

**METLIFE PPO DENTAL PLAN
HIGH OPTION
STATESIDE EMPLOYEES
SUMMARY PLAN DESCRIPTION
EFFECTIVE JANUARY 1, 2018**

TABLE OF CONTENTS

THE METLIFE PPO DENTAL PLAN.....	4
BEFORE YOU BEGIN.....	4
ELIGIBILITY AND PARTICIPATION.....	5
WHO'S ELIGIBLE.....	5
ENROLLING FOR COVERAGE.....	6
WHEN COVERAGE BEGINS.....	8
MEDICAL CHILD SUPPORT ORDERS.....	9
COST OF COVERAGE.....	9
WAIVING COVERAGE.....	9
HOW THE PLAN WORKS.....	10
HOW ELIGIBLE DENTAL EXPENSES ARE DEFINED.....	10
HOW TO USE THE PLAN.....	10
SHARING IN THE COST OF YOUR DENTAL EXPENSES.....	11
MAXIMUM BENEFITS.....	11
PRE-TREATMENT ESTIMATE.....	12
METLIFE'S DENTAL CUSTOMER SERVICE CENTER.....	13
COVERED DENTAL EXPENSES.....	13
PREVENTIVE (TYPE A) DENTAL SERVICES.....	13
BASIC (TYPE B) DENTAL SERVICES.....	14
MAJOR (TYPE C) DENTAL SERVICES.....	15
ORTHODONTIA (TYPE D) SERVICES.....	16
BENEFITS WHEN ALTERNATE PROCEDURES ARE AVAILABLE.....	17
PROSTHESIS REPLACEMENT.....	18
HOW TO CLAIM BENEFITS.....	19
WHEN TO FILE CLAIMS.....	19
WHEN YOU NEED TO SUPPORT YOUR CLAIM.....	19
PROOF AND PAYMENT OF CLAIMS.....	19
ASSIGNMENT OF BENEFITS.....	20
FILING CLAIMS WHEN YOU ARE COVERED BY MORE THAN ONE PLAN.....	20
WHAT'S NOT COVERED.....	21
OTHER INFORMATION YOU SHOULD KNOW.....	24
YOUR RIGHTS AS A PATIENT.....	24
HOW BENEFITS ARE COORDINATED WITH OTHER COVERAGE.....	24
SUBROGATION AND REIMBURSEMENT.....	26
CLAIM FRAUD.....	29
OVERPAYMENT OF BENEFITS.....	29
HOW BENEFITS CAN BE FORFEITED OR DELAYED.....	29
CONTINUED COVERAGE UNDER THE FEDERAL FAMILY AND MEDICAL LEAVE ACT.....	30
WHEN COVERAGE ENDS.....	30
EXTENDED COVERAGE.....	31
CONTINUED COVERAGE DURING A MILITARY LEAVE OF ABSENCE.....	31
OWNERSHIP OF BENEFITS.....	32
PLAN ADMINISTRATION.....	32
COMPLIANCE WITH FEDERAL LAW.....	32

CLAIMS, APPEALS AND EXTERNAL REVIEW	32
CONFIDENTIALITY OF HEALTH CARE INFORMATION.....	39
NO RIGHT TO CONTINUED EMPLOYMENT	40
FUTURE OF THE PLAN.....	41
YOUR RIGHTS UNDER ERISA	42
PRUDENT ACTIONS BY PLAN FIDUCIARIES	42
ENFORCING YOUR RIGHTS	42
ASSISTANCE WITH YOUR QUESTIONS	43
GLOSSARY.....	44

THE METLIFE PPO DENTAL PLAN

Engility Corporation (“Engility”) offers the MetLife Preferred Provider Organization (PPO) Dental Plan – High Option (the “Plan”) to eligible employees. The Plan is designed to help you meet the expense of proper dental care. It encourages preventive care and provides financial assistance toward paying for a wide range of other dental services. Please contact MetLife Dental at 800-942-0854 or the Engility Benefits Service Center at 1-877-248-8519 if you have questions about the dental benefits offered to you

The Plan encourages preventive dental care and covers a wide range of other dental services.

BEFORE YOU BEGIN

This Summary Plan Description (SPD) describes the most important features of the Plan. We’ve tried to explain things in everyday language, but you will come across some words and phrases that have specific meanings within the context of the Plan. To help you understand them, they are *italicized* when first used and included in the *Glossary* that starts on page 44. Also be sure to read the *Other Information You Should Know* section of this SPD for important information and facts about your rights under the Plan. This booklet reflects Plan provisions effective January 1, 2016 and supersedes any previous version.

This SPD is expressly made part of the Plan and is legally enforceable as part of the Plan with respect to its terms and conditions. In the event there is no other plan document, this document shall serve as a Summary Plan Description and shall also constitute the Plan.

ELIGIBILITY AND PARTICIPATION

You can enroll your eligible dependents in the Plan if you enroll, as long as you provide proper documentation during the open enrollment period or within 31 days of your date of hire or after experiencing a qualified life event (see *Enrolling your dependents for coverage*, page 7).

WHO'S ELIGIBLE

Employees. You are eligible to participate in the Plan if you are:

- > a U.S.-based non-SCA employee working in the U.S. and regularly scheduled to work 30 hours or more per week;
- > employed in a job classification designated as benefits-eligible; and/or
- > on an approved leave of absence that allows for continuation of benefits.

If you are a collectively bargained employee, the terms of your collective bargaining agreement will govern your eligibility.

Eligibility may vary by project or contract. Please contact the Engility Benefits Service Center at 877-248-8519 if you have questions about your eligibility.

Dependents. You can enroll your eligible dependents in the Plan if you enroll, as long as you provide proper documentation (see *Enrolling your dependents for coverage*, page 7). Your eligible dependents are your spouse/same-sex domestic partner and your children, defined as follows.

- > **Spouse.** Your spouse is your lawfully married opposite-sex spouse or legally married same-sex spouse. If the state where you live treats common-law marriage as legal marriage and you satisfy applicable state law requirements (including any documentation requirements), a common-law spouse of the opposite sex will also be considered a spouse for Plan purposes. Divorced or legally separated spouses are not eligible for coverage. **Please note that a decree of divorce or legal separation requiring you to provide health coverage for your ex-spouse does not make your ex-spouse eligible for coverage under the Plan** on a transitional basis.
- > **Same-sex civil union partner/domestic partner.** A same-sex civil union partner or same-sex domestic partner is eligible for dependent coverage under the medical, dental and vision care plans.
- > **Children.** Dependent children are your children under age 26 for whom proper documentation has been provided, including:
 - » your biological children;
 - » your lawfully adopted children. If you have started legal adoption procedures, the child is considered a dependent if he/she lives with you full-time and depends on you for support. If you are adopting a child from birth, the child is considered a dependent from birth;

- » the children of your same-sex spouse, same-sex civil union partner or same-sex domestic partner;
- » your stepchildren;
- » any other child, including a grandchild, niece, nephew, etc., for whom you have proof of legal guardianship, as long as the child lives with you in a parent-child relationship and depends on you for support. If you have started legal guardianship procedures, coverage is effective with the filing of the application. For coverage to continue, you must be appointed a legal guardian within three months of filing your application.

You may also cover any other dependent children for whom coverage has been court-ordered through a Qualified Medical Child Support Order (QMCSO) or through a National Medical Child Support Notice (NMCSN). **Continued coverage for handicapped children.** While coverage normally ends at midnight on the last day of the month in which a dependent child turns 26, you can apply for continued coverage for a handicapped dependent child. Children are considered handicapped when they are primarily dependent on you for financial support and maintenance because of a mental or physical condition that started before age 26. You must provide proof to MetLife that your child's handicap began before the child reached age 26, and you must do so within 31 days after the child's 26th birthday. Coverage stays in force for as long as dependent coverage under the Plan continues and the child remains handicapped, as defined above.

For all handicapped children age 26 and over, MetLife periodically requires substantiation of the child's continued handicap, which may include a physical exam. Without this proof, coverage will not be continued.

Please note: You are required to notify the Engility Benefits Service Center within 31 days if your child is age 26 or over and no longer meets the criteria described above for continued coverage for handicapped children.

When family members work for Engility. An employee cannot be enrolled as both an employee and a dependent. Similarly, dependent children of married couples who both work for Engility can be enrolled under only one parent's coverage.

ENROLLING FOR COVERAGE

Participation in the Plan is not automatic; you must enroll to have coverage. You and your dependents can enroll:

- > within 31 days of your eligibility date;
- > during the open enrollment period, which is held in the fall; or
- > within 31 days of a "qualifying event" (see *Making changes mid-year*, page 8).

HIPAA special enrollment rights. If you decline enrollment for yourself and/or your dependents (including your spouse/same-sex domestic partner) because you have other dental insurance or group health plan coverage and the other coverage ends, you may enroll yourself and/or your

dependents in the Plan if you request enrollment within 31 days of your other coverage ending. To enroll for coverage, you must provide written proof that your other coverage has ended. Similarly, if you decline coverage because you have other employer-sponsored coverage (such as through your spouse's/same-sex domestic partner's employer) and the employer stops contributing toward your or your dependents' other coverage, you may enroll yourself and/or your dependents in the Plan if you request enrollment within 31 days of your employer contributions for your other coverage ending. To enroll for coverage, you must provide written proof that employer contributions for your other coverage have ended.

In addition, if you have a new dependent as a result of a marriage, birth, adoption or placement for adoption, you may enroll yourself and your dependent(s) if you request enrollment within 31 days of the marriage, birth, adoption or placement for adoption. You must provide documented proof that your dependents are eligible, as described below.

To request special enrollment or obtain more information, contact the Engility Benefits Service Center.

Enrolling your dependents for coverage. When you enroll your dependents for coverage, you will be required to complete the *Dependent Documentation Form* and provide certain documents to prove that your dependents are eligible. This requirement applies in **ALL** circumstances in which you may want to enroll a dependent, whether that's as a new hire, at open enrollment or when you have a "qualifying event" that allows you to add a dependent during the *Plan Year* (see *Making changes mid-year*, page 8).

Engility reserves the right to confirm any dependent's eligibility at any time, including during open enrollment or by conducting a formal dependent eligibility audit. Such an audit may be conducted by Engility or by a third party authorized by Engility. If you do not respond to an audit request or if your dependents do not meet the requirements, coverage for your dependents will be terminated.

Please note: You are required to notify the Engility Benefits Service Center within 31 days of any event that affects a dependent's eligibility.

Open enrollment. Engility holds an open enrollment period each fall during which you can:

- > enroll for coverage;
- > change your previous election;
- > cancel your own and/or your dependents' coverage; or
- > add dependent coverage (documentation will be required).

The election you make during open enrollment takes effect on the next January 1 and stays in effect for that full Plan Year unless you have a qualifying event (see *Making changes mid-year*, below).

Choosing a coverage level. You may elect one of the following coverage levels:

- > employee only
- > employee and spouse/same-sex domestic partner

- > employee and child(ren)
- > employee and family.

You can't change your election during the Plan Year unless you have a "qualifying event." Generally if you have a qualifying event, you have 31 days from the event to change your coverage election. The change in your election must be due to and consistent with the qualifying event.

Making changes mid-year. The IRS requires that your election stays in effect throughout the full Plan Year unless you have a "qualifying event." Please note that not all "qualifying events" enable you to make mid-year changes, and any change you are permitted to make must be directly related to the impact of the event on your benefits or eligibility. Contact the Engility Benefits Service Center to discuss your specific situation.

An election change will not become effective until you provide the required enrollment materials, including appropriate written documentation of the reason for the change. Please note that you will need a dependent's Social Security number to enroll that dependent.

If the dependent does not yet have a Social Security number, you must provide one within 31 days, unless the process is delayed for reasons beyond your control. You are not required to report a Social Security number for a dependent who is not a U.S. citizen

If the dependent becomes eligible for a Social Security number, you must provide it as soon as it is received. You also will need to complete the *Dependent Documentation Form* and provide certain documents to prove that the dependent is eligible.

Contact the Engility Benefits Service Center as soon as you know that an event is about to take place (or immediately after it takes place) to make sure you allow yourself enough time to take the appropriate action. The Engility Benefits Service Center will explain the procedure to you.

WHEN COVERAGE BEGINS

For you. If you enroll for coverage, it starts on your first day at work or the first day you become eligible, whichever is later, unless otherwise specified in your collective bargaining agreement (if applicable).

For your dependents. If you enroll your eligible family members when you enroll, their coverage begins when yours does, as long as you have provided the required documentation for each dependent. If a dependent becomes eligible as a result of a qualifying event, coverage for that dependent starts on the date associated with the event as long as you provide appropriate written documentation by the applicable deadline.

If you enroll during the open enrollment period. If you enroll for coverage during the open enrollment period held each fall, coverage for you and your *enrolled dependents* starts on the following January 1.

MEDICAL CHILD SUPPORT ORDERS

If you are eligible for coverage under the Plan, you may be required to provide coverage for your child pursuant to a Qualified Medical Child Support Order (QMCSO) or a properly completed National Medical Child Support Notice (NMCSN). A QMCSO is a judgment, decree or order issued by a state court or agency that creates or recognizes the existence of an eligible child's right to receive health care coverage. A NMCSN is a standardized health care coverage child support notice that is used by state child support enforcement agencies to require children to be enrolled in an employer's group health care plan. The Order or Notice must comply with applicable law and must be approved and accepted as a QMCSO or a NMCSN by the *Plan Administrator* in accordance with Plan procedures.

If the Plan receives a QMCSO or a NMCSN requiring you to provide Plan coverage for an eligible child, deductions will be made automatically from your pay beginning as of the date specified in the QMCSO or the NMCSN. To get a free copy of the procedure followed by the Plan in determining whether an order is qualified, contact the Engility Benefits Service Center or Engility's QMCSO administrator at Engility.Benefits@engility.com:

COST OF COVERAGE

Your share of the cost of coverage is determined by Engility. Your contributions are deducted from your paycheck each pay period. Contact the Engility Benefits Service Center to find out current contribution amounts.

WAIVING COVERAGE

You also have the option of waiving participation. However, if you do so and want to enroll later, you will have to wait until the next open enrollment period or until you have a qualifying event, as described on page 8. Written proof of the qualifying event will be required.

Your share of the cost of coverage is determined by Engility. Your contributions are deducted from each paycheck on a pre-tax basis (before taxes are taken out). That means you pay less out of your pocket for coverage than if you were paying on an after-tax basis (after taxes are taken out).

HOW THE PLAN WORKS

If you are temporarily outside the U.S. and receive dental care, benefits for covered expenses will be paid on a non-network (non-PPO dentist) basis.

The Plan is designed to help you pay for *reasonably necessary dental care*. Read this section carefully to fully understand which expenses are covered, and how they're covered, keeping in mind that, as a rule, the Plan covers only those services that are considered essential to good dental health.

HOW ELIGIBLE DENTAL EXPENSES ARE DEFINED

To be considered for reimbursement, a dental service must meet the following three criteria:

1. It must be provided or performed by a *dentist* (or, for some treatments such as teeth cleaning, by a licensed dental hygienist working under the dentist's supervision).
2. It must be for reasonably necessary dental care.
3. It must be a covered expense.

HOW TO USE THE PLAN

The Plan is a fee-for-service dental plan that includes MetLife's Preferred Dentist Program (PDP). You may visit any dentist or specialist you wish. However, depending on whether or not you use a PDP Plus in-network dentist, there are some differences in how the Plan works.

Using PDP Plus in-network dentists. When you receive care from an in-network dentist you will pay less, because MetLife has negotiated discounted fees with in-network dentists. Also, in-network dentists usually will file claims for you at no extra charge. For a *directory* of participating in-network dentists in your area, visit MetLife's website (www.metlife.com/dental).

Using out-of-network dentists. When you use an out-of-network dentist, you may need to pay the dentist in full at each visit, and then follow the PPO Dental Plan claims procedure. (See page 19.) If an out-of-network dentist charges you more than the *reasonable and customary (R&C) charge* (see page 10), in addition to your normal coinsurance you will also have to pay the difference between the R&C charge and your dentist's charge. This is known as "balance billing." For example, if the R&C charge for a routine checkup is \$100 but your dentist charges you \$125, you'd be responsible for the \$25 difference.

You are responsible for any charge over the amount MetLife determines is the reasonable and customary (R&C) charge when using out-of-network dentists.

Negotiated fees. When using in-network dentists, plan reimbursements are based on the *negotiated fee* established in the dentist's agreement with MetLife. In-network dentists have agreed to accept this amount as payment in full for their services.

When using out-of-network dentists, plan reimbursements are based on the reasonable and customary (R&C) charge for each dental service or supply, which is the lowest of:

- > The dentist's actual charge for that service or supply; or
- > The dentist's usual charge for the same or similar services; or
- > The charge of most dentists in the same geographic area for the same or similar services as determined by MetLife.

SHARING IN THE COST OF YOUR DENTAL EXPENSES

You share in the cost of your eligible dental expenses through deductibles and coinsurance, as explained below.

The deductible. There is no annual deductible for Preventive Services. However, each participant has to satisfy a \$75 Individual deductible each calendar year before the Plan pays benefits for Basic and Major Services. (These services are described beginning on page 13.) The family deductible is capped at \$225 in individual deductibles. If you have "employee and child(ren)" or "employee and family" coverage, the annual family deductible is considered met once the family's combined deductible expenses reach the \$225 limit. However, in determining whether the annual family deductible has been satisfied, the Plan will not count more than \$75 per person. This means that if you have "employee and spouse/domestic partner coverage or "employee and child(ren)" coverage and/or have only two members in your family, your maximum annual deductible would be \$150 (or \$75 per person).

Coinsurance. For eligible dental services and supplies, the Plan pays a percentage of the negotiated fee (if you use in-network dentists) or the R&C charge (if you use out-of-network dentists). You are responsible for the remaining percentage, known as your "coinsurance." Keep in mind that since the negotiated fee when using in-network dentists is less than the R&C charge, the dollar amount you pay as your coinsurance will be less when you use in-network dentists.

Charges over the reasonable and customary amount. In addition to deductibles and coinsurance, out-of-network dentists may bill you for amounts that exceed reasonable and customary charge. "Reasonable and customary" is a factor only for out-of-network dentists' charges; In-network dentists are contractually obligated to accept the negotiated fee as payment in full for their services.

MAXIMUM BENEFITS

The most the Plan will pay in a calendar year for each eligible, enrolled person is \$2,000 in non-orthodontia benefits. The most the Plan will pay in orthodontia benefits for each eligible, enrolled adult (employee and spouse/domestic partner) and each enrolled child under age 26 is \$2,000 per lifetime. Please note that when you use in-network dentists, you can get more services and supplies before you reach each maximum benefit because in-network dentists generally charge less than out-of-network dentists.

PRE-TREATMENT ESTIMATE

The Pre-treatment Estimate is a special feature of the Plan that lets you know which expenses you could expect the Plan to cover and how much may be paid for a particular course of treatment. The Pre-treatment Estimate is an **estimate** of the amount and scope of benefits payable under the Plan. It is not a guarantee of benefit payments, which are determined when you submit a claim for the actual services and/or supplies rendered during a *course of dental treatment*.

Pre-treatment Estimates are strongly recommended for treatment that is expected to cost more than \$300.

When to get a Pre-treatment Estimate. A Pre-treatment Estimate is strongly recommended before having a course of dental treatment expected to cost at least \$300. This way, you have an idea of what the Plan might pay before you actually have the expense.

Understanding what's meant by a "course of dental treatment." A course of dental treatment is a planned program of one or more services or supplies provided by one or more dentists to treat a dental condition diagnosed by the attending dentist as a result of an oral examination. A course of treatment starts on the date your dentist first provides a service to correct or treat the diagnosed dental condition.

If you go to your dentist and an exam is performed, he or she should advise you of all the problems with your teeth (for example, five cavities and one root canal), not just some of the problems. Whether you choose to have all the work done at once or over a period of time is your decision, but keep in mind that if correcting all the problems will exceed \$300, a Pre-treatment Estimate is recommended.

What you'll have to provide. When submitting a Pre-treatment Estimate, your dentist should include as much objective diagnostic information as possible. Pre-operative x-rays are requested only in connection with prosthetics, fixed bridgework or cast restorations. Generally, x-rays are not requested where standard filling materials are used. Occasionally, MetLife may request x-rays that relate to other dental services. If you or your dentist is uncertain about the types of supporting documentation required for your Pre-treatment Estimate, contact MetLife's Dental Customer Service Center for a detailed description. (See page 19 for details on required documentation.)

How to file a Pre-treatment Estimate. Your dentist should send a description of the proposed procedures to be performed, along with an estimate of charges, to MetLife before treatment starts. (The dental claim form includes the pre-treatment information.) Benefits will then be "pre-stated," which means MetLife will notify you of the estimated benefits payable based upon the proposed course of treatment. (Generally, MetLife's Pre-treatment Estimate is considered valid for up to one year from the date it is forwarded to your dentist.) Your dentist can discuss the Pre-treatment Estimate with you. It is then up to you whether or not to proceed with the proposed course of treatment.

In determining the amount of benefits payable, MetLife will take into account alternate procedures, services or courses of treatment for the dental condition concerned in order to accomplish the appropriate result. (See *Benefits When Alternate Procedures Are Available*, page 17, for more information on alternate dental procedures.)

In determining the amount of benefits payable, MetLife will take into account alternate procedures, services or courses of treatment for the dental condition concerned in order to accomplish the appropriate result.

METLIFE'S DENTAL CUSTOMER SERVICE CENTER

Contact MetLife's Dental Customer Service Center at 1-800-942-0854 if you want more information regarding a particular in-network provider. The Customer Service Center also can answer questions about your benefits and claim status. You can contact MetLife's Dental Customer Service Center, Monday through Friday, 8:00 a.m. to 11:00 p.m., Eastern time.

For the hearing-impaired. If you need to contact MetLife's Dental Customer Service Center from a TDD (Telecommunications Device for the Deaf) telephone, call 1-800-855-2880. This line is staffed Monday through Friday, 8:00 a.m. to 11:00 p.m., Eastern Time.

MetLife online. You can find out about dentists who participate in the PDP Plus network by visiting www.metlife.com/dental. In addition to customized provider searches, you can log in to MyBenefits (www.mybenefits.metlife.com), MetLife's secure member website, where you can view Plan facts, check the status of a claim or print forms. Online provider directories are updated continually and are available 24 hours a day, seven days a week. When making an appointment with your chosen provider, be sure to confirm that he/she participates in the MetLife PDP Plus network.

Plan members will not receive a Dental ID card. When visiting the dentist, provide the office staff with your name, SSN and/or Engility's Group number (313007) and date of birth. The dentist's office will contact MetLife to verify your and your dependent(s)' eligibility. While there is no need to present an ID card when visiting the dentist, if you would like to have a paper ID card, you may print one from www.mybenefits.metlife.com.

COVERED DENTAL EXPENSES

Below is a summary of the expenses that are eligible for reimbursement, as well as the percentage of the negotiated fee or the reasonable and customary (R&C) charge, as applicable, at which they are paid.

PREVENTIVE (TYPE A) DENTAL SERVICES

The Plan will pay 100% of the negotiated fee (for in-network care) or 100% of the R&C charge (for out-of-network care) for the Preventive (Type A) Dental Services shown below, up to the annual benefit maximum. There is no annual deductible for these services.

- > Two routine oral examinations by a dentist each calendar year
- > Cleaning (prophylaxis) of teeth twice each calendar year
- > Topical application of fluoride twice each calendar year for enrolled dependents under age 14
- > Sealants (limited to one application per tooth every three years for non-restored, non-decayed first and second molars and permanent bicuspids only for enrolled dependents under age 14)

- > A full series of routine x-rays for non-emergency dental treatment, subject to the following limitations:
 - » not more than one full mouth x-ray series in any 36-month period; and
 - » not more than one set of bitewing x-rays in a calendar year
- > Periapical x-rays (single films)
- > Intra-oral, occlusal view, maxillary or mandibular x-rays.

BASIC (TYPE B) DENTAL SERVICES

Basic (Type B) Dental Services are covered at 80% of the negotiated fee (for in-network care) or 80% of the R&C charge (for out-of-network care) after the annual deductible, up to the annual benefit maximum.

After you meet the \$75 annual deductible, the Plan will pay 80% of the negotiated fee (for in-network care) or 80% of the R&C charge (for out-of-network care) for the Basic (Type B) Dental Services shown below, up to the annual benefit maximum.

- > The initial installation of a *space maintainer* to prevent loss of space for prematurely lost baby molars (deciduous molars). This service is covered for enrolled dependent children to age 12.
- > Amalgam and composite restorations
- > Periodontal scaling and root planning
- > Periodontal surgery
- > Periodontal maintenance treatments and prophylaxis, limited to two treatments per calendar year
- > Non-surgical endodontic treatment, such as *root canal therapy*
- > Repair of removable, complete or partial dentures
- > Relining or rebasing of dentures, limited to one relining every 24 months
- > Re-cementing of crowns, inlays/onlays or fixed bridgework
- > Repair of fixed bridgework
- > Oral surgery procedures that MetLife considers to be dental in nature
- > Addition of teeth to an existing partial, removable denture
- > Extraction of teeth, including extraction of impacted teeth. Pre-treatment Estimates are strongly recommended before having impacted wisdom teeth removed.
- > General anesthesia when dentally *necessary* in conjunction with covered oral surgery, extractions or other covered dental services.

MAJOR (TYPE C) DENTAL SERVICES

Major (Type C) Dental Services are covered at 60% of the negotiated fee (for in-network care) or 60% of the R&C charge (for out-of-network care) after the annual deductible, up to the annual benefit maximum.

After you meet the \$75 annual deductible, the Plan will pay 60% of the negotiated fee (for in-network care) or 60% of the R&C charge (for out-of-network care) for the Major Type C) Dental Services shown below, up to the annual benefit maximum.

- > Onlays, inlays or crowns
- > Initial placement of fixed bridgework or full or partial dentures to replace one or more natural teeth extracted while the individual is covered by the Plan, subject to the Alternate Procedure rule. (See *Benefits When Alternate Procedures Are Available*, page 17.) **No benefits are payable for the initial insertion of fixed bridgework if the tooth or teeth were extracted before the patient was covered under the Plan.**
- > Replacement of existing crowns, bridges, or dentures. Only replacements that meet the Prosthesis Replacement Rule will be covered. (See *Prosthesis Replacement*, page 18.)
- > Implants. If you have only one missing tooth per arch, one endosseous implant per arch may be covered, including related crowns and prosthodontics, if the tooth was extracted while you are covered under the Plan and all your other teeth are periodontally and endodontically sound, and your remaining teeth are restored to form and function. Coverage is subject to Plan exclusions and limitations. (See *Benefits When Alternate Procedures Are Available*, page 17 and *Prosthesis Replacement*, page 18.)
- > Occlusal guard for bruxism (limited to one every 36 months).
- > Tissue conditioning
- > Adjustment of a denture if at least six months ~~after~~ have passed since the installation of the denture

Please note that fees for dentures and partial dentures include relines, rebases and adjustments within six months after installation. Fees for relines and rebases include adjustments within six months after installation. Specialized techniques and characterizations are not eligible.

Restorative replacements. Replacements of bridges, dentures and implants are covered when MetLife determines that the present bridge, denture or implant cannot be made serviceable. In addition, the original bridge, denture or implant had to have been inserted at least eight years prior to its replacement.

ORTHODONTIA (TYPE D) SERVICES

Orthodontia (Type D) Services are covered at 50% of the negotiated fee (for in-network care) or 50% of the R&C charge (for out-of-network care) after the annual deductible, up to the lifetime Orthodontia benefit maximum.

The Plan will pay 50% of the negotiated fee (for in-network care) or 50% of the R&C charge (for out-of-network care) for dental procedures performed in connection with orthodontic treatment while the patient is covered by the Plan, up to the lifetime Orthodontia benefit maximum. Covered services may include:

- > Diagnosis and treatment plan—to correct crooked, crowded or protruding teeth
- > Diagnostic casts
- > Braces
- > Examinations and related x-rays
- > Appliances—to control harmful habits and for tooth guidance
- > Appliance adjustments

Orthodontia benefits are provided for enrolled adults (employee and spouse/domestic partner) and dependent children under age 26. Benefits may be based on an alternate treatment. (See page 17.) If a course of orthodontic treatment begins before a patient becomes eligible for the Plan, benefits are payable only for services rendered following the patient's eligibility date. Orthodontia benefits end when coverage under the Plan terminates (see page 30).

BENEFITS WHEN ALTERNATE PROCEDURES ARE AVAILABLE

Sometimes there are several ways to treat a dental problem, all of which provide acceptable results and are recognized by the profession as appropriate methods of treatment in accordance with broadly accepted national standards of dental practice. When alternate services or supplies can be used, the Plan will cover the least expensive services or supplies necessary to treat the condition if such services:

- > would produce a professionally acceptable result under generally accepted dental standards; and
- > would qualify as a covered service.

For example:

- > when an amalgam filling and a composite filling are both professionally acceptable methods for filling a molar, the Plan may base its benefit determination upon the amalgam filling which is the less costly service;
- > when a filling and an inlay are both professionally acceptable methods for treating tooth decay or breakdown, the Plan may base its benefit determination upon the filling which is the less costly service;
- > when a filling and a crown are both professionally acceptable methods for treating tooth decay or breakdown, the Plan may base its benefit determination upon the filling which is the less costly service; and
- > when a partial denture and fixed bridgework are both professionally acceptable methods for replacing multiple missing teeth in an arch, the Plan may base its benefit determination upon the partial denture which is the less costly service.

If the Plan pays benefits based upon a less costly service in accordance with this subsection, the dentist may charge you or your dependent for the difference between the service that was performed and the less costly service. This is the case even if the service is performed by an in-network dentist.

Of course, you and your dentist can still choose the more costly treatment method, in which case you would be responsible for any charges the Plan will not cover.

In addition, certain comprehensive dental services have multiple steps associated with them. These steps can be completed at one time or during multiple sessions. For benefit purposes under this SPD, these separate steps of one service are considered to be part of the more comprehensive service. Even if the dentist submits separate bills, the total benefit payable for all related charges will be limited by the maximum benefit payable for the more comprehensive service. For example, root canal therapy includes x-rays, opening of the pulp chamber, additional x-rays, and filling of the chamber. Although these services may be performed in multiple sessions, they all constitute root canal therapy. Therefore, the Plan will only pay benefits for the root canal therapy.

To avoid any misunderstandings, you should discuss treatment options with your dentist before services are rendered, and obtain a Pre-treatment Estimate of benefits prior to receiving certain high-

cost services such as crowns, bridges or dentures. See page 12 for information on requesting a Pre-treatment Estimate.

PROSTHESIS REPLACEMENT

Dentures, bridgework and implants are subject to the Plan's Prosthesis Replacement Rule. That means certain replacements or additions to existing dentures, bridgework and implants are covered only when you give proof to MetLife that:

- > the replacement or addition of teeth is required to replace teeth extracted after the existing denture, bridgework or implant was inserted, and that the work was done while the patient was participating in the Plan
- > the present temporary full denture was inserted at least eight years before its replacement and cannot be repaired and the permanent full denture is installed within six months after the temporary denture was installed
- > the present fixed bridgework was inserted at least eight years before its replacement and cannot be made serviceable
- > the present implant and implant prosthesis were inserted at least eight years before their replacement and cannot be made serviceable.

Immediate upper denture coverage includes limited follow-up care.

HOW TO CLAIM BENEFITS

If you use an out-of-network dentist, you are responsible for filing claims with MetLife.

WHEN TO FILE CLAIMS

If you use an in-network dentist, the dentist will file claims for you.

If you use an out-of-network dentist, you are responsible for filing claims with MetLife. You can obtain a dental claim form from the Engility Benefits Service Center or by contacting MetLife's Dental Customer Service Center. You and your dentist should then complete the form, following the printed instructions. Mail your claim, along with any other documentation that may be required, to MetLife at this address:

MetLife
P.O. Box 981282
El Paso, TX 79998-1282

Fax: 1-859-389-6505

WHEN YOU NEED TO SUPPORT YOUR CLAIM

When you use an in-network dentist, your dentist will file claims for you and will provide MetLife with additional information needed to support your claim.

To avoid a processing delay when you use an out-of-network dentist, be sure to include all pertinent information that may be required when you submit your claim. Be sure all supporting information is well identified and attached to the claim form.

It is the responsibility of you and your provider to provide MetLife with all required information to support your claim. Generally, x-rays are not requested where standard filling materials are used. Pre-operative x-rays are requested only in connection with prosthetics, fixed bridgework or cast restorations. Occasionally, MetLife may request x-rays that relate to other dental services. Your provider also may want to call MetLife's Dentists' telephone number (1-877-638-3379) for detailed instructions on submitting documentation in support of a claim.

PROOF AND PAYMENT OF CLAIMS

Claims must be submitted within 3 months after the end of the Plan Year; otherwise you will not receive payment.

Benefits are payable upon MetLife's receipt of adequate proof of your claim. Claims must be submitted within 3 months after the end of the Plan Year; otherwise you will not receive payment. (X-rays and other appropriate diagnostic and evaluative materials may be needed as part of the required proof as the basis for determining benefits; see *When You Need To Support Your Claim*, page 19.) However, failure to furnish proof within the specified time will not invalidate or reduce any claim if you could not reasonably furnish that proof within the 24-month time frame.

ASSIGNMENT OF BENEFITS

If you receive out-of-network dental care and your dentist accepts an assignment of benefits, you can ask MetLife to pay your dentist directly. MetLife will choose the method of payment to your provider. If you want MetLife to pay your dentist directly, be sure to complete the appropriate section on the claim form. Forward the claim to MetLife, along with the itemized bill. Keep in mind that if you assign benefits, you are still responsible for paying any deductible amounts and coinsurance, which you would pay directly to your dentist.

FILING CLAIMS WHEN YOU ARE COVERED BY MORE THAN ONE PLAN

The claims procedure for participants who also have coverage under another group dental plan depends on whether our Plan is “primary” or “secondary.” (See *How Benefits Are Coordinated With Other Coverage*, page 24.)

When our Plan is primary. When our Plan is your primary coverage, send your original bills with your claim form to MetLife. Be sure to keep copies of the bills. After your claim is processed, send a copy of the Explanation of Benefits you receive from MetLife, and copies of the bills, to the secondary plan.

When our Plan is secondary. If our Plan is your secondary coverage, file a claim with your primary dental plan first. After you have received written notification of payment (or denial) from your primary plan, make a copy of it and submit it with your claim to MetLife.

Contact MetLife's Dental Customer Service Center at 1-1-800-942-0854 if you need claims assistance.

WHAT'S NOT COVERED

This is a representative list of dental expenses the Plan does not cover in any circumstance. To find out whether an unlisted dental procedure is excluded, contact MetLife's Dental Customer Service Center.

- > services which are not dentally necessary, those which do not meet generally accepted standards of care for treating the particular dental condition, or which MetLife deems experimental in nature
- > services for which you would not be required to pay in the absence of dental insurance
- > services or supplies received by you or your Dependent before the dental insurance starts for that person
- > services which are primarily cosmetic
- > services which are neither performed nor prescribed by a dentist except for those services of a licensed dental hygienist which are supervised and billed by a dentist and which are for:
 - » scaling and polishing of teeth; or
 - » fluoride treatments;
- > services or appliances which restore or alter occlusion or vertical dimension
- > restoration of tooth structure damaged by attrition, abrasion or erosion
- > restorations or appliances used for the purpose of periodontal splinting
- > counseling or instruction about oral hygiene, plaque control, nutrition and tobacco
- > personal supplies or devices including, but not limited to: water picks, toothbrushes or dental floss
- > decoration, personalization or inscription of any tooth, device, appliance, crown or other dental work
- > missed appointments
- > services:
 - » covered under any Workers' Compensation or occupational disease law
 - » covered under any employer liability law
 - » for which the employer of the person receiving such services is not required to pay, or
 - » received at a facility maintained by Engility or a labor union, mutual benefit association or VA hospital
- > services covered under other coverage provided by Engility

- > temporary or provisional restorations
- > temporary or provisional appliances
- > prescription drugs
- > services for which the submitted documentation indicates a poor prognosis
- > the following when charged by the dentist on a separate basis:
 - » claim form completion
 - » infection control such as gloves, masks and sterilization of supplies
 - » local anesthesia, non-intravenous conscious sedation or analgesia such as nitrous oxide
- > dental services arising out of accidental injury to the teeth and supporting structures, except for injuries to the teeth due to chewing or biting of food
- > caries susceptibility tests
- > initial installation of a fixed and permanent denture to replace one or more natural teeth which were missing before such person was covered by the Plan, except for congenitally missing natural teeth
- > other fixed denture prosthetic services not described elsewhere in this SPD
- > precision attachments, except when the precision attachment is related to implant prosthetics
- > initial installation of a full or removable denture to replace one or more natural teeth which were missing before such person was covered by the Plan
- > addition of teeth to a partial removable denture to replace one or more natural teeth which were missing before such person was covered by the Plan, except for congenitally missing natural teeth
- > adjustment of a denture made within six months after installation by the same dentist who installed it
- > replacement of an orthodontic device, duplicate prosthetic devices, or appliances
- > replacement of a lost or stolen appliance, cast restoration or denture
- > intra and extraoral photographic images
- > any surgical or non-surgical treatment of a temporomandibular joint disorder
- > any type of splinting of teeth
- > consultations
- > detailed and extensive oral evaluation re-evaluation – limited, problem focused

- > comprehensive periodontal evaluation – new or established patient
- > pulp caps
- > periodontal grafting and soft tissue allografts
- > full mouth debridement
- > other drugs and/or medicaments
- > local chemotherapeutic agents
- > therapeutic drug injections
- > occlusal adjustments
- > pulpal therapy
- > distal or proximal wedge procedure

OTHER INFORMATION YOU SHOULD KNOW

This section contains important administrative information and facts about your rights as a participant in this Plan.

This Summary Plan Description (SPD) describes the benefits that are offered under the MetLife PPO Dental Plan (the “Plan”) and the steps you must follow to take full advantage of the Plan. The previous sections describe the most important features of the Plan; what you’ll find here is important administrative information and facts about your rights as a participant in the Plan.

This booklet is the SPD for the MetLife PPO Dental Plan. It provides a complete description of the dental benefits offered under the Plan. The Plan is part of the Engility Corporation Group Health Plan. There is an official Plan document for the Group Health Plan. If the terms of this SPD conflict with the terms of the official Plan document for the Group Health Plan, the terms of the Group Health Plan document will govern.

YOUR RIGHTS AS A PATIENT

You have the right to obtain complete and current information concerning a diagnosis, treatment and prognosis from any provider in terms that you or your authorized representative easily understands. You also have the right to all information necessary for you to give informed consent before undergoing any procedure or treatment. And you have the right to refuse treatment to the extent the law allows, in which case you will be advised of the dental consequences of doing so.

HOW BENEFITS ARE COORDINATED WITH OTHER COVERAGE

If you or your dependents are covered under the Plan and are also covered by another group dental plan or governmental program, benefits will be coordinated between the plans on what is known as a “non-duplication” basis. Non-duplication means that when the Plan is the secondary payer, the total benefits paid for a *single processed claims transaction* will never be more than the amount the Plan would have paid as the primary payer. (For example, if the expense is for Basic Dental Services and the total covered amount is \$200, assume the Plan would have paid 80%, or \$160. If another group dental plan is primary and pays 70%, or \$140, the Plan, as secondary coverage, would make up the \$20 difference after the deductible is met.)

Please note: The Plan **always** is the secondary payer to any motor vehicle policy that may be available to you, including MedPay, Personal Injury Protection (PIP) or no-fault coverage. You may wish to review your automobile insurance policy to ensure that you have responded correctly to any questions about the order of payment for dental benefits.

When the Plan is primary, the benefits paid under the secondary plan will be disregarded in determining the benefits the Plan pays.

This Plan is always primary for you while you are an active employee, unless you are insured through Delta Dental TRICARE as a retiree.

Determining when our Plan is primary. The Plan is always primary for you while you are an active employee, unless you are insured through Delta Dental TRICARE as a retiree. The Plan is also primary if:

- > the expenses are for your enrolled child and your birth date occurs earlier in the Plan Year than the birth date of the child's other parent. If both parents have the same birth date, then the primary plan is the one that has been in effect the longest. This rule applies only if the parents are married to each other; or
- > the expenses are for your enrolled spouse/ same-sex domestic partner who is either disabled or at least age 65 and eligible for Medicare; or
- > your enrolled dependents have no other coverage.

If your enrolled dependent has his or her own employer-sponsored coverage as an employee, that coverage is primary and Engility's Plan is secondary.

How the primary plan is determined in other instances. If one of the other group plans that covers you coordinates benefits based on gender, its provisions prevail. This means that such a plan covering the male spouse would be primary for any enrolled dependent children. When a child is claimed as a dependent by separated or divorced parents, the primary plan is determined in the following order.

1. The plan of the parent who has been charged with financial responsibility for the dependent child's health care expenses by a court; if there is no court order, then
2. The plan of the parent who has custody of the child; if the parent who has custody of the child does not have coverage, then
3. The plan of the stepparent who is married to the parent with custody of the child, if the stepparent claims the child as a dependent; if this is inapplicable, then
4. The plan of the parent who does not have custody; if the parent who does not have custody of the child does not have coverage, then
5. The plan of the stepparent who is married to the parent who does not have custody of the child.

If these rules do not establish which plan is primary, the plan that has covered the person for the longest period of time becomes primary. If the other group plan(s) does not have a coordination of benefits provision, the plan without the coordination provision becomes the primary plan.

Special coordination of benefits rules apply when you are covered under the Plan and also have dental coverage with Delta Dental TRICARE as a Department of Defense retiree.

Delta Dental TRICARE for Department of Defense retirees. When you have dental coverage with Delta Dental TRICARE through the Department of Defense (DOD) and are also covered under the Engility MetLife PPO Dental Plan, the following rules are used in determining the primary carrier:

- > If the primary enrollee DOD retiree or non-remarried surviving spouse has another dental plan that is principally a dental program, the plan that was effective first would be the first to pay.
- > If the spouse has his or her own dental plan that is principally a dental program, claims for the spouse's dental treatment should be filed with that plan first.
- > In the case of a child who is covered under two dental plans, the primary plan is typically determined by the "birthday rule", as explained under *Determining when our Plan is primary* on page 25.
- > In custody cases, if one parent has been awarded custody, the child is covered by that parent's coverage first and by the non-custodial parent's coverage second.
 - » If the parent with custody remarries, his or her coverage usually pays first and the stepparent's coverage pays second.
 - » If the custodial parent does not have other coverage, but the child's stepparent does, then the stepparent's coverage may pay first and the non-custodial parent's coverage pays second.
 - » If it's not possible to determine which coverage should pay first even after checking these rules, the dental plan that has covered the person the longest usually pays first.
 - » When there is a court decree specifying which parent is responsible for insurance coverage that coverage will pay first.

SUBROGATION AND REIMBURSEMENT

MetLife, on behalf of the Plan, has a legal right to reimbursement of benefits paid to you if someone else (e.g., an insurance company) is legally responsible for your or your enrolled dependents' covered dental expenses.

Subrogation and reimbursement provisions apply when the Plan pays benefits as a result of injuries or illnesses you sustained and you have a right to a recovery or have received a recovery from any source. A "recovery" includes, but is not limited to, monies received from any person or party, any person's or party's liability insurance, uninsured/underinsured motorist proceeds, Workers' Compensation insurance or fund, "no-fault" insurance and/or automobile medical payments coverage, whether by lawsuit, settlement or otherwise. Regardless of how you, your representative or any agreements characterize the money you receive as a recovery, it shall be subject to these provisions.

Subrogation. The Plan has the right to recover payments it makes on your behalf from you or any party responsible for compensating you for your illnesses or injuries. The legal term for this right of recovery is “subrogation.” The following provisions will apply:

- > You must assign to the Plan all rights of recovery to the extent of the reasonable value of services and benefits provided by the Plan, plus reasonable costs of collection.
- > The Plan has first priority from any recovery for the full amount of benefits it has paid regardless of whether you are fully compensated, and regardless of whether the payments you receive make you whole for your losses, illnesses and/or injuries.
- > In the event that you or your legal representative fails to do whatever is necessary to enable the Plan to exercise its subrogation rights, the Plan shall be entitled to deduct the amount the Plan paid from any future benefits under the Plan.
- > The Plan has the right to take whatever legal action it sees fit against any person, party or entity to recover the benefits paid under the Plan, including filing suit in your name.
- > To the extent that the total assets from which a recovery is available are insufficient to satisfy in full the Plan’s subrogation claim and any claim held by you, the Plan’s subrogation claim shall be first satisfied before any part of a recovery is applied to your claim, your attorney fees, other expenses or costs.
- > The Plan is not responsible for any attorney fees, attorney liens, other expenses or costs you incur without the Plan’s prior written consent. The “common fund” doctrine does not apply to any funds recovered by any attorney you hire regardless of whether funds recovered are used to repay benefits paid by the Plan.

Reimbursement. If you obtain a recovery and the Plan has not been repaid for the benefits the Plan paid on your behalf, the Plan shall have a right to be repaid from the recovery in the amount of the benefits paid on your behalf and the following provisions will apply:

- > You must reimburse the Plan from any recovery to the extent of benefits the Plan paid on your behalf regardless of whether the payments you receive make you whole for your losses, illnesses and/or injuries.
- > Notwithstanding any allocation or designation of your recovery (e.g., pain and suffering) made in a settlement agreement or court order, the Plan shall have a right of full recovery, in first priority, against any recovery. Further, the Plan’s rights will not be reduced due to your negligence.
- > You and your legal representative must hold in trust for the Plan the proceeds of the gross recovery (i.e., the total amount of your recovery before attorney fees, other expenses or costs) to be paid to the Plan immediately upon your receipt of the recovery. You must reimburse the Plan, in first priority and without any set-off or reduction for attorney fees, other expenses or costs. The “common fund” doctrine does not apply to any funds recovered by any attorney you hire regardless of whether funds recovered are used to repay benefits paid by the Plan.

- > If you fail to repay the Plan, the Plan shall be entitled to deduct any of the unsatisfied portion of the amount of benefits the Plan has paid or the amount of your recovery, whichever is less, from any future benefit under the Plan if:
 1. The amount the Plan paid on your behalf is not repaid or otherwise recovered by the Plan; or
 2. You fail to cooperate.
- > In the event that you fail to disclose the amount of your settlement to the Plan, the Plan shall be entitled to deduct the amount of the Plan's lien from any future benefit under the Plan.
- > The Plan shall also be entitled to recover any of the unsatisfied portion of the amount the Plan has paid or the amount of your recovery, whichever is less, directly from the providers to whom the Plan has made payments on your behalf. In such a circumstance, it may then be your obligation to pay the provider the full billed amount, and the Plan will not have any obligation to pay the provider or reimburse you.
- > The Plan is entitled to reimbursement from any recovery, in first priority, even if the recovery does not fully satisfy the judgment, settlement or underlying claim for damages or fully compensate you or make you whole.

Your duties. Your duties consist of the following:

- > You must notify the Plan promptly of how, when and where an accident or incident resulting in personal injury or illness to you occurred and all information regarding the parties involved.
- > You must cooperate with the Plan in the investigation, settlement and protection of the Plan's rights. In the event that you or your legal representative fails to do whatever is necessary to enable the Plan to exercise its subrogation or reimbursement rights, the Plan shall be entitled to deduct the amount the Plan paid from any future benefits under the Plan.
- > You and your legal representative must do whatever is necessary to enable the Plan to exercise the Plan's rights and you must not do anything to prejudice the Plan's rights.
- > You must send the Plan copies of all police reports, notices or other papers received in connection with the accident or incident resulting in personal injury or illness to you.
- > You must promptly notify the Plan if you retain an attorney or if a lawsuit is filed on your behalf.
- > You must assign to the Plan all rights of recovery to the extent of the reasonable value of services and benefits provided by the Plan, plus reasonable costs of collection.
- > You must not accept any settlement that does not fully compensate or reimburse the Plan without its prior written approval.

The Plan sponsor has sole discretion to interpret the terms of the subrogation and reimbursement provision of this Plan in its entirety and reserves the right to make changes as it deems necessary.

If the covered person is a minor, any amount recovered by the minor, the minor's trustee, guardian, parent, or other representative, shall be subject to this provision. Likewise, if the covered person's relatives, heirs, and/or assignees make any recovery because of injuries sustained by the covered person that recovery shall be subject to this provision.

The Plan is entitled to recover its attorney's fees and costs incurred in enforcing these provisions.

These provisions apply to the participant, his or her enrolled spouse/same-sex domestic partner and enrolled dependents in the same manner.

The Plan has the right to recover payments it makes on your behalf from you or any party responsible for compensating you for your illnesses or injuries. The legal term for this right of recovery is "subrogation."

CLAIM FRAUD

MetLife regularly evaluates claims to detect fraud or false statements and will notify Engility about these matters. MetLife must be advised of any discounts or price adjustments made to you by any provider. A provider who waives or refunds deductibles or coinsurance is entering into a discount arrangement with you. MetLife calculates the benefit payment based on the amount actually charged, less any discounts, rebates, waivers or refunds of deductibles or coinsurance you receive. Failure to notify MetLife or the Plan Administrator of such price adjustments may result in an overpayment of benefits and constitutes a serious violation of the provisions of the Plan.

MetLife regularly evaluates claims to detect fraud or false statements and will notify Engility about these matters.

OVERPAYMENT OF BENEFITS

If MetLife mistakenly pays more for your claim than you're entitled to, it has the right to recover the excess. You must give MetLife any documents or paperwork it asks for, and you must return any benefit payments that were made in error.

HOW BENEFITS CAN BE FORFEITED OR DELAYED

Benefits can be forfeited or delayed under certain situations. Most of these circumstances are described in the previous sections. However, benefit payments also may be forfeited or delayed if:

- > you or your beneficiary does not properly file an application for benefits within the time periods required;
- > you do not furnish information required by MetLife to complete or verify your claim; or
- > your current address is not on file with Engility or with MetLife.

You should know that benefits are not payable for expenses that dependents may have after they become ineligible for any reason including but not limited to age, divorce, legal separation or termination of same-sex domestic partner status.

CONTINUED COVERAGE UNDER THE FEDERAL FAMILY AND MEDICAL LEAVE ACT

If you take a leave that qualifies under the federal Family and Medical Leave Act (FMLA), you may continue or stop your participation in the Plan, according to the procedures established by Engility. You will be subject to the same rules regarding deductibles, coinsurance and contributions as an active employee. For further information, contact Engility benefits at Engility.Benefits@engility.com.

WHEN COVERAGE ENDS

Unless otherwise specified in a collective bargaining agreement (if applicable), your coverage ends at midnight on the last day of the month in which either of the following occurs:

- > your employment terminates; or
- > you otherwise cease to be an eligible employee (e.g., your hours are reduced).

Coverage would also end at midnight on the date Engility stops offering the Plan to employees.

Dependent coverage ends when your coverage ends, when a dependent is no longer considered an eligible dependent (as defined on page 5) or if Engility stops offering the Plan to dependents. Specifically, for an event that disqualifies the individual for coverage, dependent coverage ends, as follows:

- > **spouse/same-sex domestic partner:** at midnight on the date a divorce, legal separation or termination of same-sex domestic partner status becomes effective
- > **children who are not handicapped:** at midnight on the last day of the month following the child's 26th birthday
- > **children who are handicapped:** at midnight on the date the child is declared to be no longer handicapped or the date you fail to provide MetLife with required proof of the child's continued handicap, whichever happens first.

You can't convert this group coverage to an individual policy, but you and/or your enrolled dependent(s) may be eligible for continued coverage through the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended (COBRA).

Dependent coverage ends when your coverage ends, a dependent is no longer considered an eligible dependent (as defined on page 5) or if Engility stops offering the Plan to dependents.

If you are rehired. If you leave Engility and are rehired within 30 days of your termination, your election that was in effect before your termination will be reinstated; you may not make a new election. If you are rehired more than 30 days after your termination, you may make a new election as a new hire; your prior election will not be reinstated automatically.

EXTENDED COVERAGE

In certain circumstances, your or your dependents' coverage under the Plan may be extended by Engility past the date it otherwise would end. For example, if you die and have coverage for your dependents, your dependents' coverage may be continued for a limited period after your death. Similarly, if your employment ends because you become disabled, you may be able to continue your and your dependents' coverage for a limited period. Any period of coverage continued due to your death or disability will be included as part of the total period of coverage under COBRA. The Engility Benefits Service Center can give you more information about available coverage extensions.

COBRA Administrator. The COBRA Administrator for the Plan is:

Alight COBRA Benefit Center

29984 Network Place

Chicago, IL 60673-1299

Phone: 1-877-248-8519

COBRA Fax: 1-800-305-3920

Other coverage options besides COBRA. Instead of enrolling in COBRA continuation coverage, there may be other coverage options for you and your family through the Health Insurance Marketplace, Medicaid or other group health plan coverage options (such as a spouse's plan) through what is called a "special enrollment period." Some of these options may cost less than COBRA continuation coverage. You can learn more about many of these options at www.healthcare.gov.

If you have questions. If you have any questions about your COBRA continuation coverage, contact Alight or the nearest office of the Employee Benefits Security Administration (EBSA), U.S. Department of Labor, listed in your telephone directory. Addresses and phone numbers of EBSA offices are available at www.dol.gov/ebsa.

To protect your family's rights to COBRA coverage, keep the Engility Benefits Service Center informed of any changes of address for you and your family members.

COBRA continuation coverage cannot under any circumstances extend beyond 36 months from the date of the qualifying event that originally made you or a dependent eligible to elect COBRA.

CONTINUED COVERAGE DURING A MILITARY LEAVE OF ABSENCE

If you are on a military leave of absence, your and your dependents' coverage under the Plan will continue in accordance with the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA). You may request a copy of Engility's USERRA policy from your Benefits Department.

OWNERSHIP OF BENEFITS

The benefits described here are exclusively for Plan participants and, if applicable, their eligible enrolled dependents. These benefits cannot be sold, transferred or assigned for any reason (except as provided by law).

PLAN ADMINISTRATION

Engility Corporation, as the Plan Administrator, is responsible for the administration of the Plan. The Engility Benefits Service Center and Engility's Benefits Department act on behalf of the Plan Administrator and are responsible for routine Plan administration and answering questions about eligibility and coverage. The Plan Administrator has the full and complete discretionary authority and responsibility to administer the Plan and may delegate any or all of its authority and responsibility to any individuals or entities.

The Plan Administrator has delegated to MetLife the discretionary authority and responsibility to determine claims for benefits under the Plan. MetLife has the full and complete discretionary authority and responsibility to decide whether you are entitled to benefits under the Plan.

If there is a conflict between the information you receive from MetLife, the Engility Benefits Service Center or Engility's Benefits Department and the terms of the Plan document, the terms of the Plan document will prevail.

If conflicts arise. The Engility Benefits Service Center, the Engility Benefits Department and MetLife will always try to give you the most complete and accurate information regarding the Plan. If there is a conflict between the information you receive from MetLife, the Engility Benefits Service Center or Engility's Benefits Department and the terms of this Summary Plan Description, the terms of this Summary Plan Description will prevail. If there is a conflict between the information in this Summary Plan Description and the Plan document, the terms of the Plan document will prevail.

COMPLIANCE WITH FEDERAL LAW

As a group health plan, the Plan is governed by the Employee Retirement Income Security Act of 1974, as amended (ERISA), the Internal Revenue Code (the "Code") and certain other federal law. In general, ERISA preempts state law that relates to group dental plans subject to ERISA.

The Plan will be construed and administered in accordance with ERISA, the Code and other applicable federal law, in all respects. In the event that there is no controlling federal law, the law of Virginia will apply (including its statute of limitations and all substantive and procedural law, and without regard to its conflict of laws provision).

CLAIMS, APPEALS AND EXTERNAL REVIEW

Filing claims. Under the Plan, you may file claims for Plan benefits and appeal adverse claim determinations. Any reference to "you" in this Claims, Appeals and External Review section includes you and your Authorized Representative. An "Authorized Representative" is a person you authorize, in writing, to act on your behalf. The Plan will also recognize a court order giving a person authority to

submit claims on your behalf. In the case of an urgent care claim, a health care professional with knowledge of your condition may always act as your Authorized Representative.

If your claim is denied in whole or in part, you will receive a written notice of the denial from Metropolitan Life Insurance Company (MetLife). The notice will explain the reason for the denial and the appeal procedures available under the Plan.

Urgent Care Claims. An “Urgent Care Claim” is any claim for dental care or treatment for which the application of the time periods for making non-urgent care determinations could seriously jeopardize your life or health or your ability to regain maximum function, or, in the opinion of a physician with knowledge of your medical condition, would subject you to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim.

If the Plan requires advance approval of a service, supply or procedure before a benefit will be payable, and if MetLife or your physician determines that it is an Urgent Care Claim, you will be notified of the decision, whether adverse or not, as soon as possible but not later than 72 hours after the claim is received.

If there is not sufficient information to decide the claim, you will be notified of the information necessary to complete the claim as soon as possible, but not later than 24 hours after receipt of the claim. You will be given a reasonable additional amount of time, but not less than 48 hours, to provide the information, and you will be notified of the decision not later than 48 hours after the end of that additional time period (or after receipt of the information, if earlier).

Other claims (Pre-Service and Post-Service). If the Plan requires you to obtain advance approval of a non-urgent service, supply or procedure before a benefit will be payable, a request for advance approval is considered a pre-service claim. You will be notified of the decision not later than 15 days after receipt of the pre-service claim.

For other claims (post-service claims), you will be notified of the decision not later than 30 days after receipt of the claim.

For either a pre-service or a post-service claim, these time periods may be extended up to an additional 15 days due to circumstances outside MetLife’s control. In that case, you will be notified of the extension before the end of the initial 15 or 30-day period. For example, they may be extended because you have not submitted sufficient information, in which case you will be notified of the specific information necessary and given an additional period of at least 45 days after receiving the notice to furnish that information. You will be notified of MetLife’s claim decision no later than 15 days after the end of that additional period (or after receipt of the information, if earlier).

For pre-service claims which name a specific claimant, medical condition, and service or supply for which approval is requested, and which are submitted to an MetLife representative responsible for handling benefit matters, but which otherwise fail to follow the Plan’s procedures for filing pre-service claims, you will be notified of the failure within five days (within 24 hours in the case of an urgent care claim) and of the proper procedures to be followed. The notice may be oral unless you request written notification.

Ongoing course of treatment. If you have received pre-authorization for an ongoing course of treatment, you will be notified in advance if the previously authorized course of treatment is intended to be terminated or reduced so that you will have an opportunity to appeal any decision to MetLife and receive a decision on that appeal before the termination or reduction takes effect. If the course of treatment involves urgent care, and you request an extension of the course of treatment at least 24 hours before its expiration, you will be notified of the decision within 24 hours after receipt of the request.

Health claims – standard appeals. As an individual enrolled in the Plan, you have the right to file an appeal from an Adverse Benefit Determination relating to service(s) you have received or could have received from your health care provider under the Plan. An “Adverse Benefit Determination” is defined as a denial, reduction, termination of, or failure to, provide or make payment (in whole or in part) for a service, supply or benefit. Such Adverse Benefit Determination may be based on:

- > Your eligibility for coverage, including a retrospective termination of coverage (whether or not there is an adverse effect on any particular benefit);
- > Coverage determinations, including plan limitations or exclusions;
- > The results of any Utilization Review activities;
- > A decision that the service or supply is experimental or investigational; or
- > A decision that the service or supply is not *medically necessary*.

A “Final Internal Adverse Benefit Determination” is defined as an Adverse Benefit Determination that has been upheld by the appropriate named fiduciary (MetLife) at the completion of the internal appeals process, or an Adverse Benefit Determination for which the internal appeals process has been exhausted.

Exhaustion of internal appeals process. Generally, you are required to complete all appeal processes of the Plan before being able to obtain External Review or bring an action in litigation. However, if MetLife, or the Plan or its designee, does not strictly adhere to all claim determination and appeal requirements under applicable federal law, you are considered to have exhausted the Plan’s appeal requirements (“Deemed Exhaustion”) and may proceed with External Review or may pursue any available remedies under §502(a) of ERISA or under state law, as applicable.

There is an exception to the Deemed Exhaustion rule. Your claim or internal appeal may not go straight to External Review if:

- > A rule violation was minor and is not likely to influence a decision or harm you; and
- > It was for a good cause or was beyond MetLife’s or the Plan’s or its designee’s control; and
- > It was part of an ongoing good faith exchange between you and MetLife or the Plan.

This exception is not available if the rule violation is part of a pattern or practice of violations by MetLife or the Plan.

You may request a written explanation of the violation from the Plan or MetLife, and the Plan or MetLife must provide such explanation within 10 days, including a specific description of its bases, if any, for asserting that the violation should not cause the internal claims and appeals process to be deemed exhausted. If an External Reviewer or a court rejects your request for immediate review on the basis that the Plan met the standards for the exception, you have the right to resubmit and pursue the internal appeal of the claim. In such a case, within a reasonable time after the External Reviewer or court rejects the claim for immediate review (not to exceed 10 days), you will receive notice of the opportunity to resubmit and pursue the internal appeal of the claim. Time periods for re-filing the claim shall begin to run upon your receipt of such notice.

Full and fair review of claim determinations and appeals. MetLife will provide you, free of charge, with any new or additional evidence considered, relied upon, or generated by MetLife (or at the direction of MetLife), or any new or additional rationale as soon as possible and sufficiently in advance of the date on which the notice of Final Internal Adverse Benefit Determination is provided, to give you a reasonable opportunity to respond prior to that date.

You may file an appeal in writing to MetLife at the address provided in this booklet, or, if your appeal is of an urgent nature, you may call MetLife's Dental Customer Service Center at the toll-free phone number on your ID card. Your request should include the group name (that is, your employer), your name, member ID, or other identifying information shown on the front of the Explanation of Benefits form, and any other comments, documents, records and other information you would like to have considered, whether or not submitted in connection with the initial claim.

A MetLife representative may call you or your health care provider to obtain medical records and/or other pertinent information in order to respond to your appeal.

You will have 180 days following receipt of an Adverse Benefit Determination to appeal the determination to MetLife. You will be notified of the decision not later than 15 days (for pre-service claims) or 30 days (for post-service claims) after the appeal is received. You may submit written comments, documents, records and other information relating to your claim, whether or not the comments, documents, records or other information were submitted in connection with the initial claim. A copy of the specific rule, guideline or protocol relied upon in the Adverse Benefit Determination will be provided free of charge upon request by you or your Authorized Representative. You may also request that MetLife provide you, free of charge, copies of all documents, records and other information relevant to the claim.

If your claim involves urgent care, an expedited appeal may be initiated by a telephone call to the phone number included in your denial, or to MetLife's Dental Customer Service Center. MetLife's Dental Customer Service Center telephone number is on your Identification Card. You or your Authorized Representative may appeal urgent care claim denials either orally or in writing. All necessary information, including the appeal decision, will be communicated between you or your Authorized Representative and MetLife by telephone, facsimile, or other similar method. You will be notified of the decision not later than 36 hours after the appeal is received.

If you are dissatisfied with the appeal decision on an urgent care claim, you may file a second level appeal with MetLife. You will be notified of the decision not later than 36 hours after the appeal is received.

If you are dissatisfied with a pre-service or post-service appeal decision, you may file a second level appeal with MetLife within 31 days of receipt of the level one appeal decision. MetLife will notify you of the decision not later than 15 days (for pre-service claims) or 30 days (for post-service claims) after the appeal is received.

If you do not agree with the Final Internal Adverse Benefit Determination on review, you have the right to bring a civil action under Section 502(a) of ERISA, if applicable.

Health claims – voluntary appeals, external review. “External Review” is a review of an eligible Adverse Benefit Determination or a Final Internal Adverse Benefit Determination by an Independent Review Organization/External Review Organization (ERO) or by the State Insurance Commissioner, if applicable.

A “Final External Review Decision” is a determination by an ERO at the conclusion of an External Review.

You must complete all of the levels of standard appeal described above before you can request External Review, other than in a case of Deemed Exhaustion. Subject to verification procedures that the Plan may establish, your Authorized Representative may act on your behalf in filing and pursuing this voluntary appeal.

You may file a voluntary appeal for External Review of any Adverse Benefit Determination or any Final Internal Adverse Benefit Determination that qualifies as set forth below.

The notice of Adverse Benefit Determination or Final Internal Adverse Benefit Determination that you receive from MetLife will describe the process to follow if you wish to pursue an External Review, and will include a copy of the *Request for External Review Form*.

You must submit the *Request for External Review Form* to MetLife within 123 calendar days of the date you received the Adverse Benefit Determination or Final Internal Adverse Benefit Determination notice. If the last filing date would fall on a Saturday, Sunday or Federal holiday, the last filing date is extended to the next day that is not a Saturday, Sunday or federal holiday. You also must include a copy of the notice and all other pertinent information that supports your request.

If you file a voluntary appeal, any applicable statute of limitations will be tolled while the appeal is pending. The filing of a claim will have no effect on your rights to any other benefits under the Plan. However, the appeal is voluntary and you are not required to undertake it before pursuing legal action.

If you choose not to file for voluntary review, the Plan will not assert that you have failed to exhaust your administrative remedies because of that choice.

Request for external review. The External Review process under this Plan gives you the opportunity to receive review of an Adverse Benefit Determination (including a Final Internal Adverse Benefit

Determination) conducted pursuant to applicable law. Your request will be eligible for External Review if the claim decision involves medical judgment and the following are satisfied:

- > MetLife, or the Plan or its designee, does not strictly adhere to all claim determination and appeal requirements under federal law (except for minor violations); or
- > the standard levels of appeal have been exhausted; or
- > the appeal relates to a rescission, defined as a cancellation or discontinuance of coverage which has retroactive effect.

An Adverse Benefit Determination based upon your eligibility is not eligible for External Review.

If upon the final standard level of appeal, the coverage denial is upheld and it is determined that you are eligible for External Review, you will be informed in writing of the steps necessary to request an External Review.

An independent review organization refers the case for review by a neutral, independent clinical reviewer with appropriate expertise in the area in question. The decision of the independent external expert reviewer is binding on you, MetLife and the Plan unless otherwise allowed by law.

Preliminary review. Within five business days following the date of receipt of the request, MetLife must provide a preliminary review determining: you were covered under the Plan at the time the service was requested or provided, the determination does not relate to eligibility, you have exhausted the internal appeals process (unless Deemed Exhaustion applies), and you have provided all paperwork necessary to complete the External Review and you are eligible for External Review.

Within one business day after completion of the preliminary review, MetLife must issue to you a notification in writing. If the request is complete but not eligible for External Review, such notification will include the reasons for its ineligibility and contact information for the Employee Benefits Security Administration (toll-free number 866-444-EBSA [3272]). If the request is not complete, such notification will describe the information or materials needed to make the request complete and MetLife must allow you to perfect the request for External Review within the 123-calendar-days filing period or within the 48-hour period following the receipt of the notification, whichever is later.

Referral to ERO. MetLife will assign an ERO accredited as required under federal law, to conduct the External Review. The assigned ERO will timely notify you in writing of the request's eligibility and acceptance for External Review, and will provide an opportunity for you to submit in writing within 10 business days following the date of receipt, additional information that the ERO must consider when conducting the External Review. Within one business day after making the decision, the ERO must notify you, MetLife and the Plan.

The ERO will review all of the information and documents timely received. In reaching a decision, the assigned ERO will review the claim and not be bound by any decisions or conclusions reached during the Plan's internal claims and appeals process. In addition to the documents and information provided, the assigned ERO, to the extent the information or documents are available and the ERO considers them appropriate, will consider the following in reaching a decision:

- > Your medical records;
- > The attending health care professional's recommendation;
- > Reports from appropriate health care professionals and other documents submitted by the Plan or issuer, you, or your treating provider;
- > The terms of your Plan to ensure that the ERO's decision is not contrary to the terms of the Plan, unless the terms are inconsistent with applicable law;
- > Appropriate practice guidelines, which must include applicable evidence-based standards and may include any other practice guidelines developed by the Federal government, national or professional medical societies, boards, and associations;
- > Any applicable clinical review criteria developed and used by MetLife, unless the criteria are inconsistent with the terms of the Plan or with applicable law; and
- > The opinion of the ERO's clinical reviewer or reviewers after considering the information described in this notice to the extent the information or documents are available and the clinical reviewer or reviewers consider appropriate.

The assigned ERO must provide written notice of the Final External Review Decision within 45 days after the ERO receives the request for the External Review. The ERO must deliver the notice of Final External Review Decision to you, MetLife and the Plan.

After a Final External Review Decision, the ERO must maintain records of all claims and notices associated with the External Review process for six years. An ERO must make such records available for examination by the claimant, Plan, or state or federal oversight agency upon request, except where such disclosure would violate state or federal privacy laws.

Upon receipt of a notice of a Final External Review Decision reversing the Adverse Benefit Determination or Final Internal Adverse Benefit Determination, the Plan immediately must provide coverage or payment (including immediately authorizing or immediately paying benefits) for the claim.

Expedited external review. The Plan must allow you to request an expedited External Review at the time you receive:

- > An Adverse Benefit Determination if the Adverse Benefit Determination involves a medical condition for which the timeframe for completion of an expedited internal appeal would seriously jeopardize your life or health or would jeopardize your ability to regain maximum function and you have filed a request for an expedited internal appeal; or
- > A Final Internal Adverse Benefit Determination, if you have a medical condition where the timeframe for completion of a standard External Review would seriously jeopardize your life or health or would jeopardize your ability to regain maximum function, or if the Final Internal Adverse Benefit Determination concerns an admission, availability of care, continued stay, or health care item or service for which you received emergency services, but have not been discharged from a facility.

Immediately upon receipt of the request for expedited External Review, MetLife will determine whether the request meets the reviewability requirements set forth above for standard External Review. MetLife must immediately send you a notice of its eligibility determination.

Referral of expedited review to ERO. Upon a determination that a request is eligible for External Review following preliminary review, MetLife will assign an ERO. The ERO shall render a decision as expeditiously as your medical condition or circumstances require, but in no event more than 72 hours after the ERO receives the request for an expedited External Review. If the notice is not in writing, within 48 hours after the date of providing that notice, the assigned ERO must provide written confirmation of the decision to you, MetLife and the Plan.

CONFIDENTIALITY OF HEALTH CARE INFORMATION

Engility's Dental Plans are required to protect the confidentiality of your private health information under the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and the rules issued by the U.S. Department of Health and Human Services. The official *Notice of Privacy Practices*, which is distributed to all Plan participants, is summarized here.

The intent of HIPAA is to make sure that private health information that identifies (or could be used to identify) you is kept private. This individually identifiable health information is known as "protected health information" (PHI). The Plan will not use or disclose your PHI without your written authorization except as necessary for treatment, payment, Plan operations and Plan administration, or as permitted or required by law. In particular, the Plan will not, without your written authorization, use or disclose PHI for employment-related actions and decisions or in connection with benefits under another employee benefit plan.

The Plan also hires professionals and other companies to advise the Plan and help administer and provide dental benefits. The Plan requires these individuals and organizations, called "Business Associates," to comply with HIPAA's privacy rules. In some cases, you may receive a separate notice from one of the Plan's Business Associates (for example, MetLife, the Plan's *Claims Administrator*). That notice will describe your rights with respect to benefits administered by that individual/organization.

The Plan is required to protect the confidentiality of your private health information under the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and the rules issued by the U.S. Department of Health and Human Services.

Under federal law, you have certain rights where your PHI is concerned, including certain rights to see and copy the information, receive an accounting of certain disclosures of the information and, under certain circumstances, change or correct the information. You have the right to request reasonable restrictions on disclosure of information about you, and to request confidential communications. You also have the right to file a complaint with the Plan or with the Secretary of the Department of Health and Human Services, if you believe your rights have been violated.

If you have questions about the privacy of your health information or if you would like a copy of the official *Notice of Privacy Practices*, please contact the Engility Benefits Service Center.

NO RIGHT TO CONTINUED EMPLOYMENT

Your eligibility or right to benefits under the Plan does not confer any legal right to continued employment by Engility. Engility at all times retain the right to discharge any employee at any time, for any reason.

FUTURE OF THE PLAN

Engility intends to continue the Plan but reserves the right to change, terminate, suspend, withdraw, amend or modify the Plan at any time, in any manner, at Engility's sole discretion, by action of the Senior Vice President, Benefits of Engility Corporation, subject to applicable collective bargaining agreements. Any change, termination, suspension, withdrawal, amendment or modification of benefits will be based solely on the decisions of Engility and may apply to active employees and employees covered through COBRA as one group. You will be notified of any change; however, the change may be effective before any notice is given to you.

Premium and contribution rates may change each year.

YOUR RIGHTS UNDER ERISA

As a participant in the Plan, you are entitled to the following rights and protections under the Employee Retirement Income Security Act of 1974, as amended (ERISA).

ERISA provides that you will be entitled to receive information about your Plan and benefits, as follows:

- > Examine, without charge, at the Plan Administrator's office and at other specified locations, such as work sites and union halls, all documents governing the Plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the Plan Administrator with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.
- > Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and an updated Summary Plan Description (SPD). The Plan Administrator may make a reasonable charge for the copies.
- > Receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report.

Under ERISA, you have the right to obtain copies of documents governing the operation of the Plan.

ERISA also provides that you will be entitled to continue dental plan coverage for yourself, your spouse and your dependents if there is a loss of coverage under the Plan because of a qualifying event. You or your dependents may have to pay for such coverage. You should review this SPD and the documents governing the Plan for the rules governing your COBRA continuation coverage rights.

Please note that while federal law does not require that continuation coverage be offered to same-sex domestic partners, Engility will offer COBRA continuation coverage to enrolled same-sex domestic partners. See page 5 for more information.

PRUDENT ACTIONS BY PLAN FIDUCIARIES

In addition to creating rights for Plan participants, ERISA imposes duties upon the people who are responsible for the operation of the Plan. The people who operate the Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of you and other Plan participants and beneficiaries. No one, including your employer, your union or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a benefit or exercising your rights under ERISA.

ENFORCING YOUR RIGHTS

If your claim for a benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision, without charge, and to appeal any denial, all within certain time schedules.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of Plan documents or the latest annual report from the Plan and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to \$110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator.

If you have a claim for benefits that is denied or ignored, in whole or in part, you may file suit in a state or federal court after you have followed the Plan's claim procedures. In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, you may file suit in a federal court.

If it should happen that Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in federal court.

The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

ASSISTANCE WITH YOUR QUESTIONS

If you have any questions about your Plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory, or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue NW, Washington, DC 20210. You can get publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration. To visit the Department of Labor's website, go to www.dol.gov.

Contact the nearest area office of the Employee Benefits Security Administration if you have questions about ERISA. You can get publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

GLOSSARY

This Glossary is provided to help you understand the Plan by summarizing several of its key terms. However, any questions about Plan coverage that concern these terms will be answered by MetLife, which has full discretionary authority to use its own materials, procedures and expertise to define these terms. MetLife is not limited to the summary definitions provided in this Glossary.

Claims Administrator is MetLife, or its affiliate, which provides certain claim administration services for the Plan.

Cosmetic, as used here, means any services or supplies that alter, improve or enhance appearance.

Course of dental treatment is a planned program of one or more services or supplies rendered by one or more dentists to treat a dental condition diagnosed by the attending dentist as a result of an oral examination. A course of dental treatment starts on the date your dentist first renders a service to correct or treat the diagnosed dental condition.

Dentist is a legally licensed dentist practicing within the scope of his or her license, or a legally licensed physician authorized by his or her license to perform the particular dental services rendered.

Directory is a listing of all network providers serving the class of employees to which you belong. Network provider information is available through MetLife's online provider directory.

Enrolled dependent is a dependent who is properly enrolled under the Plan.

Experimental treatment, as used here, consists of procedures, services, drugs and other supplies that, as determined by MetLife, fall into any of the following categories:

- > there are insufficient outcomes data available from controlled clinical trials published in the peer-reviewed literature to substantiate its safety and effectiveness for the disease or injury involved
- > if required by the FDA, approval has not been granted for marketing
- > a recognized national medical or dental society or regulatory agency has determined, in writing, that it is experimental, investigational or for research purposes, or
- > the written protocol or protocols used by the treating facility or the protocol or protocols of any other facility studying substantially the same drug, device, procedure or treatment or the written informed consent used by the treating facility or by another facility studying the same drug, device, procedure or treatment states that it is experimental, investigational or for research purposes.

Handicapped dependent child is a dependent child who depends chiefly on you for support and maintenance and is not able to earn his or her own living because of a mental or a physical condition which began prior to age 26. Proof of the child's handicap must be submitted to MetLife within 31 days after the child's 26th birthday. MetLife has the right to require proof of the continuation of the handicap, including examining the child as often as needed while the handicap continues, at MetLife's own expense. Please note, however, that an exam will not be required more often than once each year after two years following the child's 26th birthday. Coverage for a handicapped dependent child

will end when the child is no longer handicapped, when you fail to provide proof of the continued handicap, when you fail to submit to any required exam, or if Engility stops offering the Plan to dependents, whichever happens first.

Medicaid is a state program of medical aid for needy individuals, established under Title XIX of the Social Security Act of 1965, as amended.

Medicare is the federal health insurance program for people 65 and older, certain disabled people, and those with end-stage renal disease (ESRD).

Necessary (or “medically necessary”), as used here, means a medical or dental service, supply or prescription drug that a physician, other health care provider or dental provider, exercising prudent clinical judgment, would provide to a patient for the purpose of preventing, evaluating, diagnosing or treating an illness, injury, disease or its symptoms. To be appropriate, the service or supply must be:

- > in accordance with generally accepted standards of medical or dental practice;
- > clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for the patient’s illness, injury or disease;
- > not primarily for the convenience of the patient, physician, other health care or dental provider; and
- > not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that patient’s illness, injury or disease.

For these purposes “generally accepted standards of medical or dental practice” means standards that are based on credible scientific evidence published in peer-reviewed literature generally recognized by the relevant medical or dental community, or otherwise consistent with physician or dental specialty society recommendations and the views of physicians or dentists practicing in relevant clinical areas and any other relevant factors.

Negotiated fee is the maximum charge a network provider has agreed to make for any service or supply for the purpose of the benefits under the Plan.

Orthodontic treatment is any medical service or supply, or dental service or supply, furnished to prevent, diagnose or correct a misalignment of the teeth, the bite or the jaws or jaw joint relationship, whether or not it is for the purpose of relieving pain.

Plan Administrator is Engility Corporation or its designee, as that term is defined under ERISA.

Plan Year is the 12-month period from January 1 through December 31 during which the Plan is administered and during which the annual deductible and annual benefit limits are recorded.

Reasonable and customary charge (or R&C charge) for each service or supply is the lowest of:

- > The dentist's actual charge for that service or supply; or
- > The dentist's usual charge for the same or similar services; or
- > The charge of most dentists in the same geographic area for the same or similar services as determined by MetLife.

Reasonably necessary dental care, as determined by MetLife, consists of covered dental services and supplies prescribed by a legally qualified dentist for the diagnosis, prevention and treatment of dental disease.

Root canal therapy is the treatment of teeth having diseased or damaged pulp. The procedure consists of completely removing the pulp, sterilizing the pulp chamber and root canals and filling those spaces with a sealing material.

Sound, natural teeth are teeth that are free of decay, large restorations, endodontic therapy and periodontal disease.

Single processed claims transaction is a group of actual or prospective charges submitted to MetLife for consideration that have been grouped together for administrative purposes as a claims transaction.

Space maintainer is an appliance placed to maintain space created by the premature loss of one or more teeth.