AEROSPACE
Assuring Space Mission Success

The Aerospace Retiree Medical Plan

As revised December 2016

The Aerospace Retiree Medical Plan
(the "Plan")

Introduction

The Plan helps supplement Participant payments toward medical insurance premiums charged by selected providers during a Participant's retirement. Under the Plan, The Aerospace Corporation (the "Corporation") enters into contracts with various health insurance providers and health maintenance organizations to provide group health coverage to eligible participating retirees.

The Corporation established and contributes money to a trust to fund this Plan. Continued contributions by the Corporation are subject to certain contingencies. Your rights and amount of benefits under the Plan will be determined in accordance with the Plan language, any pertinent corporate Policies and Practices, the date you were hired or rehired, your years of service, and the appropriate Defined Dollar Benefit (DDB) under schedule Tier A or Tier B described below.

The Plan pays up to a specified dollar amount of the monthly premiums for the medical coverage selected by a participant (i.e., the Defined Dollar Benefit), and the Participant is required to pay the remaining portion of any premium due. The percentage of the Defined Dollar Benefit paid by the Plan for any particular Participant depends on a number of factors, including the Participant's date of hire or rehire and, in certain circumstances, the Participant's years of service with the Corporation.

Payment for retiree medical may be deducted from the monthly pension, if the pension amount is sufficient or by check or other form accepted by Aerospace. If the cost-sharing payment is 30 or more days late the Plan will automatically terminate coverage and it will not ever be reinstated.

Retiree medical benefits under this Plan are not vested, and all such benefits may be modified, increased, decreased, or terminated in accordance with the Plan, at any time with or without notice.

This Plan is intended to be a stand-alone retiree-only health plan, and is therefore not subject to the insurance market reforms found in title 27 of the Public Health Service Act, as added by the Patient Protection and Affordable Care Act.

What is the Defined Dollar Benefit (DDB)?

The Defined Dollar Benefit is the amount paid monthly from the Plan on behalf of a retiree or survivor toward the cost of retiree medical insurance premiums.

Who is eligible for benefits under the Plan?

You may be covered under the Plan if you meet the eligibility requirements as summarized herein.

Enrollment in Medicare

The retiree and/or eligible spouse if age 65 or older at employee's retirement date or if he/she turns age 65 after retirement date must enroll in Medicare Parts A, B and D in order to be eligible to participate in the Plan. Medicare Part D forms for your particular insurance carrier are available from the Employee Benefits Department. Failure to enroll in Medicare

will result in permanent exclusion from the Plan. The retiree and/or spouse would be prohibited from enrolling in the Retiree Medical Plan if they do not assign Medicare Parts A, B, and D to the Aerospace RMP.

TIER A: Employees Hired or Rehired before July 1, 1987:

You and your eligible dependents are eligible for "Tier A" coverage under the Plan if you:

- Were hired or rehired before July 1, 1987; and,
- Are at least age 55 and retire from regular active service at the Corporation; and,
- Have at least 10 years of service with the Corporation and the last 5 years immediately before retirement are consecutive, and,
- Are eligible for the Corporation's medical insurance coverage immediately before retirement.

Retired employees who had Tier A coverage, then were rehired, and subsequently retire again will go back into Tier A coverage.

What will an eligible retiree pay for coverage under Tier A?

When an employee retires from the Corporation, there is a transition period during which the retiree pays the lesser of:

A) the monthly employee cost-sharing amount, or

B) the monthly retiree cost-sharing amount until the following July 31.

For example, if an individual retires on August 1, they pay the lesser of A) or B) above for 12 months. The following August 1, and thereafter, they pay the retiree monthly cost-sharing amount. If an individual retires on July 1, they pay the lesser of A) or B) above until August 1 (one month) and thereafter they pay the retiree monthly cost-sharing amount. The retiree cost-sharing amount paid by a participant who retires under Tier A coverage is based on the difference between the DDB amount and the premium for the medical coverage selected by the retiree. Premiums charged for current retirees in Tier A can be viewed on the Employee

Benefits website at http://pages.aero.org/benefits. A copy of the monthly premium rate sheet is also available from the Employee Benefits Department.

TIER B: Employees Hired or Rehired On or After July 1, 1987:

You and your eligible dependents are eligible for "Tier B" coverage under the Plan if you:

- Were hired or rehired on or after July 1, 1987; and
- Are at least age 55 and retire from regular active service at the Corporation; and,
- Have at least 10 years of service with the Corporation and the last 5 years immediately before retirement are consecutive; and,
- Are eligible for the Corporation's medical insurance coverage immediately before retirement.

Rehired employees receive credit for prior employment with the Corporation when calculating years of service. Retired employees who had Tier B retiree medical coverage, then are rehired and subsequently retire again will go back into Tier B retiree medical coverage with additional years of service, if applicable. Service time is rounded down to the nearest year.

What will an eligible retiree pay for coverage under Tier B?

When an employee retires from the Corporation, there is a transition period during which the retiree pays the lesser of:

A) the monthly employee cost-sharing amount, or

B) the monthly retiree cost-sharing amount until the following July 31.

For example, if an individual retires on August 1, they pay the lesser of A) or B) above amount for 12 months. The following August 1, and thereafter, they pay the retiree monthly cost-sharing amount. If an individual retires on July 1, they pay the lesser of A) or B) above until August 1 (one month) and thereafter they pay the retiree monthly cost-sharing amount. The amount paid by a participant who retires under Tier B coverage is based on the difference between the percentage of the DDB paid by the Plan and the amount for the medical coverage selected by the retiree. For employees covered under Tier B, the

percentage of DDB is calculated using the employee's total years of service, rounded down to the nearest year, at the retirement date. Premiums charged for current retirees in Tier B can be viewed on the Human Resources Employee Benefits website at http://pages.aero.org/benefits.

See Table 1 below.

Table 1
Percentage of Defined Dollar Benefit (DDB) to be Paid by the Plan for Eligible Employees Hired or Rehired On or After July 1, 1987 ("Tier B Coverage")

TIER B

Total Years of Service at Retirement	Percentage of DDB Plan Pays (%)
10	34
11	37
12	40
13	43
14	46
15	49
16	52
17	55
18	58
19	61
20	64
21	67
22	70
23	73
24	76
25	79
26	82
27	85
28	88
29	91
30	94
31	97
32 +	100

Who are eligible dependents?

Your legally married spouse and dependent children up to age 26 are eligible for coverage. Dependent children are eligible up to the age of 30 in Florida.

Dependent children up to age 26 include your own or legally adopted children and stepchildren who live with you in a regular parent-child relationship for more than 6 months during the year. Proof of legal guardianship or adoption is required by the Corporation.

If proof of legal guardianship or adoption is filed with the Plan Administrator, you may also cover any other children who live with you in a regular parent-child relationship and depend on you for support. If a court order for medical support exists, a dependent child cannot be denied coverage because he or she does not live with you. The child(ren) will be subject to all applicable terms of the master policy agreement for your health insurance coverage. You must make an application to the Plan Administrator for enrollment of the dependent child(ren) within 90 days of the issuance of the court order. A copy of the court order must be given to the Plan Administrator when the application for enrollment is submitted. The Plan is not required to enroll the dependent child(ren) who does not live with you, if he or she is outside the Plan's geographic service area.

A dependent child may continue to be eligible after age 26 if he or she is incapable of self-support due to physical or mental incapacity that began before age 26 and while a covered dependent. The carrier must approve the application to extend the coverage. You must apply for this continued coverage within 31 days of the date your child reaches age 26. Proof of incapacity and dependency may be requested from time to time.

NOTE:

New dependents are not automatically added to your coverage. To enroll them, you must complete a medical enrollment form at the Aerospace Employee Benefits Department. Be sure to enroll new dependents within 31 days after they become eligible due to a life status event. After that time, coverage can only be available at the Corporation's next open enrollment period unless medical coverage under another group plan is lost or there is a change in life event status. Proof of dependent eligibility (for example, birth certificate, marriage certificate, decree of adoption, appointment as guardian, appointment as conservator) will be required. A qualifying life event change is defined by IRS regulations as a change in your status such as marriage, birth or adoption of a child, death of an immediate family member, divorce, or the loss/gain of insurance coverage by your spouse.

Domestic Partners of Retirees

Domestic partners of retirees who participate in the Plan may be eligible for coverage under an Aerospace retiree group medical plan. Registered same-sex domestic partners who participate in the Plan are also eligible after reaching age 55. Registered opposite sex domestic partners may be eligible if they are age 62 or older, and are collecting Social Security retirement benefits (not Social Security disability benefits). All domestic partners must be registered as such with the state of residence and provide proof to the Plan Administrator.

What happens to my family's coverage if I die?

If the participating retiree dies while receiving retiree medical benefits, dependent coverage will continue if the dependents are not eligible to participate in any other group plan, as follows:

- The retiree's surviving eligible spouse and eligible dependent children may elect to continue coverage by paying the premium monthly cost-sharing amount, beginning the first of the month following the retiree's death, as determined based on the retiree's Tier A or Tier B status, and adjusted to reflect any change in the Defined Dollar Benefit for single or family coverage, premium rate changes, and dependent coverage. Dependent children of a deceased retiree may be covered until age 26. Premiums are adjusted annually.

- If the surviving spouse remarries, all health coverage including dependents will be terminated and will not ever be reinstated.

- If an active employee dies and is at least age 65, meets eligibility for retiree medical and if the surviving spouse or dependent[s] was continuously covered by the active medical program for at least 12 months before the employee's death and is not eligible for other group coverage outside the Corporation, the surviving spouse/dependent(s) will be eligible for retiree medical coverage. The **survivor** will be eligible for the appropriate Defined Dollar Benefit amount based on the deceased employee's total years of service with the Corporation rounded down. Payment for survivor medical begins the first of the month following the employee's death.

- If the spouse, dependent, or both, are thirty (30) days late with the payment of the required premium cost-sharing amount, participation in the Plan will automatically terminate coverage and it will not ever be reinstated.

What if my spouse and I are both Aerospace Retirees and we both meet retiree medical eligibility requirements?

The retiree with longer service can cover the spouse with the shorter service as a dependent. The spouse with the shorter service must waive their own coverage in order to take advantage of their spouse's service level. If the primary participating retiree dies, the dependent retiree/surviving spouse will be treated the same as any other eligible survivor and will be eligible for the appropriate DDB amount based on the deceased retiree's total years of service with the Corporation rounded down. If the dependent retiree/surviving spouse subsequently remarries, his/her survivor coverage will cease, and he/she may enroll in retiree medical based on their own total years of service with the Corporation rounded down.

Administrative Facts

Plan Administrator

The Aerospace Retiree Medical Plan is administered by the Employee Benefits Department of The Aerospace Corporation at 2310 East El Segundo Boulevard, El Segundo, CA 90245, under the direction of the Vice President of Human Resources and Plan Administrator. The Plan Administrator's telephone number is 310.336.5107.

Service of Process

The Office of General Counsel is designated as the agent for service of legal process. Ms. Clinton is the General Counsel and her address is The Aerospace Corporation, 2310 E. El Segundo Blvd. El Segundo, CA 90245-2957. The Plan Administrator may also receive service of legal process.

Employer Identification Number and Plan Number

The Employer Identification Number assigned to The Aerospace Corporation is 95-2102389. The Plan Number assigned to the Retiree Medical Plan is 503.

Amendment, Change, Modification, or Termination of Plan

This Summary Plan Description is not an employment contract or an offer to enter into an employment contract, nor does it constitute an agreement by the Corporation to continue to maintain the plan described or referred to herein.

Although the Corporation intends to continue the plan, the Corporation reserves the right to amend, change, modify, or terminate the plan at any time. Prior to amending, changing, modifying, or terminating the plan, the Plan Administrator will review with appropriate officers of the Corporation and members of management any proposal to amend, change, modify or terminate the plan.

When required, or at the discretion of the President (or designee), proposal(s) to amend, change, modify, or terminate the plan will be submitted to the Board of Trustees (or responsible Board Committee) for review and appropriate action. Unless the decision to amend, change, modify, or terminate the plan requires action by the Board of Trustees, the Plan Administrator, subsequent to the review process described in this paragraph, will be authorized to make the final decision to amend, change, modify, or terminate the plan.

The determination of whether any decision to amend, change, modify or terminate the plan requires action by the Board of Trustees will be made by reference to the terms of the insurance contract or other document relating to the provision of plan benefits. If the contract or document is silent on this point, the Plan Administrator will be deemed to have the authority to amend, change, modify, or terminate the Plan without requiring any action by the Board of Trustees. During the process described in this paragraph, the Corporation will comply with all applicable agreements that affect employee benefits. The Corporation's decision to amend, change, modify, or terminate the plan may be due to changes in federal or state laws governing welfare benefits, the requirement of the Internal Revenue Code, the

requirements of ERISA, the provisions of a contract or a policy involving an insurance company, or for any other reason.

Participating retirees, spouses, and eligible dependents do not have a vested right in any plan benefits. The Corporation's decision to amend, change, modify, or terminate the plan may be due to changes in federal or state laws governing welfare benefits, the requirements of the Internal Revenue Code, the requirements of ERISA, the provisions of a contract or a policy involving an insurance company, or for any other reason.

Your ERISA Rights

If you are a Participant in this Plan, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all plan participants shall be entitled to:

Examine, without charge, at the Plan Administrator's office, all Plan documents, including insurance contracts, and copies of all documents filed by the Plan with the U.S, Department of Labor, such as detailed annual reports and Plan descriptions.

Obtain copies of all Plan documents and other Plan information upon written request to the Plan Administrator. The Plan Administrator may make a reasonable charge for the copies.

Receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to furnish each plan participant with a copy of this summary annual report.

In addition to creating rights for Plan Participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate your Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of you and other Plan Participants and beneficiaries. No one, including your employer or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercise your rights under ERISA. If your claim for a welfare benefit is denied in whole or in part, you must receive a written explanation of the reason for the denial. Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request materials from the Plan and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $100 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator. If you have a claim for benefits that is denied or ignored, in whole or in part, you may file in a state or federal court. If it should happen that Plan fiduciaries misused the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court.

The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees; for example, if it finds your claim is 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, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory or the Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210.