AEROSPACE
Assuring Space Mission Success

The Aerospace Corporation Health and Welfare Benefits Plan

Plan Document and Summary Plan Description

Amended and Restated January 1, 2018

The Aerospace Health Maintenance Organizations

Dental Expense Plan

Aerospace Group Life

Vision Service Plan

Short-Term Disability for Non-California Employees

Long Term Disability

Occupational Accident Insurance

Voluntary Personal Accident Insurance

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Introduction to Your Plan

The Aerospace Corporation (the "Company") maintains the Aerospace Corporation Health and Welfare Benefits Plan (the "Plan") for the exclusive benefit of its Eligible Employees and their eligible family members. This document summarizes important information about the Plan.

The insured health and welfare benefits under the Plan are summarized in Evidence of Coverage booklets, which also may be known as certificates of insurance (the "Insurance Contracts") issued by each insurance company. A copy of each Insurance Contract is attached to this document in the Attachments.

Purpose of this Wrap Plan SPD Document

You are being provided this document to give you an overview of the Plan and to address certain information that may not be addressed in the Attachments. This document, together with the Attachments, is the plan document and the summary plan description (SPD) required by ERISA §§ 402 and 102 respectively, for each of the benefits subject to ERISA.

Each of the health and welfare benefits under the Plan is intended, for purposes of ERISA, to be an individual plan. The benefits have been included in this Plan document for purposes of efficiency and convenience only. Each benefit offered through an applicable group insurance contract will be offered and administered as an individual plan.

This document is not intended to give you any substantive rights to benefits that are not already provided by the Attachments. If you have not received a copy of the Attachments, contact the Employee Benefits Director of the Aerospace Corporation (the "Employee Benefits Director"). **You must read the Attachments and this document together to understand your benefits.**

Definitions

Attachments means the documentation identified in this Plan and attached to this document which together with this document constitute the written plan.

Casual Employee means an Employee who normally works fewer than 20 hours a week on a non-continuous, irregular, infrequent, and unscheduled basis.

COBRA means the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended.

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

Company means The Aerospace Corporation or any successor thereof.

Eligible Employee means an Employee who works on a regularly scheduled and assigned basis, either full or part time, is eligible to participate in and receive benefits under the terms of the Insurance Contract(s), and is otherwise eligible to participate in the Plan.

Employee means, with respect to the Plan, any individual, including his or her eligible dependents, who is, notwithstanding any eligibility criteria in the Insurance Contracts, employed as a common law employee of the Company, either on a full or a part-time basis. However, "Employee" does not include the following: (a) any leased employee (including but not limited to those individuals defined as leased employees in Code §414(n)) or individual classified by the Company as an independent contractor for the period during which such individual is so classified, whether or not any such individual is on the

Company's W-2 payroll or is determined by the IRS or others to be a common-law employee of the Company; (b) any individual who performs services for the Company but who is paid by a temporary or other employment or staffing agency for the period during which such individual is paid by such agency, whether or not such individual is determined by the IRS or others to be a common-law employee of the Company; and (c) Casual Employees. The term Employee does include Temporary Employees who work for the Company for less than 12 months for the limited purpose of allowing eligibility for group medical benefits. Additionally, the term Employee does include former Employees for the limited purpose of allowing continued eligibility for benefits under the Plan for the remainder of the Plan Year in which an Employee ceases to be employed by the Company, but only to the extent specifically provided elsewhere under the Plan.

FMLA means the Family and Medical Leave Act of 1993, as amended.

GINA means the Genetic Information Nondiscrimination Act of 2008.

HIPAA means the Health Insurance Portability and Accountability Act of 1996, as amended.

HITECH means the Health Information Technology for Economic and Clinical Health Act.

Insurance Contracts means the provisions of the effective group medical, dental, vision, disability or life insurance contracts, plans or booklets (or portion thereof) as from time to time amended in accordance herewith, describing medical, dental, vision, short-term disability, long-term disability, or life insurance benefits available to such Employees. As of the effective date of the Plan, the applicable group insurance contracts and plans are:

- The Aerospace Health Maintenance Organizations,
- Dental Expense Plan,
- Vision Service Plan,
- Short-Term Disability Plan for Non-California Employees,
- Aerospace Group Life,
- Long Term Disability,
- Voluntary Personal Accident Insurance, and
- Occupational Accident Insurance.

MHPA means the Mental Health Parity Act of 1996.

MHPAEA means the Mental Health Parity and Addiction Equity Act of 2008.

Michelle's Law means the law that requires group health plans to allow seriously ill or injured college students who are covered dependents to continue coverage for up to one year while on medically necessary leaves of absence.

NMHPA means the Newborns' and Mothers' Health Protection Act of 1996, as amended.

Participant means an Eligible Employee, spouse, or dependent who is actively participating in the Plan.

PPACA means the Patient Protection and Affordable Care Act, as amended by the Health Care and Education Reconciliation Act of 2010.

Temporary Employee means an Employee who works for a period or not more than 12 months.

WHCRA means the Women's Health and Cancer Rights Act of 1998.

Information About the Plan

Plan Name
The Aerospace Corporation Wrap Health and Welfare Benefits Plan.

Type of Plan
The Plan is a welfare benefit plan that provides group health and welfare benefits.

Plan Year
The plan year begins on January 1st and ends on December 31st.

Plan Number
The numbers assigned to each insured benefit provided for in the Attachments, as benefit components that comprise the Plan, are listed below.

Benefit Component	Plan Number
Short-Term Disability for Non-California Employees	501
Dental Expense Plan	504
Aerospace Group Life	505
Long Term Disability	507
Occupational Accident Insurance	508
Voluntary Personal Accident Insurance	509
The Aerospace Health Maintenance Organizations	511
Vision Service Plan	517

Effective Date
The effective date of this Plan is January 1, 2017.

The individual Plans have been amended several times since their original effective dates.

Funding Method and Type of Plan Administration
Benefits under the Plan are fully insured. The Company is responsible for administering the Plan and shares that responsibility with the respective insurance companies.

Insurance premiums for employees and their eligible family members are paid in part by the Company out of its general assets and in part by employees. The Plan Administrator provides a schedule of the applicable premiums during the initial and subsequent open enrollment periods and upon request. Some employee contributions are made on a pre-tax basis from the Company's cafeteria plan. There is no trust for the Plan.

The Company will bear its incidental costs of administering the Plan.

Plan Sponsor
The Aerospace Corporation
2310 East El Segundo Blvd M1/064
El Segundo, CA 90245

Phone: (310) 336-0426
EIN: 95-2102389

Insurance Companies
Benefits are provided through group insurance contracts with the insurance companies listed below. The Insurance Contracts in the Attachments contain the applicable contact information with respect to each insurance company.

The Aerospace Health Maintenance Organizations
- Anthem Blue Cross HMO - Group No. 174218
- Kaiser Foundation Health Plan (Southern California) - Group No. 100232
- Northern California Kaiser Foundation Health Plan - Group No. 7698
- Kaiser Permanente Mid-Atlantic - Group No. 3283

Dental Expense Plan
- Cigna Dental Plan - Group No. 3327584
- Dental Net-Blue Cross - Group No. 174151

Vision Service Plan
- Vision Service Plan - Group No. 12008869

Short-Term Disability Plan for Non-California Employees
- Hartford Life and Accident - Group No. 402802G

Aerospace Group Life
- Hartford Life and Accident - Group No. 402802G

Long Term Disability
- Hartford Life and Accident - Group No. 402802G

Voluntary Personal Accident Insurance
- Zurich-American Insurance Company - Group No. GTU8365008

Occupational Accident Insurance
- Zurich-American Insurance Company - Group No. GTU8365008

Plan Administrator
Principal Director, Total Rewards
The Aerospace Corporation
Mail Station M3-433
2310 East El Segundo Blvd
El Segundo, CA 90245
Phone: (310) 336-0426

Named Fiduciary
Each insurance company is a named fiduciary with respect to decisions regarding whether a claim for benefits will be paid under the Insurance Contract.

Service of Legal Process
The General Counsel of the Aerospace Corporation is designated as the agent for service of legal process. The address is The Aerospace Corporation at 2310 East El Segundo Boulevard, El Segundo, CA 90245-4609. The Plan Administrator may also receive service of legal process.

Disclaimer – Insurance Contracts Control
The Plan is fully insured. Benefits hereunder are provided pursuant to insurance contracts. If the terms of this SPD conflict with the terms of any Insurance Contract, then the terms of the Insurance Contract will control, rather than this SPD document, unless otherwise required by law.

Compliance with State and Federal Mandates
To the extent applicable, the Plan will provide coverage and benefits in accordance with the requirements of all applicable laws, including USERRA, COBRA, HIPAA, HITECH, NMHPA, WHCRA, FMLA, MHPA, MHPAEA, Michelle's Law, GINA, and PPACA.

No Contract of Employment
The Plan is not intended to be, and may not be construed as constituting, a contract or other arrangement between you and the Company to the effect that you will be employed for any specific period of time.

No Guarantee of Tax Consequences
Notwithstanding any provision in the Plan (including the Insurance Contracts) to the contrary, neither the Plan nor the Company makes any commitment or guarantee that any amounts paid to or on behalf of an Eligible Employee under the Plan will be excludable from the Eligible Employee's gross income for federal or state income tax purposes.

Governing Law
Except to the extent required by federal law, the Plan shall be construed and enforced according to the laws of California, without regard to its conflicts of laws principles.

Severability
In the event that any provision of this Plan (including the Insurance Contracts) is considered invalid or illegal for any reason, said invalidity or illegality shall not affect the remaining provisions of this Plan. The provision shall be fully severable. The Plan shall be construed and provisions enforced as if such invalid or illegal provision had never been part of the Plan.

Your Questions
If you have any question regarding your eligibility for, or the amount of, any benefit payable under the Plan, please contact the appropriate insurance company.

Eligibility and Participation Requirements

Enrollment
Eligible Employees must complete an application form (available through the Employee Benefits Service Center) or online enrollment to enroll themselves and/or their eligible spouses and dependents. New employees must enroll within certain time periods after being hired, as discussed in the Insurance Contracts attached. Otherwise, enrollment is generally limited to the annual open enrollment period that occurs before January 1 of each year with certain exceptions.

Special Enrollment Rights
In certain circumstances, enrollment may occur outside the open enrollment period. The terms of your applicable Insurance Contract in the Attachment as well as the "Special Enrollment Notice" contain information about these special enrollment rights.

When Participation Begins
Coverage under the Plan begins once you, as an Eligible Employee, have completed the necessary enrollment paperwork pursuant to the information contained in the Attachments.

When Participation Ends
Coverage under the Plan stops according to the terms and conditions reflected in the Attachments. Note that coverage under this Plan terminates on the last day of the month in which you terminate employment with the Company. Coverage under the Plan may terminate earlier if you fail to pay your share of the premiums, if your hours drop below any required eligibility threshold, if you submit false claims, and for certain other reasons described in the Attachments. Coverage for your covered family members stops when your coverage stops. Coverage for a family member will also stop if that family member becomes ineligible (for example, due to divorce) or for other reasons specified in the Attachments (such as nonpayment of applicable premiums). It is your responsibility to provide accurate information and to make accurate and truthful statements regarding family status, age, relationships, etc., and to update previously provided information and statements. Failure to do so may be considered a misrepresentation of material fact, and may result in termination of coverage; such termination may be retroactive. Coverage also ceases for employees, spouses, and dependents upon termination of the Plan.

Qualified Medical Child Support Orders
The Plan will extend benefits to an Eligible Employee's non-custodial child, as required by any qualified medical child support order (QMCSO), under ERISA § 609. The Plan has procedures for determining whether an order qualifies as a QMCSO. Participants and beneficiaries can obtain, without charge, a copy of such procedures from the Employee Benefits Director.

Continuation Coverage
If the health insurance coverage for an Eligible Employee or his or her covered eligible family members ceases due to certain "qualifying events" specified in COBRA (for example, termination of employment, reduction in hours, divorce, death, or a child no longer meeting the definition of dependent), then the Eligible Employee or his or her covered eligible family members may have the right to purchase continuation coverage for a temporary period of time for certain insured benefits. More information about these rights is included in the Insurance Contracts in the Attachments.

Continuation and reinstatement rights may also be available if you are absent from employment due to service in the uniformed services pursuant to the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA). More information about coverage available under USERRA is included in the attached Insurance Contracts.

Continuation coverage will also be made available as required by applicable state law.

Plan Benefits

Benefits Provided
The Plan provides insurance coverage to Eligible Employees and their eligible spouses and dependents. These benefits are provided under group insurance contracts entered into between the Company and the insurance companies listed above.

Funding
The Plan is fully insured. The cost of the benefits provided through the Plan will be funded in part by Company contributions and in part by employee contributions through payroll deductions, subject to the terms of the Company's cafeteria plan document and the Attachments. The Company will determine and periodically communicate your share of the cost of the benefits provided through the Plan, and it may change that determination at any time. The Company will make its contributions in an amount that (in the Company's sole discretion) is at least sufficient to fund the benefits or a portion of the benefits that are not otherwise funded by your contributions. The Company will pay its contribution and forward your contributions to the insurer.

Any refund, rebate, dividend, experience adjustment, or other similar payment under the group Insurance Contracts entered into between the Company and the insurance companies shall be allocated, consistent with the fiduciary obligations imposed by ERISA, to reimburse the Company for premiums it has paid.

Right to Recover Benefit Overpayments and Other Erroneous Payments
The Insurance Contracts in the Attachments contain information about the Plan's right to subrogation or reimbursement of benefits. If, for any reason, any benefit under the Plan is erroneously paid or exceeds the amount appropriately payable under the Plan to a Participant, the Participant shall be responsible for refunding the overpayment to the Plan to the fullest extent permitted by law. In addition, if the Plan makes any payment that, according to the terms of the Plan, should not have been made, the applicable insurance company, the Plan Administrator, or the Plan Sponsor (or person designated by the Plan Sponsor) may, to the fullest extent permitted by law, recover that incorrect payment, whether or not it was made due to the applicable insurance company's or Plan Administrator's (or his or her designee's) error, from the person to whom it was made or from any other appropriate party.

As may be permitted in the sole discretion of the Plan Administrator, the refund or repayment may be made in one or a combination of the following methods: (a) in the form of a single lump-sum payment, (b) as a reduction of the amount of future benefits otherwise payable under the Plan, (c) as automatic deductions from pay (as authorized by the Eligible Employee) or (d) any other method as may be required or permitted in the sole discretion of the Plan Administrator or the applicable insurance company. The Plan may also seek recovery of the erroneous payment or benefit overpayment from any other appropriate party to the fullest extent permitted by applicable law.

With respect to component benefit programs provided through insurance, the Insurance Contract language may contain information regarding the Plan's right to subrogate or seek reimbursement of erroneously paid benefits (including payments in excess of the amount appropriately payable).

Coordination of Benefits
To the extent an Insurance Contract (including the certificate of insurance) contains terms or conditions that conflict or are inconsistent with this document, the terms of the Insurance Contract shall control, rather than this document, unless such terms are prohibited by or inconsistent with applicable law. For this purpose, silence in an Insurance Contract is not necessarily a conflict or inconsistency.

Eligible Employee Information and Responsibilities
Each Eligible Employee shall be responsible for providing the Plan Administrator and the Company and, if required by an insurance company, the insurance company with his or her current address and, if required, with the address of any individual covered through the Eligible Employee. Any notices required or permitted to be given under the Plan shall be deemed given if directed to the address most recently provided by the Eligible Employee and mailed by first-class United States mail.

Right to Information and Fraudulent Claims
Any person claiming benefits under the Plan shall furnish the Plan Administrator or the insurance company with such information and documentation as may be necessary to verify eligibility for or entitlement to benefits under the Plan.

The Plan Administrator and the insurance company shall have the right and opportunity to have a Participant examined when benefits are claimed, and when and as often as it may be required during the pendency of any claim under the Plan.

If a person is found to have falsified any document in support of a claim for benefits or coverage under the Plan, or failed to have corrected information which such person knows or should have known to be incorrect, or failed to bring such misinformation to the attention of the Plan Administrator or the insurance company, the Plan Administrator may, without the consent of any person and to the fullest extent permitted by applicable law, terminate the person's Plan coverage, including retroactively. In addition, the insurance company may refuse to honor any claim for benefits under the Plan for the Participant related to the person submitting the falsified information. Such person shall be responsible to provide restitution, including monetary repayment to the Plan, with respect to any overpayment or ineligible payment of benefits.

Plan Administration

The Principal Director, Total Rewards is the Plan Administrator. The Plan Administrator is responsible for satisfying certain legal requirements under ERISA with respect to the Plan (for example, distributing SPDs). The Employee Benefits Director is the person who acts on behalf of the Plan Administrator. The Company has agreed to indemnify the Employee Benefits Director and the Plan Administrator for any liability that he or she incurs as a result of administering the Plan, unless such liability is due to his or her gross negligence or misconduct.

The principal duty of the Plan Administrator is to see that the Plan functions both according to its terms and for the exclusive benefit of persons entitled to participate in the Plan. The administrative duties of the Plan Administrator include, but are not limited to, interpreting the Plan, prescribing applicable procedures, determining eligibility for and the amount of benefits, authorizing benefit payments, and gathering information necessary for administering the Plan. The Plan Administrator may delegate any of these administrative duties among one or more persons or entities, provided that such delegation is in writing, expressly identifies the delegate(s), and expressly describes the nature and scope of the delegated responsibility.

To the fullest extent permitted by law, the Plan Administrator, and any other fiduciary with respect to the Plan to the extent that such individual or entity is acting in its fiduciary capacity, shall have full and sole discretionary authority to interpret all plan documents and to make all interpretive and factual determinations as to whether any individual is entitled to receive any benefit under the terms of this Plan, and to determine all questions arising in connection with the administration, interpretation, and application of the Plan, including the eligibility and coverage of individuals and the authorization or denial of payment or reimbursement of benefits. Any construction of the terms of any plan document and any determination of fact adopted by the Plan Administrator shall be final and legally binding on all parties. Any interpretation, determination, or other action of the Plan Administrator shall be subject to review only if it is arbitrary or capricious or otherwise an abuse of discretion. Any review of a final decision or action of the Plan Administrator shall be based only on such evidence presented to or considered by the Plan Administrator at the time the Plan Administrator made the decision that is the subject of review. Accepting any benefits or making any claim for benefits under this Plan constitutes

agreement with and consent to any decisions that the Plan Administrator makes, in its sole discretion and, further, constitutes agreement to the limited standard and scope of review described by this section.

Power and Authority of Insurance Companies
Benefits under the Plan are fully insured. These benefits are provided under group insurance contracts entered into between the Company and the applicable insurance companies. Claims for benefits under the Plan are submitted to the insurance companies. The insurance companies, not the Company, are responsible for determining and paying claims. The insurance companies are responsible for (a) determining eligibility for a benefit and the amount of any benefits payable under the Plan; and (b) providing the claims procedures to be followed and the claims forms to be used by eligible individuals under the Plan. (See the Claims Procedures section below for more information about claims.)

As the named fiduciaries for benefit determinations, the insurance companies, to the fullest extent permitted by law, have the full discretionary authority to interpret the Plan and to make all factual interpretations under the Plan. The insurance companies also have the authority to require eligible individuals to furnish them with such information as they determine necessary for the proper administration of the Plan.

Circumstances That May Affect Benefits

Denial, Recovery, or Loss of Benefits
Your benefits (and the benefits of your eligible family members) will cease when your participation in the Plan terminates, including upon termination of the Plan. Other circumstances can result in the termination, reduction, or denial of benefits. The applicable Insurance Contracts, plans, and other governing documents in the Attachments provide additional information about the termination, denial, or loss of benefits.

Preexisting Conditions and Other Exclusions
The Plan's Insurance Contracts contain information about any exclusion due to preexisting conditions or other exclusions.

Amendment or Termination
The Company, as the sponsor of the Plan, has the general right to amend or terminate the Plan at any time. The Plan may be amended or terminated by a written instrument duly adopted by the Company or any of its delegates, including but not limited to the Company President or the Plan Administrator, both of whom are authorized to amend or terminate the Plan and to sign Insurance Contracts with the insurance companies, including amendments to those contracts, and may adopt (by a written instrument) amendments to the Plan that he or she considers to be administrative in nature or advisable in order to comply with applicable law. Note, for this purpose, that an Insurance Contract is not necessarily the same as the Plan. An Insurance Contract is how benefits under the Plan are provided. Consequently, termination of an Insurance Contract does not necessarily terminate the Plan.

Plan Participants, retirees, spouses, and eligible dependents do not have a vested right in any Plan benefits. If the Plan is amended, changed, modified, or terminated with respect to any of the component benefits provided herein, Plan Participants, retirees, spouses, and eligible dependents will not be vested in any Plan benefits or have any further rights other than payment of covered expenses Plan Participants, retirees, spouses, and eligible dependents had before the Plan was amended, changed, modified, or terminated.

Administrative Requirements and Timelines
As described in the Attachments, there may be reasons that a claim for benefits is not paid, or is not paid in full. For example, claims must generally be submitted for payment within a certain period of time, and failure to submit within that time period may result in the claim being denied. For details regarding administrative requirements that may impact benefit availability, please consult the Attachments.

Claims for Benefits

Claims Procedure
For purposes of determining the amount of and entitlement to benefits, the insurers are the named fiduciaries under the Plan with the full power to interpret and apply the terms of the Plan as they relate to the benefits provided under the applicable Insurance Contracts.

To obtain benefits from the insurers you must follow the insurers' claims procedures. (See the Attachments for more information.) The insurer will decide your claim in accordance with its reasonable claims procedures, as required by ERISA and other applicable law. If the insurer denies your claim in whole or in part, you will receive a written notification setting forth the reason(s) for the denial. If your claim is denied, you may appeal to the insurer for a review of the denied claim. The insurer will decide your appeal in accordance with its reasonable claims procedures, as required by ERISA and other applicable law. If you do not appeal on time, you may lose your right to file suit in a state or federal court, because you will not have exhausted your internal administrative appeal rights (which generally is a prerequisite to bringing suit in state or federal court). See the Attachments for more information about the claims process for benefits.

Claims Deadline
Unless specifically provided otherwise in the Attachments or pursuant to applicable law, a claim for benefits under this Plan must be made within one year after the date of the event that gave rise to the claim. It is the responsibility of the employee or covered family member, or his or her designee, to make sure this requirement is met.

External Review
Under certain circumstances, you may have the right to obtain external review (that is, review of your claim by someone outside of the Plan). The Insurance Contracts in the Attachments provide additional details regarding this right to external review where your benefits are provided through that insurer.

Statement of ERISA Rights

As a participant, 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 and at other specified locations, such as the Company's Regional Offices, 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 exercising 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, and you have fully exhausted administrative review procedures, you may file suit in a state or federal court. If it should happen that plan fiduciaries misuse the plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court.

The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, 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 Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210.

Limitations Period for Filing Suit

Unless specifically provided otherwise in the Attachments or pursuant to applicable law, a suit for benefits under this Plan must be brought within one year after the date of a final decision on the claim in accordance with the applicable claims procedures.

Attachments

The Aerospace Health Maintenance Organizations

- Anthem Blue Cross HMO - Group No. 174218
- Kaiser Foundation Health Plan (Southern California) - Group No. 100232
- Kaiser Foundation Health Plan (Northern California) - Group No. 7698
- Kaiser Permanente Mid-Atlantic - Group No. 3283

Dental Expense Plan

- Cigna Dental Plan - Group No. 3327584
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Vision Service Plan

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Voluntary Personal Accident Insurance; Occupational Accident Insurance

- Zurich-American Insurance Company - Group No. GTU8365008