

**HANFORD EMPLOYEE WELFARE TRUST
(HEWT)**

**RETIREE HEALTH REIMBURSEMENT
ARRANGEMENT**

January 1, 2011

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HEALTH REIMBURSEMENT ARRANGEMENT

INTRODUCTION

The Sponsors hereby adopt this Hanford Employee Welfare Trust Retiree Health Reimbursement Arrangement (the “Plan”) for the purpose of allowing certain retirees and their eligible dependents reimbursement of eligible medical expenses effective January 1, 2011. The Sponsors intend this Plan to 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, as amended, and the Plan will be interpreted at all times in a manner consistent with such intent. The Sponsors have appointed the Trustees of the Hanford Employee Welfare Trust as the Plan Administrator. Mission Support Alliance, LLC has the responsibility under their Contract with the United States Department of Energy for administering this Plan.

ARTICLE I DEFINITION OF TERMS

1.1 Definitions. Whenever used in this Plan, the following terms shall have the meanings set forth below.

- (a) “HRA Account” means the bookkeeping arrangement established for a Participant to hold his or her Benefit Credits.
- (b) “Benefit Credit” means the amount credited to a Participant’s HRA Account for the provision of benefits under the Plan as provided in Section 4.2.
- (c) “COBRA” means the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended from time to time.
- (d) “Code” means the Internal Revenue Code of 1986, as amended from time to time.
- (e) “Effective Date” means January 1, 2011.
- (f) “Eligible Dependent” means any Dependent who has satisfied the eligibility requirements described in the Administrative Wrapper for the Hanford Retiree Welfare Benefit Plans.
- (g) “Eligible Retiree” means any former employee of a Sponsor who has satisfied the eligibility requirements described in the Administrative Wrapper for the Hanford Retiree Welfare Benefit Plans.
- (h) “ERISA” means the Employee Retirement Income Security Act of 1974, as amended from time to time.

(i) “Health Care Expense” means an expense incurred by a Participant or by a Dependent in the Participant’s family, for medical care as defined in Code Section 213(d) and the rules, regulations and Internal Revenue Service interpretations thereunder, including premiums for health care insurance coverage and premiums for long-term care insurance coverage. Health Care Expenses shall not include expenses reimbursed or reimburseable under any private, employer-provided, or public health care reimbursement or insurance arrangement or any amount claimed as a deduction on the federal income tax return of the Participant or the Participant’s Dependent. “Health Care Expenses” are incurred when the medical care is provided, not when the Participant is formally billed, charged for, or pays the expenses.

(j) “Participant” means any Eligible Retiree or his or her Eligible Dependent, who has satisfied the eligibility requirements of Article III hereof and has not, for any reason, become ineligible to participate in the Plan.

(k) “Plan” means this Hanford Employee Welfare Trust Retiree Health Reimbursement Arrangement set forth herein, as may be amended from time to time.

(l) “Plan Administrator” means the Trustees of the Hanford Employee Welfare Trust.

(m) “Plan Year” means, with respect to the initial Plan Year, the period from the Effective Date through the next following December 31. Thereafter, “Plan Year” means the twelve (12)-month period commencing on each January 1.

(n) “Provider” means any entity with which the Plan Administrator has entered into a contract for the purpose of processing claims under the Plan or otherwise administering benefits under the Plan.

(o) “Sponsor” means one of the employers listed on Attachment B to the Administrative Wrapper for the Hanford Retiree Welfare Benefit Plans.

(p) “Spouse” means the legally married husband or wife of an Eligible Retiree, as determined under federal law.

1.2 Gender and Number. When used in this Plan, the masculine shall include the feminine, the singular shall include the plural, and vice versa.

ARTICLE II PARTICIPATION

2.1 Agreement to Participate. An Eligible Retiree or his or her Eligible Dependent, shall become a Participant in this Plan on the date he or she has:

(a) become eligible for coverage under Subchapter XVIII of Chapter 7 of Title 42 of the United States Code (Medicare);

(b) obtained an individual health insurance policy (including TRICARE or health care benefits from Veterans Health Administration) through Extend Health, Inc. or any affiliate; and

(c) completed any enrollment form (which may be electronic) or any enrollment procedures as specified by the Plan Administrator or its delegate from time to time.

2.2 Cessation of Participation. A Participant shall cease to be a Participant on the earliest of:

(a) with respect to an Eligible Retiree, the date he or she ceases to be an Eligible Retiree for any reason, including death;

(b) with respect to an Eligible Dependent, the date he or she ceases to be an Eligible Dependent for any reason, including death;

(c) with respect to an Eligible Dependent, the date he or she ceases to be eligible for coverage under Subchapter XVIII of Chapter 7 of Title 42 of the United States Code (Medicare);

(d) with respect to an Eligible Dependent Spouse, the date he or she divorces the Eligible Retiree;

(e) with respect to an Eligible Retiree, the date he or she is rehired as an active employee of a Sponsor;

(f) the effective date of any Plan amendment that renders him or her ineligible to participate; or

(g) the termination of the Plan.

Reimbursement from the Participant's HRA Account after termination of participation shall be governed by Section 4.3.

ARTICLE III FUNDING

3.1 Funding. The benefits provided herein shall be provided by the Sponsors out of its general assets, and no assets shall be segregated or earmarked for the purpose of providing benefits hereunder, nor shall any person have any right, title or claim to such assets prior to their payment hereunder. As such, each HRA Account established pursuant to the Plan shall be a hypothetical account which merely reflects a bookkeeping concept and does not represent assets that are actually set aside for the exclusive purpose of providing benefits to the Participant under the terms of the Plan or that are protected from the reach of the Sponsors' creditors. In no event may any benefits under the Plan be funded with Participant contributions.

3.2 Benefit Credits. The Sponsors shall credit the HRA Account of each Participant with a Benefit Credit in the amount of \$1800 on the first day of each Plan Year. The Benefit

Credit to be made on behalf of a Participant who is an Eligible Dependent shall be made to the combined HRA Account of the Eligible Dependent and his or her Eligible Retiree. Upon request, the Plan Administrator may establish a separate HRA Account for the Eligible Dependent of an Eligible Retiree. No earnings shall be credited at any time with respect to any HRA Account.

ARTICLE IV BENEFITS

4.1 Provision of Benefits. The Plan will reimburse Participants for Health Care Expenses, up to the unused amount in the Participant's HRA Account. A Participant shall be entitled to reimbursement under this Plan only for Health Care Expenses incurred after he or she becomes a Participant in the Plan and before his or her participation has ceased. In no event shall any benefits under this Plan be provided in the form of cash or any other taxable or nontaxable benefit other than reimbursement for Health Care Expenses.

4.2 Amount of Reimbursement. At all times during a Plan Year, a Participant shall be entitled to benefits under this Plan for payment of Health Care Expenses in an amount that does not exceed the balance of his or her HRA Account. Each reimbursement hereunder shall be a charge to such HRA Account available to pay Health Care Expenses under the Plan.

4.3 Expense Reimbursement Procedure. Reimbursement for Health Care Expenses shall be made in accordance with this Section 4.3.

(a) *Submitting a Claim:* A Participant desiring to receive reimbursement for Health Care Expenses under this Plan shall submit a written application to the Provider. Notwithstanding the preceding, upon loss of eligibility as provided in Section 3.2, coverage under the Plan ceases, the Participant shall receive no further Benefit Credits under the Plan, and his or her Health Care Expenses incurred after such date will not be reimbursed hereunder even if Benefit Credits remain in the Participant's HRA Account. The Participant may submit claims for reimbursement for Health Care Expenses incurred prior to his or her loss of eligibility, provided the Participant files such claims within one hundred eighty (180) days of such loss of eligibility.

(b) *Claims Substantiation:* The Plan Administrator may require the Participant to furnish a bill, receipt, cancelled check, or other written evidence or certification of payment or of obligation to pay Health Care Expenses. The Provider will reimburse the Participant from the general assets of the Sponsors for expenses that it determines are Health Care Expenses up to the balance in the Participant's HRA Account at such intervals as the Plan Administrator may deem appropriate (but not less frequently than quarterly). The Plan Administrator reserves the right to verify to its satisfaction all claimed Health Care Expenses prior to reimbursement. Each request for reimbursement shall include the following information:

(1) the amount of the Health Care Expense for which reimbursement is requested;

(2) the date the Health Care Expense was incurred;

- (3) a brief description and the purpose of the Health Care Expense;
- (4) the name of the person for whom the Health Care Expense was incurred and, if such person is not the Participant requesting reimbursement, the relationship of the person to such Participant;
- (5) the name of the person, organization or other provider to whom the Health Care Expense was or is to be paid;
- (6) a statement that the Participant has not been and will not be reimbursed for the Health Care Expense by insurance or otherwise, and has not been allowed a deduction in a prior year (and will not claim a tax deduction) for such Health Care Expense under Code Section 213; and
- (7) A written bill from an independent third party stating that the Health Care Expense has been incurred and the amount of such expense and, at the discretion of the Plan Administrator, a receipt showing payment has been made.

Expenses eligible for coverage under any medical, HMO, dental, or vision care plans in which the Participant or his or her Dependents are enrolled must be submitted first to all appropriate claims administrators for such plans before submitting the expenses to the Provider for reimbursement under the Plan. A Participant who is entitled to payment or reimbursement under a health care reimbursement account in a cafeteria plan under Code Section 125 must receive his or her maximum annual reimbursement under the health care reimbursement account in the cafeteria plan before he or she is entitled to any reimbursement under this Plan.

Claims will be paid in the order in which they are filed with the Provider and will be charged to the HRA Account of the Participant who submits the claim. The Plan Administrator may establish such other rules as it deems desirable regarding the frequency of reimbursement of expenses, the minimum dollar amount that may be requested for reimbursement and the maximum amount available for reimbursement during any single month.

(c) *Timing:* The Provider shall review such claim and respond thereto within thirty (30) days after receiving the claim. If the Provider determines that an extension is necessary due to matters beyond the control of the Plan, the Provider will notify the claimant within the initial thirty (30)-day period that the Provider needs up to an additional fifteen (15) days to review the claim. If such an extension is necessary because the claimant failed to provide the information necessary to evaluate the claim, the notice of extension will describe the information that the claimant will need to provide to the Provider. The claimant will have no less than forty-five (45) days from the date he or she receives the notice to provide the requested information. The Provider shall provide to every claimant 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 claimant:

- (1) the specific reason or reasons for the denial;
- (2) specific reference to pertinent plan provisions on which denial is based;

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

(4) 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

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

(d) *Claims Denied*: Claims that are partially or wholly denied may be appealed to the Plan Administrator as provided in Section 6.6.

4.4 Carryover of Accounts. To the extent a Participant has a balance in his or her HRA Account at the end of a Plan Year, the balance shall be carried over to the following Plan Years.

4.5 Death.

(1) If the Eligible Retiree dies with no Eligible Dependents who are Participants that share his or her HRA Account, his or her HRA Account shall be immediately forfeited upon his or her death; provided, however, that his or her estate or representatives may submit claims for Health Care Expenses incurred by the Eligible Retiree and his or her Dependents prior to the Eligible Retiree's death, as long as such claims are submitted no later than one-hundred eighty (180) days after the Eligible Retiree's death.

(2) If the Eligible Retiree dies with one or more Eligible Dependents who are Participants that share his or her HRA Account, his or her HRA Account shall continue and such Participants may continue to submit Health Care Expenses for reimbursement in the normal course so long as the surviving Eligible Dependent Participants remain entitled to receive Benefit Credits to the HRA Account after the Eligible Retiree's death. However, no further Benefit Credits shall be made to the HRA Account on behalf of the deceased Participant. If the Eligible Dependent Participants are not entitled to continue to receive Benefit Credits to the HRA Account after the Eligible Retiree's death, the HRA Account shall be immediately forfeited upon the Eligible Retiree's death; provided, however, that his or her estate or representatives may submit claims for Health Care Expenses incurred by the Eligible Retiree and his or her Dependents prior to the Eligible Retiree's death, as long as such claims are submitted no later than one-hundred eighty (180) days after the Eligible Retiree's death.

(3) If an Eligible Dependent who is also a Participant dies, the HRA Account shall continue if it is shared, but no further Benefit Credits shall be made to the HRA Account on behalf of the deceased Participant.

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.

4.7 ERISA Legal Provisions.

(a) The Plan may not restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than forty-eight (48) hours following a normal vaginal delivery, or less than ninety-six (96) hours following a cesarean section, or require that a provider obtain authorization from the Plan or the insurance issuer for prescribing a length of stay not in excess of the above periods.

(b) To the extent the Plan provides benefits with respect to mastectomy, it will provide, in the case of an individual who is receiving benefits in connection with a mastectomy and who elects reconstruction in connection with such mastectomy, coverage for all stages of reconstruction of the breast on which a mastectomy was performed, surgery and reconstruction of the other breast to provide a symmetrical appearance, prostheses, and coverage of physical complications at all stages of the mastectomy, including lymphedemas.

ARTICLE V CONTINUATION COVERAGE

5.1 Definitions. For purposes of this Article, the following terms shall have the meanings set forth below:

(a) “COBRA Continuation Coverage” means the continuation of the Plan benefits being provided to a Qualified Beneficiary immediately prior to a Qualifying Event.

(b) “Election Period” means a period of at least sixty (60) days’ duration that begins not later than the date on which the Qualified Beneficiary’s coverage under the Plan would otherwise terminate by reason of a Qualifying Event and that ends sixty (60) days after the later of: (1) the date such coverage would otherwise end, or (2) the date that the Qualified Beneficiary receives notice of his or her right to continued coverage under the Plan pursuant to Section 5.4.

(c) “Qualified Benefits” means the HRA benefit under this Plan.

(d) “Qualified Beneficiary” means the Participant’s Spouse, former Spouse, Dependent children, and any Dependent child born to, adopted by, or placed for adoption with a Participant during the period of COBRA Continuation Coverage.

(e) “Qualifying Event” means any of the following events which, but for this Article, would result in the loss of coverage of a Qualified Beneficiary:

- (1) the death of a Participant;
- (2) the divorce or legal separation of a Participant and his or her

Spouse; or

(3) a Dependent child of a Participant ceasing to be classified as a Dependent.

(f) “Similarly Situated Beneficiary” means, in the case of any Qualified Beneficiary who has a Qualifying Event, an individual who has the same coverage options under the Plan that the Qualified Beneficiary would have had if the Qualifying Event had not occurred; provided that determinations of similar status shall be made by the Plan Administrator in accordance with and taking into account the factors permitted under Code Section 4980B and the regulations issued thereunder to the extent such law or regulations apply.

5.2 COBRA Continuation Coverage. The Dependent, Spouse or former Spouse of a Participant may elect COBRA Continuation Coverage under the Plan pursuant to this Article if the Spouse or former Spouse or Dependent is no longer eligible for Qualified Benefits because of a Qualifying Event described in Section 5.1(e).

5.3 Period of Coverage. A Qualified Beneficiary who elects COBRA Continuation Coverage under the Plan shall be provided coverage identical to that being provided at that time to a Similarly Situated Beneficiary. COBRA Continuation Coverage under this Plan shall continue for up to thirty-six (36) months, but shall be terminated earlier upon the occurrence of any of the following events:

- (a) The date the Qualified Beneficiary’s HRA Account is exhausted;
- (b) The date the Qualified Beneficiary notifies the Plan Administrator that he or she wishes to discontinue coverage;
- (c) Any required monthly premium is not paid when due or during the applicable grace period;
- (d) The date, after the date of the Qualified Beneficiary’s COBRA election, 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
- (e) The Sponsors cease to provide any group health plan to any employee.

5.4 Notices.

- (a) Qualified Beneficiaries must notify the Plan Administrator in writing within sixty (60) days of a Qualifying Event described in Section 5.1(e)(2) or (3).
- (b) A Sponsor must notify the Plan Administrator within thirty (30) days of any Qualifying Event described in Section 5.1(e)(1).
- (c) Within fourteen (14) days of its receipt of any notice required by subsection (a) or (b) of this Section, the Plan Administrator shall notify the Qualified Beneficiary of his or her right to COBRA Continuation Coverage under the Plan. Any notification to a Spouse or former Spouse of a Participant by the Plan Administrator shall also be treated as notification to all other Qualified Beneficiaries residing with said Spouse at the time such

notification is made. Notice from the Plan Administrator shall be deemed complete upon placement of the notice of Election Period in the United States mail, provided there is sufficient postage for first class mailing and said notice is addressed to the Qualified Beneficiary's last known primary residence (any address other than the Qualified Beneficiary's last known primary residence shall only be known to the Plan Administrator if the Qualified Beneficiary specifically notifies the Plan Administrator of the change in address).

5.5 Election of Coverage. Upon notification by the Plan Administrator of his or her right to COBRA Continuation Coverage under the Plan, a Qualified Beneficiary must affirmatively elect COBRA Continuation Coverage before the expiration of the Election Period.

5.6 Contributions. A Qualified Beneficiary who elects COBRA Continuation Coverage under the Plan shall be required to pay a premium for any period of continued coverage, such premium to be one hundred and two percent (102%) of the cost to the Plan of coverage for Similarly Situated Beneficiaries. The first required payment must be paid within forty-five (45) days of the date the COBRA Continuation Coverage is elected under Section 5.5.

5.7 Alternative Coverage. If made available by the Plan Administrator, a Qualified Beneficiary may elect between COBRA Continuation Coverage and the alternative coverage made available under the Plan. If, prior to the expiration of the Election Period, the Qualified Beneficiary elects COBRA Continuation Coverage in lieu of alternative coverage, his or her right to alternative coverage shall be forever waived and he or she shall not thereafter be entitled to elect the alternative coverage. If, prior to the expiration of the Election Period, the Qualified Beneficiary elects alternative coverage in lieu of COBRA Continuation Coverage, his or her right to COBRA Continuation Coverage shall be forever waived and he or she shall not thereafter be entitled to elect the COBRA Continuation Coverage.

ARTICLE VI ADMINISTRATION

6.1 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.

6.2 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:

- (1) To prescribe procedures to be followed by Participants in making elections under the Plan and in filing claims under the Plan;
- (2) To prepare and distribute information explaining the Plan to Participants;
- (3) To receive from Participants and Dependents such information as shall be necessary for the proper administration of the Plan;
- (4) To keep records of elections, claims, and disbursements for claims under the Plan, and any other information required by ERISA or the Code;
- (5) To appoint individuals or committees to assist in the administration of the Plan and to engage any other agents as it deems advisable;
- (6) To accept, modify or reject Participant elections under the Plan;
- (7) To promulgate election forms and claims forms to be used by Participants, which may be electronic in nature;
- (8) To determine and enforce any limits on benefit elections hereunder; and
- (9) 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 or Dependent, in whatever manner the Plan Administrator deems appropriate, including suspensions or recoupment of, or offsets against, future payments due that Participant or Dependent .

6.3 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 by reduction of Participant HRA Accounts to the extent not paid by the Sponsors.

6.4 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.

6.5 Information to be Supplied by Sponsor. Each 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 a Sponsor.

6.6 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:

- (1) specific reasons for the decision;
- (2) specific references to the pertinent plan provisions on which the decision 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 claim for benefits;
- (4) 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

(5) a statement of the claimant'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.

6.7 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 VII GENERAL PROVISIONS

7.1 Amendment and Termination. Although the Sponsors intend to maintain the Plan for an indefinite period, the Sponsors reserve 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, benefits paid by the Plan, and the amount of Benefit Credits to be credited, and the right to reduce or eliminate existing HRA Accounts.

7.2 Sponsor Liability. Benefits under the Plan are paid by the Sponsors out of their general assets.

7.3 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.

7.4 QMCSO. In the event the Plan Administrator receives a medical child support order (within the meaning of ERISA Section 609(a)(2)(B)), the Plan Administrator shall notify the affected Participant and any alternate recipient identified in the order of the receipt of the order and the Plan's procedures for determining whether such an order is a qualified medical child support order (within the meaning of ERISA Section 609(a)(2)(A)). Within a reasonable period, the Plan Administrator shall determine whether the order is a qualified medical child support order and shall notify the Participant and alternate recipient of such determination.

7.5 Facility of Payment. If the Plan Administrator deems any person incapable of receiving benefits to which he or she is entitled by reason of minority, 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 Sponsors.

7.6 Lost Distributees. Any benefit payable hereunder shall be deemed forfeited if, after reasonable efforts, the Plan Administrator is unable to locate the Participant to whom payment is due.

7.7 Status of Benefits. Neither the Sponsors nor the Plan Administrator makes 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 or Sponsors 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.

7.8 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.

7.9 Capitalized Terms. Capitalized terms shall have the meaning set forth in Article II.

7.10 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 Trustees have caused this Retiree Health Reimbursement Arrangement to be executed this _____ day of December, 2010.

HANFORD EMPLOYEE WELFARE TRUST

By _____
Its Chairman of the Board of Trustees