AEROSPACE

Legally Required Notices

and Other Important Information for Aerospace Health and Welfare Plans and the Aerospace Corporation 401(k) Plan

Aerospace Active Employees

Each year, there are legally required notices and disclosures that Aerospace (or our insurance carriers) are required to make to participants in Aerospace benefit plans. These notices and disclosures are for your information.

Please call the Employee Benefits Service Center at 844.361.2400 if you have questions about any of these notices.

Notice Regarding Exchange Coverage Under the Affordable Care Act

Key parts of the Affordable Care Act, also known as the Health Care Reform Law, went into effect January 1, 2014. As a result, there are new ways to buy health insurance: the Health Insurance Marketplace (the Marketplace). To assist you as you evaluate options for you and your family, this notice provides some basic information about the new Marketplace and employment-based health coverage offered by The Aerospace Corporation.

What Is the Health Insurance Marketplace?

The Marketplace is designed to help individuals find health insurance that meets their needs and fits their budget. It offers "one-stop shopping" to find and compare private health insurance options. All U.S. citizens and legal residents will have access to individual health insurance policies through the Marketplace in their state.

Individuals may also be eligible for a tax credit that lowers their monthly premium right away. Open enrollment for 2021 health insurance coverage through the Marketplace runs from November 1, 2019 through December 15, 2020.

Can Individuals Save Money on Health Insurance Premiums in the Marketplace?

Some people who do not have access to affordable, minimum value health care coverage through their employer may be eligible for a federal subsidy in order to make buying insurance through the Marketplace more affordable. The savings these individuals would be eligible for depends on household income.

It's important to know that because Aerospace's health plans meet the government's standards for minimum value and affordability, you will not qualify for a federal subsidy if you are eligible for Aerospace benefits. You will likely find more affordable coverage through our health plans, or if available, through your spouse's employer plan, or through your parent's employer plan (if you are under the age of 26).

Does Employer Health Coverage Affect Eligibility for Premium Savings through the Marketplace?

Yes. Individuals who have an offer of health coverage from their employer that meets certain standards (as does Aerospace's health coverage) are not eligible for a tax credit through the Marketplace and may wish to enroll in their company's health plan. Some people may be eligible for a tax credit that lowers their monthly premiums, or a reduction in certain cost-sharing if their employer does not offer coverage at all or does not offer coverage that meets certain standards. If the cost of a plan from an employer for employee-only coverage is more than 9.78 percent of an employee's household income for the year, or if the coverage the employer provides does not meet the "minimum value" standard set by the health care reform law, an employee may be eligible for a tax credit. An employer-sponsored health plan meets the "minimum value" standard if the plan's share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs.

What If I'm Not Eligible for Aerospace's Health Plans?

If you are not eligible for Aerospace's health plans, you should consider other options available to you, such as coverage through your spouse's employer plan, your parent's employer plan, Medicaid, Medicare or your state's Marketplace. If you decide to enroll through the Marketplace, you will need to provide the Marketplace with the following information about Aerospace and our plans:

Employer name: The Aerospace Corporation

Employer Identification Number (EIN): 95-2102389

Employer address: 2310 East El Segundo Blvd.,
El Segundo, CA 90245-4609

Employer telephone number: 310.336.5000

Contact: Employee Benefits Service Center

Contact telephone number
(if different from above): 844.361.2400

Email address of contact:
EmployeeBenefitsServiceCenter@aero.org

Note: If you purchase a health plan through the Marketplace instead of accepting health coverage offered by Aerospace, then you will lose Aerospace's contribution to the company-offered coverage. Also, this contribution — as well as your employee contribution to Aerospace offered coverage — is excluded from income for federal and state income tax purposes. Your payments for coverage through the Marketplace are made on an after-tax basis.

Why Are We Sending This Information?

Most U.S. employers are required to send this notice to employees to raise awareness of the new Marketplace and to help them understand how having access to their employer's health care plan may limit their eligibility for tax credits in the Marketplace.

How Can I Get More Information?

The health care reform law requires almost all Americans to have health care coverage. If you have questions, please go to the Aerospace Employee Benefits website under "Health Care Reform" or go to www.healthcare.gov. You can also contact The Employee Benefits Service Center at 844.361.2400 or via email at EmployeeBenefitsServiceCenter@aero.org.

Newborns and Mothers Health Protection Act

The Newborns and Mothers Health Protection Act of 1996 (NMHPA) allows mothers and newborns to stay in the hospital at least 48 hours following the birth of the child. Group health plans may not limit the hospital stay to less than 48 hours following a normal delivery or less than 96 hours following a delivery by cesarean section. Stays of less than 48 hours or 96 hours, as applicable, are allowed if the attending provider, after consultation with the mother, discharges the mother or newborn earlier. Precertification and other requirements may be necessary for stays beyond 48 or 96 hours, but coverage levels or out-of-pocket costs may not be set so that any portion is covered less favorably.

Women's Health and Cancer Rights Act

The Women's Health and Cancer Rights Act of 1998 (WHCRA) requires the following notice of coverage of medical care following mastectomy.

The group health plans and HMOs currently offered by Aerospace provide coverage for medically necessary mastectomy and associated lymph node dissection. Reconstructive surgery and prosthetic devices following mastectomy are also covered, including those required on the other breast to produce a symmetrical appearance. In addition, nipple and areola reconstruction and repigmentation are also covered, and coverage for complications, including lymphedema, is provided.

Prior authorization is not required for length of inpatient stay for mastectomies or lymph node dissection. Length of stay for these procedures will be determined by the attending physician in consultation with the patient. Prior authorization for hospital admissions for mastectomies is not required.

Notice of HIPAA Special Enrollment Rights

A federal law called HIPAA requires that we notify you about your right to enroll in the Aerospace group health plans (the Plans) if you acquire a new dependent, or if you decline coverage under the Plans for yourself or an eligible dependent while other coverage is in effect and later lose that other coverage for certain qualifying reasons.

Special Enrollment Rights

Loss of Other Coverage (Excluding Medicaid or a State Children's Health Insurance Program). If you decline enrollment for yourself or for an eligible dependent (including your spouse) while other health insurance or group health plan coverage is in effect, you may be able to enroll yourself and your dependents in an Aerospace group medical plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing toward your or your dependents' other coverage). However, you must request enrollment within 30 days after your or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage).

Loss of Coverage for Medicaid or a State Children's Health Insurance Program. If you decline enrollment for yourself or for an eligible dependent (including your spouse) while Medicaid coverage or coverage under a State Children's Health Insurance Program is in effect, you may be able to enroll yourself and your dependents in an Aerospace group medical plan if you or your dependents lose eligibility for that other coverage. However, you must request enrollment within 60 days after your or your dependents' coverage ends under Medicaid or a State Children's Health Insurance Program. Additional information on this special enrollment right is included in this Legally Required Notices Booklet.

New Dependent by Marriage, Birth, Adoption, or Placement for Adoption. If you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your new dependents in an Aerospace group medical plan. However, you must request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption.

Eligibility for Medicaid or a State Children's Health Insurance Program. If you or your dependents (including your spouse) become eligible for a state premium assistance subsidy from Medicaid or through a State Children's Health Insurance Program with respect to coverage under the Plans, you may be able to enroll yourself and your dependents in an Aerospace group medical plan. However, you must request enrollment within 60 days after your or your dependents' determination of eligibility for such assistance. Additional information on this special enrollment right is included in this Legally Required Notices Booklet.

Change in Status Events

In exchange for the favorable tax treatment of pretax salary deductions for your share of the cost for the Aerospace Group Hospital Medical, Health Maintenance Organizations, Dental, Vision, and/or Flexible Spending Account Plans and certain other benefit plans, Treasury Regulations restrict coverage elections outside the open enrollment period for benefit plans paid for with pre-tax dollars. You can make certain changes in your elections during the year **only if** you provide proof of one or more **change in status events** as defined in IRS regulations, such as:

- Change in legal marital status (marriage, divorce, legal separation);
- Change in number of eligible dependents (birth, adoption, custody, death);
- Change in dependent's eligibility (loss or gain of other coverage, attainment of maximum age);
- Change in employment status, work schedule, residence, or worksite that affects benefit coverage eligibility for you, your spouse, or your dependent under the benefits plan; or
- Any event that triggers a HIPAA Special Enrollment Right, including a change in eligibility status under Medicaid, a State Children's Health Insurance Program (CHIP), or a state premium assistance program.

Any election changes you make outside the annual enrollment period must be consistent with your change in status event. For example, if you get married, you can add dependent coverage to your current medical plan within 31 days of marriage, but you cannot change medical plans. However, you may change medical plans during the year if, for example, you move out of the service area for the plan you selected during open enrollment. **All changes must be made within 31 days of the eligible change in status event,** unless otherwise permitted in accordance with applicable law.

Note that you must notify the Employee Benefits Service Center within 31 days when you have a change in status event that may trigger the right to change your coverage elections.

COBRA—Coverage Continuation

This notice has important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Aerospace Group Hospital Medical Plan, Health Maintenance Organizations, Dental Expense Plan or Vision Service Plan (the Aerospace Group Medical Plans). **This notice explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect your right to get it.** When you become eligible for COBRA, you may also become eligible for other coverage options that may cost less than COBRA continuation coverage.

The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to you and other members of your family when group health coverage would otherwise end. For more information about your rights and obligations under the Aerospace Group Medical Plans and under federal law, please see the "Other Benefits" section on the Aerospace Benefits website or contact the Plan Administrator.

You may have other options available to you when you lose group health coverage. For example, you may be eligible to buy an individual plan through the Health Insurance Marketplace. By enrolling in coverage through the Marketplace (state or federal exchange), you may qualify for lower costs on your monthly premiums and lower out-of-pocket costs. Additionally, you may qualify for a 30-day special enrollment period for another group health plan for which you are eligible (such as a spouse's plan), even if that plan generally doesn't accept late enrollees.

What is COBRA continuation coverage?

COBRA continuation coverage is a continuation of your coverage under the Aerospace Group Medical Plans when it would otherwise end because of a life event. This is also called a "qualifying event." Specific qualifying events are listed later in this notice. After a qualifying event, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." You, your spouse, and your dependent children could become qualified beneficiaries if coverage is lost because of the qualifying event. Qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

Qualified beneficiaries who participate in an Aerospace Group Medical Plan may elect to continue coverage if medical coverage ends because:

- You terminate employment (except if you are terminated for gross misconduct) or
- You are no longer eligible because of a reduction in your hours.

Covered spouses and eligible dependents may elect to continue coverage if coverage ends because one of the following qualifying events occurs while you are actively employed:

- Your death,
- You terminate employment (except if you are terminated for gross misconduct),
- You are no longer eligible because of a reduction in your hours,
- There is a change in your marital status (divorce, dissolution, or legal separation),
- You become entitled to Medicare benefits (under Part A, Part B, or both), or
- Your eligible dependent stops being eligible for coverage as a "dependent child."

Qualified beneficiaries must contact the Aerospace Employee Benefits Service Center within 60 days of a divorce, dissolution, a legal separation, or cessation of dependent status. Upon receiving notification, the Aerospace Employee Benefits Service Center will send the impacted person an election form and more information. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. The person must inform the Aerospace Employee Benefits Service Center that he or she wants coverage continuation within 60 days from the later of: (1) the date he or she would lose coverage because of one of the events described in this notice; or (2) the date he or she is notified of your right to elect coverage. Covered employees may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation coverage on behalf of their children. COBRA continuation coverage is a temporary continuation of coverage that generally lasts for 18 months due to employment termination or reduction of hours of work. Certain qualifying events, or a second qualifying event during the initial period of coverage, may permit a beneficiary to receive a maximum of 36 months of coverage

COBRA—Coverage Continuation (continued)

There are also ways in which this 18-month period of COBRA continuation coverage can be extended:

Disability extension of 18-month period of COBRA continuation coverage

If you or anyone in your family covered under the Aerospace Group Medical Plans is determined by Social Security to be disabled and you notify the Aerospace Employee Benefits Service Center in a timely fashion, you and your entire family may be entitled to get up to an additional 11 months of COBRA continuation coverage, for a maximum of 29 months. The disability would have to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of COBRA continuation coverage. The Aerospace Employee Benefits Service Center may require additional information regarding the disability determination. The notice should be delivered no later than 30 days following the disability determination.

Second qualifying event extension of 18-month period of continuation coverage

If your family experiences another qualifying event during the 18 months of COBRA continuation coverage, the spouse and dependent children in your family can get up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if the Aerospace Employee Benefits Service Center is properly notified about the second qualifying event. This extension may be available to the spouse and any dependent children getting COBRA continuation coverage if the employee or former employee dies; becomes entitled to Medicare benefits (under Part A, Part B, or both); gets divorced or legally separated; or if the dependent child stops being eligible under the Aerospace Group Medical Plans as a dependent child. This extension is only available if the second qualifying event would have caused the spouse or dependent child to lose coverage had the first qualifying event not occurred.

If continuation of coverage is elected, qualified beneficiaries must pay the **full cost of the elected coverage plus a two percent administrative fee.** During the continuation of coverage, eligible COBRA participants may select another medical plan during the annual open enrollment period. If you do not elect continuation coverage, you may be able to convert your coverage to an individual policy. Contact the Aerospace Employee Benefits Service Center for more details.

Continuation coverage will stop when one of the following occurs:

(1) the indicated time period ends;

(2) the person receiving COBRA benefits becomes covered under another group health plan that does not impose any applicable pre-existing condition exclusions;

(3) the person receiving COBRA benefits becomes entitled to Medicare benefits;

(4) the required premiums are not paid on time; or

(5) the Aerospace Group Medical Plan is terminated.

Questions concerning your coverage under the Aerospace Group Medical Plans or your COBRA continuation coverage rights should be addressed to the Aerospace Employee Benefits Service Center. For more information about your rights under the Employee Retirement Income Security Act (ERISA), including COBRA, the Patient Protection and Affordable Care Act, and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit www.dol.gov/ebsa. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.) For more information about the Marketplace, visit www.healthcare.gov.

Keep your Plan informed of address changes

To protect your family's rights, let the Aerospace Employee Benefits Service Center know about any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Aerospace Employee Benefits Service Center.

Privacy Notice for the Aerospace Group Medical Plans and Flexible Spending Account (FSA) Plan

This notice describes how medical information about you may be used and disclosed and how you can obtain access to this information. Please review it carefully.

Introduction

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) requires group health plans to maintain the privacy of your Protected Health Information (PHI). This notice provides you with information about how the Flexible Spending Account Plan, Dental Expense Plan, Vision Service Plan, Health Maintenance Organizations and Group Hospital Medical Plan of The Aerospace Corporation (collectively, the Plans) will use and disclose your PHI, and your rights with respect to this information.

For purposes of the Plans, PHI includes any information that identifies you and that relates to health care services provided to you, or the payment for health care services provided to you, including your genetic information.

The Plans must comply with the provisions of this notice, although it reserves the right to change the terms of this notice, as described below.

Permitted use and disclosure

The Plans may not use or disclose your PHI unless they are permitted or required to do so. The Plans may use and disclose your PHI for purpose of providing you with coverage under the Plans. This section of the notice describes all the permitted uses and disclosures of your PHI by the Plans.

Payment and Health Care Operations

The Plans will use and disclose PHI for the purposes of payment and health care operations without your authorization. Examples of the uses and disclosures that the Plans may make for each of these purposes are described below:

- **Payment** — Payment refers to the activities of the Plans in providing coverage and paying claims under the Plans. For example, the Plans use and disclose PHI to process your claims under the Plans for reimbursement of medical expenses. This claim-processing function is performed by Aetna, who currently is the Plans' third-party administrator for the General Purpose Health Flexible Spending Account.
- **Health Care Operations** — Health Care Operations refers to the basic business functions necessary to operate the Plans. For example, the Plans may use and disclose PHI to conduct quality assessment studies of the Plans' third- party administrator or it may disclose PHI to consultants who provide legal or auditing services for the Plans.

Disclosures to the Plan Sponsor

The Plans may disclose your PHI to The Aerospace Corporation (the Plan Sponsor) to the extent necessary for the Plan Sponsor to carry out administrative functions of the Plans. Such disclosures to the Plan Sponsor may be made for the following purposes: informing the Plan Sponsor that you are enrolled in a plan so that the Plan Sponsor can withhold the appropriate amount of pre-tax contribution to the plan from your paycheck; the Plan Sponsor's review of appeals of denied claims by the third-party administrator; and to modify, amend, or terminate the Plans.

Other use and disclosure allowed without authorization

The Plans may also use and/or disclose your PHI without your authorization in the following circumstances:

- To you, to a personal representative that you designate to receive the information (such as a relative), or to a representative designated by law (such as a parent or legal guardian of a minor child).
- To a business associate as part of a contractual agreement under which the business associate agrees to perform services for one or more of the Plans. (Each business associate must agree in writing to ensure the continuing confidentiality and security of your protected health information.)
- As required by law.
- To the Secretary of Health and Human Services (HHS) or any employee of HHS as part of an investigation to determine the Plan's compliance with the HIPAA Privacy Rules.

- For public health activities.
- To a health oversight agency for its activities as authorized by law, such as its audits, investigations, or inquiries regarding the Plans.
- In response to a court order, subpoena, discovery request, or other judicial or administrative proceeding.
- To law enforcement officials for limited law enforcement purposes, such as to avert a serious threat to your health or safety or the health or safety of others.
- To a governmental authority that is authorized to receive reports of abuse, neglect, or domestic violence.
- For specialized government functions, including national security and intelligence activities.
- To appropriate military authorities, if you are a member of the armed forces or, if you are a member of a foreign military service, to the foreign military authority.
- To a coroner or medical examiner for duties regarding a deceased person as authorized by law.
- To an organ procurement organization, in limited circumstances.
- For research purposes, in limited circumstances.
- As required to comply with workers' compensation or other similar programs that provide benefits for work-related injuries or illnesses.

If your state has a privacy law that provides you greater protections, the Plans will comply with that law.

As described above, PHI may be disclosed to a personal representative that you designate. Your personal representative will be required to produce evidence of his or her authority to act on your behalf before he or she will be given access to your PHI or allowed to take any action for you. The Plans may elect not to treat the person as your personal representative if the applicable plan has a reasonable belief that you have been, or may be, subjected to domestic violence, abuse, or neglect by such person; treating such person as your personal representative could endanger you; or the applicable plan determines that it is not in your best interest to treat the person as your personal representative.

Pursuant to an authorization

Your written authorization will be required for the Plans to use or disclose your PHI other than as described above or otherwise permitted by applicable law. You may revoke an authorization at any time by providing written notice to the Plans that you wish to revoke an authorization. The Plans will honor a request to revoke an authorization for future uses and disclosures of PHI in writing. However, the revocation will not be effective for information that the Plans have used or disclosed in reliance on the authorization.

Please note that written authorization is also required for the Plans to use or disclose PHI that contains your genetic information.

Your rights

1. **Right to request restriction on use and/or disclosure of PHI**

   You have the right to request restrictions on the Plans' uses and disclosures of PHI for payment or health care operations. You also have the right to request that the Plans restrict disclosures to individuals who may be involved in your health care or payment for your health care. The Plans are not required to agree to your request. However, if you pay out-of-pocket in full for any health care item or service, you may ask your health care provider not to disclose any PHI regarding that item or service. To request a restriction, you must submit a written request to the contact person listed at the end of this notice; your request must state the specific restriction requested and to whom that restriction would apply.

2. **Right to receive confidential communications**

   You have the right to request that the Plans' communication of PHI to you be made to you by alternative means or at an alternative location other than to your address of record if you believe that the normal method of communication would endanger you. Any such request must be made in writing to the contact person listed at the end of this notice. Your request must specify the alternative location or means for communication with you, and must state that disclosure of all or part of the PHI under the normal method would put you in danger. The Plans will accommodate any request for confidential communications that is reasonable if the normal method of disclosure of PHI could endanger you.

Privacy Notice for the Aerospace Group Medical Plans and Flexible Spending Account (FSA) Plan (continued)

3. Right to inspect and copy PHI

You have the right to inspect and obtain a copy of the PHI that the Plans maintain in a designated record set for as long as the Plans maintain the PHI. A "designated record set" contains enrollment, claim information, premium and billing records and any other records the Plans have created in making claim and coverage decisions relating to you; information that is used for quality control, that is not used to make decisions about an individual, is not included as part of the designated record set. Requests for access to your PHI should be made, in writing, to the contact person listed at the end of this notice.

Please note that, under federal law, you may not inspect or copy certain records that are created or received by the Plans, such as information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding.

If the Plans deny a request for access, then you have the right to have the denial reviewed. Aerospace will select an individual who was not involved in the initial decision to conduct the review of the initial decision.

You will be charged a reasonable fee for copying and mailing the PHI.

4. Right to amend PHI

You have the right to request in writing an amendment to your PHI, but the Plans may deny your request for amendment if it determines that the PHI or record that is the subject of the request is accurate and complete. Your request to amend PHI must be submitted in writing to the contact person listed at the end of this notice and must set forth one or more reasons in support of the proposed amendment. Any agreed upon amendment will be either attached to or included in your records.

Please do not use this formal amendment process for administrative changes such as change of address, change of name, or adding or dropping a dependent. We ask that you notify the Employee Benefits Service Center of those changes through existing procedures.

The Plans have 60 days after your request to amend your PHI to act on the request, except that an additional 30- day period is allowed if the Plans are unable to comply with your request within the initial 60-day period and the Plans give you a written statement of the reasons for the delay and the date by which the Plans will make a decision on your request.

If your request for amendment is denied, you have the right to have a statement of disagreement included with the PHI and the Plans have a right to include a rebuttal to you statement, a copy of which will be provided to you.

5. Right to receive an accounting

You have the right to request in writing an accounting of disclosures of PHI made by the Plans, within the six years prior to the date of your request, except for disclosures:

(i) To carry out payment and health care operations (i.e., for reimbursement operations as provided above);
(ii) That you authorized or that we made to you;
(iii) That occurred prior to April 14, 2003;
(iv) To persons involved in your care or payment for care;
(v) As part of a limited data set, as provided in the HIPAA Privacy Rule;
(vi) For national security or intelligence purposes as provided by law;
(vii) To correctional institutions or other custodial law enforcement officials as permitted by the HIPAA Privacy Rule; or
(viii) Incident to a use or disclosure required or permitted by the HIPAA Privacy Rule.

The Plans do not expect that there will be many, if any, disclosures for any purpose other than as described in the preceding list.

The Plans will impose a reasonable charge to cover the Plans' cost if you request an accounting more than once per year.

6. **Right to receive confidential communications**

   You have the right to request that the Plans communicate with you about your health and related issues in a particular manner or at a certain location if your life could be endangered by the disclosure of PHI. For example, you may ask that the Plans contact you at work rather than at home. The Plans will accommodate reasonable requests made in writing. Your request to receive PHI by alternative means must clearly state that your life could be endangered by the disclosure of all or part of your PHI.

7. **Right to a copy of the notice**

   You have the right to request a paper copy of this notice from the contact person listed at the end of this notice.

8. **Right to notification following breach**

   You have a right to be notified following an improper disclosure of your unsecured PHI.

Complaints

If you believe that your privacy rights have been violated, you may file a complaint with the Plans' privacy officer and/or with the Secretary of the U.S. Department of Human and Health Services. You may submit your complaint in writing by mail or electronically to the Employee Benefits Service Center. A complaint must name the person or entity that is the subject of the complaint and describe the acts or omissions believed to be in violation of the applicable requirements of HIPAA or this notice. Neither the Plan Sponsor nor the Plans will retaliate against you for filing any complaint.

Amendments to this notice

As noted above, the Plans reserve the right to revise or amend this notice at any time. The revisions or amendments may be made effective for all PHI related to the Plans even if the PHI is created or received prior to the effective date of the revision or amendment. The Plans will provide you with notice of any revisions or amendments to this notice, or changes in the law affecting this notice. You can, at any time, request a copy of the most current privacy notice that relates to the Plans from the contact person listed at the end of this notice.

Contact Person

To request access, amendment or accounting, or if you would like further information about this notice, please contact the Employee Benefits Service Center at 844.361.2400 or employeebenefitsservicecenter@aero.org.

This Notice Became Effective as of September 23, 2013.

Information Generally Required for Enrollment

Under Section 111 of the Medicare, Medicaid and SCHIP Extension Act of 2007 (MMSEA), the Centers for Medicare and Medicaid Services (CMS) generally requires Social Security numbers for employees and dependents to assist with reporting under the Medicare Secondary Payer requirements. Accordingly, when you enroll in an Aerospace group health plan, you will be required to provide Social Security numbers for yourself and any dependents you wish to enroll to assist us in complying with this requirement. If you need to add a dependent to your coverage who does not have a Social Security number, call the Aerospace Employee Benefits Service Center.

Michelle's Law Notice

Note: This is not an issue for Aerospace dependents since we cover them until they are age 26 regardless of student status. However, we are required to provide you with this notice.

If you have a dependent child older than age 18 who is enrolled at a post-secondary institution (e.g., college or university) on a full-time basis, he or she may be eligible to continue to be covered as a dependent if he or she loses full-time student status due to a serious injury or illness under a federal law referred to as "Michelle's Law."

In order to be eligible to continue coverage as a dependent under Michelle's Law:

- The dependent child must be enrolled in an Aerospace group health plan (the Plan) based on full-time student status immediately before the first day of the medically necessary leave of absence;
- A doctor's written certification of the medically necessary leave of absence must be submitted to the health insurance company; and
- Proof of full-time student status before the leave of absence may also be required to be submitted to the health insurance company.

Continued dependent coverage will be extended for at least one year after the first day of the leave of absence, but may end earlier if the dependent child does not meet the dependent eligibility requirement under the Plan. If dependent coverage under Michelle's Law ends, the dependent may be eligible for continuation of coverage under the Plan.

If an eligible dependent remains enrolled in the Plan under Michelle's Law, the dependent child will continue to participate in the same medical benefit options that he or she was in prior to the medical leave of absence.

Premium Assistance Under Medicaid and the Children's Health Insurance Program (CHIP)

If you or your children are eligible for Medicaid or CHIP and you're eligible for health coverage from your employer, your state may have a premium assistance program that can help pay for coverage, using funds from their Medicaid or CHIP programs. If you or your children aren't eligible for Medicaid or CHIP, you won't be eligible for these premium assistance programs but you may be able to buy individual insurance coverage through the Health Insurance Marketplace. For more information, visit www.healthcare.gov.

If you or your dependents are already enrolled in Medicaid or CHIP and you live in a State listed below, contact your State Medicaid or CHIP office to find out if premium assistance is available.

If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, contact your State Medicaid or CHIP office or dial 1-877.KIDS NOW or www.insurekidsnow.gov to find out how to apply. If you qualify, ask your state if it has a program that might help you pay the premiums for an employer-sponsored plan.

If you or your dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under your employer plan, your employer must allow you to enroll in your employer plan if you aren't already enrolled. This is called a "special enrollment" opportunity, **and you must request coverage within 60 days of being determined eligible for premium assistance**. If you have questions about enrolling in your employer plan, contact the Department of Labor at www.askebsa.dol.gov or call 1-866-444-EBSA (3272).

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of July 31, 2019. Contact your State for more information on eligibility –

ALABAMA – Medicaid	FLORIDA – Medicaid
Website: http://myalhipp.com/ Phone: 1-855-692-5447	Website: http://flmedicaidtplrecovery.com/hipp/ Phone: 1-877-357-3268
ALASKA – Medicaid	**GEORGIA – Medicaid**
The AK Health Insurance Premium Payment Program Website: http://myakhipp.com/ Phone: 1-866-251-4861 Email: CustomerService@MyAKHIPP.com Medicaid Eligibility: http://dhss.alaska.gov/dpa/Pages/medicaid/default.aspx	Website: https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp Phone: 678-564-1162 ext 2131
ARKANSAS – Medicaid	**INDIANA – Medicaid**
Website: http://myarhipp.com/ Phone: 1-855-MyARHIPP (855-692-7447)	Healthy Indiana Plan for low-income adults 19-64 Website: http://www.in.gov/fssa/hip/ Phone: 1-877-438-4479 All other Medicaid Website: http://www.indianamedicaid.com Phone 1-800-403-0864
COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)	**IOWA – Medicaid**
Health First Colorado Website: https://www.healthfirstcolorado.com/ Health First Colorado Member Contact Center: 1-800-221-3943/ State Relay 711 CHP+ : https://www.colorado.gov/pacific/hcpf/child-health-plan-plus CHP+ Customer Service: 1-800-359-1991/ State Relay 711	Website: http://dhs.iowa.gov/hawk-i Phone: 1-800-257-8563

KANSAS – Medicaid	NEW HAMPSHIRE – Medicaid
Website: http://www.kdheks.gov/hcf/ Phone: 1-800-766-9012 1-785-296-3512	Website: https://www.dhhs.nh.gov/oii/hipp.htm Phone: 603-271-5218 Toll free number for the HIPP program: 1-800-852-3345, ext 5218
KENTUCKY – Medicaid	**NEW JERSEY – Medicaid and CHIP**
Website: http://chfs.ky.gov Phone: 1-800-635-2570	Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ Medicaid Phone: 609-631-2392 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710
LOUISIANA – Medicaid	**NEW YORK – Medicaid**
Website: http://dhh.louisiana.gov/index.cfm/subhome/1/n/331 Phone: 1-888-695-2447	Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831
MAINE – Medicaid	**NORTH CAROLINA – Medicaid**
Website: http://www.maine.gov/dhhs/ofi/public-assistance/index.html Phone: 1-800-442-6003 TTY: Maine relay 711	Website: https://dma.ncdhhs.gov/ Phone: 919-855-4100
MASSACHUSETTS – Medicaid and CHIP	**NORTH DAKOTA – Medicaid**
Website: http://www.mass.gov/eohhs/gov/departments/masshealth/ Phone: 1-800-862-4840	Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/ Phone: 1-844-854-4825
MINNESOTA – Medicaid	**OKLAHOMA – Medicaid and CHIP**
Website: http://mn.gov/dhs/people-we-serve/seniors/health-care/health-care-programs/programs-and-services/other-insurance.jsp Phone: 1-800-657-3739	Website: http://www.insureoklahoma.org Phone: 1-888-365-3742
MISSOURI – Medicaid	**OREGON – Medicaid**
Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005	Website: http://healthcare.oregon.gov/Pages/index.aspx http://www.oregonhealthcare.gov/index-es.html Phone: 1-800-699-9075
MONTANA – Medicaid	**PENNSYLVANIA – Medicaid**
Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084	Website: http://www.dhs.pa.gov/provider/medicalassistance/healthinsurancepremiumpaymenthippprogram/index.htm Phone: 1-800-692-7462
NEBRASKA – Medicaid	**RHODE ISLAND – Medicaid**
Website: http://www.accessnebraska.ne.gov/ Phone: (855) 632-7633 Lincoln: (402) 473-7000 Omaha: (402) 595-1178	Website: http://www.eohhs.ri.gov/ Phone: 855-697-4347, or 401-462-0311 (Direct Share Line)

NEVADA – Medicaid	SOUTH CAROLINA – Medicaid
Medicaid Website: http://dhcfp.nv.gov/ Medicaid Phone: 1-800-992-0900	Website: https://www.scdhhs.gov Phone: 1-888-549-0820
SOUTH DAKOTA - Medicaid	**WASHINGTON – Medicaid**
Website: http://dss.sd.gov Phone: 1-888-828-0059	Website: https://www.hca.wa.gov/ Phone: 1-800-562-3022 ext. 15473
TEXAS – Medicaid	**WEST VIRGINIA – Medicaid**
Website: http://gethipptexas.com/ Phone: 1-800-440-0493	Website: http://mywvhipp.com/ Toll-free Phone: 1-855-MyWVHIPP (1-855-699-8447)
UTAH – Medicaid and CHIP	**WISCONSIN – Medicaid and CHIP**
Medicaid Website: https://medicaid.utah.gov/ CHIP Website: http://health.utah.gov/chip Phone: 1-877-543-7669	Website: https://www.dhs.wisconsin.gov/publications/p1/p10095.pdf Phone: 1-800-362-3002
VERMONT– Medicaid	**WYOMING – Medicaid**
Website: http://www.greenmountaincare.org/ Phone: 1-800-250-8427	Website: https://wyequalitycare.acs-inc.com/ Phone: 307-777-7531
VIRGINIA – Medicaid and CHIP	
Website: http://www.coverva.org Phone: 1-855-242-8282	

To see if any other states have added a premium assistance program since July 31, 2020, or for more information on special enrollment rights, contact either:

U.S. Department of Labor
Employee Benefits Security Administration
https://www.dol.gov/agencies/ebsa
1-866-444-EBSA (3272)

U.S. Department of Health and Human Services
Centers for Medicare & Medicaid Services
www.cms.hhs.gov
1-877-267-2323, Menu Option 4, Ext. 61565

Prescription Drug "Creditable Coverage" Notice

This notice contains information about your current prescription drug coverage with The Aerospace Corporation and your options under Medicare's prescription drug coverage. This information can help you decide if you want to join a Medicare prescription drug plan. If you are considering joining a Medicare prescription drug plan, you should compare your current coverage, including the drugs covered at what cost, with the coverage and cost of plans offering Medicare prescription drug coverage in your area. Information about where you can go for help to make your prescription drug coverage decisions is below.

Creditable/Non-Creditable Coverage pertains to the Medicare Part D prescription drug program, which became available to everyone with Medicare coverage on January 1, 2006. If you or a covered spouse are 65 or older or will turn 65 during 2021, or are eligible for Medicare due to a disability or have a disabled dependent, it is important that you read this section carefully.

First, as long as you remain covered by an Aerospace medical plan that qualifies as "creditable coverage," you do not need to enroll in a Medicare Part D prescription drug plan. Currently, all the medical plans offered by Aerospace qualify as "creditable coverage." This means that the plans on average are expected to pay out as much as a standard Medicare prescription drug plan.

(Aerospace is simply providing this Notice to fulfill requirements under the Medicare Modernization Act, so you can be aware of your rights and obligations if you or a family member are eligible for Medicare prescription drug coverage.)

If you are enrolled in a plan that qualifies as "creditable coverage" (whether through Aerospace or some other source, such as a spouse's plan), then when you retire or terminate employment and no longer have "creditable coverage," you will be able to enroll in a Medicare Part D prescription drug plan without paying a penalty – as long as you enroll immediately upon losing "creditable coverage" (i.e., with less than a 63-day break in creditable coverage). You will not be subject to any late enrollment penalties. You can join a Medicare prescription drug plan when you first become eligible for Medicare, and each year from October 15 through December 7. If you join a Medicare prescription drug plan, your coverage under the Aerospace plan will continue to be primary until you retire.

You may contact Medicare with questions regarding Medicare prescription drug plans at 1.800.MEDICARE (1.800.633.4227) or you may contact the Aerospace Employee Benefits Service Center at 844.361.2400 if you have any questions or want to obtain a copy of the Creditable Coverage Notice.

The Aerospace Corporation 401(k) Plan Default Investment Notice

Aerospace Corporation 401(k) Plan participants are reminded that if you have not made an investment election, contributions to the 401(k) Plan made by you and the Aerospace Corporation are invested on a weekly basis in a State Street Target Retirement Fund (the "Default Fund"). The specific Default Fund investment option is selected based on the year of your birth. This notice provides you with information regarding:

- A description of the circumstances under which the weekly contribution is invested in the Default Fund;
- A description of the general investment objectives of the Default Fund;
- Your rights (or your beneficiaries' rights) to redirect your contribution into any other investment alternative available under the 401(k) Plan; and
- Where you may obtain information regarding other investment alternatives.

Why would my 401(k) Plan account be invested in the Default Fund?

The 401(k) Plan lets you invest your account in a number of different investment funds. If you have not made an investment election, the weekly contribution will be invested in the Default Fund investment option based on your date of birth as described below.

What is the Default Fund?

The Default Fund is a State Street Target Retirement Fund. State Street Target Retirement Funds (other than SSgA Target Retirement Income Fund) are designed for investors expecting to retire around the retirement date range indicated for each fund. The funds gradually become more conservative over time, with a corresponding change in investment risk. Each fund seeks to achieve its objective by investing in a set of underlying SSgA collective trust funds representing various asset classes.

Can I invest my 401(k) Plan account balance in investments other than the Default Funds?

Yes. You can get more information about other investment options and change how the assets in your 401(k) Plan account are invested by going to the Fidelity website at fidelity.com/atwork or by calling Fidelity at 800.343.0860.

Default Funds and Fees

Investment Option Name	Retirement Date Range	DOB Range	Expense Information*
SSgA Target Retirement Income Non-Lending Series Fund Class W	Retired before 2013	12/31/1947 & Earlier	Expense Ratio: 0.10
SSgA Target Retirement 2015 Non-Lending Series Fund Class W	2013-2017	1/1/1948 – 12/31/1952	Expense Ratio: 0.10
SSgA Target Retirement 2020 Non-Lending Series Fund Class W	2018-2022	1/1/1953 – 12/31/1957	Expense Ratio: 0.10
SSgA Target Retirement 2025 Non-Lending Series Fund Class W	2023-2027	1/1/1958 – 12/31/1962	Expense Ratio: 0.10
SSgA Target Retirement 2030 Non-Lending Series Fund Class W	2028-2032	1/1/1963 – 12/31/1967	Expense Ratio: 0.10
SSgA Target Retirement 2035 Non-Lending Series Fund Class W	2033-2037	1/1/1968 – 12/31/1972	Expense Ratio: 0.10
SSgA Target Retirement 2040 Non-Lending Series Fund Class W	2038-2042	1/1/1973 – 12/31/1977	Expense Ratio: 0.10
SSgA Target Retirement 2045 Non-Lending Series Fund Class W	2043-2047	1/1/1978 – 12/31/1982	Expense Ratio: 0.10
SSgA Target Retirement 2050 Non-Lending Series Fund Class W	2048 - 2052	1/1/1983 - 12/31/1987	Expense Ratio: 0.10
SSgA Target Retirement 2055 Non-Lending Series Fund Class W	2053 - 2057	1/1/1988 - 12/31/1992	Expense Ratio: 0.10
SSgA Target Retirement 2060 Non-Lending Series Fund Class W	2058 - 2062	1/1/1993 – 12/31/1997	Expense Ratio: 0.10
SSgA Target Retirement 2065 Non-Lending Series Fund Class W	2063 and later	1/1/1998 and later	Expense Ratio: 0.10

* Net expense ratios as of 9/30/20, please visit the Fidelity Website for up-to-date expenses.