legal separation from the Participant, the Participant's death or a dependent child ceasing to be an Eligible Dependent. These are called "qualifying events."

Note that the Eligible Dependents are required to notify the Plan Administrator in writing of a divorce or legal separation or a dependent child losing dependent status within 60 days of the event or they will lose the right to continue coverage under the Plan.

If an Eligible Dependent elects to continue coverage, he or she is entitled to the coverage under the Plan in effect immediately preceding the qualifying event. A separate HRA Account may be established under the Plan for the Eligible Dependent. He or she may also be entitled to an increase in his or her HRA Account equal to the amounts credited to the HRA Accounts of similarly situated Participants (subject to any restrictions applicable to similarly situated Participants) so long as he or she continues to pay the applicable premium.

In order to continue coverage, the qualified beneficiary must pay a monthly premium equal to 102% of the cost of the coverage, as determined by the Plan Administrator. The Plan Administrator will notify qualified beneficiaries of the applicable premium at the time of a qualifying event.

Coverage may continue for up to 36 months following the qualifying event, but will end earlier upon the occurrence of any of the following events:

- The date the qualified beneficiary's HRA Account is exhausted;
- The date the qualified beneficiary notifies the Plan Administrator that he or she wishes to discontinue coverage;
- Any required monthly premium is not paid when due or during the applicable grace period;
- The date, after the date of the qualified beneficiary's election to continue coverage, that he or she becomes covered under another group health plan that does not contain any exclusion or limitation with respect to any pre-existing condition of the qualified beneficiary; or
- The Sponsors cease to provide any group health plan.

Q-17. Who do I contact if I have questions about the Plan?

If you have any questions about the Plan, you should contact OneExchange or the Plan Administrator:

Towers Watson OneExchange
10975 Sterling View Dr., Suite 1A
South Jordan, UT 84095
(888) 864-0764
<https://www.medicare.oneexchange.com/HEWT>

HEWT
Attn: Plan Administrator
P.O. Box 650, MSIN: H2-23
Richland, WA 99352

PART II ERISA RIGHTS

This Plan is an employee welfare benefit plan as defined in the Employee Retirement Income Security Act of 1974, as amended (“ERISA”). ERISA provides that you, as a Plan Participant, will be entitled to:

Receive Information about Your Plan and Benefits

- Examine, without charge, at the Plan Administrator’s office and at other specified locations, such as worksites and union halls, all documents governing the Plan, including insurance contracts, collective bargaining agreements, and a copy of the latest annual report (Form 5500 series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.
- Obtain, upon written request to the Plan Administrator, copies of all documents governing the operation of the Plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 series) and updated Summary Plan Description. The Plan Administrator may apply a reasonable charge for the copies.
- Receive a summary of the Plan’s annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report.

Continue Plan Coverage

Continue Plan coverage for your eligible spouse or dependents if there is a loss of coverage under the plan as a result of a qualifying event. However, your spouse or your dependents may have to pay for such coverage. Review this SPD and the documents governing the Plan for the rules governing COBRA continuation coverage rights.

Prudent Actions by Plan Fiduciaries

In addition to creating rights for Plan participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate your Plan, called “fiduciaries” of the Plan, have a duty to do so prudently and in the interest of the Plan participants and beneficiaries. No one, including your employer, your union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit from the Plan, or from exercising your rights under ERISA.

Enforcement of Your Rights

If your claim for a welfare benefit under an ERISA-covered plan is denied in whole or in part, you must receive a written explanation of the reason for the denial. You have the right to have the Plan review and reconsider your claim. Under ERISA, there are steps

you can take to enforce the above rights. For instance, if you request materials from the Plan and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to \$110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Administrator. If you have a claim for benefits that is denied or ignored in whole or in part, you may file suit in a state or federal court. In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, you may file suit in federal court. If it should happen that plan fiduciaries misuse the Plan's money or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees (e.g., if it finds your claim is frivolous).

Assistance with Your Questions

If you have any questions about the Plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance obtaining documents from the Plan Administrator, you should contact the nearest office of the U.S. Department of Labor, Employee Benefits Security Administration listed in your telephone directory, or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Ave., N.W., Washington, D.C., 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

PLAN SPONSORS

The names of the Sponsors, their addresses and their Employer Identification Numbers ("EINs") assigned by the Internal Revenue Service are described in Attachment B to the Administrative Wrapper for the Hanford Retiree Welfare Benefit Plans.

In addition, participants and beneficiaries may 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.

EMPLOYER IDENTIFICATION NUMBER AND PLAN IDENTIFICATION NUMBER

The Employer Identification Number assigned to the Trust by the Internal Revenue Service is 91-2017261. The Plan Identification Number is 551.

PLAN TRUSTEES

The name, title and address of the principal place of business of the trustees of the Plans is:

Board of Trustees of the Hanford Employee Welfare Trust
P.O. Box 650, MSIN: H2-23
Richland, WA 99352

PLAN ADMINISTRATOR

The designated Plan Administrator of the Plans is the Board of Trustees of the Trust. The rights, duties, powers, and authority of the Board of Trustees is described in the Hanford Employee Welfare Trust Agreement (the "Trust Agreement"). All of the Trustees are representatives of the Sponsors (including your Employer) who establish and maintain the Plans.

The name, address and telephone number of the Plan Administrator is:

Plan Administrator
P.O. Box 650, MSIN: H2-23
Richland, WA 99352
Attn: Lynn A. Ramos, PHR
Telephone: (509) 376-0623

PLAN ADMINISTRATOR'S DISCRETION

In carrying out its responsibilities under the Plans, the Plan Administrator has the exclusive responsibility and full discretionary authority to control the operation and administration of the Plans and to make all fiduciary decisions under the Plans, and it has all power necessary to accomplish such purposes. These powers include, but are not limited to:

- To make and enforce such rules and regulations as in its sole and absolute and uncontrolled discretion it deems necessary or proper for the efficient administration of the Plans that are not inconsistent with the terms of the Plans or the Employee Retirement Income Security Act of 1974, as amended ("ERISA").
- To interpret the Plan documents in its discretion and its interpretation in good faith. Such interpretation is final and conclusive on all persons claiming benefits under the Plans.
- To use, employ, discharge or consult with one or more individuals, corporations or other entities with respect to advice regarding any responsibility, obligation or duty in connection with the Plan.
- To allocate fiduciary responsibilities by written instrument signed in the same manner as provided for delegations.

- To designate other individuals, corporations or other entities to carry out fiduciary responsibilities, obligations and duties under the Plan, and to revoke, modify or change any such delegation, revocation or modification by written instrument.

In carrying out its responsibilities, the Plan Administrator shall be fully protected to the fullest extent permitted under ERISA. In the event of any delegation in accordance with the above, no fiduciary shall be liable for any act or action, whether of commission or omission, taken by the person to whom the delegation is made. Fiduciary responsibilities shall be exercised severally and not jointly and each fiduciary's powers, duties, obligations and responsibilities shall be limited to those specifically allocated to such fiduciary or in accordance with the terms of this document.

PLAN RECORDS AND PLAN YEAR

The fiscal records for all Plans are maintained and reported on a twelve-month period of time, known as the Plan Year. The Plan Year begins on January 1 and ends on December 31.

SOURCE AND AMOUNT OF CONTRIBUTIONS

All benefits paid through this Plan will be paid out of such Sponsor's general assets.

TYPE OF PLAN ADMINISTRATION

This Plan is administered by a third-party administrator and a claims submission agent. The name and address of the Third-Party Administrator is:

Towers Watson OneExchange
10975 Sterling View Dr., Suite 1A
South Jordan, UT 84095
(888) 864-0764
<https://www.medicare.oneexchange.com/HEWT>

The name and address of the Claims Submission Agent is:

PayFlex
P.O. Box 2396
Omaha, NE 68103-2396
Fax: (855) 321-2605

NAME AND ADDRESS OF AGENT FOR LEGAL PROCESS

The name and address of the agent for service of legal process for the Plans is:

Mr. Jason Froggatt
Davis Wright Tremaine LLP
1201 Third Avenue, Suite 2200
Seattle, WA 98101

Legal process may also be served upon a Plan Trustee or the Plan Administrator.

APPEAL PROCEDURES

The appeals procedures are described in the Administrative Wrapper for the Hanford Retiree Welfare Benefit Plans.