PLAN DOCUMENT AND SUMMARY PLAN DESCRIPTION

FOR

International Association of Machinists and Aerospace Workers District Lodge W-24 Flexible Spending Account Plan

Restated Effective January 1, 2011

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INTRODUCTION

International Association of Machinists and Aerospace Workers District Lodge W-24, (the “Employer”) is pleased to sponsor Flexible Benefit Plans for you and your fellow employees.

International Association of Machinists and Aerospace Workers District Lodge W-24 (the “Employer”) established the Flexible Spending Account Plan (the "Plan") for its Employees. The Plan is intended to qualify as a cafeteria plan under the provisions of Code Section 125.

The “Plan” consists of Health Care and Dependent Care Flex benefits. You are allowed to use pre-tax dollars to pay for qualified services & expenses by entering into a salary reduction arrangement with the Employer. This Plan helps you because the benefits you elect are nontaxable (e.g., you save social security and income taxes on the amount of your salary reduction).

This information is an overview of the Flexible Benefit Plan offered by International Association of Machinists and Aerospace Workers District Lodge W-24 (the Employer). This SPD describes the basic features of the Plan. Nothing within this document says or implies that participation in the plan is a guarantee of continued employment. Nor is it a guarantee that participation under the plan for employees will exist or remain unchanged in the future years. No oral interpretations can change this Plan.

The Employer intends to maintain this Plan. However, it reserves the right to amend, terminate, suspend, discontinue or amend this Plan at any time and for any reason. Changes in this Plan may occur in any or all parts of this Plan.

The Plan will pay benefits only for the expenses incurred while this coverage is in force. No benefits are payable for expenses incurred before coverage began or after coverage terminated, an expense for a service or supply is incurred on the date the service or supply is furnished.

If the Plan is terminated, amended, or benefits are eliminated, the rights of Covered Persons are limited to covered charges incurred before termination, amendment, or elimination.

This document summarizes this Plan’s rights and benefits for covered Employees and their covered dependents. The Heath Care Plan is an ERISA Health plan subject to DOL health claim regulations, ERISA Rights, and HIPAA. The Dependent Care Flex benefits are not ERISA plans and therefore not subject to DOL health claim regulations, ERISA Rights, and HIPAA.

PLAN INFORMATION

Employer/Plan Sponsor Information

Name, address, and telephone number of the Employer/Plan Sponsor:	International Association of Machinists and Aerospace Workers District Lodge W-24 25 Cornell Ave Gladstone, OR 97027 503-656-1475
Employer's Federal Tax Identification Number:	27-4665913
Effective Date of the Plan:	January 1, 2010
Effective Date of Restatement	January 1, 2011
Plan Year:	January 1st to December 31st
Name, address, and telephone number of the Plan Administrator:	International Association of Machinists and Aerospace Workers District Lodge W-24 Attn: Connie Bays 25 Cornell Avenue Gladstone, OR 97027 503-656-1475
Plan Number:	503
Third-Party Administrator:	A&I Benefit Plan Administrators, Inc. 1220 SW Morrison Suite #300 Portland, OR 97205 503-222-7696 800-811-8853 ext. 1124 woodworkersflex@aibpa.com www.woodworkersflex.aibpa.com
Name and address of the person designated as the Plan's agent for services of legal process:	Dan Sass 25 Cornell Avenue Gladstone, OR 97027 503-656-1475 • Fax 503-657-2254

THE PRE-TAX ADVANTAGE

How Pre-Tax Dollars Work

Your deposits to the spending account(s) are made with "pre-tax dollars". This money is deducted (payroll deferral(s)) from your paycheck on a monthly basis. Federal income tax, Social Security tax (and most state income taxes) is calculated after this money has been deducted for your paycheck. As a result, your taxable pay is lower and you pay less in taxes. Accordingly, there could be a decrease in your Social Security benefits and/or other benefits (e.g., pension, disability and life insurance) that are based on taxable compensation.

Tax Savings Methods

Because tax laws change frequently, you should talk with a qualified tax advisor before deciding whether to use the flexible spending accounts. By law, the employer can't offer you advice on your spending account decisions or tax issues.

Health Care Spending Account

Two ways to receive tax savings on your health care expenses:

- Defer pre-tax money into the Health Care Spending Account and reimburse yourself to pay for eligible expenses; or
- Deduct unreimbursed expenses from your tax return (expenses are more than 7.5% of your family's gross adjusted income).

You cannot choose both methods of savings; you must decide which tax savings method is best for you.

Dependent Care Spending Account

Two ways to receive a tax break on your dependent care expenses:

- Defer pre-tax money into the Dependent Care Spending Account and reimburse yourself with pre-tax dollars for eligible expenses; or
- Receive a credit on your federal income tax return.

You may be able to use the account and the tax credit in combination; consult your tax advisor for advice.

HOW EACH ACCOUNT WORKS

1. Estimate how much you'll spend for:
    - Eligible health care expenses not reimbursed under any health plan or dental plan in the coming year.
    - Eligible dependent care expenses for the coming year.
2. Enroll in account(s) by completing the appropriate election forms.
3. Payroll deferrals (pre-tax dollars) are deposited into the appropriate account(s) on the last business day of the month from that month's payroll.
4. Pay for eligible service or health care item.
5. File a claim for reimbursement from your account(s).

Amount Available for Reimbursement

The total amount you have chosen to deposit into your Health Care Spending Account is available beginning on the day your participation begins. For Dependent Care, only the balance in your account is available when a claim is submitted.

Claims will be paid on a first come first serve basis upon the availability of funds.

Note: Dependent Care benefits are only reimbursable after services are rendered.

Unused Balances Are Forfeited

Health Care Spending Account

Money remaining in your account at the end of the year for which it was deposited is available for reimbursement for eligible expenses you incurred during that year. Claims for eligible expenses must be received by the Run Out Period (30 days after the end of the plan year for an active employee, 30 days after date of termination of a terminated employee, unless eligible for, timely elects, and pays for COBRA Continuation Coverage).

Any left over dollars beyond the last day of the plan year (or run out period for a terminated employee) must be forfeited.

Unused Balances Are Forfeited (continued)

Dependent Account

Money remaining in your account at the end of the year for which it was deposited is available for reimbursement for eligible expenses you incurred during that year. Claims for eligible expenses must be received by the Run Out Period (30 days after the end of the plan year for an active employee, 30 days after date of termination of a terminated employee).

Any left over dollars beyond the last day of the plan year (or run out period for a terminated employee) must be forfeited.

If You Terminate Employment

If your employment terminates, any claims incurred after the termination date will be ineligible for reimbursement. Unless a COBRA election and payment is made, participants shall not be entitled to receive reimbursement for eligible Medical expenses incurred after employment ceases. Health Care Account balances is forfeited if COBRA election and payment are not received timely.

Refer to “Continuing Coverage” for additional information.

No Transfers between Accounts

Each Account is administered separately and can't be mixed or transferred from one account to another. The money deposited into your Health Care Account can not be used to pay for dependent care expenses, and vice versa.

ELIGIBILTY & ENROLLMENT

Employee Eligibility

Each Employee who works at least 80 hours each month shall be eligible to participate in the Health FSA and Dependent Care FSA Plan.

Your Eligibility date, if you are an eligible employee is the effective date of this Plan. Otherwise, it is the date you commence active work for your Employer or, if later, the date you become an eligible employee.

The employee's commencement of participation in the Plan is conditioned on the employees properly completing and submitting the applicable election forms(s).

Enrolling in the Spending Accounts

Health Care FSA

Each year, you decide if you want to participant in the Health Care Spending Account during the annual open enrollment.

If you're hired or become eligible for benefits during the year, you must complete and return the applicable election form(s) within 30 days of the date you become eligible to participant in the plan.

Dependent Care FSA

Each year, you decide if you want to participant in the Dependent Care Flexible Spending Account during the annual open enrollment.

If you're hired or become eligible for benefits during the year, you must complete and return the applicable election form(s) within 30 days of the date you become eligible to participant in the plan.

If You Don't Enroll

Health Care & Dependent Care FSA

If you choose not to participant in the above spending accounts, you will not be eligible to participate in these accounts until the next annual enrollment (unless you have a qualified change in family status).

When Participation Begins

The date your participation in the spending accounts begins depends on when you are first eligible, and provided you submit your election forms by the deadline. Deductions for the spending account(s) will begin as soon as administratively possible.

If you:	Your Participation Begins:
Enroll during annual enrollment.	January 1
Become eligible on or after January 1 and return your enrollment form within 30 days of the date you become eligible for coverage.	On your eligibility date, such as hire date. Deductions will begin as soon as administratively possible.
Make a change in your benefits selection within 30 days of qualifying family status change (Health Care & Dependent Care).	The date of the qualifying family status change. Deductions will begin as soon as administratively possible.

Changing Your Health Care or Dependent Care Spending Account(s)

If one or more of the following "Changes in Status" occur, you may revoke your old election and make a new election, provided that both the revocation and new election are on account of and correspond with the Change in Status (as described below). Those occurrences that qualify as a Change in Status include the events described below, as well as any other events that the Plan Administrator determines are permitted under subsequent IRS regulations:

• a change in your legal marital status (such as marriage, legal separation, annulment, divorce or death of your Spouse);

• a change in the number of your tax dependents (such as the birth of a child, adoption or placement for adoption of a Dependent, or death of a Dependent);

• any of the following events that change the employment status of you, your Spouse, or your Dependent that affect benefit eligibility under a cafeteria plan (including this Plan and the Plan of another employer) or other employee benefit plan of an employer of you, your Spouse, or your Dependents. Such events include any of the following changes in employment status: termination or commencement of employment, a strike or lockout, a commencement of or return from an unpaid leave of absence, a change in worksite, switching from salaried to hourly-paid, union to non-union, or part-time to full-time; incurring a reduction or increase in hours of employment; or any other similar change which makes the individual become (or cease to be) eligible for a particular employee benefit (**NOTE**: the rules governing election changes when you take a leave of absence are described in the Leave of Absence section of this document);

• an event that causes your Dependent to satisfy or cease to satisfy an eligibility requirement for a particular benefit (such as attaining a specified age);

• a change in your, your Spouse’s or your Dependent’s place of residence.

If a Change in Status occurs, you must inform the Third-Party Administrator and complete a new election within 30 days of the date that you experience the Change in Status event. The election change must be on account of and correspond with the Change in Status event as determined by the Plan Administrator (or its designated third party administrator). With the exception of special enrollment resulting from birth, placement for adoption or adoption, all election changes are prospective. As a general rule, a desired election change will be found to be consistent with a Change in Status event if the event affects eligibility for coverage. A Change in Status affects eligibility for coverage if it results in an increase or decrease in the number of dependents who may benefit under the Plan.

When Participation Ends

Your participation in the spending account(s) ends on the earliest of:

- The day your employment ends;
- The last day of the pay period in which a deferral was made, if you fail to make a required deferral;
- December 31st provided you do not re-enroll during annual enrollment;
- The day you become ineligible to participate in the plan; or
- The day the plan ends.

Participants may submit claims for reimbursement for eligible expenses arising during the Plan Year and before the date of separation from service at any time until the end of the Run Out Period. The Run Out Period for terminated employees is 30 days after the day of termination.

Health Care Spending Account:

Unless a COBRA election and payment is made, participants shall not be entitled to receive reimbursement for eligible Medical expenses incurred after employment ceases.

Dependent Care Account:

Not subject to federal COBRA continuation rules.

Refer to "Continuing Coverage" for additional information.

HEALTHCARE SPENDING ACCOUNT

Participation in the Health Care Spending account is voluntary. There is no annual maximum.

Whose Expense Are Eligible

Your Health Care Flexible Spending Account can be used to reimburse health care expenses for you or your eligible dependent(s).

What's Covered

You may use your Heath Care Spending Account to reimburse yourself for healthcare expenses that are not paid through another source.

See IRS Publication 502 for a listing of qualified eligible expenses, and dependent definitions at www.irs.gov.

Expenses Not Covered

Below is a list of some common examples of expenses that are not eligible for reimbursement. Ineligible expenses include, but are not limited to:

- Cosmetic surgery;
- Electrolysis;
- Employee contributions for coverage;
- Health club dues;
- Hair transplants;
- Vitamins taken for general health purposes.

A listing of ineligible expenses can be viewed at www.irs.gov.

DEPENDENT CARE ACCOUNT

Participation in the Dependent Spending Account is voluntary. If you elect to participate, the maximum elected annual amount is $5,000.00.

IRS regulations do not allow your total reimbursements to exceed you or your spouses' income for that year.

Marital Status	Maximum Deposit
If you are: · Head of household; or · Married and file a joint income tax return; or · Single.	$5,000.00
· Both you and your spouse use a Dependent Care Account:	$5,000.00 total (your deposits & spouse's deposits)
·Married and file separate income tax returns:	$2,500.00
· If your spouse is a full-time student or is physically or mentally unable to care for himself/herself:	·$2,400.00 (one dependent) ·$4,800.00 (with two or more dependents)

Whose Expense Are Eligible

You can use the Dependent Care Spending Account to pay for the care of your children or other eligible dependents, so you and your spouse (if you are married) can work.

An eligible dependent includes your:

- Children under age 13 who qualify as dependents on your tax return; or
- Any age and physically or mentally incapable of taking care of herself or himself and you claim on your federal income tax return.

What's Covered

You may use your Dependent Care Spending Account to reimburse yourself for healthcare expenses that are not paid through another source.

Eligible expenses include:

- Day care expenses for:
    - Your children under age 13.
    - Older children who live with you and are mentally or physically incapable of self support.
    - A disabled parent or spouse who lives with you and depends on you for support.
- Eligible day care expenses include those for care in your home, in a neighbor's home (with no more than six children), at a licensed day care facility or by a relative who is not your spouse or other dependent.

Expenses Not Covered

Below is a list of some common examples of expenses that are not eligible for reimbursement. Ineligible expenses include, but are not limited to:

- Baby-sitting cost while you and your spouse go out to dinner.
- Overnight camps.
- Adult day care for a disabled parent who does not live with you.

For more information about Dependent Care Spending Accounts, refer to IRS Publication 503 Child & Dependent Care Expenses @ www.irs.gov.

CLAIM PAYMENT, FILING & REIMBURSEMENT

Claim Payment

When you have an eligible expense, pay for it and then submit a claim form to A&I Benefit Plan Administrators, Inc.

Claims will be paid on a first come first serve basis upon the availability of funds. Dependent Care funds are available only after the funds have been deducted from your payroll and deposited into your account.

HealthCare Spending Account

Submitting a Paper Claim Form

When you have an eligible expense, pay for it and then submit the claim form to A&I Benefit Plan Administrators, Inc. (A&I) for reimbursement. You must provide proof of the eligible expense with your claim.

Beginning January 1, 2011, you will be required to provide a prescription for substantiation of over-the-counter medicines and drugs per IRS requirements.

Before requesting reimbursement under your Health Care Spending Account, it is important to first submit your medical, dental or vision claim to your (and if applicable your spouses or dependents) health plan for processing. Once your claim has been processed you will receive an Explanation of Benefits (EOB). To request reimbursement under your Health Care Spending Account, simply attach a copy of the EOB that contains the eligible expense information to the claim reimbursement form and send it to A&I.

HealthCare Spending Account (Continued)

Claims will be paid on a first come first serve basis upon the availability of funds.

Run Out

Active Employees

The Run Out Period for active employees is 30 days after the end of the plan year.

Any left over dollars beyond the 30 day Run Out Period will be subject to the “use-it-or-lose it” rule.

Terminated Employees

The Run Out Period for terminated employees is 30 days after the day of termination.

Any left over dollars beyond the Run Out Period will be subject to the “use-it-or-lose it” rule.

Dependent Care Spending Account

Submitting a Paper Claim Form

When you have an eligible expense, pay for it and then submit the claim form to A&I Benefit Plan Administrators, Inc. (A&I) for reimbursement. You must provide proof of the eligible expense with your claim.

To request reimbursement under your Dependent Care Spending Account, simply attach a receipt from the provider, or complete the provider certification on the claim form and submit the claim reimbursement form to A&I.

Dependent Care funds are available only after the funds have been deducted from your payroll and deposited into your account.

Claims will be paid on a first come first serve basis upon the availability of funds in the client bank account.

Run Out

Active Employees

The Run Out Period for active employees is 30 days after the end of the plan year.

Any left over dollars beyond the Run Out Period will be subject to the “use-it-or-lose it” rule.

Terminated Employees

The Run Out Period for terminated employees is 30 days after the day of termination.

Any left over dollars beyond the Run Out Period will be subject to the “use-it-or-lose it” rule.

Denied Claims & Appeals Process

The following procedures describe how benefit claims and appeals are made and decided under this Plan. Please note that health care flexible spending account claims are handled only on a post service basis. See page 23 for the dependent care flexible spending account claims appeal procedure. Please note that all claims must be received by the claims administrator within one year of the date of service or the claim will be denied.

Claim Review Procedures

Once the plan administrator receives information necessary to evaluate the claim, a decision will be made within the time periods outlined in this section. In the event an extension is necessary due to matters beyond the plan administrator's control, you will be notified of the extension and the circumstances requiring the extension. Except where you voluntarily agree to provide the plan administrator with additional time, extensions are limited as outlined in this section. If an extension is necessary because you did not submit complete information, you will be notified of the additional information required. Such notice of incomplete information will be sent within the time periods set forth below. To continue processing your claim, the missing information must be provided to the plan administrator within the time periods outlined in this section. You may contact the plan administrator at any time for additional details about the processing of the claims.

Post-Service Claims or Requests for Benefits That Are Not Pre-Service Claims.

Post-service claim means any claim for a benefit under the plan that is not a pre-service claim. The initial review process for post-service claims or requests for benefits that are not pre-service claims lasts 30 days, unless more information is needed. A post service claim will generally be processed within 30 days of receipt. This period may be extended for up to 15 days if the plan administrator determines an extension of time for making the determination is necessary due to matters beyond the control of the plan and notifies you within the initial 30-day period of the circumstances requiring the extension of time and the date by which the plan expects to render a decision. If additional information is required to reach final determination, the claim is considered incomplete. The plan administrator is required to notify you of an incomplete claim, and the information necessary to reach final determination, within the initial 30-day time period. You will be provided 45 days from receipt of the notification to submit additional information. Upon receipt of the additional information or at the end of the 45 days, whichever is first, the plan administrator will have the remainder of the 30-day time period to reach final determination.

Denied Claims & Appeals Process (Continued)

If Your Claim is Denied
If a request for a claim is denied or partly denied, you will receive a written or electronic notice of the denial, which will include:

•The specific reason(s) for the denial;
•Reference to the specific plan provisions on which the denial is based;
•If applicable, a description of any additional material or information necessary to complete the claim and the reason why the material or information is necessary;
•A description of the appeal procedures; the applicable time frames, including your right to request an appeal within 180 days and your rights to bring a civil action following the appeal process; and
•Any other information that may be required under state or federal laws and regulations. Additionally, if the plan administrator makes an adverse benefit determination, you will receive a statement of your right to receive, upon request and free of charge, any internal rule, guideline, protocol or other similar criterion used in making an adverse benefit determination. Furthermore, if the plan administrator makes an adverse benefit determination because the treatment and/or service is considered experimental or investigational, or the treatment and/or service is not medically necessary, the notice of denial will include a statement that an explanation of the scientific or clinical judgment for such determination will be provided to you upon request, free of charge. If you request, you will also be notified of the identity of any experts consulted in connection with an adverse benefit determination.

Adverse Benefit Determination
Adverse benefit determination means a denial, reduction, or termination of, or a failure to provide or make payment, (in whole or in part), for a benefit, including, without limitation, any such denial, reduction, termination of, or failure to provide or make payment that is based upon

•Your ineligibility for coverage under the plan;
•The plan administrator's determination that the treatment or service is not a covered expense under the plan;
•A utilization review or pre-authorization determination;
•The plan administrator's determination that the treatment or service is considered experimental or investigational; or
•The plan administrator's determination that the treatment is not medically necessary. Additionally, if the plan administrator has previously approved an ongoing course of treatment to be provided over a period of time or a given number of treatments, any reduction or termination of such course of treatment by the plan administrator (other than by plan amendment or termination) before the end of such period of time or number of treatments is an adverse benefit determination.

Denied Claims & Appeals Process (Continued)

Your Right to Appeal
If a request for a claim is denied or partly denied, you shall have a reasonable opportunity for an appeal and a right to a full and fair review.

Opportunity to Request an Appeal
You shall have a reasonable opportunity to appeal an adverse benefit determination in accordance with the provision in this section. As part of the appeal, there will be a full and fair review of the claim decisions. The request for an appeal can be written, electronically or orally submitted and should include any additional information you believe may have been omitted from the plan administrator's review or that should be considered by the plan administrator. The plan administrator will establish and maintain procedures for hearing, researching, recording and resolving any appeal. The notification you receive regarding the plan administrator's claim decision will include instructions on how and where to submit an appeal. You will have no later than 180 days from your receipt of notification of the adverse benefit determination to submit a request for an appeal. By requesting an appeal, you have authorized the plan administrator, or anyone designated by the plan administrator, to review any and all records (including, but not limited to, your medical records) that the plan administrator determines may be relevant to your appeal. Response to Appeals Once the plan administrator receives your request for an appeal, you will receive a response no later than 30 days for post-service claims.

When the plan administrator makes its determination, you will receive a written or electronic notice of the denial, which will include:

- The specific reason or reasons for the adverse benefit determination;
- Reference to the specific plan provisions on which the benefit determination is based;
- A statement that you are entitled to receive without charge reasonable access to any document:
  - relied on in making the determination,
  - submitted, considered or generated in the course of making the benefit determination,
  - that demonstrates compliance with the administrative processes and safeguards required in making the determination, or
  - constitutes a statement of policy or guidance with respect to the plan concerning the denied treatment without regard to whether the statement was relied on.
- If the adverse determination is based on medical necessity or experimental or investigational treatment or a similar exclusion or limit, either an explanation of the scientific or clinical judgment, applying the terms of the plan to your medical condition, or a statement that this will be provided without charge on request; and
- If you request, you will also be notified of the identity of any experts consulted In connection with an adverse benefit determination
- A statement describing your right to bring a civil action under ERISA §502(a).

Denied Claims & Appeals Process (Continued)

Filing Appeals and Notification Requirements

If there is an adverse benefit determination on a Post-Service Care Claim, a request for appeal may be submitted. The appeal must be submitted in writing by the claimant to the below address along with the name of the enrolled employee, the name of the claimant, group name, claim number and the reason(s) you disagree with the decision.

International Association of Machinists and Aerospace Workers District Lodge W-24
c/o A&I Benefit Plan Administrators, Inc.
Attention: Appeals
1220 SW Morrison Street, Suite 300
Portland, OR 97205

Appealing a Denial of Claim for the Dependent Care Flexible Spending Account

If your claim is denied, you will be notified in writing within 90 days after the plan receives the claim. In some cases, an additional 90 days may be required to process your claim. When additional time is needed, you will be notified of the special circumstances requiring the extension and the date a final decision is expected. You will receive the notice before the initial 90 day period expires. Any extension may not exceed a total of 180 days from the date your claim was originally filed. If additional information is necessary to process the claim, you will be notified of the items needed in order to complete it. Any notice of denial of your claim for benefits will include the specific reasons for denial, a reference to the relevant plan provisions on which the denial was based, a description of any additional material or information necessary to perfect the claim and an explanation of why the material or information is necessary, and information as to steps to be taken if you wish to submit the claim for review. Within 60 days after receiving a denial, you or your authorized representative may appeal the decision by requesting a review in writing. Appeals should be sent to: A&I — International Association of Machinists and Aerospace Workers District Lodge W-24 Flex 1220 SW Morrison, Suite 300 Portland, OR 97205-2222. You also have the right to:

•Review the pertinent plan documents and,

•Submit issues and comments in writing.

If you do not submit a written request for a review within 60 days after receiving the denial, you will have waived your right to appeal the decision and the denial will stand. A decision on your appeal will normally be given to you within 60 days following the receipt of your request for review. If special circumstances warrant an extension, you will be notified in writing before the initial 60-day period expires and the decision will be made no later than 120 days after receipt of your appeal. The decision on review shall be final and binding. It will contain specific references to pertinent plan provisions on which the decision is based, will give specific reasons for the decision, and will be written in a readily understandable manner.

CONTINUING COVERAGE

Your participation in the Health Care Spending Account may be continued two different ways:

- While you're away from work (LOA); or
- If your participation in the Health Care Spending Account ends due to voluntary or involuntary termination of your employment (for reasons other than gross misconduct).

Leave of Absence

If you go on a qualifying unpaid leave under the Family and Medical Leave Act of 1993 (FMLA), to the extent required by the FMLA, the Employer will continue to maintain your Health Care FSA Plan providing coverage on the same terms and conditions as though you were still active.

Your Employer may elect to continue while they are on paid leave (provided Participants on non-FMLA paid leave are required to continue coverage). If so, you will pay your share of the contributions by the method normally used during any paid leave (for example, with Pre-tax Contributions if that is what was used before the FMLA leave began).

In the event of unpaid FMLA leave (or paid leave where coverage is not required to be continued), if you opt to continue your group health coverage, you may pay your share of the contribution with after-tax dollars while on leave, or you may be given the option to pre-pay all or a portion of your share of the contribution for the expected duration of the leave with Pre-tax Contributions from your pre-leave compensation by making a special election to that effect before the date such compensation would normally be made available to you provided, however, that pre-payments of Pre-tax Contributions may not be utilized to fund coverage during the next Plan Year, or by other arrangements agreed upon between you and the Plan Administrator (for example, the Plan Administrator may fund coverage during the leave and withhold amounts from your compensation upon your return from leave). The payment options provided by the Employer will be established in accordance with Code Section 125, FMLA and the Employer's internal policies and procedures regarding leaves of absence.

Leave of Absence (Continued)

Alternatively, the Employer may require all Participants to continue coverage during the leave. If so, you may elect to discontinue your share of the required contributions until you return from leave. Upon return from leave, you will be required to repay the contribution not paid during the leave in a manner agreed upon with the Administrator.

If your coverage ceases while on FMLA leave (e.g., for non-payment of required contributions), you will be permitted to re-enter the Plan upon return from such leave on the same basis as you were participating in the Plan prior to the leave, or as otherwise required by the FMLA. Your Health Care coverage under the Benefit Plans may be automatically reinstated provided that coverage for Employees on non-FMLA leave is automatically reinstated upon return from leave.

The Employer may, on a uniform and consistent basis, continue your coverage for the duration of the leave following your failure to pay the required contribution. Upon return from leave, you will be required to repay the contribution in a manner agreed upon by you and your Employer.

If you are commencing or returning from unpaid FMLA leave, your election under this Dependent Care Plan Benefit shall be treated in the same manner that elections for non-health Benefit Plans are treated with respect to Participants commencing and returning from unpaid non-FMLA leave.

If you go on an unpaid non-FMLA leave of absence (e.g., personal leave, sick leave, etc.) that does not affect eligibility in this Plan, then you will continue to participate and the contribution due will be paid by pre-payment before going on leave, by after-tax contributions while on leave, or with catch-up contributions after the leave ends, as may be determined by the Plan Administrator. If you go on an unpaid leave that affects eligibility under this Plan or a Benefit Plan, the election change rules in Q-4 of this SPD will apply. The Plan Administrator will have discretion to determine whether taking an unpaid non-FMLA leave of absence affects eligibility.

Continuing Health Care Spending Account Participation through COBRA

Note: The main advantage of the Health Care Spending Account is the pre-tax deposits (payroll deferrals). If you continue your participation through COBRA, your deposits are on an after-tax basis. Continued participation and deposits allows you to submit claims to your account for expenses incurred after the date your active participation ends (termination date)

If you choose continuation coverage, you may continue the level of coverage you had in effect immediately preceding the qualifying event. However, if Plan benefits are modified for similarly situated active employees, then they will be modified for you and other Qualified Beneficiaries as well. You will be eligible to make a change in your benefit election with respect to the Plan upon the occurrence of any event that permits a similarly situated active employee to make a benefit election change during a Plan Year. If you do not choose continuation coverage, your coverage under the Health Care Spending Account will end with the date you would otherwise lose coverage.

Notice Requirements

You or your covered Dependents (including your spouse) must notify the employer of a divorce, legal separation, or a child losing dependent status under the Plan within 60 days of the later of the date of the event or the date on which coverage is lost because of the event. When the Plan Administrator (or its COBRA Administrator) is notified that one of these events has occurred, the Plan Administrator will in turn notify you that you have the right to choose continuation coverage. You should contact your Plan Administrator for identification of the COBRA administrator. Notice to an employee's spouse is treated as notice to any covered Dependents who reside with the spouse.

Election Procedures and Deadlines

Each qualified beneficiary is entitled to make a separate election for continuation coverage under the Plan. In order to elect continuation coverage, you must complete the election form(s) provided to you by the Plan’s COBRA Administrator. You have 60 days from the date you would lose coverage for one of the reasons described above or the date you are sent notice of your right to elect continuation coverage, whichever is later, to inform the Plan Administrator that you wish to continue coverage. Failure to return the election form within the 60-day period will be considered a waiver, and you will not be allowed to elect continuation coverage.

Continuing Health Care Spending Account Participation through COBRA (Continued)

Cost

You will have to pay the entire cost of your continuation coverage. The cost of your continuation coverage will not exceed 102% of the applicable premium for the period of continuation coverage. The first premium payment after electing continuation coverage will be due 45 days after making your election. Subsequent premiums must be paid within a 30-day grace period following the due date. Failure to pay premiums within this time period will result in automatic termination of your continuation coverage.

Claims incurred during any period will not be paid until your premium payment is received for that period. If you timely elect continuation coverage and pay the applicable premium, however, then continuation coverage will relate back to the first day on which you would have lost regular coverage.

When Continuation Coverage Ends

The maximum period for which coverage may be continued will be until the end of the Plan Year in which the qualifying event occurs. You will be notified if you qualify for continuation coverage and of the duration of continuation coverage when you have a qualifying event. However, continuation coverage may end earlier for any of the following reasons on the dates indicated:

• the contribution for your continuation coverage is not paid on time or it is insufficient (Note if your payment is insufficient by the lesser of 10% of the required COBRA premium, or $50, you will be given 30 days to cure the shortfall);

• after you elect continuation coverage, the date that you first become covered under another group health plan under which you are not subject to a pre-existing condition exclusion limitation;

• after you elect continuation coverage, the date that you first become entitled to Medicare; or

• the date the Employer no longer provides Health Care Spending Account Plan to any of its employees.

Continuing Health Care Spending Account Participation through COBRA (Continued)

Uniformed Services Employment And Reemployment Rights Act Of 1994.

USERRA provides separate rules for continued health care coverage of the employee and dependents when employer-provided coverage would otherwise end during voluntary or involuntary duty with a United States uniformed service (e.g., Army, Navy, Air Force, Marines, and reserves).

If the period of uniformed service is less than 31 days, the employer must continue coverage provided that the employee pays any required employee contribution. If the period of duty is for more than 30 days, the employee may continue coverage under the rules similar to COBRA.

The maximum coverage period is the lesser of 24 months (effective December 10, 2004) or the period of uniformed service. Employees can be required to pay up to 102 percent of the applicable premium for coverage after the first 30 days. Except for coverage for illnesses or injuries incurred or aggravated during the performance of leave duties, no waiting period or pre-existing condition exclusion can be imposed on a returning employee and his dependents if the employee returns to employment within the specified period after completion of uniformed service and the period or exclusion would have been satisfied had the employee's coverage not terminated due to the leave for uniformed service.

NOTICE OF PRIVACY PRACTICES FOR INTERNATIONAL ASSOCIATION OF MACHINISTS AND AEROSPACE WORKERS DISTRICT LODGE W-24

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

USE AND DISCLOSURE OF HEALTH INFORMATION

International Association of Machinists and Aerospace Workers District Lodge W-24 Health Care Flexible Spending Account Plan ("HCFSA Plan") may use your health information, that is, information that constitutes protected health information as defined in the Privacy Rule of the Administrative Simplification provision of the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), for purposes of making or obtaining payment for your care and conducting health care operations. The HCFSA Plan has established a policy to guard against unnecessary disclosure of your health information.

THE FOLLOWING IS A SUMMARY OF THE CIRCUMSTANCES UNDER WHICH AND PURPOSES FOR WHICH YOUR HEALTH INFORMATION MAY BE USED AND DISCLOSED:

To Make or Obtain Payment. The HCFSA Plan may use or disclose your health information to make payment to or collect payment from third parties, such as other health plans or providers, for the care you receive and additional plan functions such as review of health care services with respect to medical necessity. For example, Health Plan may provide information regarding your coverage or health care treatment to other health plans to coordinate payment of benefits.

To Facilitate Treatment. The HCFSA Plan may use or disclose information to facilitate treatment that involves the provisions, coordination or management of health care or related services. For example, Health Plan may disclose health information about you with physicians that are treating you.

To Conduct Health Care Operations. The HCFSA Plan may use or disclose health information for its own operations to facilitate the administration of The HCFSA Plan and as necessary to provide coverage and services to all of The HCFSA Plan 's participants. Health care operations include such activities as: quality assessment and improvement activities; activities designed to improve health or reduce health care costs; clinical guideline and protocol development, case management and care coordination; contacting health care providers and participants with information about treatment alternatives and other related functions; health care professional competence or qualifications review and performance evaluation; accreditation, certification, licensing or credentialing activities; underwriting, including stop-loss underwriting, premium rating or related functions to create, renew or replace health benefits; review and auditing, including compliance reviews, medical reviews, legal services and including fraud and abuse detection and compliance programs; business planning and development including cost management and planning related analyses and formulary development; business management and general administrative activities of Health Plan, including customer service and resolution of appeals and internal grievances.

For Treatment Alternatives. The HCFSA Plan may use and disclose your health information to tell you about or recommend possible treatment options or alternatives that may be of interest to you.

For Distribution of Health-Related Benefits and Services. The HCFSA Plan may use or disclose your health information to provide to you information on health-related benefits and services that may be of interest to you.

For Disclosure to the Plan Sponsor. The HCFSA Plan may disclose your health information to the plan sponsor for plan administration functions performed by the plan sponsor on behalf of Health Plan. In addition, Health Plan may provide summary health information to the plan sponsor so that the plan sponsor may solicit bids or modify, amend or terminate the plan. The HCFSA Plan also may disclose to the plan sponsor information on whether you are participating in the HCFSA Plan.

Family Members, Other Relatives, or Others Involved in Your Health Care. The HCFSA Plan may make your protected health information known to a family member, or other relative, close personal friend or other personal representative that you identify. Such a use will be based on how involved the person is in your care, or payment that relates to your care. The HCFSA Plan may release information to parents or guardians, if allowed by law. If you disagree and do not want the health plan to make your protected health information known to a family member, or relative, close personal friend or personal representative that you designate, you may object and request a restriction as outlined below under, "**YOUR RIGHTS WITH RESPECT TO YOUR HEALTH INFORMATION."**

If you are not present or able to agree to these disclosures of your protected health information, then The HCFSA Plan may use our professional judgment and determine whether the disclosure is in your best interest.

Personal Representative. The HCFSA Plan will disclose your protected health information to an individual who has been designated by you as you personal representative and who has qualified for such designation in accordance with relevant state law. However, before The HCFSA Plan will disclose protected health information to such a person, you must submit a written notice of his/her designation, along with the documentation that supports his/her qualification (such as power of attorney).

Even if you designate a personal representative, the HIPAA Privacy Rules permit the HCFSA Plan to elect not to treat the person as your personal representative if the HCFSA Plan has a reasonable belief that: (1) you have been, or may be, subject to domestic violence, abuse, or neglect by such person; (2) treating such a person as your personal representative could endanger your; or (3) Health Plan determines, in its professional judgment, that it is not in your best interest to treat the person as your personal representative.

Business Associates. Business Associates perform various functions and services on behalf of the HCFSA Plan. For example, our Third Party Administrator, A&I Benefit Plan Administrators, Inc., will be handling many of the functions in connection to the operation of The HCFSA Plan. To perform these functions or provide the services, our Business Associates will receive, create, maintain, use, or disclose protected health information, but only after agreeing in writing to appropriately safeguard your information.

The Health Information Technology for Economic and Clinical Health Act (HITECH), included in the American Recovery and Reinvestment Act of 2009, extends HIPAA privacy and security requirements directly to business associates, effective February 17, 2010. The Plan must ensure that Business Associates of the Plan who create, receive, maintain, or transmit participants' electronic protected health information on behalf of the Plan agrees to comply with the HIPAA Privacy and Security provisions to maintain the privacy and security of your protected health information (PHI).

Other Covered Entities. The HCFSA Plan may use or disclose your protected health information to assist health care providers in connection with their treatment or payment activities, or to assist other covered entities in connection with payment activities and certain health care operations. For example, the HCFSA Plan may disclose protected health information to another covered entity to conduct health care operations in the areas of quality assurance.

When Legally Required. The HCFSA Plan will disclose your health information when it is required to do so by any federal, state or local law.

The Health Information Technology for Economic and Clinical Health Act (HITECH), included in the American Recovery and Reinvestment Act of 2009, extends reporting requirements related to HIPAA privacy and security breaches, effective September 23, 2009. The Plan will be required to report to individuals, the media, and the Department of Health and Human Services (HHS) when a breach of unsecured PHI has occurred. Effective February 22, 2010, all Business Associates are subject to the same rules as the Covered Entity (the Plan) and are required by law to report unsecured breaches to the Plan in order for the Plan meet the notification requirements.

To Conduct Health Oversight Activities. The HCFSA Plan may disclose your health information to a health oversight agency for authorized activities including audits, civil administrative or criminal investigations, inspections, licensure or disciplinary action. The HCFSA Plan, however, may not disclose your health information if you are the subject of an investigation and the investigation does not arise out of or is not directly related to your receipt of health care or public benefits.

In Connection With Judicial and Administrative Proceedings. As permitted or required by state law, the HCFSA Plan may disclose your health information in the course of any judicial or administrative proceeding in response to an order of a court or administrative tribunal as expressly authorized by such order or in response to a subpoena, discovery request or other lawful process, but only when the HCFSA Plan makes reasonable efforts to either notify you about the request or to obtain an order protecting your health information.

For Law Enforcement Purposes. As permitted or required by state law, the HCFSA Plan may disclose your health information to a law enforcement official for certain law enforcement purposes, including, but not limited to, if the HCFSA Plan has a suspicion that your death was the result of criminal conduct or in an emergency to report a crime.

In the Event of a Serious Threat to Health or Safety. The HCFSA Plan may, consistent with applicable law and ethical standards of conduct, disclose your health information if the HCFSA Plan, in good faith, believes that such disclosure is necessary to prevent or lessen a serious and imminent threat to your health or safety or to the health and safety of the public.

For Specified Government Functions. In certain circumstances, federal regulations require health plans to use or disclose your health information to facilitate specified government functions related to the military and veterans, national security and intelligence activities, protective services for the president and others, and correctional institutions and inmates.

Centers for Medicaid and Medicare Services (CMS) Data Sharing Requirements require Health Plans to comply with Mandatory Medicare Coordination of Benefits requirements by 7/1/2009. The Plan may share required data, including Protected Health Information, with the Coordination of Benefits Coordinator, State Medicaid agencies, or CMS directly as required.

Abuse or Neglect. The HCFSA Plan may disclose your protected health information to a government authority that is authorized by law to receive reports of abuse, neglect, or domestic violence. Additionally, as required by law, we may disclose to a governmental entity authorized to receive such information your information if we believe that you have been a victim of abuse, neglect, or domestic violence.

Research. The HCFSA Plan may disclose your protected health information to researchers when an institutional review board or privacy board has: (1) reviewed the research proposal and established protocols to ensure the privacy of the information; and (2) approved the research.

Inmates. If you are an inmate of a correctional institution, the HCFSA Plan may disclose your protected health information to the correctional institution or to a law enforcement official for: (1) the institution to provide health care to you; (2) your health and safety and the health and safety of others; or (3) the safety and security of the correctional institution.

Coroners, Medical Examiners, Funeral Directors, and Organ Donation. The HCFSA Plan may disclose protected health information to a coroner or medical examiner for purposes of identifying a deceased person, determining a cause of death, or for the coroner or medical examiner to perform other duties authorized by law. The HCFSA Plan also may disclose, as authorized by law, information to funeral directors so that they may carry out their duties. Further, health plan may disclose protected health information to organizations that handle organ, eye, or tissue donation and transplantation.

For Worker's Compensation. The HCFSA Plan may release your health information to the extent necessary to comply with laws related to worker's compensation or similar programs.

Disclosures to the Secretary of the U.S. Department of Health and Human Services. The HCFSA Plan is required to disclose your protected health information to the Secretary of the U.S. Department of Health and Human Services when the Secretary is investigating or determining Health Plan's compliance with the HIPAA Privacy Rule.

Minimum Necessary. The amount of health information used or disclosed will be limited to the "minimum necessary" for these purposes, as defined under the HIPAA Privacy Rule**.**

POTENTIAL IMPACT OF STATE LAW

The HIPAA Privacy Regulations generally do not take precedence over state privacy or other applicable laws that provide individuals greater privacy protections. As a result, to the extent state law applies, the privacy laws of a particular state, or other federal laws, rather than the HIPAA Privacy Regulations, might impose a privacy standard under which we will be required to operate. For example, where such laws have been enacted, we will follow more stringent state privacy laws.

AUTHORIZATION TO USE OR DISCLOSE HEALTH INFORMATION

Other than as stated above, Health Plan will not disclose your health information other than with your written authorization. If you authorize Health Plan to use or disclose your health information, you may revoke that authorization in writing at any time.

YOUR RIGHTS WITH RESPECT TO YOUR HEALTH INFORMATION

You have the following rights regarding your health information that the HCFSA Plan maintains:

Right to Request Restrictions. You may request restrictions on use and disclosure of your PHI to carry out treatment, payment or health care operations, including limiting information the HCFSA Plan provides to someone involved in your care, or payment for your care, such as a family member. To make such a request, send a written notice to the Privacy Official stating the PHI you want to limit, whether you want to limit use, disclosure or both and to whom you want the limits to apply. The HCFSA Plan is not required to agree to your request except in certain limited circumstances in which the PHI pertains solely to a health care item or service for which the health care provider involved has been paid out of pocket in full.

Right to Receive Confidential Communications. You have the right to request that the HCFSA Plan communicate with you in an alternate manner or at an alternate location if you feel the disclosure of your health information could endanger you. For example, you may ask that the HCFSA Plan only communicate with you at a certain telephone number or by email. If you wish to receive confidential communications, please make your request in writing to the address provided below. The HCFSA Plan will attempt to honor your reasonable requests for confidential communications.

If you submit a claim for payment, state or federal law (or our own contractual obligations) may require that we disclose certain financial claim information, such as an Explanation of Benefits (EOB) to the plan participant. If the HCFSA Plan is able to honor your request for confidential communication, the EOB will be released to the plan participant unless you have made other payment arrangements.

Right to Inspect and Copy Your Health Information. You have the right to inspect and copy your health information. A request to inspect and copy records containing your health information must be made in writing to the address provided below. If you request a copy of your health information, the HCFSA Plan may charge a reasonable fee for copying, assembling costs and postage, if applicable, associated with your request.

Right to Amend Your Health Information. If you believe that your health information records are inaccurate or incomplete, you may request that the HCFSA Plan amend the records. That request may be made as long as the information is maintained by the HCFSA Plan. A request for an amendment of records must be made in writing to the address provided below. The HCFSA Plan may deny the request if it does not include a reason to support the amendment. The request also may be denied if your health information records were not created by the HCFSA Plan, if the health information you are requesting to amend is not part of the HCFSA Plan 's records, if the health information you wish to amend falls within an exception to the health information you are permitted to inspect and copy, or if the HCFSA Plan determines the records containing your health information are accurate and complete.

Right to an Accounting. You have the right to request a list of certain disclosures of your health information that are for reasons other than treatment, payment, or health care operations or disclosures that are not in accordance with the Plan's privacy policies and applicable law. No accounting of disclosures is required for disclosures made pursuant to a signed authorization by you or your personal representative. Most disclosures of protected health information will be for purposes of treatment, payment or health care operations and, therefore, will not be subject to your right to an accounting.

The request must be made in writing to the address provided below. The request should specify the time period for which you are requesting the information. Accounting requests may not be made for periods of time going back more than six (6) years. Health Plan will provide the first accounting you request during any 12-month period without charge. Subsequent accounting requests may be subject to a reasonable cost-based fee. The HCFSA Plan will inform you in advance of the fee, if applicable.

Right to a Paper Copy of this Notice. You have a right to request and receive a paper copy of this Notice at any time, even if you have received this Notice previously or agreed to receive the Notice electronically. You also may obtain a copy of the current version of Health Plan's Notice at its Website, www.woodworkersflex.aibpa.com. To obtain a paper copy, please contact the Privacy Official International Association of Machinists and Aerospace Workers District Lodge W-24 at 503-224-0048.

Submit Written Requests to:

IAM and AW District Lodgw W-24
ATTN: Privacy Official
1220 SW Morrison St. Suite 300
Portland, Or. 97205-2222

CONTACT PERSON

Health FSA Plan has designated the Privacy Official at International Association of Machinists and Aerospace Workers District Lodge W-24 as its contact person for all issues regarding patient privacy and your privacy rights. You may contact this person at:

IAM and AW District Lodgw W-24
ATTN: Privacy Official
1220 SW Morrison St. Suite 300
Portland, Or. 97205-2222
503-224-0048

EFFECTIVE DATE

This Notice is effective January 1, 2010.

IF YOU HAVE ANY QUESTIONS REGARDING THIS NOTICE, PLEASE CONTACT:

IAM and AW District Lodgw W-24
ATTN: Privacy Official
1220 SW Morrison St. Suite 300
Portland, Or. 97205-2222
503-224-0048

RESPONSIBILITIES FOR ERISA PLAN ADMINISTRATION

Health Care Spending Account Plan Administrator. The Health Care Flex Benefit under this Flexible Spending Account Plan is to be administered by the Plan Administrator in accordance with the provisions of ERISA. An individual may be appointed by the Plan Sponsor to be Plan Administrator and serve at the convenience of the Employer. If the Plan Administrator resigns, dies or is otherwise removed from the position the Plan shall appoint a new Plan Administrator as soon as reasonably possible.

The Plan Administrator shall administer this Plan in accordance with its terms and establish its policies, interpretations, practices, and procedures. It is the express intent of this Plan that the Plan Administrator shall have maximum legal discretionary authority to construe and interpret the terms and provisions of this Plan, to make determinations regarding issues which relate to eligibility for benefits, to decide disputes which may arise relative to a Plan Participant's rights, and to decide questions of Plan interpretation and those of fact relating to this Plan. The decisions of the Plan Administrator will be final and binding on all interested parties.

Service of legal process may be made upon the Plan Administrator.

Duties of the Plan Administrator.

(1) To administer this Plan in accordance with its terms.
(2) To interpret this Plan, including the right to remedy possible ambiguities, inconsistencies or omissions.
(3) To decide disputes which may arise relative to a Plan Participant's rights.
(4) To prescribe procedures for filing a claim for benefits and to review claim denials.
(5) To keep and maintain the Plan documents and all other records pertaining to this Plan.
(6) To appoint a claims administrator to pay claims.
(7) To perform all necessary reporting as required by ERISA.
(8) To establish and communicate procedures to determine whether a medical child support order is qualified under ERISA Sec. 609.
(9) To delegate to any person or entity such powers, duties and responsibilities as it deems appropriate.

Plan Administrator Compensation. The Plan Administrator serves **without** compensation; however, all expenses for plan administration, including compensation for hired services, will be paid by this Plan.

Fiduciary. A fiduciary exercises discretionary authority or control over management of this Plan or the disposition of its assets, renders investment advice to this Plan or has discretionary authority or responsibility in the administration of this Plan.

Fiduciary Duties. A fiduciary must carry out his or her duties and responsibilities for the purpose of providing benefits to the Employees and their dependent(s), and defraying reasonable expenses of administering this Plan. These are duties which must be carried out:

(1) With care, skill, prudence and diligence under the given circumstances that a prudent person, acting in a like capacity and familiar with such matters, would use in a similar situation;

(2) By diversifying the investments of this Plan so as to minimize the risk of large losses, unless under the circumstances it is clearly prudent not to do so; and

(3) In accordance with the Plan documents to the extent that they agree with ERISA.

The Named Fiduciary. A "named fiduciary" is the one named in this Plan. A named fiduciary can appoint others to carry out fiduciary responsibilities (other than as a trustee) under this Plan. These other persons become fiduciaries themselves and are responsible for their acts under this Plan. To the extent that the named fiduciary allocates its responsibility to other persons, the named fiduciary shall not be liable for any act or omission of such person unless either:

(1) The named fiduciary has violated its stated duties under ERISA in appointing the fiduciary, establishing the procedures to appoint the fiduciary or continuing either the appointment or the procedures; or

(2) The named fiduciary breached its fiduciary responsibility under Section 405(a) of ERISA.

Claims Administrator Is Not A Fiduciary. The Claims Administrator is **not** a fiduciary under this Plan by virtue of paying claims in accordance with this Plan's rules as established by the Plan Administrator.

FUNDING THE PLAN AND PAYMENT OF BENEFITS

The Plan Administrator assumes the sole responsibility for funding the benefits. The Plan is intended to comply and be governed by the “Employee Retirement Income Security Act of 1974” (ERISA) and not state law. Therefore, state law governing guarantee funds may not cover benefits payable under the Plan if the Plan Administrator is unable to pay benefits.

The cost of this Plan is funded as follows:

For Employee and Dependent Coverage: Funding is derived from the funds of the Employer and contributions made by the covered Employees.

The level of any Employee contributions will be set by the Plan Administrator. These Employee contributions will be used in funding the cost of this Plan as soon as practicable after they have been received from the Employee or withheld from the Employee's pay through payroll deduction.

Benefits are paid directly from this Plan through the Claims Administrator.

EXCESS RISK INSURANCE

The Plan Administrator has purchased excess risk insurance coverage which is intended to reimburse the Plan Administrator for certain losses incurred and paid under the Plan by the Plan Administrator. The excess risk insurance coverage is not a part of this Plan.

THE TRUST AGREEMENT

If this Plan is established under a Trust agreement, that agreement is made a part of this Plan. A copy of the appropriate agreement is available for examination by Employees and their dependent(s) at the office of the Plan Administrator during normal business hours. Also, upon written request, the following items will be furnished to an Employee or dependent:

(1) A copy of the Trust agreement.

(2) A complete list of employers and employee organizations sponsoring this Plan.

Service of legal process may be made upon a Plan trustee.

PLAN IS NOT AN EMPLOYMENT CONTRACT

The Plan is not to be construed as a contract for or of employment.

CLERICAL ERROR

Any clerical error by the Plan Administrator or an agent of the Plan Administrator in keeping pertinent records or a delay in making any changes will not invalidate coverage otherwise validly in force or continue coverage validly terminated. An equitable adjustment of contributions will be made when the error or delay is discovered.

If, due to a clerical error, an overpayment occurs in a Plan reimbursement amount, this Plan retains a contractual right to the overpayment. The person or institution receiving the overpayment will be required to return the incorrect amount of money. In the case of a Plan Participant, if it is requested, the amount of overpayment will be deducted from future benefits payable.

AMENDING AND TERMINATING THE PLAN

If this Plan is terminated, the rights of the Plan Participants are limited to expenses incurred before termination.

The Employer intends to maintain this Plan indefinitely; however, it reserves the right, at any time, to amend, suspend or terminate this Plan in whole or in part. This includes amending the benefits under this Plan or the Trust agreement (if any).

CERTAIN EMPLOYEE RIGHTS UNDER ERISA

Plan Participants in the Health Care benefits portion of this Plan are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA specifies that all Plan Participants shall be entitled to:

(a) Examine, without charge, at the Plan Administrator's office, all Plan Documents and copies of all documents governing the Plan, including 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 Pension and Welfare Benefits Administration.

(b) Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the plan, including insurance contracts and copies of the latest annual report (Form 5500 Series) and updated summary plan description. The administrator may make a reasonable charge for the copies.

(c) Continue health care coverage for yourself, spouse or dependents if there is a loss of coverage under the plan as a result of a qualifying event. You or your dependents may have to pay for such coverage. Review this summary plan description and the documents governing the plan on the rules governing your COBRA continuation coverage rights.

(d) If a Plan Participant's Claim for a benefit is denied or ignored, in whole or in part, the participant has 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 steps a Plan Participant can take to enforce the above rights. For instance, if a Plan Participant requests a copy of Plan documents or the latest annual report from the Plan and does not receive them within 30 days, he or she may file suit in a federal court. In such a case, the court may require the Plan Administrator to provide the materials and to pay the Plan Participant up to $110 a day until he or she receives the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator. If the Plan Participant has a Claim for benefits which is denied or ignored, in whole or in part, the participant may file suit in state or federal court.

In addition, if a Plan Participant disagrees with the Plan's decision or lack thereof concerning the qualified status of a medical child support order, he or she may file suit in federal court.

If it should happen that the Plan fiduciaries misuse this Plan's money, or if a Plan Participant is discriminated against for asserting his or her rights, he or she may seek assistance from the U.S. Department of Labor, or may file suit in a federal court. The court will decide who should pay court costs and legal fees. If the Plan Participant is successful, the court may order the person sued to pay these costs and fees. If the Plan Participant loses, the court may order him or her to pay these costs and fees, for example, if it finds the claim or suit to be frivolous.

If you have any questions about your 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 in obtaining documents from the Plan Administrator, you should contact the nearest office of the, U.S. Department of Labor, listed in the telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue, 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.

GENETIC INFORMATION NONDISCRIMINATION ACT

The Plan is compliant with the Genetic Information Nondiscrimination Act which bans insurers and employers from using genetic test results to set health care premiums, refuse coverage or reject medical claims. Insurers are not to set rates for a group based on the genetic information of individual members. Nor will insurers be allowed to require or request that individuals or their family members undergo genetic testing. Purchasing, requesting or requiring genetic information for underwriting or before enrollment in the plan is also prohibited.

DEFINITIONS

"After-tax Contribution(s)" means amounts withheld from an Employee's Compensation pursuant to a Salary Reduction Agreement after all applicable state and federal taxes have been deducted. Such amounts are withheld for purposes of purchasing one or more of the Benefit Package Options available under the Plan.

"Anniversary Date" means the first day of any Plan Year.

"Benefit Package Option(s)" means those Qualified Benefits available to a Participant under this Plan as set forth in the Summary Plan Description, as amended and/or restated from time to time.

"Change in Status" means any of the events described in the Summary Plan Description, as well as any other events included under subsequent changes to Code Section 125 or regulations issued under Code Section 125 that the Plan Administrator (in its sole discretion) decides to recognize on a uniform and consistent basis as a reason to change the election mid-year. Note: See the Summary Plan Description for requirements that must be met to permit certain mid-year election changes on account of a Change in Status.

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

"Compensation" means the cash wages or salary paid to an Employee by the Employer.

"Dependent" means any individual who is a tax dependent of the Participant as defined in Code Section 152(a); however, that in the case of a divorced Employee: for purposes of accident or health coverage including the Health FSA, if offered under the Plan, a child of divorced parents shall be considered a Dependent of both parents.

"Dependent Care" "dependent care flexible spending arrangement" permits employees to pay, on a pre-tax salary reduction basis, for coverage that will reimburse them for eligible out-of-pocket dependent care expenses not reimbursed elsewhere.

"Earned Income" means all income derived from wages, salaries, tips, self employment, and other Compensation (such as disability or wage continuation benefits), but only if such amounts are includible in gross income for the taxable year. Earned income does not include any other amounts excluded from earned income under Code § 32(c) (2), such as amounts received under a pension or annuity, or pursuant to workers' compensation.

"Effective Date" of this Plan means the effective date, or the amended and restated effective date, set forth in the SPD.

"Eligible Medical Expenses" means those expenses incurred by the Employee, or the

Employee's Spouse or Dependents, after the date of the Employee's participation in the Health FSA and during the Plan Year to the extent that the expense satisfies the conditions set forth in the Summary Plan Description and are for “medical care” as defined by Code Section 213(d). For purposes of this Plan, the following expenses are not considered “Eligible Medical Expenses” even if they otherwise constitute “medical care” under Code Section 213(d):

i) Expenses for qualified long term care services (as defined in Code § 7702B); and
ii) Expenses for health insurance premiums

For purposes of this Plan, an expense is “incurred” when the Participant or beneficiary is furnished the medical care or services giving rise to the claimed expense, regardless of when the expense is paid.

"Employee" means an individual who the Employer classifies as a common-law employee and who is on the Employer’s W-2 payroll, but does not include any of the following: (a) any leased employee (including, but not limited to, those individuals defined in Code § 414(n)); (b) an individual classified by the Employer as a contract worker or independent contractor; (c) an individual classified by the Employer as a temporary employee or casual employee, whether or not any such persons are on the Employer’s W-2 payroll; and (d) any individual who performs services for the Employer but who is paid by a temporary or other employment agency such as "Kelly," "Manpower," etc., or any employee covered under a collective bargaining agreement, except as otherwise provided for in the collective bargaining agreement.

"Employer" means International Association of Machinists and Aerospace Workers District Lodge W-24. and any Affiliated Employer who adopts the Plan pursuant to authorization provided by International Association of Machinists and Aerospace Workers District Lodge W-24. Notwithstanding the previous sentence when the Plan provides that the Employer has a certain power (e.g., the appointment of a third party administrator, entering into a contract with a third party insurer, or amendment or termination of the plan) the term "Employer" shall mean only International Association of Machinists and Aerospace Workers District Lodge W-24. Affiliated Employers who adopt the Plan shall be bound by the Plan as adopted and subsequently amended unless they clearly withdraw from participation herein. Affiliated Employers who have adopted the Plan are set forth in the Summary Plan Description.

"ERISA" shall mean the Employee Retirement Income Security Act of 1974, as amended.

"Health FSA" a.k.a. “medical expense reimbursement plan” permits employees to pay , on a pre-tax salary reduction basis, for coverage that will reimburse them for eligible out-of-pocket medical expenses not reimbursed elsewhere..

"Highly Compensated Individual" means an individual defined under Code Section 105(h), 125(e), or 414(q), as amended, as a "highly compensated individual" or a "highly compensated employee."

"Key Employee" means an individual who is a "key employee" as defined in Code Section 125(b) (2), as amended.

"Nonelective Contribution(s)" means any amount that the Employer, in its sole discretion, may contribute on behalf of each Participant to provide benefits for such Participant and his or her Dependents, if applicable, under one or more of the Benefit Package Option(s) offered under the Plan. The amount of employer contribution that is applied towards the cost of the Benefit Package Option(s) for each Participant and/or level of coverage shall be subject to the sole discretion of the Employer and may be adjusted upward or downward at any time in the contributing Employer's sole discretion. The amount shall be calculated for each Plan Year in a uniform and nondiscriminatory manner and may be based upon the Participant's dependent status, commencement or termination date of the Participant's employment during the Plan Year, and such other factors as the Employer shall prescribe. To the extent set forth in the Summary Plan Description or enrollment material, the Employer may make Nonelective Contributions available to Participants and allow Participants to allocate the Nonelective Contributions among the various Benefit Package Options offered under the Plan in a manner set forth in the Summary Plan Description or enrollment material. In no event will any Nonelective Contribution be disbursed to a Participant in the form of additional, taxable Compensation except as otherwise provided in the Summary Plan Description or enrollment material.

"Participant" means an Employee who becomes a Participant pursuant to Article II.

"Plan" means this Flexible Spending Account Plan established by the Employer.

"Plan Administrator" means the person(s) or Committee identified in the Summary Plan Description that is appointed by the Employer with authority, discretion, and responsibility to manage and direct the operation and administration of the Plan. If no such person is named, the Plan Administrator shall be the Employer, acting through its duly authorized officers and their designees.

"Plan Year" shall be the period of coverage set forth in the Summary Plan Description.

"Pre-tax Dollars/Contribution(s)" means amounts withheld from an Employee's Compensation pursuant to a Salary Reduction Agreement before any applicable state and federal taxes have been deducted. The amounts are withheld for purposes of purchasing one or more of the Benefit Package Options available under the Plan. This amount shall not exceed the premiums or contributions attributable to the most costly Benefit Package Option afforded hereunder, and for purposes of Code Section 125, shall be treated as an Employer contribution (this amount may, however, be treated as an Employee contribution for purposes of state insurance laws).

"Qualified Benefit" means any benefit excluded from the Employee's taxable income under Chapter 1 of the Code other than Sections 106(b), 117, 124, 127, or 132 and any other benefit permitted by the Income Tax Regulations (i.e., any group-term life insurance coverage that is includable in gross income by virtue of exceeding the dollar limitation on nontaxable coverage under Code Sec. 79). Notwithstanding the previous sentence, long-term care insurance is not a "Qualified Benefit."

"Qualifying Individual" means a person eligible by law and under the eligibility rules of the plan:

"Reimbursement Account(s) or Account(s)" shall be the funding mechanism by which amounts are withheld from an Employee's Compensation and retained for future Health Care Reimbursement (as defined in Section 1.18 herein) to the extent adopted by the Employer as set forth in the Summary Plan Description. No money shall actually be allocated to any individual Participant Account(s); any such Account(s) shall be of a memorandum nature, maintained by the Administrator for accounting purposes, and shall not be representative of any identifiable trust assets. No interest will be credited to or paid on amounts credited to the Participant Account(s).

"Salary Reduction Agreement" means the actual or deemed agreement pursuant to which an eligible Employee or Participant elects to contribute his share of the cost of chosen Benefit Package Options with Pre-tax or After-tax Contributions and/or Benefit Credits (if offered under the Plan) in accordance with Article III herein. If the Employer utilizes an interactive voice response (IVR) system or web-based program for enrollment, the Salary Reduction Agreement may be maintained on an electronic database in accordance with all applicable federal and/or state laws.

"Spouse" means an individual who is recognized under the federal law as legally married to a Participant (and who is treated as a spouse under the Code).

"Summary Plan Description" or "SPD" means the Flexible Spending Account Plan SPD and all appendices incorporated into and made a part of the SPD that is adopted by the Employer and attached to this Plan Document as Attachment I, as amended from time to time. The SPD and appendices are incorporated herein by reference.