HEALTH REIMBURSEMENT ARRANGEMENT PLAN

Eligible U.S. Participants
CONTENTS

About This Summary Plan Description ................................................................. 2
  Updates ................................................................................................................. 2
About The HRA ....................................................................................................... 3
Eligibility and Enrollment ....................................................................................... 3
  How and When to Enroll ...................................................................................... 4
  When Participation Ends ...................................................................................... 4
About The HRA Contribution ................................................................................ 5
  Eligible Expenses ............................................................................................... 6
  Ineligible Expenses ............................................................................................. 6
Getting Reimbursed From Your HRA ................................................................. 7
  Claim Submission Timeframes .......................................................................... 7
  COBRA Coverage ............................................................................................... 9
  Converting Coverage .......................................................................................... 10
Rules and Regulations ......................................................................................... 10
  Your Rights Under ERISA ................................................................................ 10
  Claim Review and Appeals Procedures ............................................................ 12
  Right of Recovery ............................................................................................... 14
  Plan Termination ............................................................................................... 14
  Administrative Information .............................................................................. 15
Contacts .................................................................................................................. 17
Glossary .................................................................................................................. 18
ABOUT THIS SUMMARY PLAN DESCRIPTION

This summary plan description (SPD) provides a concise description of the Weyerhaeuser Health Reimbursement Arrangement (HRA) Plan (the “Plan”) effective January 1, 2015.

This SPD contains detailed and important information about the HRA. Every attempt has been made to communicate this information clearly and in easily understandable terms. Certain terms used to describe the Plan may be found in the “Glossary.”

If there is any conflict between the information in this SPD and the legal Plan document, the legal Plan document will govern. Weyerhaeuser Company (“Weyerhaeuser” or “the Company”) or its applicable delegate has sole and absolute discretion and authority to interpret the terms of Weyerhaeuser employee benefit plans, resolve any ambiguities and inconsistencies in the Plan, and make all decisions about eligibility for and entitlement to benefits.

Weyerhaeuser Company is the Plan sponsor and Plan administrator. Weyerhaeuser contracts with third party administrators (OneExchange) to provide customer service and claims administration for the benefits described in this SPD.

Weyerhaeuser intends to continue the Plan described in this SPD indefinitely. It does, however, reserve the right to amend, modify, suspend, or terminate any benefits in whole or in part, at any time and for any reason. Nothing in this SPD creates a guarantee of current or future benefits.

Updates

If the Company changes the Plan, you will receive a summary of material modifications (SMM) document that describes the changes. SMMs and the Plan changes they describe become part of this SPD and, as such, should be kept with this SPD.
ABOUT THE HRA

The HRA is a Weyerhaeuser-funded account that can be used to reimburse your qualified health care expenses, on a tax-free basis. The Plan is administered by Towers Watson’s OneExchange. Enrollment in a medical insurance policy through OneExchange is required. An HRA will be established for participants who are eligible to receive retiree medical financial assistance from Weyerhaeuser on or after January 1, 2015 and who are enrolled in (and maintain enrollment in) an individual health insurance policy through OneExchange. The HRA funds are not taxable and can be used to reimburse expenses you have for your health care premiums and your share of qualified health care expenses during the year.

ELIGIBILITY AND ENROLLMENT

You must meet the Plan’s eligibility requirements to be eligible for an HRA. Coverage under the HRA is provided as follows:

<table>
<thead>
<tr>
<th>Weyerhaeuser retiree</th>
<th>Spouse of Weyerhaeuser retiree</th>
<th>Disabled dependent child of Weyerhaeuser retiree</th>
</tr>
</thead>
<tbody>
<tr>
<td>You are eligible for the Plan if you are:</td>
<td>If you are eligible* to receive financial assistance from Weyerhaeuser, your spouse (as defined by federal law) is eligible for this Plan if he/she is:</td>
<td>In limited circumstances, your permanently disabled dependent child is eligible for this Plan if you are eligible* to receive retiree medical financial assistance from Weyerhaeuser and that assistance includes subsidizing coverage for dependent children. You or your spouse must be enrolled in an individual health insurance policy through OneExchange to enroll an eligible child.</td>
</tr>
<tr>
<td>- A Medicare-eligible Weyerhaeuser retiree who is eligible* to receive retiree medical financial assistance from Weyerhaeuser on or after January 1, 2015, and are</td>
<td>- Eligible for Medicare,</td>
<td>To maintain HRA eligibility, your dependent child must continue to be permanently disabled, must enroll in coverage through OneExchange** and not be covered by any other group health plan sponsored by Weyerhaeuser.</td>
</tr>
<tr>
<td>- Enrolled in (and maintain enrollment in) an individual health insurance policy through OneExchange.*</td>
<td>- Enrolled in (and maintain enrollment in) an individual health insurance policy through OneExchange** and</td>
<td></td>
</tr>
<tr>
<td></td>
<td>- Not enrolled in any other group health plan sponsored by Weyerhaeuser.</td>
<td></td>
</tr>
</tbody>
</table>

* You are not eligible for HRA funding if you are classified as a Salaried Plan 2 retiree, unless Weyerhaeuser has determined that you have extended eligibility based on contractual rights supplemental to the Plan.

**The only exceptions to the OneExchange enrollment requirement is if you are enrolled in TRICARE or can demonstrate there is no individual health or prescription drug plan available in your area through OneExchange. Contact OneExchange for more information.
How and When to Enroll
If you meet the Plan’s eligibility requirements, you are automatically a participant in this Plan. Other than enrollment in an individual policy through OneExchange, no enrollment in the HRA is required.

When Participation Ends
Participation in the HRA ends as follows:

<table>
<thead>
<tr>
<th>If you are a...</th>
<th>Your participation in the HRA ends...</th>
</tr>
</thead>
<tbody>
<tr>
<td>Weyerhaeuser retiree</td>
<td>• When you are no longer eligible for an HRA, for any reason,</td>
</tr>
<tr>
<td></td>
<td>• On the date you are rehired by Weyerhaeuser as an active employee,</td>
</tr>
<tr>
<td></td>
<td>• When you are no longer eligible for Medicare,</td>
</tr>
<tr>
<td></td>
<td>• When you die,</td>
</tr>
<tr>
<td></td>
<td>• When you are no longer enrolled in an individual health policy through OneExchange,</td>
</tr>
<tr>
<td></td>
<td>• On the effective date of any amendment terminating your eligibility under the Plan, or</td>
</tr>
<tr>
<td></td>
<td>• On the date the Plan is terminated.</td>
</tr>
<tr>
<td>Spouse and/or eligible dependent child</td>
<td>• When you are no longer eligible for an HRA, for any reason,</td>
</tr>
<tr>
<td></td>
<td>• When you are no longer eligible for Medicare,</td>
</tr>
<tr>
<td></td>
<td>• When you die,</td>
</tr>
<tr>
<td></td>
<td>• On the date you are no longer considered an eligible dependent, for any reason,</td>
</tr>
<tr>
<td></td>
<td>• When you are no longer enrolled in an individual health policy through OneExchange,</td>
</tr>
<tr>
<td></td>
<td>• On the effective date of any amendment terminating your eligibility under the Plan, or</td>
</tr>
<tr>
<td></td>
<td>• On the date the Plan is terminated.</td>
</tr>
</tbody>
</table>
ABOUT THE HRA CONTRIBUTION

The HRA is an account that Weyerhaeuser establishes on your behalf. Weyerhaeuser will make an annual HRA contribution on behalf of each eligible participant on the first day of each Plan year. The contributions are evaluated each year and Weyerhaeuser reserves the right to change or discontinue funding the Plan in the future.

The HRA funds are not taxable and can be used to reimburse eligible expenses for health care premiums and/or your share of qualified health care expenses during the year on a tax-free basis. You may not make additional contributions to the account.

For participants who become eligible for an HRA during the year, Weyerhaeuser will prorate the annual HRA contribution for the number of months remaining in the calendar year.

EXAMPLE:

<table>
<thead>
<tr>
<th>If you become eligible for the HRA on...</th>
<th>Weyerhaeuser will contribute...</th>
</tr>
</thead>
<tbody>
<tr>
<td>July 1</td>
<td>50 percent of the annual contribution to reflect the six months you are eligible for the Plan.</td>
</tr>
<tr>
<td>October 1</td>
<td>25 percent of the annual contribution to reflect the three months you are eligible for the Plan.</td>
</tr>
</tbody>
</table>

An HRA will be established for you and your Medicare-eligible spouse if each of you enrolls in an individual health policy through OneExchange and are eligible to receive financial assistance from Weyerhaeuser. In limited circumstances, an HRA will be funded for dependent children who meet eligibility requirements.

You will receive account statements that show your HRA balance and reimbursement activity. This information is also available online at https://medicare.oneexchange.com/wy.

Individual vs. Joint HRA Account

The type of account that is set up depends on how many family members are enrolled in an individual health policy through OneExchange and eligible for an HRA. If only one family member is enrolled in an individual health policy through OneExchange, the HRA will be established as an individual account. This means that only expenses for the eligible participant are eligible for reimbursement.

If both you and your spouse are Medicare-eligible and enrolled in policies through OneExchange, the account will be a joint account.

This means that eligible expenses for both you and your spouse will be eligible for reimbursement under the joint account. The same joint-account feature applies for eligible dependent children with an HRA. If one participant loses eligibility during the year (e.g., death, no longer considered eligible, etc.) the remaining eligible participants may be reimbursed from the joint HRA account for their eligible expenses.
HRA Amount Does Not Continue From One Year to Next

All HRA amounts allocated to you for a given calendar year must be used in the same year. They do not continue to the next year. See “Claim Submission Timeframes” for more information.

Eligible Expenses

To be eligible for reimbursement, an expense must be incurred by an eligible participant and it must be an eligible health care expense. Eligible health care expenses include:

- Premiums for coverage under a:
  - Medicare Part B plan (and Medicare Part A if applicable).
  - Medicare Supplement plan.
  - Medicare Advantage plan.
  - Medicare Part D prescription drug plan.
  - Dental plan.
  - Vision plan.
  - Long-term care insurance plan.
- Out-of-pocket medical expenses like deductibles, copayments, and your share of coinsurance.
- Out-of-pocket prescription drug expenses.
- Dental and vision out-of-pocket expenses.

Ineligible Expenses

The following expenses cannot be reimbursed under the HRA:

- Expenses that may be reimbursed by another medical, dental, vision, workers’ compensation, or accident or private insurance, or through Medicare or another federal or state program.
- Expenses you already claimed or will claim as deductions or credits on a federal or state income tax return.
- Expenses incurred for cosmetic surgery or similar procedures, unless they are determined to be medically necessary.
- Funeral or burial expenses.
- General health and well being expenses (e.g., exercise, fitness, and nutrition programs and recreation, vacations, and spa memberships).
- Expenses that are not eligible to be claimed as deductions on your federal income tax return.
- Expenses that are incurred before you become or after you were a Plan participant.
- Tooth-whitening procedures.

For a complete list of HRA-eligible expenses, access online information at [https://medicare.oneexchange.com/wy](https://medicare.oneexchange.com/wy) or contact customer service at 888.612.8197.
GETTING REIMBURSED FROM YOUR HRA

This section provides information about claim submission timeframes. Also included are descriptions about how to submit claims – either online, via a hard copy claim form or through automatic reimbursement of premium payments.

Claim Submission Timeframes
You may submit claims for eligible expenses incurred during the Plan year (January 1 through December 31) anytime until March 31 of the following year if you remained an eligible participant for the entire Plan year. If you do not submit claim forms for the total amount available in your HRA by March 31, of the following year, the unused portion will be forfeited.

If you were not eligible for the HRA for the entire calendar year, only expenses incurred while you were eligible may be reimbursed. (Note: You still have until March 31 of the following year to submit those expenses but they must be for dates of service while you were an eligible participant.)

In the case of death, a participant’s estate may submit claims for eligible health care expenses incurred by the participant as long as the claims are submitted within the lesser of 180 days (six months) after the participant’s death or by March 31 of the following year.

In the case of a joint HRA account where one participant loses eligibility during the year, expenses for the remaining participants may be reimbursed from the joint HRA account for the remainder of the calendar year as long as they remained eligible participants.

How Automatic Reimbursement Works
Some medical policies through OneExchange offer an automatic reimbursement of insurance premiums option. This feature allows you to be reimbursed automatically from your HRA (to the extent that HRA funds are available) for your insurance premium payments without having to submit claim forms.

OneExchange can assist you in determining whether the plans you are enrolled in offer this feature.

How to Submit Claims
Claim forms may be obtained online or by calling OneExchange at 888.612.8197. You must submit supporting documentation to be reimbursed for eligible expenses. Documentation on the HRA claim form includes:

- Name of HRA participant whose expenses you are seeking reimbursement. (Note that the claim form provides for reimbursement for two participants.)
- Name of provider.
- Date of service (or coverage period if seeking premium payment reimbursement).
- Reimbursement request amount.
Copies of your receipts and other documentation should be included with the completed claim form. If you are submitting a claim for your monthly insurance premiums, attach a copy of the premium invoice and a copy of your bank statement or cancelled check that verifies you made the payment.

Before submitting a claim, make sure that the expense will not be paid by another benefit plan (e.g., your Medicare plans, dental or prescription drug plan).

Claims are processed in the order received and reimbursement checks should be received approximately 14 days after your claim is processed. Reimbursements will either be:

- Mailed to your address on file with OneExchange.
- Deposited directly into your checking or savings account, if you elect direct deposit. Direct deposit payments are issued approximately three business days after they are approved. Contact OneExchange for more information about the direct deposit option.

If additional information is needed to process your claim which requires an extension, you will receive a written notice within 30 days after you initially submitted the claim. The notice will:

- Explain why an extension is needed,
- Identify any additional information required, and
- Indicate when a claim determination will be provided.

The administrator has up to 45 days from the date the claim was initially submitted to make a decision.

**REVISED CLAIMS**

If you do not follow the proper claim procedures (e.g., including itemized receipts, correct signatures, etc.), you will receive within 30 days a written notice that specifies what information is needed and procedures for properly submitting a claim.

<table>
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<tr>
<th>Important</th>
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<tbody>
<tr>
<td>If additional claim information is needed to process your claim, the initial notification deadline for claim determination is suspended from the time that you are contacted with the request for information until you provide the information.</td>
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</tbody>
</table>

The claim determination period resumes when the administrator receives a response to the request for additional information, without regard to whether you have supplied all the necessary information to decide the claim or on the date such information was due if you did not respond. You must respond with the requested information within 45 days after the request. A claim determination decision will then be made within 15 days of your response.
**COBRA Coverage**

This section is intended to comply with the Consolidated Omnibus Budget Reconciliation Act (COBRA) of 1985, as amended, which requires continuation of this coverage to certain eligible participants and/or their covered dependents in most circumstances when the HRA coverage would otherwise end.

If you or your HRA-eligible dependents experience a qualifying COBRA event that causes a loss of coverage under the plan, (e.g., divorce or legal separation, etc.), charges incurred after the last day you or your dependents were eligible will not be eligible for reimbursement unless you and/or your dependents enroll in COBRA and pay the required contributions. **Contact the Weyerhaeuser Employee Service Center at 800.833.0030 for additional information.**

**ELECTING COBRA COVERAGE**

If you or your dependents become eligible for COBRA coverage, contact the Employee Service Center, the COBRA administrator, about your and/or your eligible dependents’ rights to continue participation through COBRA, as well as the monthly costs.

Participants have 60 days from the date their participation ends or the date they receive COBRA notification (whichever is later) to call the Employee Service Center with a decision about whether to continue participation through COBRA.

If a person chooses to continue and pays the required COBRA premium, participation in the HRA is retroactive to the date participation originally ended.
WHEN COBRA COVERAGE ENDS
If you elect to continue your HRA account and continue to make timely COBRA payments, you will continue to be eligible for the HRA account for up to a maximum of 36 months from your COBRA qualifying event. Your COBRA coverage can end earlier if one of the following occurs:

- Weyerhaeuser terminates the Plan.
- You fail to pay the required contributions by the due date noted on your COBRA statement.
- You are found to be ineligible for COBRA. In this case, the Plan reserves the right to end participation retroactively.

Converting Coverage
After termination, you cannot convert your HRA to an individual HRA not associated with your HRA through OneExchange.

RULES AND REGULATIONS
The information in this summary plan description is intended to comply with the disclosure requirements of the regulations issued by the U.S. Department of Labor under the Employee Retirement Income Security Act of 1974 (ERISA), as amended. If there is any inconsistency between the SPD and the Plan document, the Plan document governs.

This section describes certain rules and regulations that affect you as a participant in the HRA.

Your Rights Under ERISA
As a Plan participant in the HRA, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA), as amended, that entitle you to:

- Examine, at the Plan administrator’s office and other specified locations, including work sites and union halls, if applicable, without charge, all Plan documents governing the Plan. These documents may include insurance contracts and certificates, collective bargaining agreements, if any, and 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, after sending a written request to the Plan administrator, copies of documents governing the operation of the Plan, including insurance contracts and certificates and collective bargaining agreements, if any, and copies of the latest annual report (Form 5500 Series) and updated SPD. You may be asked to pay a fee for the copies.
- Receive a written summary of the Plan’s latest annual report (Form 5500 Series). The Plan administrator is required by law to provide each participant with a copy of the summary annual report.
• Continue coverage for yourself and/or your covered dependents if there is a loss of coverage under the Plan as a result of a qualifying event. You or your covered dependents may have to pay for such coverage. Review this SPD and the documents governing the Plan on the rules related to your COBRA coverage rights.

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

If your claim for a benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

Under ERISA, there are several steps you can take to enforce your rights. For instance, if you request a copy of Plan documents or the latest annual report (Form 5500 Series) from the Plan and do not receive it 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 Plan administrator’s control.

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. If 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 federal court. In addition, if you disagree with the Plan’s decision or lack of decision about the qualified status of a domestic relations order or a medical child support order, you may file suit in 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 sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees if, for example, it finds your claim is frivolous.

If you have questions about the Plan, contact the Plan administrator. If you have questions about this statement or your rights under ERISA, or if you need assistance in obtaining documents from the Plan administrator, contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your phone directory. You may also contact:

Division of Technical Assistance and Inquiries,  
Employee Benefits Security Administration  
U.S. Department of Labor  
200 Constitution Avenue NW  
Washington, DC 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.
Claim Review and Appeals Procedures

(a) **Requesting an Appeal.** If a claim for reimbursement is partially or wholly denied under the Plan, a Participant or his or her authorized representative (each, a “Claimant”) may appeal the decision pursuant to the requirements of the Plan, which offers a two-stage appeals procedure. The terms of this procedure, as of the effective date of this SPD, are set forth below.

To request an appeal, a Claimant must submit the request in writing to the claims administrator within 180 days of receipt of a denial notice. The Claimant must send his or her written appeal to the claims administrator at the following address:

Weyerhaeuser Company HRA Claim Appeal  
Attention: Benefits & Compensation Department  
CH 3K33  
P0 Box 9777  
Federal Way, WA 98063-9777

The Claimant should state the reason why the appeal should be approved and include any information and documents supporting the appeal.

(b) **Level One Appeals.** A designated representative of the Benefits & Compensation Department will review and decide a Level One appeal. This claims administrator will be a person who did not make the initial claim decision and who is not subordinate to the initial decision maker. The decision on a Level One appeal will not afford deference to the initial claim decision.

The claims administrator will respond to a Claimant in writing with a decision within 30 calendar days after it receives an appeal.

(c) **Level Two Appeals.** If a Claimant is dissatisfied with the Level One appeal decision, the Claimant may request a second review. The procedure for requesting this review through a Level Two appeal is the same as the procedure for requesting a Level One appeal. However, the Claimant must request a Level Two appeal within 60 days of receipt of a Level One appeal denial notice. The Claimant should state the reason why he or she feels the appeal should be approved and include any information supporting the appeal.

Level Two appeals will be decided by the Weyerhaeuser Company Employee Benefit Appeals Committee (the “Appeals Committee”) as the claims administrator. The Appeals Committee has the full authority to act on behalf of the Plan Administrator with respect to appeals.

The Appeals Committee will respond to a Claimant in writing with a decision within 30 calendar days after it receives an appeal.

(d) **Rights During the Claims Administrator’s Review of an Appeal.** In connection with an appeal:

- The Claimant has the right, upon request and at no charge, to have reasonable access to and to obtain copies of all Relevant Information (defined below).
• The Claimant has the right to submit in writing any comments, documents, records and other information relating to the claim for consideration by the claims administrator during its review of the appeal.

• The Claimant has the right to request information about the medical or vocational experts, if any, consulted as a part of the claims process.

“Relevant Information” means any document, record or other information that: (1) was relied upon in making the benefit determination; (2) was submitted, considered or generated in the course of making the benefit determination, without regard to whether such document, record or other information was relied upon in making the benefit determination; (3) demonstrates compliance with the administrative processes and safeguards required by federal law in making the benefit determination; or (4) constitutes a statement of policy or guidance with respect to the Plan concerning the denied benefit, without regard to whether such advice or statement was relied upon in making the benefit determination.

(e) Notice of Benefit Determination on Appeal. If an appeal is denied, a Claimant will receive written or electronic notice. If the decision is an adverse determination, the notice will include, as applicable:

• information sufficient to identify the claim involved (including the date of service, the health care provider and the claim amount),

• the specific reasons for the denial, as well as a description of the Plan’s standard, if any, that was used in denying the claim, and a discussion of the decision,

• the references to specific Plan provisions on which the denial was based,

• a description of any additional material or information necessary for the Claimant to complete his or her claim and an explanation of why the information is necessary,

• a description of the Plan’s claims procedure, including information as to how to request an appeal, and all applicable time limits,

• a statement of the Claimant’s right to bring a civil action under Section 502(a) of ERISA following a denial of the Level Two appeal,

• any specific internal rule, guideline, protocol or similar criterion that was relied upon in denying the claim, or a statement that a copy of such criterion will be provided free of charge upon request, and

• 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 Relevant Information in connection with his or her claim for benefits.
**Legal Action.** Decisions on appeal are final and binding. However, because the Plan is governed by ERISA, a Claimant has the right to bring a civil action under Section 502(a) of ERISA if the Claimant is not satisfied with the outcome of the claims procedure. The Claimant may not initiate a legal action until he or she has completed both the Level One and Level Two appeal processes.

Any legal action under Section 502(a) of ERISA claiming benefits or challenging a denial of benefits must be filed no later than one year after a Claimant is notified of the decision on a Level Two appeal.

If a Claimant fails to file a legal action within the preceding limitations period or fails to complete and exhaust the written claims procedure prior to filing such legal action, the Claimant shall forfeit his or her right to proceed in a court of law. In the case of a claim that is appealed in a timely manner by the Claimant, the decision by the Appeals Committee shall be the final and conclusive administrative review proceeding under the Plan. Any further review, judicial or otherwise, of the Appeals Committee’s decision on the claim will be limited to whether, in the particular instance, the Appeals Committee abused its discretion. In no event will such further review, judicial or otherwise, be on a de novo basis, because the Appeals Committee has discretionary authority to determine eligibility for and the amount of benefits under the Plan and to construe and interpret the terms of the Plan.

**EXHAUSTION OF ADMINISTRATIVE REMEDIES**

You must first exhaust all administrative remedies as set forth in the Plan’s claims procedures before you may bring suit in court for the denial of any claim. If you do not do so in a timely manner, you will forfeit your right to sue.

**Right of Recovery**

If a benefit is paid that is larger than the amount allowed by the Plan or if a claim is denied and it is determined that an overpayment was made, the Plan has a right to recover the excess amount. OneExchange and the Company must produce any instruments or papers necessary to ensure the right of recovery, unless prohibited by law, and present them to the person receiving benefits.

**Plan Termination**

Weyerhaeuser intends to continue the Plan described in this SPD indefinitely. It does, however, reserve the right to amend, modify, suspend, or terminate it in whole or in part, at any time and for any reason. While Weyerhaeuser may terminate the Plan at any time, no such termination will affect the right of any participant to receive reimbursement as a Plan participant.
**Administrative Information**

The information in this SPD is intended to comply with disclosure requirements of regulations issued by the U.S. Department of Labor under the Employee Retirement Income Security Act of 1974, as amended (ERISA).

| Agent for service of legal process | Weyerhaeuser Company  
Corporate Secretary  
Law Department  
33663 Weyerhaeuser Way South  
Federal Way, WA 98003  
253.924.2345  
Service of legal process may also be made on the Plan administrator. |
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<tbody>
<tr>
<td>Employer identification number</td>
<td>91-0470860</td>
</tr>
</tbody>
</table>
| Employer name and address | Weyerhaeuser Company  
PO Box 9777  
Federal Way, WA 98063-9777 |
| Plan administrator | The Plan administrator has the authority to control and manage the operations and administration of each Plan. In exercising its discretionary powers under the Plan, the Plan administrator and any designee will have the broadest discretion permissible under ERISA and any other applicable laws, and its decisions will constitute final review of your claim by the Plan. Benefits will be paid only if the Plan administrator or its designee including OneExchange who contract with Weyerhaeuser to assist with plan administration, decides in its discretion that the applicant is entitled to them. You can reach the administrator at:  
Weyerhaeuser Company  
Benefits & Compensation  
CH 3K33  
PO Box 9777  
Federal Way, WA 98063-9777  
800.833.0030 |
<p>| Plan name | The Plan name is the Weyerhaeuser Health Reimbursement Arrangement (HRA) Plan. |
| Plan number | 677 |</p>
<table>
<thead>
<tr>
<th>Plan sponsor</th>
<th>Weyerhaeuser Company</th>
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<tbody>
<tr>
<td></td>
<td>Benefits &amp; Compensation</td>
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<tr>
<td></td>
<td>CH 3K33</td>
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<td>PO Box 9777</td>
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<td>Federal Way, WA 98063-9777</td>
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<td></td>
<td>800.833.0030</td>
</tr>
<tr>
<td>Plan year</td>
<td>January 1 through December 31</td>
</tr>
<tr>
<td>Source of benefits funding</td>
<td>Weyerhaeuser pays the full cost of the Plan. Claims are paid directly from the Company’s general assets.</td>
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<tr>
<td>Claims submission agent</td>
<td>Towers Watson</td>
</tr>
<tr>
<td></td>
<td>P.O. Box 2396</td>
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<td>Omaha, NE 68103-2396</td>
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<td>Fax: 855-321-2605</td>
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## CONTACTS

<table>
<thead>
<tr>
<th>Plan eligibility and participation</th>
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<tbody>
<tr>
<td>Ask questions about Plan eligibility and participation changes</td>
<td>Weyerhaeuser Company Employee Service Center CH 3H37 PO Box 9777 Federal Way, WA 98063-9777 800.833.0030</td>
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<tr>
<td>Ask HRA questions</td>
<td>OneExchange 10975 S. Sterling View Drive, Suite A-1 South Jordan, UT 84905 888.612.8197</td>
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<tr>
<th>Filing claims for reimbursement</th>
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<tbody>
<tr>
<td>Where to file claims</td>
<td>Towers Watson P.O. Box 2396 Omaha, NE 68103-2396 Fax: 855-321-2605</td>
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<tr>
<th>COBRA enrollment information and costs</th>
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<tbody>
<tr>
<td>Ask questions about COBRA</td>
<td>Weyerhaeuser Company Employee Service Center CH 3H37 PO Box 9777 Federal Way, WA 98063-9777 800.833.0030</td>
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<th>HRA claims and appeals</th>
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<tr>
<td>HRA claims and appeals</td>
<td><strong>Level One Appeals:</strong> Weyerhaeuser Company HRA Claim Appeal Attention: Benefits &amp; Compensation Department CH 3K33 PO Box 9777 Federal Way, WA 98063-9777 <strong>Level Two Appeals:</strong> Weyerhaeuser Company HRA Claim Appeal Attention: Employee Benefit Appeals Committee Chairperson CH 3K33 PO Box 9777 Federal Way, WA 98063-9777</td>
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GLOSSARY

Appeal
An inquiry submitted for reconsideration of a denied claim. A claims administrator reviews the inquiry and decides if the claim’s previous denial should be overturned. Certain inquiries are governed by requirements set forth by the Employment Retirement Income Security Act of 1974, as amended, (ERISA), including how inquiries are submitted and responded to, relevant time frames, and responsibilities of the claimant and claims administrator.

Company
Weyerhaeuser Company and its participating U.S. subsidiaries.

Deductible
The amount of out-of-pocket expense you must pay for services before the Plan pays most expenses.

Effective date
The earliest date for which you are eligible to participate in the Plan.

ERISA
The Employee Retirement Income Security Act of 1974 (ERISA), as amended, which provides certain rights to eligible participants.

Plan year
The 12-month period from January 1 through December 31.

Summary plan description
A summary plan description (SPD) is a legally required document that describes your benefits in detail, how the Plan operates, how to file claims, and your rights and responsibilities as an eligible Plan participant. This booklet is your summary plan description for the Weyerhaeuser Health Reimbursement Arrangement (HRA) Plan.

Tax information
Although your HRA claims are processed carefully to help you ensure compliance with Internal Revenue Code tax rules related to eligible expenses, you are ultimately responsible for determining which expenses are eligible for reimbursement. The Plan makes no guarantee that any expenses reimbursed through your HRA may be excluded from your gross income for federal or state income tax purposes.

If an expense reimbursement should not have been excluded from your income for tax purposes, you are solely responsible for federal or state income tax reporting and payment corrections that may be required.