THE AEROSPACE CORPORATION HEALTH AND WELFARE BENEFITS PLAN

Amended and Restated January 1, 2021

PLAN NAME:	The Aerospace Corporation Health and Welfare Benefits Plan
PLAN SPONSOR:	The Aerospace Corporation
PLAN EFFECTIVE DATE:	January 1, 2021
PLAN NUMBER	501
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

The Aerospace Corporation sponsors and maintains The Aerospace Corporation Health and Welfare Benefits Plan, as amended from time to time (the "Plan") for its Eligible Employees. The Plan provides various health and welfare benefits, including medical, prescription drug, dental, vision, life insurance, employee assistance program, personal accident and occupational insurance, short-term disability insurance, long-term disability insurance, and the Aerospace Corporation Cafeteria Plan (including pre-tax premiums, health care flexible spending account, dependent care flexible spending account and health savings account), which, in accordance with Code Section 125, allows Eligible Employees of the Employer to choose among various employee benefits or cash compensation. The Plan is hereby restated in its entirety effective as of January 1, 2021 and supersedes all prior versions.

The provisions on the following pages are a part of this Plan. Such provisions alone, including any attachments, schedules, appendices, and incorporated documents, constitute the agreement under which payments will be made, and are a part of this Plan as fully as if recited over the signatures hereto affixed. Such attachments, schedules, appendices, and incorporated documents may change from time to time, in the sole discretion of the Plan Administrator.

The Plan Sponsor intends to continue this Plan indefinitely, however, the Plan Sponsor at any time and from time to time may amend, change, revoke or terminate the Plan without the consent of any Covered Person or any other persons entitled to receive payment of benefits under the Plan.

IN WITNESS WHEREOF, this Plan has been amended and restated by The Aerospace Corporation on this __27____ day of _September__, 2022, effective as of January 1, 2021.

SIGNED BY: 

Namd and Title: David Roberts - Principal Director, Total Rewards

THE AEROSPACE CORPORATION

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ATTACHMENT A
List of Aerospace Corporation Component Plans, which are incorporated by reference in this Plan.

ATTACHMENT B
List of Affiliated Employers Participating in the Plan.

ARTICLE I

INTRODUCTION

1.1 Purpose of the Plan

The purpose of this Plan is to provide Eligible Employees (as determined under Plan Article III) of the Employer and their eligible Dependents with medical care benefits, prescription drug benefits, dental care benefits, vision care benefits, life insurance benefits, employee assistance program benefits, personal accident and occupational insurance benefits, short- and long-term disability benefits, and Aerospace Corporation Cafeteria Plan benefits (including pre-tax premiums, health care flexible spending account, dependent care flexible spending account and health savings account). Such benefits may be insured or self-insured and the summary plan descriptions for those benefits and any applicable insurance and/or administrative service only contracts (and/or certificates) for such benefits are hereby incorporated into this Plan by reference and are listed in Attachment A. Such Aerospace Corporation Cafeteria Plan benefits are described in the Aerospace Corporation Cafeteria Plan that is hereby incorporated into this Plan by reference.

This Plan, including the components that are incorporated by reference in Attachment A ("Component Plans"), is a single employer health and welfare benefit plan within the meaning of Section 3(1) of ERISA and for all purposes under ERISA (except for the dependent care flexible spending account and health savings account, which are not subject to ERISA).

1.2 Interpretation and Law

The Plan shall be construed and interpreted in a manner consistent with the requirements of Code Sections 79, 105, 106, 125 and 129 the applicable sections of the Code, ERISA, HIPAA, PPACA, COBRA, the Genetic Information Nondiscrimination Act, the Aerospace Corporation Cafeteria Plan, and any other applicable law and any amendments thereto and any regulations issued thereunder.

Except as otherwise provided, each Component Plan is a separate plan for purposes of satisfying the nondiscrimination requirements of the Code. However, each Component Plan that is a self-insured group health plan, together with any HMO coverage that is offered in lieu of coverage under any such Component Plan, shall constitute a single plan for purposes of the nondiscrimination requirements of Section 105(h)(2) of the Code. It is intended that all applicable nondiscrimination requirements of the Code be satisfied, including all requirements under Code Sections 79, 105(h), 125 and 129 and any nondiscrimination rules issued under the PPACA applicable to fully insured benefits, to the extent applicable to a particular Component Plan, upon the effective date of such rules.

1.3 Effective Date

The Plan is hereby restated in its entirety effective as of January 1, 2021.

ARTICLE II

DEFINITIONS

The following words and phrases as used herein shall have the following meanings unless a different meaning is plainly required by the context.

2.1 **Aerospace Corporation Cafeteria Plan** means the flexible benefits plan (with pre-tax premiums, health care flexible spending account, and dependent care flexible spending account and health savings account programs), together with any and all amendments, supplements and appendices that is hereby incorporated into this Plan by reference, providing certain Eligible Employees the opportunity to choose among cash and certain other benefits as therein described.

2.2 **Affiliated Employer** means any corporation which is a member of a controlled group of corporations (as defined in Code section 414(b)) which includes the Employer, any trade or business (whether or not incorporated) which is under common control (as defined in section 414(c) of the Code) with the Employer, any organization (whether or not incorporated) which is a member of an affiliated service group (as defined in Code section 414(m)) which includes the Employer, and any other entity required to be aggregated with the Employer pursuant to regulations under Code section 414(o).

2.3 **Annual Enrollment Period** means the period, other than a Special Enrollment Period or any other enrollment periods, such as a Qualified Change in Status, as specifically described in the Aerospace Corporation Cafeteria Plan, designated by the Plan Administrator preceding each calendar year during which each Eligible Employee not currently enrolled may elect coverage under the Plan, or if currently enrolled, may change the contribution category. Such Annual Enrollment may be designed by the Plan Administrator as a "passive enrollment" or an "active enrollment" each year, as communicated to Participants.

2.4 **COBRA** means the Consolidated Omnibus Budget Reconciliation Act of 1985, as now in effect or as hereafter amended, including any regulations and rulings promulgated thereunder and any successor statute of similar import. Reference to any section or subsection of COBRA includes references to any comparable or succeeding provisions of any legislation that amends, supplements, or replaces such section or subsection. "COBRA Continuation Coverage" means a temporary extension of coverage under any Component Plan which is considered a "group health plan" pursuant to COBRA, elected by a Participant or the Participant's covered spouse or covered dependent, following a "qualifying event" (as defined under COBRA and under the Component Plans) which caused a loss of coverage under such Component Plan.

2.5 **Code** means the Internal Revenue Code of 1986, as now in effect and as hereafter amended, including any regulations or rulings promulgated thereunder and any successor statute or statutes of similar import. Reference to any section or subsection of the Code includes

references to any comparable or succeeding provisions of any legislation that amends, supplements, or replaces such section or subsection.

2.6 **Component Plans** means those plans designated or incorporated in the Attachments to this Plan which may include the following benefits, as established by the Employer: medical benefits, prescription drug benefits, dental benefits, vision benefits, employee assistance program benefits, life insurance, personal accident and occupational insurance, short-term and long-term disability benefits, business travel medical insurance, business travel accident insurance, and Aerospace Corporation Cafeteria Plan benefits described in Attachment A.

2.7 **Covered Person** means an Eligible Employee or eligible Dependent who is covered under this Plan, including the Component Plans that are incorporated into this Plan by reference in Attachment A.

2.8 **Dependent** means "dependent" as defined in the Component Plans.

2.9 **Effective Date** means, as amended and restated, January 1, 2021. Annually, the Attachments to the Plan may be changed, at the discretion of the Plan Administrator, without having to formally amend the main section of the Plan.

2.10 **Eligible Employee** means an employee who is:

a. An active, full-time employee of the Employer or an Affiliated Employer that is participating in the Plan (as identified in Attachment B); and

b. Regularly scheduled to work at least 20 hours each week, unless otherwise specified in underlying Component Plan documents; and

c. Employed on a regular salaried or hourly basis; and

d. Not a member of a group of employees covered by a collective bargaining agreement, unless the collective bargaining agreement provides for coverage under the Plan; and

e. Not a leased employee or an independent contractor or consultant.

The Plan only covers those eligible employees (and their eligible dependents) that the Employer or Affiliated Employer treats as employees for federal income and employment tax purposes. A person treated by the Employer or Affiliated Employer as a non-employee for federal income and/or employment tax purposes is not eligible to be covered under the Plan, even if the person is later determined by a court or by the Internal Revenue Service (IRS) or by any other agency or body to have been a common law employee.

The Component Plans specify additional requirements that must be satisfied in order to be considered an Eligible Employee for the purpose of electing to participate in certain benefits under the Component Plans.

2.11 **Employee** means any person who renders services to the Employer for remuneration that is subject to federal income tax withholding and FICA taxes and classified as a common-law employee of the Employer. "Employee" specifically excludes the following:

> Any individual classified by the Employer as an independent contractor, leased employee, any individual who performs services for the employer whose remuneration for services is not initially reported by the employer on IRS Form W-2 and any temporary individual whose services are contracted from or through an entity which is not an affiliate, regardless of any later classification or reclassification of any such individual as a common-law employee of the Employer by the IRS, any other governmental agency or authority, a court, or any other individual or entity. For purposes of this definition of Employee, "leased employee" means any person, other than an Employee, who pursuant to an agreement between the Employer and any other person has performed services for the Employer on a substantially full-time basis for a period of at least one year, and such services are performed under primary direction or control by the Employer.

2.12 **Employer** means The Aerospace Corporation, or any successor thereto or any Affiliated Employer who is participating in the Plan (as identified in Attachment B).

2.13 **Enrollment Period** means the Annual Enrollment, the Special Enrollment Period and any other enrollment periods specifically described in the Aerospace Corporation Cafeteria Plan for purposes of the Component Plans listed in Attachment A.

2.14 **ERISA** means the Employee Retirement Income Security Act of 1974, as now in effect or as hereafter amended, including any regulations and rulings promulgated thereunder and any successor statute of similar import. Reference to any section or subsection of ERISA includes references to any comparable or succeeding provisions of any legislation that amends, supplements, or replaces such section or subsection.

2.15 **Family and Medical Leave Act or FMLA** means the Family and Medical Leave Act of 1993, as now in effect or as hereafter amended, including any regulations and ruling promulgated thereunder and any successor statute of similar import.

2.16 **HIPAA** means the Health Insurance Portability and Accountability Act of 1996 as now in effect or as hereafter amended, including any regulations and rulings promulgated thereunder and any successor statute of similar import. Reference to any section or subsection of HIPAA includes references to any comparable or succeeding provisions of any legislation that amends, supplements, or replaces such section or subsection.

2.17 **Leave of Absence** means the Employee has obtained an approved leave of absence from the Employer as provided for in the Employer's rules, policies, procedures and/or practices, including absence under the FMLA and leave for duty in the Uniformed Services. Leave of Absence shall also mean any other unpaid Leave of Absence as administered and approved by the Employer.

2.18 **Named Fiduciary** means the Plan Administrator and any other person designated as such in writing.

2.19 **Participant** means any Eligible Employee who participates in the Plan in accordance with Article III, who has commenced participation in the Plan accordingly and whose participation has not terminated under any other applicable provisions of the Plan.

2.20 **Plan** means The Aerospace Corporation Health and Welfare Benefits Plan as described in this document, together with any and all amendments, supplements, attachments, appendices, and incorporated documents hereto.

2.21 **Plan Administrator** means the Principal Director, Total Rewards of The Aerospace Corporation or any person(s) or entity(ies) whom The Aerospace Corporation appoints, to serve as plan administrator, as such term is defined under ERISA.

2.22 **Plan Sponsor** means The Aerospace Corporation.

2.23 **Plan Year** means a period commencing on January 1 and ending on the next December 31.

2.24 **PPACA** means the Patient Protection and Affordable Care Act of 2010 and all implementing guidance and regulations issued thereunder.

2.25 **Qualified Medical Child Support Order (QMCSO)** means an order which creates or recognizes the existence of a child's right to health benefits under the Plan and must be in the form of a judgment, decree, or order (including a settlement agreement approved by the court) issued by a court (or state administrative agency with jurisdiction) that is deciding the child support issues in a divorce or other family law action. A Qualified Medical Child Support Order must clearly specify:

a. The name and last known mailing address of an Eligible Employee and the name and last known mailing address of each child covered by the order;

b. A reasonable description of the type of coverage to be provided by the Plan to each child covered by the order, or the manner in which such type of coverage is to be determined;

c. The period to which the order applies; and

d. Each plan to which such order applies.

A Qualified Medical Child Support Order cannot require the Plan to provide any type of form of benefit, or any option, not otherwise provided under the Plan. The Plan Administrator shall adopt procedures respecting a Qualified Medical Child Support Order in accordance with ERISA Section 609.

2.26 **Special Enrollment Period** means, with respect to medical coverage under this Plan, the periods of enrollment other than Annual Enrollment or other open enrollment periods for:

a. Employees and Dependents who otherwise are eligible to enroll in the Plan but who have not yet done so because of other health care coverage and who subsequently lose such other coverage;

b. Newly eligible Dependents of Eligible Employees in accordance with the rules and regulations enacted under HIPAA; and

c. Eligible Employees and their eligible Dependents who:

(i) Lost coverage under their respective state Medicaid or child health insurance plan (CHIP) or

(ii) Become eligible for premium assistance under their respective state Medicaid or CHIP.

If an Eligible Employee or eligible Dependent is not already enrolled when one of the events described in a. or b. above occurs, he will be able to enroll himself and his eligible Dependent(s) within 30 days after the date of the event. If an Eligible Employee or Dependent is not already enrolled when one of the events described in c. above occurs, he will be able to enroll himself and his eligible Dependent(s) within 61 days after the date of the event.

In the case of Employees and Dependents losing other health care coverage as described in a. or b. above to be eligible to enroll prior to the next open enrollment such Employee or Dependent must:

a. Be covered by the other health care coverage at the time he previously was eligible to enroll in the Plan;

b. State in writing at that time that enrollment was being declined because of the other health care coverage (but only if the Employer requires the statement and explains its significance);

c. Be covered by other health care coverage that is either COBRA continuation coverage that was exhausted or coverage other than COBRA continuation coverage that was terminated due to termination of Employer contributions toward the coverage or loss of eligibility for the coverage (for example, as a result of legal separation, divorce, cessation of Dependent status, death, termination of employment, or reduction in hours of employment); and

d. Request enrollment in the Plan within 30 days after losing the other health care coverage in accordance with the rules and regulations enacted under HIPAA.

2.27 **Uniformed Services** means the Armed Forces, the Army National Guard, and the Air National Guard when engaged in active duty for training, inactive duty training, or full-time National Guard duty, the commissioned corps of the Public Health Service, and any other category of persons designated by the President of the United States in time of war or emergency.

2.28 **USERRA** means the Uniformed Services Employment and Reemployment Rights Act, as now in effect or as hereafter amended, including any regulations and rulings promulgated thereunder and any successor statute of similar import.

Whenever used in this Plan, a masculine pronoun or adjective shall be deemed to include the masculine and feminine gender, and a singular word shall be deemed to include the singular and the plural, unless the context clearly indicates otherwise.

ARTICLE III

PARTICIPATION

3.1 Eligibility

Any Eligible Employee will be eligible to participate in this Plan commencing on the date specified in the Component Plans in Attachment A, provided such Eligible Employee continues to be employed with the Employer.

3.2 Determination of Eligibility by Plan Administrator

The determination of an Employee's eligibility to participate in the Plan shall be made by the Plan Administrator, and the Plan Administrator's good faith determination shall be binding and conclusive upon all persons.

3.3 Commencement of Participation

An Eligible Employee shall become a Participant under the Plan in accordance with the rules set forth in the Component Plans in Attachment A, as applicable.

3.4 Elections and Changes in Elections for Benefits

For purposes of the Component Plans listed in Attachment A, the Plan Administrator may designate an Annual Enrollment Period and the benefit options available for election for the following Plan Year. The election of the benefit options shall be made in the manner and subject to the conditions specified by the Plan Administrator and in accordance with the Aerospace Corporation Cafeteria Plan. Changes to benefit elections shall also be made in accordance with the Aerospace Corporation Cafeteria Plan. Such elections and changes to elections may be designed as "passive enrollments" or "active enrollments" as determined by the Plan Administrator as communicated to Participants.

3.5 Participation During Leaves of Absence

a. Any Participant who is not at work because of a paid Leave of Absence shall continue benefits under the Plan in accordance with the Components Plans and the written Leave of Absence policies of the Employer, to the extent applicable. To continue benefits, the Participant must have elections in place before the commencement of the Leave of Absence. Regular deductions from the Participant's Compensation will continue during the Leave of Absence.

b. Any Participant who is not at work because of an unpaid FMLA leave, leave for duty in the Uniformed Services, military caregiver leave or due to any other approved unpaid Leave of Absence, may, at the Participant's option, continue certain benefits under the Plan that the Participant elected during the period of absence so long as the Participant continues to make any required contributions.

The following shall be determined in accordance with the written Leave of Absence policies of the Employer, as applicable, the Component Plans, and any applicable law, including FMLA and USERRA:

(i) Whether such benefits are available for continuation during an unpaid Leave of Absence;

(ii) Payment for such benefits are continued during Leave of Absence (or are prepaid); and

(iii) The period of time during which such benefits may be continued.

c. Any Participant returning from an FMLA, USERRA leave, military caregiver leave, or other approved unpaid Leave of Absence in the same Plan Year shall be reinstated in the same or equivalent benefits to the benefits they received prior to the unpaid Leave of Absence, adjusted for any changes in benefits that affected the workforce as a whole. Such reinstatement shall be made in accordance with the written Leave of Absence policies of the Employer, as applicable, the Component Plans, and any applicable law.

3.6 Funding Policy

The Employer shall, in its sole discretion, establish and direct the implementation of a funding policy for the Plan and the benefits provided under the Plan which may include a policy of not funding any or all of the benefits provided in the Component Plans. Benefits provided under the Plan may be funded through a trust, the general assets of the Employer, one or more insurance contracts with insurance carriers or such other funding vehicles established with respect to the Component Plans.

3.7 Contribution Basis

a. **Eligible Employee.** The coverage for which a Covered Person is eligible may be contributory, as determined by the Plan Administrator and communicated during the Annual Enrollment period for the Component Plans in Attachment A. Such contributions for Eligible Employees may be made on a pre-tax or post-tax basis as determined by the Plan Administrator and in accordance with the rules and procedures set forth in the Component Plans in Attachment A.

b. **Employer.** The Employer will make Employer contributions directly to each insurance company, pre-paid health plan or other provider or third party administrator, if applicable, and to any trust established by the Employer for self-insured benefits, to fund the benefits provided under the Component Plans for the Participants, to the extent determined by the Employer and not provided through Participant contributions, in such amounts and at such times as the Employer, in accordance with the funding policy and methods of the Plan, shall from time to time direct, including, but not limited to, contributions needed to pay current benefits, and to pay expenses; provided that, except as otherwise specifically provided

herein, the Employers shall have no liability to pay such benefits or to assure the sufficiency of any insurance company to provide such benefits.

3.8 Use of Medical Loss Ratio Rebates.

Under certain circumstances, the insurance carrier for the insured Component Plans may provide the Employer with a medical loss ratio rebate and/or refund related to the insured Component Plans, the premiums for which are paid under the Plan. In the event the Employer receives a medical loss ratio rebate and/or refund related to the insured Component Plans, the Plan Administrator, in its sole discretion, shall, in accordance with applicable law, regulations, and guidance, determine the appropriate use for such rebate and/or refund and what portion (if any) of such rebate must be treated as "plan assets" under ERISA. If any portion of the rebate must be treated as plan assets, the Plan Administrator will determine in its sole discretion the manner in which such amounts will be used by the Plan or applied to the benefit of Participants; which Participants need not be the same Participants who made contributions under the policy that issued the rebate. Any portion of the rebate that is not treated as plan assets will be allocated among one or more of Employer(s) as the Employer, in its sole discretion, determines appropriate.

3.9 Order of Use of Contributions

a. **Insurance Coverage.** With respect to the insured Component Plans, the entire amount of the Participant contributions for each such Component Plan benefit will be used for payment of the premiums charged by the insurance company, pre-paid health plan or similar organization for the applicable coverage, before the remaining portion of the premium for such coverage is paid by the Employer. Any premium refunds or dividends with respect to such coverage will be used to reduce the Employer's, and not the Participants', portion of the premium due. With regard to the insured Medical Plans identified on Attachment A, any premium refunds or dividends with respect to such coverage shall be used in a manner consistent with the requirements of the Medical Loss Ratio rules under the PPACA and the regulations issued thereunder.

b. **Self-Insured Benefits.** With respect to the self-insured Component Plans, the entire amount of the Participant contributions for each such benefit will be used for the payment of benefits provided under such Component Plans before any of the remaining portion of the costs of such benefits are paid by the Employer.

3.10 Effective Dates and Conditions

In order to participate in a particular Component Plan and receive benefits under this Plan, an Eligible Employee as applicable, must meet any additional participation requirements as set forth in the Component Plans listed in Attachment A, as applicable. An Eligible Employee must elect any such benefits using the procedures provided by the Plan Administrator unless the benefit is automatically provided. Such coverage shall be effective as of the date or dates set forth in the Component Plans in Attachment A, as applicable.

3.11 Rescissions of Coverage

The Plan shall not cancel or discontinue health coverage retroactively with respect to a Participant or Dependent except as provided below and in accordance with the PPACA or as otherwise permitted under applicable law. A Participant and/or his or her Dependent shall not perform an act, practice, or omission that constitutes fraud relating to his or her coverage under the Plan or coverage sought on behalf of another individual nor make an intentional misrepresentation of material fact with regard to his or her coverage under the Plan or coverage sought on behalf of another individual. A Participant's or his or her Dependent's coverage under the Plan shall be rescinded if the Participant or his or her Dependent or a person seeking Plan coverage on behalf of the Participant or Dependent:

a. Performs an act, practice, or omission that constitutes fraud relating to his or her Plan coverage; or

b. Makes an intentional misrepresentation of material fact regarding his or her coverage under the Plan.

A person who receives a benefit under the Plan as a result of false/fraudulent/misleading representation shall repay all amounts paid by the Plan and shall be liable for all costs of collection, including attorneys' fees.

The Plan shall provide 30 days advance written notice to each Participant and/or Dependent who would be affected by a rescission before coverage under the Plan is rescinded. A rescission of Plan coverage shall be effective as of the date of the act, practice, or omission constituting fraud or the date of the intentional misrepresentation of material fact on which the rescission of coverage is based.

3.12 Termination Coverage

Coverage under this Plan of any Employee or Dependent will terminate in accordance with the rules and procedures set forth in Attachment A, as applicable.

3.13 Continuation/Conversion

Notwithstanding Plan Sections 3.12, opportunities to continue and/or convert coverage under this Plan, including under the respective Component Plans (the terms of which appear as attachments to and are incorporated into this Plan), shall be provided in accordance with applicable state and federal law, including COBRA and USERRA, and the terms under the respective Component Plans.

3.14 Incorporation of Plans and Policies

The eligibility provisions, benefit provisions and such other provisions of the Component Plans, as may be modified from time to time hereafter, and as are consistent with the terms and conditions of this Plan shall be incorporated herein by reference and shall be of the same force and effect under this Plan as if they were set forth herein.

3.15 QMCSO

The Plan Administrator shall adopt procedures respecting QMCSOs in accordance with ERISA Section 609. Such procedures shall comply with ERISA Section 609 and shall be administered in a nondiscriminatory manner by the Plan Administrator.

ARTICLE IV

BENEFITS

4.1 Generally

Subject to the requirements of the Aerospace Corporation Cafeteria Plan that is hereby incorporated into this Plan by reference regarding benefit elections, each Participant who is an Eligible Employee (as defined in the Component Plans in Attachment A) may elect to purchase any of the benefits set forth in the Component Plans in Attachment A for which he or she is eligible.

The Component Plans may be the subject of separate plan documents, trust agreements, or contracts, the terms of which are incorporated in the Attachments to this Plan.

4.2 Benefit Election

During the Enrollment Period, a Participant (who is an Eligible Employee for purposes of the Component Plans in Attachment A) may elect to either receive any or all of the benefits described in the Component Plans. Each Component Plan shall describe whether the Participant shall make contributions for such benefits and whether such contributions shall be made on a pre-tax or post-tax basis. The price of each option shall be determined annually by the Plan Administrator or at any other time as determined by the Plan Administrator in its sole discretion. Each Participant shall be notified of the price of each benefit option prior to the Annual Enrollment Period for the Plan Year or at any other time that the Plan Administrator deems appropriate. Such Annual Enrollment Period may be designed as a "passive election" or "active election" at the Plan Administrator's discretion as communicated to the Participant.

4.3 Coordination of Benefits

The Component Plans may contain special procedures for coordinating benefits when a Covered Person has group health coverage (including medical, prescription drug, dental and vision coverage) under two or more plans. The coordination of benefits procedures to be followed by Covered Persons to obtain payment of benefits under this Plan shall be in accordance with the rules and procedures set forth in the Component Plans in Attachment A.

4.4 Dual Coverage Rules

The Component Plans may contain special procedures for providing benefits to Covered Persons where both spouses are both Eligible Employees under the Plan. Such procedures may limit the eligibility for participation and/or the amount of benefits available under the Plan.

4.5 Essential Health Benefits

In determining whether a benefit or service is an Essential Health Benefit for purposes of permissible annual or lifetime limits and cost sharing limits under PPACA, the Plan has chosen the State of Utah as its benchmark state.

4.6 No Lifetime or Annual Limits

The Plan shall not impose a lifetime or annual limit on the dollar value of Essential Health Benefits under any benefit plan available under the Plan unless the benefit plan is an Excepted Benefit to which PPACA does not apply.

4.7 No Preexisting Condition Exclusions

The Plan shall not impose a preexisting condition exclusion under any medical Benefit offered under the Plan.

4.8 Preventive Services

Notwithstanding anything in the Plan to the contrary, in-network preventive health care services will be covered at 100%. No cost-sharing (e.g., co-payments, deductibles, or coinsurance) will apply for these in-network services. Preventive health services have been defined to include the following:

a. Evidence-based items or services with an A or B rating recommended by the United States Preventive Services Task Force;

b. Immunizations for routine use in children, adolescents, or adults recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention;

c. Evidence-informed preventive care and screening provided for in the comprehensive guidelines supported by the Health Resource and Services Administration ("HRSA") for infants, children and adolescents; and

d. Other evidence-informed preventive care and screening provided for in comprehensive guidelines supported by HRSA for women.

4.9 Coverage of Clinical Trials

The Plan shall not deny a Participant or a Dependent participation in an approved clinical trial for which such Participant or Dependent is a qualified individual with respect to the treatment of cancer or another life-threatening disease or condition, or deny (or limit or impose additional conditions on) the coverage of routine patient costs for drugs, devices, medical treatment, or procedures provided or performed in connection with participation in such an approved clinical trial. A Participant or Dependent participating in such an approved clinical trial will not be discriminated against on the basis of his or her

participation in the approved clinical trial. For purposes of this Section 4.9, the terms "qualified individual," "life-threatening disease or condition," "approved clinical trial" and "routine patient costs" shall have the same meaning as found in the Public Health Services Act §2709.

4.10 Cost-Sharing

The Plan shall comply with the overall cost-sharing limit (i.e., out-of-pocket maximum) mandated by PPACA, indexed annually. For purposes of this provision, cost-sharing includes deductibles, co-insurance, co-payments or similar charges, and any other required expenditure that is a qualified medical expense with respect to Essential Health Benefits covered under the Plan. Cost-sharing shall not include premiums, balance billing amounts for non-network providers or spending for services that are not covered under the Plan.

4.11 Wellness Program

Any wellness program and related financial incentive offered under the Plan shall comply with the requirements and limitations of HIPAA, GINA, ADA, PPACA and related guidance.

4.12 Newborns and Mothers' Health Protection Act of 1996

Notwithstanding the precertification requirements of the Plan to the contrary, the Plan shall provide maternity care benefits in accordance with the Newborns' and Mothers' Health Protection Act of 1996 (the "Newborn's Act"), effective on the date specified in the Newborn's Act. In accordance with the Newborn's Act, the Plan shall provide benefits for a minimum of forty-eight (48) hours of inpatient hospital stay for a normal vaginal delivery and a minimum of ninety-six (96) hours of inpatient hospital stay for caesarean section delivery unless the health care provider and the mother agree that discharge from the hospital shall occur earlier.

4.13 Women's Health and Cancer Rights Act of 1998

Medical and surgical benefits provided for mastectomies under the Plan will be provided in accordance with the Women's Health and Cancer Rights Act of 1998 (the "Women's Health Act"). In accordance with the Women's Health Act, coverage will be provided for the following:

a. Reconstruction of the breast on which the mastectomy has been performed;

b. Surgery and reconstruction of the other breast to produce a symmetrical appearance; and

c. Prostheses and coverage for any complications in all stages of mastectomy, including lymphedema.

4.14 Medicare Part D Prescription Drug Coverage

The Plan Administrator has determined that the prescription drug coverage offered as part of the Health Benefits is, on average for all Plan participants, expected to pay out as much as the standard Medicare prescription drug coverage pays and is considered "creditable coverage" under the Medicare Part D prescription drug coverage rules. Because this coverage is, on average, at least as good as standard. Medicare prescription drug coverage, actively employed Participants can keep this coverage and not pay a higher premium (a penalty) if they later decide to join a Medicare drug plan. Only to the extent required by applicable law, the Plan Administrator will distribute certificates of creditable coverage to Medicare eligible individuals upon participation in the Plan, during each subsequent open enrollment period, and any time the prescription drug coverage ends or is no longer considered creditable coverage.

4.15 Patient Protections

To the extent applicable, group health coverage under the Plan shall comply with the patient protections regarding choice of health care professionals and emergency care services under Public Health Services Act §2719A.

4.16 Mental Health Parity

The Plan will provide parity between mental health or substance use disorder benefits and medical/surgical benefits with respect to financial requirements and treatment limitations under group health plans and health insurance coverage offered in connection with the Plan, as required by Code Section 9812 and ERISA Section 712, and the related regulations thereunder. More specifically, the following restrictions will apply to the Plan:

a. **Lifetime or Annual Dollar Limits:** The Plan will not impose an aggregate lifetime or annual dollar limit, respectively, on mental health or substance use disorder benefits.

b. **Financial Requirement or Treatment Limitations:** The Plan will not apply any financial requirement or treatment limitation (whether quantitative or nonquantitative to mental health or substance use disorder benefits in any classification (as determined by the Plan Administrator in accordance with applicable regulations) that is more restrictive than the predominant financial requirement or treatment limitation of that type applied to substantially all medical/surgical benefits in the same classification.

c. **Criteria for Medical Necessity Determinations:** The criteria for making medical necessity determinations relative to claims involving mental health or substance use disorder benefits will be made available by the Plan Administrator to any current or potential Participant, beneficiary, or in-network provider upon request.

The manner in which the foregoing restrictions apply to the Plan will be determined by the Plan Administrator, in its sole discretion, in light of applicable regulations and other guidance.

ARTICLE V

CLAIMS PROCEDURES

5.1 Claims Procedure

The claim procedure to be followed by Covered Persons to obtain payment of benefits under this Plan shall be in accordance with the rules and procedures set forth in the Component Plans in Attachment A, as applicable.

5.2 Claims and Appeals Procedures

Benefits that are covered under this Plan shall be paid in accordance with the rules and procedures set forth in the Component Plans in Attachment A, as applicable. Such Component Plans shall govern the claims and appeals procedures in accordance with the requirements of ERISA and PPACA, to the extent applicable.

5.3 Timeliness of Payments

Payments shall be made as soon as administratively feasible after the required forms and documentation has been submitted to the Plan Administrator or any third-party administrator designated by the Plan Administrator.

5.4 Recovery of Payments

Unless a Component Plan specifically provides otherwise, the Plan has the right to deduct from any benefits properly payable under this Plan the amount of any payment that has been made:

a. In error; or

b. Pursuant to a misstatement contained in a proof of loss; or

c. Pursuant to an intentional misstatement made to obtain coverage under this Plan within two years after the date such coverage commences (explained further in Section 3.11 of the Plan, "Rescission of Coverage"); or

d. With respect to an ineligible person; or

e. In anticipation of obtaining a recovery in subrogation; or

f. Pursuant to a claim for which benefits are recoverable under any policy or act of law providing for coverage for occupational injury or disease to the extent that such benefits are recovered. This provision (f) shall not be deemed to require the Plan to pay benefits under this Plan in any such instance.

Such deduction may be made against any claim for benefits under this Plan by a Covered Person if such payment is made with respect to such covered Employee or any person

covered or asserting coverage as a Dependent of such covered Employee. Any such reduction in benefit shall be subject to the review and appeal process as set forth in the Component Plans in Attachment A, as applicable.

5.5 Coordination with Components

Article V of this Plan applies with respect to each Component Plan as listed or attached, unless the Component Plan specifically addresses these issues in a manner that is consistent with applicable state and federal law.

5.6 Medicare Secondary Payer Rules

This Plan will at all times be maintained and administered in a manner that is consistent with the "Medicare Secondary Payer" rules of the Social Security Act which are set forth at 42 U.S.C. Section 1395y(b).

ARTICLE VI

PLAN ADMINISTRATION

6.1 Plan Administrator The Plan Administrator is to supervise the administration of the Plan. It shall be a principal duty of the Plan Administrator to ensure that the Plan is carried out, in accordance with its terms, for the exclusive benefit of persons entitled to participate in the Plan. Subject to and in accordance with any applicable requirements of law, the Plan Administrator shall have the full discretionary power to administer the Plan in all of its detail. For this purpose, the Plan Administrator's powers and duties include, but shall not be limited to, the following authority in addition to all other powers provided by this Plan:

a. Interpret the terms and provisions of the Plan, its good faith interpretation thereof to be final and conclusive on all persons claiming benefits under the Plan;

b. Make and enforce such rules and regulations it deems necessary or proper for the efficient administration of the Plan including the establishment of any claims procedures that may be required by the provisions of any applicable law;

c. Perform all acts necessary to meet the reporting and disclosure obligations imposed by ERISA, the Code or PPACA, if any;

d. Delegate, in writing, specific responsibilities for the operation and administration of the Plan to any Employees, agents, or third parties it deems advisable;

e. Appoint such agents, counsel, accountants, consultants, and other persons as may be required to assist in the administration of the Plan;

f. Maintain records and accounts pertaining to the Plan;

g. Receive, review, and keep on file the annual reports of the Plan, if any;

h. Determine eligibility under the Plan; such good faith determination to be binding and conclusive on all persons; and

i. Correct any defect, supply any omission, or reconcile any inconsistencies in the manner and to the extent the Employer considers proper to carry the Plan into effect.

6.2 Records and Reports of the Plan Administrator

The Plan Administrator shall keep such written records as it shall deem necessary or proper, which records shall be open to inspection by the Employer. The Plan Administrator shall prepare and submit to the Employer an annual report which shall include such information as the Plan Administrator deems necessary or advisable.

6.3 Named Fiduciaries

a. The Plan Administrator, and any other person designated as such in writing, shall be the "Named Fiduciaries" of the Plan for the purposes of ERISA Section 402(a)(1), and shall have only those duties, responsibilities, and obligations (referred to collectively as "fiduciary duties") as specifically are given them under the Plan or as otherwise are imposed by applicable law. The fiduciary responsibilities of the named fiduciaries shall be exercisable separately and not jointly, and each named fiduciary's responsibilities will be limited to the specific areas indicated for such named fiduciary. However, the named fiduciaries may by written agreement allocate fiduciary responsibilities among themselves.

b. Section 402 of ERISA also authorizes the Employer to designate one or more named fiduciaries under the Plan, each with complete authority to review all claims for benefits and determine all issues under the Plan with respect to which it has been designated named fiduciary. In exercising its fiduciary responsibilities with respect to the Plan, each named fiduciary designated hereunder shall have the fullest discretionary authority permitted under law to determine whether and to what extent employees and their eligible dependents are entitled to Plan benefits and to construe disputed or doubtful terms. Each named fiduciary shall be responsible for construing and interpreting the particular provisions of the Plan for which it has been designated a named fiduciary in accordance with ERISA and the terms of any contracts or policies entered into between the Employer and the named fiduciary. Each named fiduciary designated hereunder shall be deemed to have properly exercised such authority unless it has abused its discretion hereunder by acting arbitrarily and capriciously.

c. The designation of any entity as a named fiduciary under the Plan shall not create any right or expectation on the part of such entity to continue in such position for any particular period of time. The Employer may, in its sole and absolute discretion and at any time, terminate, replace, substitute, or otherwise remove any named fiduciary designated under the Plan.

d. Each named fiduciary may appoint and/or employ a person or persons other than a named fiduciary under the Plan to render advice with regard to any responsibility such fiduciary has under the Plan. Any such appointment or employment shall be solely at the expense of that named fiduciary, and shall be effective only with the written consent of the Employer.

6.4 Examination of Records

The Plan Administrator shall make available to each Participant such of his records under the Plan as pertain to him, to the extent not prohibited under applicable law, for examination at reasonable times during normal business hours.

6.5 Reliance on Tables, etc.

In administering the Plan, the Plan Administrator shall be entitled, to the extent permitted by law, to rely conclusively on all tables, valuations, certificates, opinions, and reports

which are furnished by, or in accordance with the instructions of, accountants, counsel or other experts employed or engaged by the Plan Administrator. All actions taken in a good faith reliance on advice from such advisors are conclusive and binding upon all persons.

6.6 Indemnification of Plan Administrator

As permitted by law, and as limited by any written agreement between the Employer and the Plan Administrator, the Employer agrees to indemnify and to defend any employee, individual, officer, or director serving as the Plan Administrator or as a member of a committee designated as Plan Administrator, (including any employee or former employee, individual, officer or director who formerly served as Plan Administrator or as a member of any such committee) against all liabilities, claims, loss, damages, costs and expenses (including attorneys' fees and amounts paid in settlement of any claims approved by the Employer) occasioned by any act or omission to act in connection with the Plan, if such act or omission is in good faith.

6.7 Availability of Documents

A copy of the Plan and any and all future amendments and such records and data as are required under ERISA shall be available to any Participant, Employee, or an employee organization that represents Employees of the Employer at reasonable times during normal business hours at the business office of the Plan Administrator or the business office of the Employer.

6.8 Legal Process

The Plan Administrator shall be the agent for service of legal process unless it designates in writing another person to be such agent and communicates such information to Participants (such as in a summary plan description).

6.9 Administrative Expenses

All expenses incurred prior to termination of the Plan that shall arise in connection with the administration of the Plan, including but not limited to administrative expenses, and compensation and other expenses and charges of any actuary, accountant, counsel, specialist, or other person who shall be employed by the Plan Administrator in connection with the administration, shall be paid by the Employer.

6.10 Delegation

The Plan Administrator has the discretion to delegate to any other person or persons (including, but not limited to, the applicable Provider and/or Claims Administrator) the authority to act on behalf of the Plan Administrator, including, but not limited to, the authority to make any Benefits determination, or to sign checks or other instruments incidental to the operation of the Plan, for which the Plan Administrator would otherwise be responsible.

6.11 Bonding

To the extent required by ERISA or other applicable law with respect to the Component Plans subject to ERISA, every fiduciary of the Plan, and every person handling funds of the Plan or such component thereunder shall be bonded. The Plan Administrator may apply for and obtain fiduciary liability insurance insuring the Plan against damages by reason of breach of fiduciary responsibility at the Plan's expense and insuring each fiduciary against liability to the extent permissible by law at the Employer's expense.

6.12 Several Fiduciary Liability

To the extent permitted by law, the Plan Administrator shall not incur any liability for any acts or for failure to act, except for its own willful misconduct or willful breach of this Plan.

6.13 Coordination with Component Plans

Article VI of this Plan applies with respect to each Component Plan in Attachment A, unless the Component Plan specifically addresses these issues in a manner that is consistent with applicable state and federal law. However, any references to Plan Administrator shall be construed in accordance with the definition and description of duties contained in this Article VI.

6.14 Missing Persons

Unless otherwise determined, if any amount becomes payable under the Plan to a Participant or any of his or her Dependents and the same shall not have been claimed, or if any check issued under the Plan remains uncashed, and reasonable care shall have been exercised by the Plan Administrator in attempting to make such payments, the amount shall be forfeited within such period as is necessary to prevent escheat under any applicable law and shall cease to be a liability of the Plan. Notwithstanding the foregoing, in the event a Participant or his or her Dependent is later found, the Plan Administrator shall repay any amount forfeited, without earnings, pursuant to this Section 6.14 to the applicable Participant or Dependent.

ARTICLE VII

SUBROGATION AND RIGHT OF REIMBURSEMENT AND OFFSET; RIGHT TO RECOVERY

7.1 Subrogation Rights, In General

If a Participant, Dependent, or his or her heir, legatee, administrator, executor, personal representative, beneficiary or assignee (hereinafter, individually and collectively, the "Claimant") has any claim, right, or cause of action against any other person or party for payment of expenses covered under the Plan as a result of an injury or illness for which any third party may be legally responsible or obligated to compensate or indemnify the Claimant (including, without limitation, under any contract or policy of insurance), the Plan shall, to the extent of such payment made by the Plan, be subrogated to all of the Claimant's rights of recovery arising out of any claim or cause of action that may accrue because of the alleged negligent, willful or other conduct of a third party.

The Plan's rights of subrogation and/or reimbursement, as set forth in this Article, extend to all insurance coverage available to Claimant due to injury, illness, or any other condition for which the Plan has paid claims (including, but not limited to, liability coverage, medical payments coverage, workers' compensation coverage, no fault coverage or any first party insurance coverage). The Plan is always secondary to automobile no-fault coverage, personal injury protection (PIP) coverage, or medical payments coverage.

The Plan may assert a claim or file suit in Claimant's name and take any and all appropriate action to assert its subrogation claim, with or without Claimant's consent. The Plan is not required to pay Claimant part of any recovery it may obtain, even if the Plan files suit in Claimant's name.

7.2 Right of Reimbursement; Received Amounts to Be Held in Trust but Recovery Rights Not Conditioned on Existence of Trust

A Claimant who receives any payments, directly or indirectly from any third party, including, but not limited to an insurer, as a result of an injury or illness in which the Plan has paid benefits will hold the payments received in trust, to the extent of any benefits paid under the Plan, for the sole use and benefit of the Plan, and the Plan shall maintain the right to sue in any court of competent jurisdiction to enforce its legal and equitable right to recover any amount being held by the Claimant, without regard to whether the Claimant has held such payments in trust or commingled such payments with the Claimant's other assets, and without any duty to trace any payments the Claimant has received. All rights of recovery by the Plan will be limited to the amounts paid under the Plan as the result of such injury or illness. In furtherance of the foregoing, the Plan shall have an equitable lien against any right the Claimant may have to recover any payments made by the Plan from any third party. The Plan's equitable lien also shall attach to any right to payment for workers' compensation, whether by judgment, settlement or otherwise, where the Plan has

paid expenses otherwise eligible as covered expenses under the Plan prior to a determination that the covered expenses arose out of, and in the course of, employment. Payment by workers' compensation insurers or programs or the Company will be deemed to mean that such a determination has been made. This equitable lien shall also attach to the first right of recovery to any money or property that is obtained by anyone (including, but not limited to, the Claimant, the Claimant's attorney, and/or a trust) as a result of an exercise of the Claimant's rights of recovery. The Plan shall also be entitled to seek any other equitable remedy against any party possessing or controlling such monies or properties.

7.3 Plan Has Right to Participate in Third Party Recovery Action(s)

The Plan shall be entitled, acting in its discretion, to participate in any legal or equitable action the Claimant brings against a third party to be compensated for any injury or illness for which the Plan has paid benefits or to otherwise recover expenses (whether or not any party to such an action uses an attorney). The Plan shall have the right to select the attorney(s) who will represent the Claimant and Plan in such actions. The Plan shall be entitled to bring a lawsuit in any court of competent jurisdiction to enjoin the use of any proceeds that anyone receives from a third party in a case where the Plan has paid benefits to ensure the Plan may recover the benefits it paid. The Plan's expenses, costs, and any attorneys' fees the Plan may directly or indirectly incur, shall be paid out of any recovery or settlement received by the Claimant.

In addition, the Plan shall be entitled to file suit in the Claimant's name, to recover expenses the Plan may pay on the claim if the responsible party does not pay for the expenses voluntarily, and if the Claimant does not sue the responsible party for recovery of the expenses.

7.4 Make Whole, Common Fund Doctrines Inapplicable

The Plan's subrogation, reimbursement and recovery rights under this Article will apply to any full or partial recovery a Claimant obtains from a third party, so long as otherwise covered hereby, even if the Claimant has not been "made whole" for the loss accruing because of the alleged negligent, willful, or other conduct of such third party. The Plan specifically rejects and will not apply the "make whole" doctrine, the "common fund" doctrine, the "fund" doctrine, comparative/contributory negligence, "collateral source" rule, "attorney's fund" doctrine, regulatory diligence or any other equitable defenses that may affect the Plan's right to subrogation, reimbursement, or recovery. Further, the Plan's right of reimbursement and offset shall have first priority over the Claimant's rights to the extent of any benefits paid hereunder regardless of how any payment or recovery obtained from a third party is characterized in any agreement or judgment or otherwise.

7.5 Acceptance of Benefits Treated as Consent

By filing any claim for and/or accepting any benefits under the Plan, the Claimant is deemed to have consented to the Plan's subrogation, reimbursement, and recovery rights,

and to have agreed to cooperate with the Plan and the Company in any respect necessary or advisable to make, perfect, or prosecute the Plan's right to assert any claim, right or bring any cause of action, regardless of whether the Claimant chooses to pursue such claim, right or cause of action, and the Claimant shall enter into a subrogation and/or reimbursement and offset agreement with the Plan upon the request of the Plan. The attorneys for all such injured persons filing claims under the Plan must be authorized and directed by them to sign, and, if requested by the Plan, must sign an agreement that they shall honor and enforce the terms of the Plan's subrogation, reimbursement, and offset right before disbursing the proceeds of any third-party recovery.

7.6 Duty to Cooperate, Not Compromise or Interfere With Plan's Rights

Claimant shall cooperate fully with the Plan's efforts to recover benefits paid. Claimant has a duty to notify the Plan within 30 days of the date when any notice is given to any party, including but not limited to an insurance company or attorney, of Claimant's intention to pursue or investigate a claim to recover damages or obtain compensation due to Claimant's injury, illness, or condition. Claimant and any and all of Claimant's agents shall provide all information requested by the Plan, the Claims Administrator or its representative including, but not limited to, completing and submitting any applications or other forms or statements as the Plan may reasonably request and all documents related to or filed in personal injury litigation.

Claimant shall do nothing to prejudice the Plan's subrogation or recovery interest or to prejudice the Plan's ability to enforce the terms of this Article. This includes, but is not limited to, refraining from making any settlement or recovery that attempts to reduce or exclude the full cost of all benefits provided by the Plan. If Claimant fails to cooperate with the Plan in its efforts to recover such amounts or does anything to hinder or prevent such a recovery, Claimant will cease to be entitled to any further Plan benefits. The Plan will also have the right to withhold or offset future benefit payments up to the amount of any settlement, judgment, or recovery Claimant obtains, regardless of whether the settlement, judgment or recovery is designated to cover future benefits or expenses.

The Plan has the right to conduct an investigation regarding Claimant's injury, illness, or condition to identify potential sources of recovery. The Plan reserves the right to notify all parties and his/her agents of its lien. Agents include, but are not limited to, insurance companies and attorneys.

If Claimant and/or Claimant's representative fail to cooperate and comply with this Article, the Plan shall be entitled to recover reasonable attorney fees incurred in enforcing its right of recovery.

The Plan has the right pursuant to HIPAA to share Claimant's personal health information in exercising its subrogation and reimbursement rights.

7.7 Right to Delay, Withhold Payment

The Plan shall not be liable for, nor shall it have any obligation to pay, any benefit arising out of a third-party incident unless and until a properly executed and fully enforceable subrogation, reimbursement and offset agreement is received by the Plan. However, failure to receive a properly executed agreement shall not limit any of the Plan's rights.

7.8 Right to Offset Future Payments

At the discretion of the Plan Administrator, the Plan may reduce any current or future benefit payments otherwise available to the Claimant under the Plan by an amount up to the total amount of payments previously made by the Plan which are subject to the Plan's subrogation, reimbursement, and recovery rights hereunder.

7.9 Applicable to All Settlements and Judgments

The terms of this Article shall apply, and the Plan is entitled to full recovery regardless of whether any liability for payment is admitted and regardless of whether the settlement or judgment identifies the benefits the Plan provided or purports to allocate any portion of such settlement or judgment to payment of expenses other than expenses for benefits. The Plan is entitled to recover from any and all settlements or judgments, even those designated as pain and suffering, non-economic damages and/or general damages only. The Plan's claim will not be reduced due to your own negligence.

7.10 Subrogation, Reimbursement, Offset and Recovery Rights Are Separate and Severable

The Plan's rights under any subrogation, reimbursement and/or offset agreement, the Plan's subrogation, reimbursement, and offset rights set forth in this Article, and the Plan's equitable rights (whether to recover assets held in trust for its benefit, or otherwise) are each separate and distinct rights and obligations. Accordingly, any failure or invalidity, in whole or in part, of any one such right or obligation shall not impair or otherwise adversely affect any other such right or obligation.

7.11 Substitution of Claims Administrator's Rules

In the event a claims administrator has contractually undertaken to administer all or a portion of the Plan's benefits or benefit provisions, and such claims administrator has adopted its own subrogation, reimbursement and recovery rules, such rules shall be substituted for the provisions of this Article.

7.12 Right to Recover Excess Payments or Payments Made in Error

If the Plan makes any payment(s) in error, or in excess of the amount(s) necessary to satisfy the Plan's unconditional obligations, the Plan will have the right to recover such payment(s) from any persons or parties to whom, or with respect to whom, such payments

were made, or at the election of the applicable Plan fiduciary or claims administrator, from any person or party that should have made such payment(s).

The Component Plans may contain third party recovery and/or subrogation rules that differ from those in this Article. In that event, the rules of the Component Plans will govern.

7.13 Interpretation

In the event that any claim is made that any part of this Article is ambiguous, or questions arise concerning the meaning or intent of any of its terms, the Claims Administrator for the Plan shall have the sole authority and discretion to resolve all disputes regarding the interpretation of this provision.

ARTICLE VIII

INSURANCE/SELF-INSURANCE

8.1 Insurance Generally

To the extent that insurance is procured, the Participant's right to such benefits shall be limited to the amounts payable by such insurance and the receipt thereof shall be subject to satisfaction of all of the terms, covenants, conditions, rules and regulations of the insurer. The Employer shall not have any independent obligation or duty to provide benefits to Covered Persons to the extent that such benefits are to be provided by insurance. The Plan Administrator shall have the right from time to time to change the coverages or carriers of any one or more insurance policies.

8.2 Provisions Relating to Insurers

No insurer shall be required or permitted to issue an insurance policy or contract that is inconsistent with the purposes of this Plan, nor be bound to take any action not in accordance with the terms of any policy or contract in connection with this Plan.

8.3 Conflicting Provisions

If any provision of any insurance policy or contract conflicts with the provisions of this Plan, the provisions of the insurance policy or contract shall prevail, except as otherwise specifically provided in this Article VIII.

8.4 Source of Payments

The Employer shall pay any benefits to which a Participant is entitled to under this Plan from its general assets to the extent such benefits are not payable from an insurance contract.

ARTICLE IX

AMENDMENT AND TERMINATION

9.1 Authority for Amendment and Termination

The Employer, as Plan Sponsor, 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 Employer 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, 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, 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, spouses, and eligible Dependents had before the Plan was amended, changed, modified, or terminated.

9.2 Effect of Changes

All changes to this Plan shall become effective as of a date established by The Aerospace Corporation or the appropriate individual or committee except that no increase or reduction in benefits shall be effective with respect to covered expenses incurred prior to the date a change was adopted by such person(s), regardless of the effective date of the change. Upon termination or discontinuance, contributions and benefits elections relating to the Plan shall terminate.

9.3 Acquisitions

In the event that the Employer acquires an entity, the Employer shall retain the discretion to maintain such entity's current employee benefit program or to provide coverage under this Plan. However, in no event shall any Employee be eligible to participate in this Plan unless he or she meets all eligibility and participation requirements specified in this Plan.

9.4 Discontinuance of Contributions

It is the expectation that the Employer will continue the payment of contributions under this Plan, but the continuation of such payments is not assumed as a contractual obligation of any Employer; and the right is reserved by each Employer at any time, and for any reason, to reduce, suspend or discontinue its contributions under this Plan, subject to such terms and conditions as the Employer may impose.

ARTICLE X

GENERAL PROVISIONS

10.1 Entire Contract

This Plan, including all supplements and appendices hereto, and the applications of the Covered Persons, if any, constitutes the entire contract of coverage under this Plan between the Employer and the Covered Persons.

10.2 Written Notice

Any written notice required under this Plan shall be deemed received by a Covered Person if sent by regular mail, postage prepaid, to the last address of such Covered Person on the records of the Plan Administrator.

10.3 Information to be Furnished

Participants shall provide the Employer and Plan Administrator with such information and evidence, and shall sign such documents, as may reasonably be requested from time to time for the purpose of administration of the Plan. All communications in connection with the Plan made by a Participant shall become effective only when duly executed on any forms (or in compliance with the procedures) as may be required by the Plan Administrator.

10.4 Limitation of Rights

Neither the establishment of the Plan nor any amendment thereof, or the payment of any benefits, shall be construed as giving to any Participant, Employee, or other person any legal or equitable right against the Employer, any officer, agent or other employee of the Employer, Plan Administrator or member of the Plan Administrator, except as expressly provided herein or as provided by applicable federal law.

10.5 No Guarantee of Employment

Neither the establishment and maintenance of this Plan, nor any modification thereof, nor the creation of any account, nor the payment of any benefits shall be construed as giving to any Employee or other person, any legal right or equitable right against the Employer, any officer or employee of the Employer, or against the Plan Administrator, except as herein provided. Under no circumstances shall the terms of employment of any Participant or Employee be modified or in any way affected by this Plan.

10.6 No Vested Interest

Except for the right to receive any benefit payable under the Plan, no person has any right, title, or interest in or to the assets of the Employer because of the Plan.

10.7 Clerical Error/Delay

Clerical errors made on the records of the Plan Administrator and delays in making entries on such records shall not invalidate coverage or cause coverage to be in force or to continue in force. Rather, the effective dates of coverage shall be determined solely in accordance with the provisions of this Plan regardless of whether any contributions with respect to Covered Persons have been made or have failed to be made because of such errors or delays. Upon discovery of any such error or delay, an equitable adjustment of any such contributions will be made.

10.8 Applicable Law

This Plan shall be construed, administered and enforced according to the applicable federal laws governing employee benefit plans and, to the extent not inconsistent therewith, in accordance with the laws of the State of California. Any provision of this Plan in conflict with the law of any governmental body or agency which has jurisdiction over this Plan shall be interpreted to conform to the minimum requirements of such law.

10.9 Waiver

The failure of the Plan Administrator to strictly enforce any provision of this Plan shall not be construed as a waiver of the provision. Rather, the Plan Administrator shall have the right to strictly enforce each and every provision of this Plan at any time regardless of the prior conduct of the Plan Administrator and regardless of the similarity of the circumstances or the number of prior occurrences.

10.10 Severability

If any provision of the Plan shall be held invalid or illegal for any reason, any invalidity or illegality shall not affect the remaining parts of the Plan, but the Plan shall be construed and enforced as if the invalid or illegal provision had never been inserted. The Employer shall have the privilege and opportunity to correct and remedy those questions of invalidity or illegality by amendment as provided in the Plan.

10.11 Nonalienation of Benefits

A Participant or his beneficiary may not assign, transfer, or convey any of the benefits provided by this Plan, except pursuant to a Qualified Domestic Relations Order or a Qualified Medical Child Support Order. Similarly, a Participant of beneficiary cannot assign, transfer, or convey any rights that such person has or may have under ERISA. This prohibition on assignments of rights specifically includes any legal right such person has or may have to bring claims for benefits, breaches of fiduciary duty, prohibited transactions, statutory violations and statutory penalties. Any attempt to assign any Plan benefits or legal rights to any third party, including, but not limited to, a healthcare provider, shall be immediately invalid, void, and unenforceable. The purported assignments a Participant or beneficiary may be asked to sign by a healthcare provider, at or around the time of service, do not invalidate, alter or supersede these prohibitions.

Benefits hereunder shall not be subject to attachment or garnishment or other legal process by any creditor of any such Participant or beneficiary, nor shall any such Participant or beneficiary have any right to alienate, anticipate, commute, pledge, encumber or assign any of the benefits which he may expect to receive, contingently or otherwise, under this Plan, and any attempt to anticipate, alienate, commute, pledge, encumber, or assign any right to benefits hereunder shall be void. Notwithstanding the foregoing, solely as a convenience to a Covered Person, the Plan Administer may pay Plan benefits directly to the provider of services (whether in-network or out-of-network) and such payment shall not constitute an assignment of benefits under the Plan or a waiver of this provision. Such payment shall fully discharge the Plan Administrator from further liability under the Plan. Additionally, while a Covered Person, under ERISA, may appoint an authorized representative to file a claim for benefits or appeal a denied claim for benefits on his or her behalf in accordance with the relevant provisions under ERISA, no such appointment may be made to an out-of-network provider and no such appointment to any provider shall render any provider, or otherwise cause such provider to be, a beneficiary under the Plan.

10.12 Workers' Compensation

This Plan is not instead of and does not affect any requirement for coverage by Workers' Compensation insurance.

10.13 Gender

The use of masculine pronouns in this Plan shall apply to persons of both sexes unless the context clearly indicates otherwise.

10.14 Headings

The headings used in this Plan are for the purpose of convenience of reference only. Covered Persons are advised not to rely on any provisions because of the heading. In all cases, the full text of this Plan will control.

10.15 Disability or Death

If the Plan Administrator shall find that any Employee or covered Dependent to who or for whom any amount is payable under this Plan, is unable to care for his affairs because of illness or accident, or is a minor, or has died, then any payment due him or his estate (unless a prior claim therefore has been made by a duly appointed legal representative) may, if the Plan Administrator so elects, be paid to his spouse, a child, a relative, an institution maintaining or having custody of such person, or any other person deemed by the Plan Administrator to be a proper recipient on behalf of such person otherwise entitled to payment. Any such payment shall be a complete discharge of the liability of the Employer, the Plan Administrator, the Plan, and any of the Component Plans.

10.16 Legal Actions

In any action or proceeding involving the Plan assets or any property constituting part or all thereof, or the administration thereof, no Employee, former Employee, Dependent, Covered Person, or any other person having or claiming to have an interest in this Plan shall be necessary parties and no such person shall be entitled to any notice or process, except to the extent required by applicable law. Any final judgment which is not appealed or appealable that may be entered in any such action or proceeding shall be binding and conclusive on the parties hereto and upon all persons having or claiming to have any interest in this Plan.

10.17 Plan Funding

Benefits are funded by Participant and Employer contributions for Eligible Employee, in accordance with the Aerospace Corporation Cafeteria Plan that is hereby incorporated into this Plan by reference for pre-tax benefits and following similar rules for post-tax benefits. The Employer shall make contributions, including Employee salary redirections prescribed by their Aerospace Corporation Cafeteria Plan pre-tax elections and any other contributions required of Participants and remitted to the Employer in such amounts and at such times as shall be required to provide benefits as described in this Plan. The determinations of the Plan Sponsor with respect to the amounts and times of payment shall be binding upon each Employer**.**

10.18 Inability to Locate Payee

If the Plan Administrator is unable to make payment to any Participant or other person to whom a payment is due under the Plan because he cannot ascertain the identity or whereabouts of such Participant or person after reasonable efforts have been made to identify or locate such Participant or person (including a notice of the payment so due) mailed to the last known address of such Participant or other person as shown on the records of the Employer, such payment and all subsequent payments otherwise due to such Participant or other person shall be forfeited according to the administrative procedures of the applicable Component Plan or as otherwise required by any applicable state or federal law.

10.19 Tax Effects

Neither the Employer nor the Plan Administrator makes any warranty or other representation as to whether any payments made to or on behalf of any Covered Person will be treated as excludable from gross income for state or federal income tax purposes.

10.20 Employee Authorization of Payroll Deductions

The Plan Administrator may distribute and collect information or conduct transactions by means of electronic media, including, but not limited to, electronic mail systems, Internet, or voice response system, except when a specific provision of the Code, ERISA or other guidance of general applicability sets forth rules or standards regarding the media through

which such dissemination of information or transaction may be conducted. By using electronic media, an Eligible Employee and Participant, as applicable, consents to (a) deductions from his Compensation in accordance with his elections made through the system, and (b) the recording of his telephone call on the voice response system.

10.21 Quality of Health Services

The selection by the Employer of the coverages that may be financed through the Plan or a Component Plan does not constitute any warranty, express or implied, as to the quality, sufficiency, or appropriateness of the services that may be provided by any dental, health, or vision care service provider, nor does the Employer assume or accept any responsibility with respect to the denial by any prospective provider of access to, or financial support for, any service, whether or not such denial is appropriate under the circumstances. Each Participant for whom enrollment is provided under any coverage agrees, as a condition of such enrollment, that such Employee will look only to appropriately certified or licensed providers, and not to the Employer, for benefit related services, and further that the Participant releases, discharges, indemnifies, and holds harmless the Employer, the Plan Administrator, their respective employees, officers, directors, and shareholders, and all other persons associated with them, with respect to all matters relating to (a) the quality, sufficiency, and appropriateness of health, prescription drug, dental, vision or employee assistance services provided, (b) the failure by any provider to provide any service needed, or to properly obtain informed consent prior to rendering or withholding any service, regardless of the reason for such failure, (c) professional malpractice by a service vendor or provider, or (d) the failure of any insurance carrier to pay for any care for which the Participant or other service recipient believes himself entitled to reimbursement.

10.22 Legal Remedy

Before pursuing a legal remedy, an individual claiming benefits or seeking redress under the Plan shall first exhaust all claims, review and appeal procedures available or required under the Plan. Because the Plan is governed by ERISA, an individual has the right to bring a civil action under Section 502(a) of ERISA if he or she is not satisfied with the outcome of the claims, review and appeals procedures available or required under the Plan. An individual that files his or her claim within the required timeframe and who exhausts his or her required claim, review and appeal rights may sue over his or her claim (unless he or she has executed a release of his or her claim). An individual must commence such a suit within 12 months after completing the appeals process, and no more than two years after the event that prompted the original claim, or such the right to bring such an action will be lost.

10.23 Force Majeure

Should the performance of any act required by the Plan be prevented or delayed by reason of a natural catastrophe, strike, lock-out, labor dispute, war, riot, or any other cause beyond the Plan's control, the time for performance of the act will be extended for a reasonable period of time, and non-performance of the act during the period of delay shall be excused.

In such event, however, all parties shall use reasonable efforts to perform their respective obligations under the Plan.

10.24 Employer Joinder and Withdrawal

While it is not the present intention of any Employer to withdraw from the Plan, any Employer, other than The Aerospace Corporation, shall have the right, at any time, under such terms and conditions as The Aerospace Corporation may provide (including but not limited to requiring the Employer to make additional payments with respect to the Employer's share of claims incurred prior to the Employer's withdrawal), to withdraw from the Plan by delivering The Aerospace Corporation and the Plan Administrator written notice of its election to withdraw.

10.25 Venue

The exclusive venue for all disputes arising out of and relating to the Plan is in the federal district court located in Los Angeles County, California.

ARTICLE XI

HIPAA PRIVACY AND SECURITY

11.1 HIPAA Privacy Compliance

The Plan shall comply with applicable requirements of the Privacy Standards of HIPAA and its implementing regulations found at 45 C.F.R. Parts 160 and 164, as amended from time to time, with respect to the benefits under the Plan which meet the definition of a "group health plan" as defined by HIPAA (including the medical, prescription drug, dental, vision, health care flexible spending account, and employee assistance plan). Accordingly, the Plan is a Hybrid Entity as defined in HIPAA Section 164.103 and this Section shall apply only to the identified health care component benefits under the Plan, and the Plan's workforce responsible for performing administrative functions for the identified health care components of the Plan. Compliance shall include, but not be limited to the following:

a. **Plan Sponsor Uses and Disclosures**. The Plan shall establish and determine the permitted and required uses and disclosures of Protected Health Information ("PHI," as defined by HIPAA) by the Plan Sponsor, provided that such permitted and required uses and disclosures may not be inconsistent with the HIPAA regulations.

b. **Plan Sponsor Obligations.** The Plan shall disclose PHI to the Plan Sponsor only upon the Plan Sponsor's agreement that the Plan Sponsor shall:

(i) Not use or further disclose PHI other than as permitted or required by the Plan document or as required by law;

(ii) Ensure that any agents to whom the Plan Sponsor provides PHI received from the Plan agree to the same restrictions and conditions that apply to the Plan Sponsor with respect to such information;

(iii) Not use or disclose PHI for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of the Plan Sponsor;

(iv) Report to the Plan any use or disclosure of PHI that is inconsistent with the uses or disclosures permitted by HIPAA of which the Plan Sponsor becomes aware;

(v) Make PHI available in accordance with the provisions of HIPAA granting individuals access to their own PHI contained in the Plan's designated record set;

(vi) Make PHI available for amendment by the individual who is the subject of the PHI and incorporate any amendments to such person's PHI in accordance with relevant HIPAA provisions;

(vii) Make available the information required to provide an accounting of PHI disclosures to an individual covered by the Plan in accordance with relevant HIPAA provisions;

(viii) Make the Plan Sponsor's internal practices, books and records relating to the use and disclosure of PHI received from the Plan available to the Secretary of Health and Human Services for purposes of determining compliance by the Plan with HIPAA;

(ix) If feasible, return or destroy all PHI received from the Plan that the Plan Sponsor still maintains in any form and retain no copies of such information when no longer needed for the purpose for which disclosure was made, except that, if such return or destruction is not feasible, the Plan Sponsor shall limit further uses and disclosures to those purposes that make the return or destruction of the information infeasible; and

(x) Provide for adequate separation between the Plan and the Plan Sponsor, as set forth below.

The Plan Sponsor hereby agrees to abide by the above obligations and to certify to the Plan that the Plan has been amended to incorporate the foregoing provisions.

c. **Adequate Separation.**

(i) Only those Employees or classes of Employees or other persons under the control of the Plan Sponsor who are responsible for plan administrative functions shall be given access to the PHI to be disclosed, including any employee or person who receives PHI relating to payment under, health care operations of, or other matters pertaining to the Plan in the ordinary course of business.

(ii) The Plan shall restrict the access to and use by such Employees or classes of Employees or other persons under the control of the Plan Sponsor to plan administrative functions that the Plan Sponsor performs for the Plan.

(iii) The Plan shall provide an effective mechanism for resolving any issues of noncompliance with the provisions of this by such Employees and other persons under the control of the Plan Sponsor.

d. **Plan Disclosures**. The Plan may:

(i) Disclose PHI to the Plan Sponsor for purposes of the Plan's administrative functions that the Plan Sponsor performs consistent with the provisions of this Plan;

(ii) Not permit a health insurance issuer or Health Maintenance Organization ("HMO") with respect to the Plan to disclose PHI to the Plan Sponsor except as permitted by this;

(iii) Not disclose, and not permit a health insurance issuer or HMO to disclose, PHI to the Plan Sponsor as otherwise permitted by this unless the disclosure is included in the Plan's Notice of Privacy Practices distributed to Plan Participants; and

(iv) Not disclose PHI to the Plan Sponsor for the purpose of employment-related actions or decisions or in connection with any other benefit or employee benefit plan of the Plan Sponsor.

e. **Summary Information**. The Plan may disclose summary health information to the Plan Sponsor if the Plan Sponsor requests the summary health information for the purpose of:

(i) Obtaining premium bids from health plans for providing health insurance coverage under the Plan; or

(ii) Modifying, amending or terminating the Plan.

f. **Enrollment Information**. The Plan may disclose to the Plan Sponsor information on whether an individual is participating in the Plan or is enrolled or has disenrolled from a health insurance issuer or HMO offered by the Plan.

11.2 HIPAA Security Compliance

The Plan shall comply with the applicable requirements of HIPAA's Security Standards and the implementing regulations found at 45 C.F.R. Parts 160 and 164, as amended from time to time, with respect to the programs under the Plan which meet the definition of a "group health plan" as defined by HIPAA (including the medical, prescription drug, dental, vision, health care flexible spending account, and employee assistance plan). Accordingly, the Plan is a Hybrid Entity as defined by HIPAA and this shall apply only to the identified health care component benefits under the Plan, and the Plan's workforce responsible for performing Plan administrative functions for the identified health care components of the Plan, to the extent Electronic Protected Health Information ("ePHI") is created, received, maintained or transmitted by the Plan. Compliance shall include, but not be limited to the following:

a. **Plan Obligations**. The Plan shall disclose ePHI to the Plan Sponsor only upon the Plan Sponsor's agreement that the Plan Sponsor shall:

(i) Implement administrative, physical and technical safeguards that reasonably and appropriately protect the confidentiality, integrity and availability of ePHI that the Plan Sponsor creates, receives, maintains or transmits on behalf of the Plan;

(ii) Ensure that any agents, including subcontractors, to whom the Plan Sponsor provides ePHI agree to implement reasonable and appropriate security measures to protect the ePHI; and

(iii) Report to the Plan any security incident (as defined by HIPAA) or breach (as defined by HIPAA) of PHI of which the Plan Sponsor becomes aware.

(iv) Enrollment, disenrollment and summary health information shall not be subject to these requirements.

b. **Adequate Separation**. The Plan Sponsor shall ensure that the provisions of the Plan are supported by reasonable and appropriate security measures to the extent the identified Employees or classes of Employees or other persons under the control of the Plan Sponsor who are responsible for plan administrative functions shall be given access to ePHI.

ATTACHMENT A

The Aerospace Corporation Health and Welfare Benefits Plan

The following are Component Plans under the Plan, and the terms and conditions of each of their governing plan documents as listed below, are hereby incorporated by reference into the Plan:

Plan Name	Carrier/TPA Name	Insured/ Self-Insured Status	Benefit Coverage	Pre-Tax/ Post-Tax Status
Group Hospital – Medical Plan	Reliastar Life Insurance Company; Monumental Life Insurance Company; Blue Cross of California (Anthem EAP)	Self-Insured; Insured	Medical	Pre-Tax – Employee
The Aerospace Health Maintenance Organizations	Blue Cross of California; Kaiser Foundation Health Plan of Mid-Atlantic States, Inc.; Kaiser Foundation Health Plan, Inc. (Southern CA; Northern CA); Kaiser Foundation Health Plan of Colorado	Insured	Medical	Pre-Tax – Employee
Dental Plan	Cigna; Blue Cross of California; Delta Dental of California; Safeguard Health Plans, Inc.	Self-Insured; Insured	Dental	Pre-Tax – Employee

Plan Name	Carrier/TPA Name	Insured/ Self-Insured Status	Benefit Coverage	Pre-Tax/ Post-Tax Status
Vision Service Plan	Vision Service Plan (VSP)	Insured	Vision	Pre-Tax – Employee
Aerospace Group Life	Hartford Life and Accident	Insured	Life Insurance (Basic) Life Insurance (Employee Optional, Dependent)	Basic Life Coverage– Employer Paid – Post-Tax Employee Optional, Dependent Coverage – Employee Paid – Post-Tax
Short-Term Disability for Non-California Employees	Hartford Life and Accident	Insured	Short-term Disability Benefits	No Employee Contributions
Long-Term Disability Plan	Hartford Life and Accident	Insured	Long-term Disability Benefits (Group & Supplemental)	Partial Employee Contributions
Voluntary Personal Accident Insurance	Zurich-American Insurance Company	Insured	Voluntary Personal Accident	Employee Paid
Occupational Accident Insurance	Zurich-American Insurance Company	Insured	Occupational Accident	No Employee Contributions
Severance Pay	The Aerospace Corporation	Self-Insured	Severance Pay	No Employee Contributions

ATTACHMENT B

Affiliated Employers Participating in the Plan

The entities identified below are Affiliated Employers with respect to the Plan:

- The Aerospace Corporation