THE IMPORTANCE OF HEALTH INSURANCE: While the cost of basic health care can quickly add up, the cost of care for a major illness or injury can be devastating. Health insurance can help you prepare for the worst that could happen. Now having health insurance is also the law. The Affordable Care Act requires that everyone must have health insurance. If you don’t have it, you will pay a penalty.

To help you better understand our 2017 benefits program in more detail, DI is providing you this brief guide containing your 2017 benefit options. Please refer to plan documents for details, including important coverage exclusions and limitations.

Disclaimer: Benefits are provided pursuant to a Plan Document on file at DynCorp International. The plans are also summarized in a Summary Plan Description (SPD). If there is a conflict involving the language provided in the Plan Document, the SPD or any communication regarding these benefits, the terms of the Plan Document will control, unless superseded by applicable law.

Please note: Not all DI employees are eligible to participate in the plans described. Eligibility is dependent on the terms of any applicable CBA, contract, service contract act, employee classifications and the operation of host country and/or U.S. law. Please consult your HR Generalist if you have questions regarding the applicability of any of the plans described.
<table>
<thead>
<tr>
<th>Welcome</th>
<th>i</th>
</tr>
</thead>
<tbody>
<tr>
<td>Eligibility To Enroll For Benefits</td>
<td>1</td>
</tr>
<tr>
<td>Dependent Coverage</td>
<td>1</td>
</tr>
<tr>
<td>Required Dependent Documents</td>
<td>1</td>
</tr>
<tr>
<td>Changing Benefits During The Plan Year</td>
<td>1</td>
</tr>
<tr>
<td>Qualifying Life Events</td>
<td>1</td>
</tr>
<tr>
<td>Online Tools and Resources</td>
<td>1</td>
</tr>
<tr>
<td>Online Enrollment Instructions</td>
<td>1</td>
</tr>
<tr>
<td>Tobacco-Free Premium Reduction</td>
<td>1</td>
</tr>
<tr>
<td>New For 2017</td>
<td>2</td>
</tr>
<tr>
<td>DI Preferred Plan w/Health Savings Account (HSA)</td>
<td>3-4</td>
</tr>
<tr>
<td>Telemedicine – Teladoc (Call a doctor)</td>
<td>5</td>
</tr>
<tr>
<td>How to Choose an Appropriate Care Center</td>
<td>6</td>
</tr>
<tr>
<td>Benefit Summary: DI Preferred w/HSA Plan</td>
<td>7</td>
</tr>
<tr>
<td>Tiered HSA Contribution Schedule / Critical Illness Insurance</td>
<td>8</td>
</tr>
<tr>
<td>Voluntary Dental Benefit Summary (Core Plan &amp; Enhanced Plan)</td>
<td>9-10</td>
</tr>
<tr>
<td>Voluntary Vision Summary</td>
<td>11</td>
</tr>
<tr>
<td>MotivateMe: a Wellness Program</td>
<td>12</td>
</tr>
<tr>
<td>Flexible Spending Accounts (FSAs)</td>
<td>13</td>
</tr>
<tr>
<td>Tax-Savings Accounts</td>
<td>14</td>
</tr>
<tr>
<td>Basic Life Insurance / Basic Supplemental Accidental Death &amp; Dismemberment (AD&amp;D)</td>
<td>15</td>
</tr>
<tr>
<td>Disability Benefits</td>
<td>15</td>
</tr>
<tr>
<td>401(k)</td>
<td>16</td>
</tr>
<tr>
<td>Employee Assistance Program (EAP)</td>
<td>16</td>
</tr>
<tr>
<td>Group Voluntary Critical Illness and Group Voluntary Accident insurance</td>
<td>16</td>
</tr>
<tr>
<td>ADDED BENEFITS</td>
<td>16</td>
</tr>
<tr>
<td>Provider Contact List</td>
<td>17</td>
</tr>
<tr>
<td>Glossary</td>
<td>18</td>
</tr>
<tr>
<td>Required Notices</td>
<td>19</td>
</tr>
<tr>
<td>Appendix: HSA Associated Fees</td>
<td>19</td>
</tr>
</tbody>
</table>
DynCorp International LLC (DI) is committed to providing you access to quality health care now and for years to come.

We encourage you to take the time to review your benefit guide information. Read and learn how your benefits can meet your needs and the needs of your dependents, then select the plan that will accommodate your specific needs. Remember, it is your responsibility to become educated about the benefits made available to you and to take an active role in your overall health care. We hope you find the information in this booklet helpful.

As a reminder, the content is this guide is not all-inclusive, may not reflect recent changes, and is not intended to be a legal document. For the most current information, please consult the actual plan documents, available from the DI Human Resources Department. If you have questions about enrollment procedures, or any general benefits questions, please contact the DI Human Resources Department.

Thank you and we wish you a happy and healthy 2017.

HR Global Benefits Team
ELIGIBILITY TO ENROLL FOR BENEFITS
• You are benefit eligible for health and welfare benefits if you are an active, regular, full time employee working a minimum of 30 hours for DI and its subsidiaries
• New hires are eligible upon their individual hire date
• Eligibility for the 401(k) plan is automatic and immediate upon date of hire
• Eligibility for the Paid Time Vested (PTV) benefit may vary; please consult your Human Resources policies or CBA (as applicable) for information on vacation, sick time, paid holiday, and leave of absence

DEPENDENT COVERAGE
Dependents are considered to be your:
• Spouse
  • Legally married spouse of the same or opposite sex, and common-law spouse in recognized states
  • Effective January 1, 2017, spouses who have other coverage available through their own employer will no longer be eligible for coverage under the DI Plan.
  • Spouses who do not have access to other coverage will continue to be eligible, however, at an additional cost
• Children
  • Biological, Step, Adopted or Foster child(ren) up to age 26
  • Your disabled child over the age of 26, unable to support him/herself

IMPORTANT NOTE: If your child is married, their spouse and children are not eligible for coverage. Additionally, benefits coverage will terminate at the end of the month in which the child turns age 26.

REQUIRED DEPENDENT DOCUMENTATION
• Legally married spouse of the same or opposite sex: Certified marriage certificate
• Common-law Spouse: Common-law certificate (in a state that recognizes common-law marriage)
• Children up to age 26: Certified birth certificate, adoption agreement, court/agency approved documentation
• Disabled child: Executed Incapacitated Dependent Certification Form (available through health care provider)

You have 15 calendar days from your date of hire to provide required dependent documents. If you do not provide the appropriate dependent documentation your dependent(s) will not be enrolled in the DI health care plan and will not be eligible for enrollment until the next annual enrollment, unless you experience a Qualifying Life Event.

CHANGING BENEFITS DURING THE PLAN YEAR
In order to change benefits during the year, you must experience a Qualifying Life Event change in status. You have 31 days from the date of the event to notify your local Human Resources Department.

QUALIFYING LIFE EVENTS
• Marriage or divorce
• Birth or adoption of your child
• Death of your spouse or child
• Change in your child’s dependent status
• Change in your benefit eligibility status
• Change in your spouse’s benefit eligibility or employment status

ONLINE TOOLS AND RESOURCES
• Pre-enrollment line is available — For plan specifics currently available contact a Cigna representative at 1-800-401-4041
• Visit www.mycigna.com to view member benefits, locate participating doctors and other healthcare professionals, eligibility, claims, wellness incentive program, order ID cards and more
• Mobile App (My CIGNA) — Available for download at the App Store or Google Play
• Cigna Customer Service is available 24 hours a day, 7 days a week at 1-800-972-0334

ONLINE ENROLLMENT INSTRUCTIONS
• You have 15 calendar days to enroll for benefits following your date of hire
• To enroll, log onto the enrollment website at: https://people.dyn-intl.com
• If you do not have a password, click on “New User or Password Reset”
• On the enrollment website you will find your personal enrollment summary which contains specific information about the benefit options currently available to you — including bi-weekly costs
• Click through the enrollment site and elect the benefits you would like to enroll
• If you experience any issues with the enrollment process, please notify your local Human Resources Generalist
• If you need technical assistance, please call the DI service desk at 1-817-224-6500 or 1-800-822-2429

TOBACCO-FREE PREMIUMS
Employees enrolled in DI’s medical plan for 2017 are encouraged to voluntarily self-identify their tobacco status. Those employees who self-identify as a tobacco user during the 2016 annual enrollment will need to notify Human Resources if they have a change in their tobacco status. Tobacco users will pay an additional charge of $47 per pay period.

NEW FOR 2017

Elimination of the Premier Medical Plan
The Premier Plan is no longer a viable, cost-effective choice for DI or our participants. In place of the Premier Plan, DI is offering the DI Preferred Plan with Health Savings Account.

You will retain access to the same hospital, physician, and pharmacy networks without disruption. To ensure a smooth plan transition, DI continues to offer a supplemental Critical Illness Insurance Policy to help offset expenses in the event of a catastrophic illness.

ACTION REQUIRED: Due to the Premier Plan elimination, those having previously elected this coverage must make an active enrollment election for 2017 in order to have coverage. 2016 elections will not automatically roll to the Preferred Plan for 2017.

Health Savings Account (HSA) Contributions
For 2017, DI is funding 100% of the Company Health Savings Account contribution upfront at the beginning of the Plan Year. First bank deposit will be in January for those who enroll during Annual Enrollment.

ATTENTION NEW HIRES: If you're hired after the annual enrollment period HSA contributions are pro-rated and contributions made on a bi-weekly basis.

Tiered Premium and HSA Contribution Schedule
DI has implemented a tiered premium and HSA contribution schedule which takes into consideration an employee’s ability to pay based upon the employee’s compensation. DI executive management is shouldering a greater burden of responsibility as it relates to health care costs through payment of higher premiums and little to no company contribution into an HSA. See page 8 for the Tiered Contribution and Premium Schedules.

Spousal Eligibility Certification
DI is changing the definition of eligibility as it relates to spouses. Effective January 1, 2017, spouses who have other coverage available through their own employer will no longer be eligible for coverage under the DI Plan. Spouses who do not have access to other coverage will continue to be eligible.

ACTION REQUIRED: In order to retain spousal coverage; you will be asked to certify that your spouse meets eligibility requirements when you enroll for 2017. If you do not certify your spouse, they will not be enrolled in the plan. You must make an active election.

Teladoc Plan Design Changes
Due to IRS regulations that impact HSA’s, there is a requirement to charge a fee for Teladoc service in 2017. Beginning January 1, 2017 the fee will be $42 per call.

Elimination of Weight Loss Surgery
Effective January 1, 2017, DI’s health plan will no longer cover the cost of Weight Loss Surgery.
DI Preferred w/HSA

DI’s Preferred w/HSA Plan is a qualified high deductible health plan (HDHP). These types of plans are often referred to as Consumer-Driven Health Plans (CDHPs).

Your HSA plan coverage includes:
• In-network and out-of-network benefits
• Free preventive care
• Free preventive care generic mail order prescription drugs
• Free preferred brand medications*

An HSA is designed to create more awareness of overall plan cost.

*Qualifying preventive generic and preferred brand medications through mail order only, used for the prevention of the following conditions, are covered at 100% by DI’s pharmacy plan when you’re enrolled in the DI Preferred w/HSA Plan:
• Asthma
• High Blood Pressure
• High Cholesterol
• Diabetes
• Osteoporosis
• Heart Attack or Stroke
• Prenatal Nutrient Deficiency

Once you’re enrolled in the DI Preferred w/HSA Plan, DI helps you save money by funding 100% of the Company Health Savings Account contribution upfront at the beginning of the Plan Year. First bank deposit will be made mid-January. (See page 8 for both the Premium and Tiered Schedules)

ATTENTION NEW HIRES: If you’re hired after the annual enrollment period HSA contributions are pro-rated and contributions made on a bi-weekly basis

Your Health Savings Account (HSA) is owned by one person— you!

As the “account-holder,” the IRS requires that you meet certain criteria to open your HSA. You:
• Must be covered under a qualified high deductible health plan (HDHP) — such as the DI Preferred w/HSA Plan
• Cannot have other health coverage — including a spouse’s Flexible Spending Account — unless permitted by the IRS
• Cannot be enrolled in Medicare or TRICARE or claimed as a dependent on someone else’s tax return
• May not have any other health plan coverage that would include a full purpose health care Flexible Spending Account (FSA). The IRS prevents any individual from having both a full purpose FSA and an HSA.
• May not have received any Veterans Administration benefits in the last three months

Advantage of being in an HSA
• An HSA is “employee-owned”
• You can contribute additional funds at any time
• DI contributes an upfront contribution
• Unused funds rollover year-to-year
• If you leave DI, the money is yours and goes with you!
• Not taxed for withdrawals for qualified expenses
• Change your contributions at any time during the year

Building your HSA: Contributions

Fund your HSA through pre-tax payroll deductions and annual contributions from DI. Your total annual contribution to your HSA account (including contributions from DI) cannot exceed $3,400 for individual coverage and $6,750 for family coverage.

Growing your HSA: Investing

Once you have attained the minimum balance of $2,000 in your HSA, you have the option to invest your money in up to 36 different mutual funds offered by Cigna. There is minimum deposit per fund.

Catch-up contributions

As an extra incentive and to help you save for expenses during retirement, the IRS allows individuals 55 and older to make an additional $1,000 catch-up contribution each year. Keep in mind, if you and your spouse both have an HSA, your combined contribution (minus the catch-up contributions) cannot exceed the family maximum contribution.

Tax savings

Every dollar you contribute to your HSA is tax-exempt, up to the allowable IRS annual maximum contribution limit. The more you contribute, the more you can lower your taxable income.

For example, depending on your current tax rate, a $2,500 annual HSA contribution could lower your taxes significantly — and save you as much as $1,016 a year.

<table>
<thead>
<tr>
<th>FEDERAL TAX RATE</th>
<th>STATE TAX RATE</th>
<th>PAYROLL TAXES</th>
<th>ESTIMATED ANNUAL SAVINGS</th>
</tr>
</thead>
<tbody>
<tr>
<td>15%</td>
<td>5%</td>
<td>7.7%</td>
<td>$691</td>
</tr>
<tr>
<td>25%</td>
<td>5%</td>
<td>7.7%</td>
<td>$941</td>
</tr>
<tr>
<td>28%</td>
<td>5%</td>
<td>7.7%</td>
<td>$1,016</td>
</tr>
</tbody>
</table>

Keep your receipts

The IRS requires you to keep your receipts in order to verify that your HSA funds were used to pay for qualified medical expenses. Visit myCigna.com and take advantage of expense tracking tools to help manage expenses and transactions — you can even upload copies of receipts for safekeeping.
Special allowances if you are age 65 or older

When you turn age 65, your HSA becomes even more flexible! At age 65 you are allowed to continue using your HSA on a “tax-free” basis for expenses not covered by Medicare or other supplemental insurance. You can also choose to use your HSA to supplement your retirement income.

Your HSA funds can be used to pay for qualified medical expenses for any family member who qualifies as a tax dependent. However, if the tax dependent isn’t covered under your plan, his/her expenses will not be applied toward your plan’s deductible.

My beneficiary

When you establish an HSA you will be asked to designate a beneficiary. If your spouse is the designated beneficiary, your HSA will be treated as your spouse’s HSA after your death.

If your spouse is not your designated beneficiary, the account stops being an HSA and the fair market value of your account becomes taxable to the beneficiary in the year in which you die.

HSA highlights

Visit myCigna.com to use the Cigna Choice Fund HSA calculator — to help determine your tax savings and potential future value based on contribution election.

Use your HSA funds tax free for eligible out-of-pocket health care expenses. For a full list of eligible expenses, please visit myCigna.com/expenses. All balance and transaction activity is available at mycigna.com or via the myCigna Mobile App.
TELEMEDICINE - TELADOC

Instead of visiting a physician’s office or an urgent care facility for “non-emergency” health-related issues (cold and flu, ear infections, etc.) call Teladoc at 1.855.847-3627. Prior to your initial call, you must register at: www.teladoc.com/feelbetter

IMPORTANT NOTE: Due to IRS regulations that impact HSA’s, beginning 1-1-2017 DI is required to charge a $42 fee for Teladoc services.

Advantages of TELADOC:
- Available 24/7/365 (weekends and holidays too!)
- Speak with a U.S. board-certified physician
- Physicians recommend treatment, prescribe short-term medication, can send prescriptions to your pharmacy
- Teladoc physicians will share information with your personal physician regarding your call

WHEN CAN I USE TELADOC?
- When you need care now
- If your doctor is unavailable
- If you’re considering the ER or urgent care center for a non-emergency issue
- On vacation, on a business trip, or away from home
- For short-term prescription refills

GET THE CARE YOU NEED
Teladoc doctors can treat many medical conditions, including:
- Cold & flu symptoms
- Allergies
- Bronchitis
- Skin problems
- Respiratory infection
- Sinus problems

SHARE WITH YOUR PCP
With your consent, Teladoc is happy to provide information about your Teladoc consult to your primary care physician.

KNOW WHERE TO GO FOR THE RIGHT CARE

<table>
<thead>
<tr>
<th>Nurse Line</th>
<th>Teladoc</th>
<th>Convenience Clinic</th>
<th>Primary Care Doctor</th>
<th>Urgent Care</th>
<th>Emergency Room</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Any health concern • 24/7</td>
<td>• Common &amp; minor health conditions • Access to a doctor by mobile app, online video and phone call • 24/7/365</td>
<td>• Common &amp; minor health condition • Day, evening and weekend hours</td>
<td>• Any health concerns • Weekdays, some after hours</td>
<td>• Common &amp; minor health conditions, minor emergencies • Weekdays, after hours &amp; some weekends</td>
<td>• True emergency, life threatening conditions • 24/7</td>
</tr>
<tr>
<td>$0</td>
<td>$42</td>
<td>$89 avg.</td>
<td>$111 avg.</td>
<td>$152 avg.</td>
<td>$1,351 avg.</td>
</tr>
</tbody>
</table>
## HOW TO CHOOSE AN APPROPRIATE CARE CENTER

<table>
<thead>
<tr>
<th>Care Center</th>
<th>Why would I use this care center?</th>
<th>What are examples of conditions that can be treated?</th>
<th>What are the cost and time considerations?</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Doctor’s Office</strong></td>
<td>You need routine care or treatment for a current health issue&lt;br&gt;Referral to see a specialist is not required</td>
<td>Routine check-ups&lt;br&gt;Immunizations&lt;br&gt;Preventive services&lt;br&gt;Manage your general health</td>
<td>Must meet deductible requirements&lt;br&gt;Normally requires an appointment&lt;br&gt;Little wait time with scheduled appointment</td>
</tr>
<tr>
<td><strong>Convenience Care Clinic</strong></td>
<td>You cannot get into your doctor’s office, but your condition is not urgent or an emergency&lt;br&gt;Staffed by nurse practitioner and/or physician assistants</td>
<td>Common infections (i.e. strep throat)&lt;br&gt;Minor skin conditions (i.e. poison ivy)&lt;br&gt;Flu shots&lt;br&gt;Pregnancy tests&lt;br&gt;Minor cuts and earaches</td>
<td>Must meet deductible requirements&lt;br&gt;Walk-in patients welcome with no appointment necessary, but wait times vary</td>
</tr>
<tr>
<td><strong>Urgent Care Center</strong></td>
<td>You may need care quickly, but it is not an emergency and your primary physician may not be available&lt;br&gt;Staffed by qualified physicians</td>
<td>Sprains and strains&lt;br&gt;Minor broken bones&lt;br&gt;Minor infections&lt;br&gt;Minor burns &amp; stitches</td>
<td>Must meet deductible requirements&lt;br&gt;Walk-in patients welcome, but wait time could be longer as patients with more urgent needs are treated first</td>
</tr>
<tr>
<td><strong>Emergency Room (ER)</strong></td>
<td>You need immediate treatment of a very serious or critical condition&lt;br&gt;Do not ignore an emergency situation. If a situation seems life threatening, take action and call 911 or your local emergency number right away</td>
<td>Heaving bleeding/large open wounds&lt;br&gt;Sudden change in vision, chest pain&lt;br&gt;Major burns or broken bones&lt;br&gt;Spinal injuries, severe head injury or difficulty breathing</td>
<td>Deductible/coinsurance (if applicable)&lt;br&gt;Open 24/7, waiting periods may be longer - patients with life-threatening emergencies are treated first</td>
</tr>
<tr>
<td><strong>Teladoc</strong></td>
<td>When you need care now&lt;br&gt;If your doctor is unavailable&lt;br&gt;If considering the ER or urgent care center for a non-emergency issue&lt;br&gt;On vacation, on a business trip, or away from home</td>
<td>Cold &amp; flu symptoms&lt;br&gt;Allergies&lt;br&gt;Bronchitis&lt;br&gt;Skin problems&lt;br&gt;Respiratory infection&lt;br&gt;Sinus problems</td>
<td>Due to IRS regulations that impact HSA’s, beginning 1-1-2017 DI is required to charge a $42 fee for Teladoc services.</td>
</tr>
</tbody>
</table>

**PLEASE NOTE: THIS IS A SAMPLE LIST ONLY AND IT IS NOT ALL INCLUSIVE.**
<table>
<thead>
<tr>
<th>PLAN HIGHLIGHTS</th>
<th>IN-NETWORK</th>
<th>OUT-OF-NETWORK</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lifetime Maximum</td>
<td>Unlimited</td>
<td>Unlimited</td>
</tr>
<tr>
<td>coinsurance</td>
<td>80%</td>
<td>50%</td>
</tr>
<tr>
<td>Maximum Reimbursable Charge</td>
<td>N/A</td>
<td>110%</td>
</tr>
<tr>
<td>Calendar Year Deductible: Individual: $2,000 / Family: $6,000</td>
<td></td>
<td>Individual: $4,000 / Family: $12,000</td>
</tr>
<tr>
<td>Calendar Year Out-of-Pocket Maximum (Medical &amp; Rx): Individual: $6,450 / Family: $12,900</td>
<td></td>
<td>Individual: $13,200 / Family: $26,400</td>
</tr>
<tr>
<td>Physician Services (all services including Lab &amp; X-ray)</td>
<td>80%*</td>
<td>50%*</td>
</tr>
<tr>
<td>Preventive Care</td>
<td>Covered 100%</td>
<td>Covered 100%</td>
</tr>
<tr>
<td>Mammogram, PAP, and PSA Tests</td>
<td>Covered 100%</td>
<td>Covered 100%</td>
</tr>
<tr>
<td>Immunizations</td>
<td>Covered 100%</td>
<td>Covered 100%</td>
</tr>
</tbody>
</table>

**Inpatient Services**

- Inpatient (hospital, physician’s visit, professional services) 80%* 50%

**Outpatient Facility Services**

- Outpatient Professional Services (Services performed by surgeons, radiologists, pathologists and anesthesiologists) 80%* 50%
- Short-Term Rehabilitation 80%* 50%

**Other Health Care Facilities Services**

- Home Healthcare (outpatient nursing subject to necessity) 80%* 50%
  - 120 days max per cal. yr. / 16 hours max. per day
- Skilled Nursing Facility, Rehabilitation Hospital, Sub-Acute Facility (60 days maximum per calendar year) 80%* 50%
- Durable Medical Equipment (Unlimited max. per cal. yr.) 80%* 50%

**Place of Services**

- Lab & X-ray
  - Physician Office Covered 100%* 50%
  - Independent Lab Covered 100%* 50%
  - Emergency Room/Urgent Care Covered 100%* Covered 100%
- Advanced Radiology Imaging
  - Physician Office Covered 100%* 50%
  - Independent Lab Covered 100%* 50%
  - Emergency Room/Urgent Care Covered 100%* Covered 100%

**Emergency Care**

- Emergency Room/Urgent Care Facility 80%* 80%
- Outpatient Facility 80%* 80%
- Ambulance 80%* 80%
- Urgent Care
  - Emergency Room/Urgent Care 80%* 80%
  - Outpatient Facility 80%* 80%
  - Ambulance No coverage for non-emergency* No coverage for non-emergency*
- Mental Health (Inpatient / Outpatient) 80%*/ 80%* 50%*/ 50%*
- Substance Abuse (Inpatient / Outpatient) 80%*/ 80%* 50%*/ 50%*

**Cigna Pharmacy – 3 Tier Copay**

(Qualifying preventive generic and preferred brand medications thru mail order only - Covered at 100% by DI’s pharmacy plan)

Patient responsible for the applicable coinsurance based upon tier of the dispensed medication.

Preventive Preferred Brands and Generic Drugs FREE medication for Asthma, Blood Pressure, Blood Thinner, Cholesterol and more. For a complete list of covered illness and medication click on the link below: [insert DI intranet link here]

Please note: List of covered items is subject to change.
ATTENTION NEW HIRES: If you're hired after the annual enrollment period HSA contributions are pro-rated and contributions made on a bi-weekly basis.

OUR DI PREFERRED PLAN w/ HSA COMES WITH CRITICAL ILLNESS INSURANCE — AT NO COST TO YOU

You will receive free Critical Illness Insurance through Allstate Benefits. In the event of a catastrophic diagnosis, the critical illness policy helps you pay your deductible. This benefit includes coverage for your children at no additional cost and you may purchase coverage for your spouse. The table below illustrates both the benefit and the benefit coverage amounts.

<table>
<thead>
<tr>
<th>INITIAL CRITICAL ILLNESS/ CANCER BENEFITS</th>
<th>BENEFIT AMOUNT</th>
<th>SUPPLEMENTAL CRITICAL ILLNESS BENEFITS</th>
<th>BENEFIT AMOUNT</th>
</tr>
</thead>
<tbody>
<tr>
<td>Heart Attack (100%)</td>
<td>$5,000</td>
<td>Advanced Alzheimer’s Disease (25%)</td>
<td>$1,250</td>
</tr>
<tr>
<td>Stroke (100%)</td>
<td>$5,000</td>
<td>Advanced Parkinson’s Disease</td>
<td>$1,250</td>
</tr>
<tr>
<td>Coronary Artery By-Pass Surgery (25%)</td>
<td>$1,250</td>
<td>Benign Brain Tumor (100%)</td>
<td>$5,000</td>
</tr>
<tr>
<td>Major Organ Transplant (100%)</td>
<td>$5,000</td>
<td>Coma (100%)</td>
<td>$5,000</td>
</tr>
<tr>
<td>End Stage Renal Failure (100%)</td>
<td>$5,000</td>
<td>Complete Blindness (100%)</td>
<td>$5,000</td>
</tr>
<tr>
<td>Invasive Cancer (100%)</td>
<td>$5,000</td>
<td>Complete Loss of Hearing (100%)</td>
<td>$5,000</td>
</tr>
<tr>
<td>Carcinoma in Situ (25%)</td>
<td>$1,250</td>
<td>Paralysis (100%)</td>
<td>$5,000</td>
</tr>
</tbody>
</table>

SPOUSE/CHILD COVERAGE

Spouse Coverage 50% coverage ($2,500) available for purchase; enrollment information is emailed to you

Child(ren) 50% coverage ($2,500) included with employee policy at no cost to employee

WELLNESS BENEFIT $75 annual reimbursement when you receive select wellness screenings
D1 offers two voluntary PPO dental plans to choose from, both are provided through Cigna. Select the dental plan that will best meet your needs.

- **Cigna Core Plan**
- **Cigna Enhanced Plan**

Brief benefit summaries are provided to the right. Please refer to your plan documents for complete details including important coverage limitations. A complete list of preferred “In-Network” dental providers may be found by visiting: [www.mycigna.com](http://www.mycigna.com) or by calling **1.800.244.6224**.

### Core Plan

<table>
<thead>
<tr>
<th>BENEFIT</th>
<th>IN-NETWORK</th>
<th>OUT-OF-NETWORK</th>
</tr>
</thead>
<tbody>
<tr>
<td>Calendar Year Maximum (Class II &amp; Class III Expenses)</td>
<td>$1,000</td>
<td>All deductibles, plan maximums, and service specific maximums (dollar and occurrence) cross accumulate between in and out of network</td>
</tr>
<tr>
<td>Annual Deductible: Individual</td>
<td>$0 per person</td>
<td>$50 per person</td>
</tr>
<tr>
<td>Reimbursement Levels</td>
<td>Based on Reduced Contracted Fees</td>
<td>80th Percentile of Reasonable &amp; Customary Allowance</td>
</tr>
</tbody>
</table>

#### Class I

**Preventive & Diagnostic Care**

- Oral Exams Routine
- Cleanings Full (2 per year)
- Mouth X-rays and Bitewing X-rays (1 per year)
- Panoramic X-ray and Periapical X-rays (once every 3 years)
- Fluoride Application (up to age 19)
- Sealants (up to age 16)
- Space Maintainers
- Emergency Care to Relieve Pain
- Histopathology Exams

<table>
<thead>
<tr>
<th>PLAN PAYS</th>
<th>YOU PAY</th>
</tr>
</thead>
<tbody>
<tr>
<td>100%</td>
<td>No Charge</td>
</tr>
<tr>
<td>80%</td>
<td>20%</td>
</tr>
</tbody>
</table>

#### Class II

**Basic Restorative Care**

- Fillings/Root Canal Therapy/Endodontics
- Osseous Surgery
- Periodontal Scaling and Root Planing
- Denture Adjustments/Repairs
- Oral Surgery – Simple Extractions
- Oral Surgery – All except simple extractions
- Anesthetics
- Surgical Extractions of Impacted Teeth
- Repairs (Bridges, Crowns, Inlays)

<table>
<thead>
<tr>
<th>PLAN PAYS</th>
<th>YOU PAY</th>
</tr>
</thead>
<tbody>
<tr>
<td>80%*</td>
<td>20%*</td>
</tr>
<tr>
<td>Subject to annual deductible</td>
<td>Subject to annual deductible</td>
</tr>
<tr>
<td>50%*</td>
<td>50%*</td>
</tr>
<tr>
<td>Subject to annual deductible</td>
<td>Subject to annual deductible</td>
</tr>
</tbody>
</table>

#### Class III

**Major Restorative Care**

- Crowns
- Dentures / Bridges
- Inlays/Onlays
- Prosthesis Over Implant

<table>
<thead>
<tr>
<th>PLAN PAYS</th>
<th>YOU PAY</th>
</tr>
</thead>
<tbody>
<tr>
<td>60%*</td>
<td>40%*</td>
</tr>
<tr>
<td>Subject to annual deductible</td>
<td>Subject to annual deductible</td>
</tr>
<tr>
<td>50%*</td>
<td>50%*</td>
</tr>
<tr>
<td>Subject to annual deductible</td>
<td>Subject to annual deductible</td>
</tr>
</tbody>
</table>

#### Class IV

**Orthodontia**

<table>
<thead>
<tr>
<th>PLAN PAYS</th>
<th>YOU PAY</th>
</tr>
</thead>
<tbody>
<tr>
<td>Not Covered</td>
<td>100% of Dentist’s usual fees</td>
</tr>
<tr>
<td>Not Covered</td>
<td>100% of Dentist’s usual fees</td>
</tr>
</tbody>
</table>

*All deductibles, plan maximums, and service specific maximums (dollar and occurrence) cross accumulate between in and out of network.  
*Subject to annual deductible.*
## Calendar Year Maximum (Class II & Class III Expenses)

$2,000

All deductibles, plan maximums, and service specific maximums (dollar and occurrence) cross accumulate between In- and Out-of-network.

### Plan Deductibles

<table>
<thead>
<tr>
<th>Category</th>
<th>In-Network</th>
<th>Out-of-Network</th>
</tr>
</thead>
<tbody>
<tr>
<td>Individual</td>
<td>$0 per person</td>
<td>$50 per person</td>
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</tbody>
</table>

### Class I - Preventive & Diagnostic Care

- Oral Exams Routine
- Cleanings Full (2 per year)
- Mouth X-rays and Bitewing X-rays (1 per year)
- Panoramic X-ray and Periapical X-rays (once every 3 years)
- Fluoride Application (up to age 19)
- Sealants (up to age 16)
- Space Maintainers
- Emergency Care to Relieve Pain
- Histopathology Exams

**Reimbursement Levels Based on Reduced Contracted Fees**

<table>
<thead>
<tr>
<th>PLAN PAYS</th>
<th>YOU PAY</th>
</tr>
</thead>
<tbody>
<tr>
<td>100%</td>
<td>No Charge</td>
</tr>
</tbody>
</table>

**Reimbursement Levels Based on Reduced Contracted Fees**

<table>
<thead>
<tr>
<th>PLAN PAYS</th>
<th>YOU PAY</th>
</tr>
</thead>
<tbody>
<tr>
<td>90%</td>
<td>10%</td>
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</tbody>
</table>

### Class II - Basic Restorative Care

- Fillings/Root Canal Therapy/Endodontics
- Osseous Surgery
- Periodontal Scaling and Root Planing
- Denture Adjustments/Repairs
- Oral Surgery – Simple Extractions
- Oral Surgery – All except simple extractions
- Anesthetics
- Surgical Extractions of Impacted Teeth
- Repairs (Bridges, Crowns, Inlays)

**Reimbursement Levels Based on Reduced Contracted Fees**

<table>
<thead>
<tr>
<th>PLAN PAYS</th>
<th>YOU PAY</th>
</tr>
</thead>
<tbody>
<tr>
<td>85%*</td>
<td>15%*</td>
</tr>
</tbody>
</table>

### Class III - Major Restorative Care

- Crowns
- Dentures / Bridges
- Inlays/Onlays
- Prosthesis Over Implant

**Reimbursement Levels Based on Reduced Contracted Fees**

<table>
<thead>
<tr>
<th>PLAN PAYS</th>
<th>YOU PAY</th>
</tr>
</thead>
<tbody>
<tr>
<td>75%*</td>
<td>25%*</td>
</tr>
</tbody>
</table>

### Class IV - TMJ

- 50%

### Class IX - Implants

- Deductible
  - $0 per person
  - $0 per family
- Annual Maximum
  - Subject to plan annual maximum

**Reimbursement Levels Based on Reduced Contracted Fees**

<table>
<thead>
<tr>
<th>PLAN PAYS</th>
<th>YOU PAY</th>
</tr>
</thead>
<tbody>
<tr>
<td>75%</td>
<td>25%</td>
</tr>
</tbody>
</table>

*Subject to annual deductible.
A brief benefit summary is provided here. For complete details, including important coverage limitations, please refer to plan documents. To learn more about what other benefits might be available visit: [www.mycigna.com](http://www.mycigna.com) or contact them at [1.800.244.6224](tel:1.800.244.6224).

<table>
<thead>
<tr>
<th>BENEFIT COVERAGE</th>
<th>VISION</th>
<th>IN-NETWORK</th>
<th>OUT-OF-NETWORK</th>
<th>FREQUENCY PERIOD*</th>
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</thead>
<tbody>
<tr>
<td>Exam Copay</td>
<td>$15</td>
<td>N/A</td>
<td></td>
<td>12 months</td>
</tr>
<tr>
<td>Exam Allowance (Once per frequency period)</td>
<td>Covered 100% after Copay</td>
<td>Up to $50</td>
<td></td>
<td>12 months</td>
</tr>
<tr>
<td>Materials Copay (Lens + Frames/Therapeutic)</td>
<td>$25</td>
<td>N/A</td>
<td></td>
<td>12 months</td>
</tr>
<tr>
<td>Contact Lenses Allowances (In lieu of glasses) (one pair or single purchase per frequency period)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Elective</td>
<td>Up to $130</td>
<td>Up to $105</td>
<td></td>
<td>12 months</td>
</tr>
<tr>
<td>Therapeutic</td>
<td>Covered 100%</td>
<td>Up to $210</td>
<td></td>
<td>12 months</td>
</tr>
<tr>
<td>Frame Retail Allowance (Once a year)</td>
<td>Up to $130</td>
<td>Up to $70</td>
<td></td>
<td>12 months</td>
</tr>
</tbody>
</table>

*Frequency period begins January 1 (Calendar year basis).*
MOTIVATEMe: A Wellness Program — CIGNA

The easiest way to begin behavior change is to “start small.” Be specific about how you are going to reach your goals. Visualize in detail how your life will be different when you reach them. Remember, the steps you take today will result in what you want to accomplish.

DI, along with Cigna, offer extra rewards to help you achieve your wellness goals. But first, you must meet the eligibility requirements.

Important Note: If you are unable to meet a standard for a reward under the MotivateMe wellness program, you might qualify for an opportunity to earn the same reward by different means. Contact Global Benefits/Cigna and they will work with you and/or your doctor to determine alternative methods for your participation.

WELLNESS PROGRAM ELIGIBILITY REQUIREMENTS

- Must be enrolled the DI Preferred Plan w/HSA and achieve certain health/wellness goals to automatically receive a DI Visa® Prepaid Card, up to $500 per employee and/or up to $500 for your enrolled spouse
- Complete a health risk assessment – $50 reward
- Biometric screening – $100 award

IMPORTANT NOTE: Before you participate in any of the activities listed below, and to be eligible to receive any of the awards associated with these activities, you must first complete both the health risk assessment and biometric screening.
- Preventive care exam – $50 award
- Talk to a health coach/Make progress toward goal to overcome a health issue – $100 award
- Talk to a health coach/Achieve goal to overcome a health problem – $100 award
- Complete stress, weight or tobacco cessation (telephonic program) – $100 award
- Participate in a wellness activity, make smart food choices, take part in a physical activity and weight management – $25 award for each (maximum potential earnings in each activity category – total $50)
- Preventive dental exam (one exam per year) – $50 award
- Preventive vision exam (one exam per year) – $25 award

There are several programs or activities associated with MotivateMe that will help you get started:
- Online Health Assessment
- Biometric Screenings
- Health and Wellness Exhibitions
- Monthly Lunch and Learns
- Health Outcomes (body mass index, total cholesterol, LDL cholesterol, blood pressure)
- Health Activities (health management, healthy eating, physical activity, weight management)

To learn more about the MotivateMe wellness program visit the Cigna website: www.mycigna.com or contact them at 1.800.244.6224.
DI offers three types of voluntary flexible spending accounts:

- Full Purpose Health Care FSA
- Dependent Care FSA
- Limited Purpose FSA

These accounts are administered by TaxSaver Plan. FSAs let you set aside pre-tax funds via convenient payroll deductions. Use the money to reimburse yourself for eligible health care and/or dependent care expenses.

**How the plans work**

You determine how much you would like to contribute through pre-tax payroll deductions. When you have eligible expenses, you pay them from your account(s).

It is important to estimate your annual contribution amount carefully. Remember to keep your receipts in case of an IRS audit. The Internal Revenue Service requires that you forfeit any unclaimed funds in your account(s) after December 31—this is known as the “use it or lose it” rule.

**Benefit card**

If you enroll in a flexible spending account, a debit benefit card will be mailed to your on-file home address. This card works like a debit card and makes paying for qualified expenses convenient.

**Full Purpose Health Care FSA**

You can open a Health Care FSA and contribute up to $2,550 each year to cover qualified out-of-pocket costs such as:

- Medical, dental and vision care deductibles, copayments and/or coinsurance
- Hearing aids
- Eyeglasses, contact lenses or Lasik surgery
- Orthodontia expenses

**Important Note:** Per the IRS, you are not eligible to be enrolled in a Full Purpose FSA if you are already enrolled in an HSA.

**Eligible health care expenses**


**Grace period**

The FSA plan year is January 1, 2017 – December 31, 2017. Participants have an additional 2 ½ month grace period to file claims for the 2017 plan year.

**Dependent Care FSA**

Money you contribute to the Dependent Care FSA can be used toward care for dependent children under the age of 13 who live with you and for whom you provide more than 50% support, or for any dependent living with you who is physically or mentally incapable of caring for him or herself. The annual contribution limit for the Dependent Care FSA is $5,000.

**Limited Purpose FSA**

A limited-purpose health flexible spending account (referred to as a limited-purpose FSA) is much like a typical, general-purpose health FSA. However, under a limited-purpose FSA, eligible expenses are limited to qualifying dental and vision expenses for you, your spouse, and your eligible dependents.

Here’s how a limited-purpose FSA works. Money is set aside from your paycheck before taxes are taken out. You can then use your pre-tax FSA dollars to pay for eligible vision or dental expenses throughout the plan year. You save money on expenses you’re already paying for, like dental checkups, vision exams, eyeglasses, and much more.

For additional information on FSAs contact:

**TaxSaver Customer Service Representative**

Telephone: 1.800.328.4337
Email: csr@taxsaverplan.com
Website: [www.taxesaverplan.com](http://www.taxesaverplan.com)
TAX ADVANTAGE ACCOUNTS

DI offers several tax-advantaged accounts that you can use to pay for qualified expenses. All employees are eligible for the Child/Elder Care Flexible Spending Account (FSA), our dependent care account. You may be eligible for more than one health care account:

If you enroll in the DI Preferred with HSA Plan, you are eligible to enroll in a Health Savings Account (HSA) and/or Limited Purpose FSA.

Quick comparisons between the accounts

<table>
<thead>
<tr>
<th>FEATURES</th>
<th>TYPE OF ACCOUNTS</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>HEALTH SAVINGS ACCOUNT (HSA)</td>
</tr>
<tr>
<td>Before-Tax Contributions: Your contributions to the account are made on a before-tax basis. Contributions can be made up to the IRS limit.</td>
<td>·</td>
</tr>
<tr>
<td>Tax-Free Earnings: All earnings on the money in your account grows tax free. (State tax treatment varies, check with your state’s department of revenue to find out more.)</td>
<td>·</td>
</tr>
<tr>
<td>Tax-Free Withdrawals: Withdrawals are tax free as long as you use the money to pay for qualified expenses.</td>
<td>·</td>
</tr>
<tr>
<td>Balance Carry Over: Unused funds are carried over from year-to-year. The account is yours, even if you leave the company.</td>
<td>·</td>
</tr>
<tr>
<td>Access to Funds: Only funds already in the account are available to be paid out. Your elected annual contribution amount is not available immediately.</td>
<td>·</td>
</tr>
<tr>
<td>Convenient Debit Card: You receive a debit card. If you use it, you do not have to file a claim for reimbursement.</td>
<td>·</td>
</tr>
<tr>
<td>Option to Change Contributions: You may stop, start, decrease or add* to your contributions during the year without experiencing a qualifying change in status.</td>
<td>·</td>
</tr>
</tbody>
</table>

*Subject to IRS limits.

ATTENTION HSA PARTICIPANTS!

Per the IRS, you are not eligible to open a Health Care (General Purpose) FSA if you participate in the high deductible health plan and have an HSA. However, you may participate in the Limited Purpose Health Care FSA for vision and dental-related expenses. There are no restrictions on the Dependent Care FSA.
**BASIC LIFE INSURANCE / BASIC SUPPLEMENTAL ACCIDENTAL DEATH & DISMEMBERMENT (AD&D) — METLIFE**

Ensure financial security for your family in the event of injury or death. DynCorp International (DI) offers Life, Accidental Death and Dismemberment (AD&D) coverage through MetLife. Please consult your Human Resources policies or CBA (as applicable) for your DI-paid insurance benefit. This is an added benefit — at no cost to you.

Purchase additional coverage for yourself, your spouse or your children.

- **Employee Supplemental Life** – variable levels available
- **Dependent Life** – variable levels available (per child):
  - $100,000 spouse and $25,000
  - $75,000 spouse and $20,000
  - $50,000 spouse and $15,000
  - $25,000 spouse and $10,000
  - $10,000 spouse and $5,000
  - $5,000 spouse and $2,500
- **Employee Supplemental AD&D** – variable levels available

**IMPORTANT NOTES:**

It is important that you name a beneficiary for all life insurance coverages. You can review/change your life insurance beneficiary at any time by visiting MetLife’s website at: www.metlife.com/mybenefits.

New hires or newly eligible employees may choose up to the maximum coverage when they first become eligible to enroll in the Life Insurance and AD&D insurance plans.

**TRICARE SUPPLEMENT — SELMAN & COMPANY**

Selman & Company offers supplement plans for second-career retirees. If you plan to obtain your supplement coverage through DynCorp International LLC via a qualified cafeteria plan, you and your family can access a health program that:

- Pays your TRICARE cost share
- Pays your TRICARE copays including your prescriptions, and is available using pre-tax dollars

**DISABILITY BENEFITS — THE HARTFORD**

Short-Term and Long-Term Disability insurance benefits are offered through The Hartford. Both plans pay a percentage of your base pay when you are unable to work due to illness or injury.

**Eligibility:** Eligibility is dependent upon the terms of any applicable CBA, contract, service contract act, employee classifications and the operation of host country and/or U.S. law. Contact your Human Resource Department if you have questions regarding disability benefits. Short-Term Disability (STD) is a company-paid benefit. This is an added benefit – at no cost to you.

**Short-Term Disability**

60% of Pre-Disability Earnings

You are automatically enrolled. Benefits commence in two ways:

- **Disability caused by injury:** on the 1st day of total disability or disabled and working
- **Disability caused by sickness:** on the 8th consecutive day of total disability or disabled and working

75% of Pre-Disability Earnings

This benefit is employee-paid. Benefits commence in two ways:

- **Disability caused by injury:** on the 1st day of total disability or disabled and working
- **Disability caused by sickness:** on the 4th consecutive day of total disability or disabled and working

**Maximum Duration of Benefits Payable:** 26 weeks or until benefits become payable under Long-Term Disability, whichever occurs first.

**Long-Term Disability**

Approved benefits are payable after 6 months of your disability. You may elect long-term disability as follows:

- 50% of base annual earnings
- 60% of base annual earnings
- 70% of base annual earnings

This after-tax benefit is paid by the employee. Cost will vary based on the plan you select and is based on your covered annual compensation. LTD is paid on a monthly basis with a maximum benefit payable of $25,000 per month. **Enrollment is voluntary and may be waived by the employee.**
401(k) — T. ROWE PRICE
You are eligible to join the DynCorp International LLC Savings Plan. To get additional information regarding the plan, election deferral and yearly contribution maximums, contact: T. Rowe Price directly at: 1.800.922.9945 or visit their website at: www.rps.troweprice.com.

EMPLOYEE ASSISTANCE PROGRAM — INOVA
Inova Employee Assistance is our employee assistance and work life program. All employees and their family members have access to free, confidential resources to assist with a variety of work and personal issues.

Available services include:
- Legal services
- Confidential counseling services
- Financial services
- Identity theft services
- Work life referral services

To learn more about this valuable benefit, contact Inova Employee Assistance at 1.877.847.4518 or visit their website at: www.inova.org/eap.
- Username: dyncorp
- Password: dyncorp

GROUP VOLUNTARY CRITICAL ILLNESS AND GROUP VOLUNTARY ACCIDENT INSURANCE — ALLSTATE
During annual enrollment, you are eligible to enroll in Allstate Benefit’s Group Voluntary Accident Insurance and Group Voluntary Critical Illness Insurance.

Critical Illness coverage provides a lump-sum cash benefit to help cover out-of-pocket expenses in the event of a diagnosis of a critical illness such as cancer, stroke, heart attack or the need for an organ transplant.

Accident Coverage provides cash benefits for out-of-pocket expenses associated with an accidental injury. Benefits correspond with treatment for on- and off-the-job accidental injuries including hospitalization, emergency treatment, intensive care, fractures and more.

**ACT NOW!** Employees have the opportunity to enroll in these two plans without having to answer medical questions or provide proof of good health; but ONLY during DI’s annual benefits enrollment period.

For additional information or to enroll, visit www.dynaddedbenefits.com or call 1.855.819.4460.

ADDED BENEFITS®
The Added Benefits® Program offers you:
- Free, no-obligation auto and home insurance quotes from MetLife Auto & Home®, Travelers, and Liberty Mutual® with special savings and discounts. Plus, auto quotes are faster than ever with their online Comparative Rater tool
- Legal services from LegalShield, providing legal protection whenever the need arises for just $15.95 per month. Consult with LegalShield on topics, such as: Real Estate Matters, Consumer Finance, Family Law, and more.
- An affordable and responsible way to purchase name brand computers, electronics, and more through manageable payroll deductions with Purchasing Power
- Comprehensive pet insurance from Veterinary Pet Insurance (VPI®) with a 5% discount for DI employees
- Discounts and employee pricing on every day purchases including eating out and household goods to larger ticket items such as computers and vehicles through Dyn Marketplace Discount Program.

For information about these benefits, visit: www.dynaddedbenefits.com or call 1.855.819.4460.
<table>
<thead>
<tr>
<th>PROVIDER CONTACT LIST</th>
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<table>
<thead>
<tr>
<th>BENEFITS PROVIDER</th>
<th>BENEFIT PLAN</th>
<th>TELEPHONE</th>
<th>WEBSITE / EMAIL</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cigna</td>
<td>• Medical/Rx</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Dental</td>
<td></td>
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<tr>
<td></td>
<td>• Vision</td>
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<td></td>
<td>• Wellness Program</td>
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<td></td>
<td>• HSA Bank</td>
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<td></td>
<td>1.800.CIGNA24</td>
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<td></td>
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<td></td>
<td>(1.800.244.6224)</td>
<td></td>
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<tr>
<td></td>
<td><a href="http://www.mycigna.com">www.mycigna.com</a></td>
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<tr>
<td>MetLife Insurance</td>
<td>• Life Insurance and AD&amp;D</td>
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<tr>
<td></td>
<td>1.800.638.5000</td>
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<td><a href="http://www.metlife.com/mybenefits">www.metlife.com/mybenefits</a></td>
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<td>The Hartford</td>
<td>• Disability Benefits</td>
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<td>1.800.741.4306</td>
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<td><a href="http://www.thehartfordatwork.com">www.thehartfordatwork.com</a></td>
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<tr>
<td>Selman &amp; Company</td>
<td>• Tricare Supplement</td>
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<td></td>
<td>1.800.735.6262</td>
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<td></td>
<td><a href="http://www.selmanco.com">www.selmanco.com</a></td>
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<tr>
<td>T. Rowe Price</td>
<td>• 401(k) / Roth Retirement Plan</td>
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<td></td>
<td>1.800.328.4337</td>
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<td></td>
<td><a href="http://www.rps.troweprice.com">www.rps.troweprice.com</a></td>
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<tr>
<td>TaxSaver</td>
<td>• Flexible Spending Accounts</td>
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<tr>
<td></td>
<td>1.800.328.4337</td>
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<td><a href="http://www.taxesaverplan.com">www.taxesaverplan.com</a></td>
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<td><a href="mailto:csr@taxsaver.com">csr@taxsaver.com</a></td>
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<td>Inova</td>
<td>• Employee Assistance Program</td>
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<td>Added Benefits</td>
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<td><a href="http://www.dynaddedbenefits.com">www.dynaddedbenefits.com</a></td>
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</table>
**Brand Name Drugs**—Drugs that have trade names and are protected by patents. Brand name drugs are generally the most costly choice.

**Coinsurance**—The percentage of a covered charge paid by the plan.

**Consumer Driven Health Plan (CDHP)**—A medical plan used in conjunction with a health reimbursement account (HRA) or a health savings account (HSA).

**Copayment (Copay)**—A flat dollar amount you pay for medical or prescription drug services regardless of the actual amount charged by your doctor or health care provider.

**Deductible**—The annual amount you and your family must pay each year before the plan pays benefits.

**Generic Drugs**—Generic drugs are less expensive versions of brand name drugs that have the same intended use, dosage, effects, risks, safety and strength. The strength and purity of generic medications are strictly regulated by the Federal Food and Drug Administration.

**High Deductible Health Plan (HDHP)**—A medical plan that may be used in conjunction with a health reimbursement account (HRA) or a health savings account (HSA).

**Health Care FSA**—A health care FSA can reimburse you or help you pay for eligible health care expenses not covered by your health plan. The portion of your paycheck you put into your FSA is taken out before you pay federal income taxes, Social Security taxes and most state taxes. It’s a great way to save money.

**Health Savings Account (HSA)**—A fund you can use to help pay for eligible medical costs not covered by your medical plan. Both employers and employees may contribute to this fund; employees do so through pre-tax payroll deductions. Equity partners can have monthly contributions charged against their monthly draw account.

**Limited Purpose FSA**—A limited-purpose health flexible spending account (referred to as a limited-purpose FSA) is much like a typical, general-purpose health FSA. You can then use your pre-tax FSA dollars to pay for eligible vision or dental expenses throughout the plan year.

**In-Network**—Use of a health care provider that participates in the plan’s network. When you use providers in the network, you lower your out-of-pocket expenses because the plan pays a higher percentage of covered expenses.

**Out-of-Network**—Use of a health care provider that does not participate in a plan’s network.

**Mail Order Pharmacy**—Mail order pharmacies generally provide a 90-day supply of a prescription medication for the same cost as a 60-day supply at a retail pharmacy. Plus, mail order pharmacies offer the convenience of shipping directly to your door.

**Inpatient**—Services provided to an individual during an overnight hospital stay.

**Outpatient**—Services provided to an individual at a hospital facility without an overnight hospital stay.

**Out-of-Pocket Maximum**—The maximum amount you and your family will pay for eligible expenses each plan year. Once your expenses reach the out-of-pocket maximum, the plan pays benefits at 100% of eligible expenses for the remainder of the year.

**Primary Care Physician (PCP)**—Physician (generally a family practitioner, internist or pediatrician) who provides ongoing medical care. A primary care physician treats a wide variety of health-related conditions and refers patients to specialists as necessary.

**Specialist**—A physician who has specialized training in a particular branch of medicine (e.g., a surgeon, gastroenterologist or neurologist).
**REQUIRED HEALTH NOTICES**

**Company Name (the “Company”)**
DYNCORP INTERNATIONAL LLC

**Effective Date**
JANUARY 1, 2017

**Creditable Plan Name(s)**
CIGNA

**Plan Administrator:**
Director, Global Benefits
13500 Heritage Pkwy
Fort Worth, TX 76177
1-817-224-7809

**HIPAA Privacy Official**
Human Resources Director
Telephone: 1.817.224.7809

**HIPAA Special Enrollment Deadline**
30 days

**Members of Organized Health Care Arrangement**

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**Women’s Health and Cancer Rights Notice**

The Company is required by law to provide you with the following notice:

The Women’s Health and Cancer Rights Act of 1998 ("WHCRA") provides certain protections for individuals receiving mastectomy-related benefits. Coverage will be provided in a manner determined in consultation with the attending physician and the patient, for:

- All stages of reconstruction of the breast on which the mastectomy was performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance;
- Prostheses; and
- Treatment of physical complications of the mastectomy, including lymphedemas.

The Company’s plan(s) provide medical coverage for mastectomies and the related procedures listed above, subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this plan.

If you would like more information on WHCRA benefits, please refer to your Summary Plan Description/Policy booklet or contact the Plan Administrator.

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**Newborn and Mother’s Health Protection Act**

Group health plans and health insurance issuers generally may not, under Federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a caesarean section. However, Federal law generally does not prohibit the mother’s or newborn’s attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under Federal law, require that a provider obtain authorization from the plan or the insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

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**HIPAA Notice of Privacy Policy and Procedures**

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. This notice is provided to you on behalf of the Company about the Plan. It pertains only to health care coverage provided under the Plan.
The Plan’s Duty to Safeguard Your Protected Health Information

Individually identifiable information about your past, present, or future health or condition, the provision of health care to you, or payment for the health care is considered “Protected Health Information” (“PHI”). The Plan is required to extend certain protections to your PHI, and to give you this Notice about its privacy practices that explains how, when and why the Plan may use or disclose your PHI. Except in specified circumstances, the Plan may use or disclose only the minimum necessary PHI to accomplish the purpose of the use or disclosure.

The Plan is required to follow the privacy practices described in this Notice, though it reserves the right to change those practices and the terms of this Notice at any time. If it does so, and the change is material, you will receive a revised version of this Notice either by hand delivery, mail delivery to your last known address, or some other fashion. This Notice, and any material revisions of it, will also be provided to you in writing upon your request (ask your Human Resources Department, or contact the Plan’s HIPAA Privacy Official).

You may also receive one or more other privacy notices from insurance companies that provide benefits under the Plan. Those notices will describe how the insurance companies use and disclose PHI, and your rights with respect to the PHI they maintain.

How the Plan May Use and Disclose Your Protected Health Information

The Plan uses and discloses PHI for a variety of reasons. For its routine uses and disclosures it does not require your authorization, but for other uses and disclosures, your authorization (or the authorization of your personal representative (e.g., a person who is your custodian, guardian, or has your power-of-attorney) may be required. The following offers more description and examples of the Plan’s uses and disclosures of your PHI.

Uses and Disclosures Relating to Treatment, Payment, or Health Care Operations

- Treatment: Generally, and as you would expect, the Plan is permitted to disclose your PHI for purposes of your medical treatment. Thus, it may disclose your PHI to doctors, nurses, hospitals, emergency medical technicians, pharmacists and other health care professionals where the disclosure is for your medical treatment. For example, if you are injured in an accident, and it’s important for your treatment team to know your blood type, the Plan could disclose that PHI to the team in order to allow it to more effectively provide treatment to you.

- Payment: Of course, the Plan’s most important function, as far as you are concerned, is that it pays for all or some of the medical care you receive (provided the care is covered by the Plan). In the course of its payment operations, the Plan receives a substantial amount of PHI about you. For example, doctors, hospitals and pharmacies that provide you care send the Plan detailed information about the care they provided, so that they can be paid for their services. The Plan may also share your PHI with other plans, in certain cases. For example, if you are covered by more than one health care plan (e.g., covered by this Plan, and your spouse’s plan, or covered by the plans covering your father and mother), we may share your PHI with the other plans to coordinate payment of your claims.

- Health care operations: The Plan may use and disclose your PHI in the course of its “health care operations.” For example, it may use your PHI in evaluating the quality of services you received, or disclose your PHI to an accountant or attorney for audit purposes. In some cases, the Plan may disclose your PHI to insurance companies for purposes of obtaining various insurance coverage. However, the Plan will not disclose, for underwriting purposes, PHI that is genetic information.

Other Uses and Disclosures of Your PHI Not Requiring Authorization

The law provides that the Plan may use and disclose your PHI without authorization in the following circumstances:

- To the Plan Sponsor: The Plan may disclose PHI to the employers (such as the Company) who sponsor or maintain the Plan for the benefit of employees and dependents. However, the PHI may only be used for limited purposes, and may not be used for purposes of employment-related actions or decisions or in connection with any other benefit or employee benefit plan of the employers. PHI may be disclosed to: the human resources or employee benefits department for purposes of enrollments and disenrollments, census, claim resolutions, and other matters related to Plan administration; payroll department for purposes of ensuring appropriate payroll deductions and other payments by covered persons for their coverage; information technology department, as needed for preparation of data compilations and reports related to Plan administration; finance department for purposes of reconciling appropriate payments of premium to and benefits from the Plan, and other matters related to Plan administration; internal legal counsel to assist with resolution of claim, coverage and other disputes related to the Plan’s provision of benefits.
• To the Plan’s Service Providers: The Plan may disclose PHI to its service providers (“business associates”) who perform claim payment and plan management services. The Plan requires a written contract that obliges the business associate to safeguard and limit the use of PHI.

• Required by law: The Plan may disclose PHI when a law requires that it report information about suspected abuse, neglect or domestic violence, or relating to suspected criminal activity, or in response to a court order. It must also disclose PHI to authorities that monitor compliance with these privacy requirements.

• For public health activities: The Plan may disclose PHI when required to collect information about disease or injury, or to report vital statistics to the public health authority.

• For health oversight activities: The Plan may disclose PHI to agencies or departments responsible for monitoring the health care system for such purposes as reporting or investigation of unusual incidents.

• Relating to descendants: The Plan may disclose PHI relating to an individual’s death to coroners, medical examiners or funeral directors, and to organ procurement organizations relating to organ, eye, or tissue donations or transplants.

• For research purposes: In certain circumstances, and under strict supervision of a privacy board, the Plan may disclose PHI to assist medical and psychiatric research.

• To avert threat to health or safety: In order to avoid a serious threat to health or safety, the Plan may disclose PHI as necessary to law enforcement or other persons who can reasonably prevent or lessen the threat of harm.

• For specific government functions: The Plan may disclose PHI of military personnel and veterans in certain situations, to correctional facilities in certain situations, to government programs relating to eligibility and enrollment, and for national security reasons.

Uses and Disclosures Requiring Authorization
For uses and disclosures beyond treatment, payment and operations purposes, and for reasons not included in one of the exceptions described above, the Plan is required to have your written authorization. For example, uses and disclosures of psychotherapy notes, uses and disclosures of PHI for marketing purposes, and disclosures that constitute a sale of PHI would require your authorization. Your authorizations can be revoked at any time to stop future uses and disclosures, except to the extent that the Plan has already undertaken an action in reliance upon your authorization.

Uses and Disclosures Requiring You to Have an Opportunity to Object
The Plan may share PHI with your family, friend or other person involved in your care, or payment for your care. We may also share PHI with these people to notify them about your location, general condition, or death. However, the Plan may disclose your PHI only if it informs you about the disclosure in advance and you do not object (but if there is an emergency situation and you cannot be given your opportunity to object, disclosure may be made if it is consistent with any prior expressed wishes and disclosure is determined to be in your best interests; you must be informed and given an opportunity to object to further disclosure as soon as you are able to do so).

Your Rights Regarding Your Protected Health Information
You have the following rights relating to your protected health information:

• To request restrictions on uses and disclosures: You have the right to ask that the Plan limit how it uses or discloses your PHI. The Plan will consider your request, but is not legally bound to agree to the restriction. To the extent that it agrees to any restrictions on its use or disclosure of your PHI, it will put the agreement in writing and abide by it except in emergency situations. The Plan cannot agree to limit uses or disclosures that are required by law.

• To choose how the Plan contacts you: You have the right to ask that the Plan send you information at an alternative address or by an alternative means. To request confidential communications, you must make your request in writing to the Privacy Official. We will not ask you the reason for your request. Your request must specify how or where you wish to be contacted. The Plan must agree to your request as long as it is reasonably easy for it to accommodate the request.

• To inspect and copy your PHI: Unless your access is restricted for clear and documented treatment reasons, you have a right to see your PHI in the possession of the Plan or its vendors if you put your request in writing. The Plan, or someone on behalf of the Plan, will respond to your request, normally within 30 days. If your request is denied, you will receive written reasons for the denial and an explanation of any right to have the denial reviewed. If you want copies of your PHI, a charge for copying may be imposed but may be waived, depending on your circumstances. You have a right to choose what portions of your information you want copied and to receive, upon request, prior information on the cost of copying.
• If you believe that there is a mistake or missing information in a record of your PHI held by the Plan or one of its vendors, you may request, in writing, that the record be corrected or supplemented. The Plan or someone on its behalf will respond, normally within 60 days of receiving your request. The Plan may deny the request if it is determined that the PHI is: (i) correct and complete; (ii) not created by the Plan or its vendor and/or not part of the Plan’s or vendor’s records; or (iii) not permitted to be disclosed. Any denial will state the reasons for denial and explain your rights to have the request and denial, along with any statement in response that you provide, appended to your PHI. If the request for amendment is approved, the Plan or vendor, as the case may be, will change the PHI and so inform you, and tell others that need to know about the change in the PHI.

• To find out what disclosures have been made: You have a right to get a list of when, to whom, for what purpose, and what portion of your PHI has been released by the Plan and its vendors, other than instances of disclosure for which you gave authorization, or instances where the disclosure was made to you or your family. In addition, the disclosure list will not include disclosures for treatment, payment, or health care operations. The list also will not include any disclosures made for national security purposes, to law enforcement officials or correctional facilities, or before the date the federal privacy rules applied to the Plan. You will normally receive a response to your written request for such a list within 60 days after you make the request in writing. Your request can relate to disclosures going as far back as six years. There will be no charge for up to one such list each year. There may be a charge for more frequent requests.

How to Complain about the Plan’s Privacy Practices

If you think the Plan or one of its vendors may have violated your privacy rights, or if you disagree with a decision made by the Plan or a vendor about access to your PHI, you may file a complaint with the person listed on the first page of these notices. You also may file a written complaint with the Secretary of the U.S. Department of Health and Human Services. The law does not permit anyone to take retaliatory action against you if you make such complaints.

Notification of a Privacy Breach

Any individual whose unsecured PHI has been, or is reasonably believed to have been used, accessed, acquired or disclosed in an unauthorized manner will receive written notification from the Plan within 60 days of the discovery of the breach.

If the breach involves 500 or more residents of a state, the Plan will notify prominent media outlets in the state. The Plan will maintain a log of security breaches and will report this information to HHS on an annual basis. Immediate reporting from the Plan to HHS is required if a security breach involves 500 or more people.

Contact Person for Information, or to Submit a Complaint

If you have questions about this Notice please contact the Plan’s Privacy Official or Deputy Privacy Official(s) (see first page). If you have any complaints about the Plan’s privacy practices, handling of your PHI, or breach notification process, please contact the Privacy Official or an authorized Deputy Privacy Official.

Organized Health Care Arrangement Designation

The Plan participates in what the federal privacy rules call an “Organized Health Care Arrangement.” The purpose of that participation is that it allows PHI to be shared between the members of the Arrangement, without authorization by the persons whose PHI is shared, for health care operations. Primarily, the designation is useful to the Plan because it allows the insurers who participate in the Arrangement to share PHI with the Plan for purposes such as shopping for other insurance bids.

HIPAA Notice of Special Enrollment Rights

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to later enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing towards your or your dependents’ other coverage).

Loss of eligibility includes but is not limited to:

• Loss of eligibility for coverage as a result of ceasing to meet the plan’s eligibility requirements (i.e., legal separation, divorce, cessation of dependent status, death of an employee, termination of employment, reduction in the number of hours of employment);
• Loss of HMO coverage because the person no longer resides or works in the HMO service area and no other coverage option is available through the HMO plan sponsor;
• Elimination of the coverage option a person was enrolled in, and another option is not offered in its place;
• Failing to return from an FMLA leave of absence; and
• Loss of coverage under Medicaid or the Children’s Health Insurance Program (CHIP).

Unless the event giving rise to your special enrollment right is a loss of coverage under Medicaid or CHIP, you must request enrollment by the HIPAA Special Enrollment Deadline after your or your dependent’s(s’) other coverage ends (or after the employer that sponsors that coverage stops contributing toward the coverage).

If the event giving rise to your special enrollment right is a loss of coverage under Medicaid or CHIP, you may request enrollment under this plan within 60 days of the date you or your dependent(s) lose such coverage under Medicaid or CHIP. Similarly, if you or your dependent(s) become eligible for a state-granted premium subsidy towards this plan, you may request enrollment under this plan within 60 days after the date Medicaid or CHIP determine that you or the dependent(s) qualify for the subsidy.

In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents. However, you must request enrollment by the HIPAA Special Enrollment Deadline, after the marriage, birth, adoption, or placement for adoption.

To request special enrollment or obtain more information, contact the Plan Administrator. Note: Additional information may be required if the plan requires that persons declining coverage under the plan state, in writing, the reason(s) for declining coverage.

Important Notice from the Company About Your Prescription Drug Coverage and Medicare under the Creditable Plan(s)

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with the Company and about your options under Medicare’s prescription drug coverage. This information can help you decide whether or not you want to join a Medicare drug plan. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

If neither you nor any of your covered dependents are eligible for or have Medicare, this notice does not apply to you or the dependents, as the case may be. However, you should still keep a copy of this notice in the event you or a dependent should qualify for coverage under Medicare in the future. Please note, however, that later notices might supersede this notice.

1. Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.

2. The Company has determined that the prescription drug coverage offered by the Creditable Plan(s) is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is considered “creditable” prescription drug coverage. This is important for the reasons described below.

Because your existing coverage is, on average, at least as good as standard Medicare prescription drug coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to enroll in a Medicare drug plan, as long as you later enroll within specific time periods.
Enrolling in Medicare—General Rules
As some background, you can join a Medicare drug plan when you first become eligible for Medicare. If you qualify for Medicare due to age, you may enroll in a Medicare drug plan during a seven month initial enrollment period. That period begins three months prior to your 65th birthday, includes the month you turn 65, and continues for the ensuing three months. If you qualify for Medicare due to disability or end-stage renal disease, your initial Medicare Part D enrollment period depends on the date your disability or treatment began. For more information you should contact Medicare at the telephone number or web address listed below.

Late Enrollment and the Late Enrollment Penalty
If you decide to wait to enroll in a Medicare drug plan you may enroll later, during Medicare Part D’s annual enrollment period, which runs each year from October 15th through December 7th. But as a general rule, if you delay your enrollment in Medicare Part D, after first becoming eligible to enroll, you may have to pay a higher premium (a penalty).

If after your initial Medicare Part D enrollment period, you go 63 continuous days or longer without “creditable” prescription drug coverage (that is, prescription drug coverage that’s at least as good as Medicare’s prescription drug coverage), your monthly Part D premium may go up by at least 1% of the premium you would have paid had you enrolled timely, for every month that you did not have creditable coverage.

For example, if after your Medicare Part D initial enrollment period you go nineteen months without coverage, your premium may be at least 19% higher than the premium you otherwise would have paid. You may have to pay this higher premium for as long as you have Medicare prescription drug coverage. However, there are some important exceptions to the late enrollment penalty.

Special Enrollment Period Exceptions to the Late Enrollment Penalty
There are “special enrollment periods” that allow you to add Medicare Part D coverage months or even years after you first became eligible to do so, without a penalty. For example, if after your Medicare Part D initial enrollment period you lose or decide to leave employer-sponsored or union-sponsored health coverage that includes “creditable” prescription drug coverage, you will be eligible to join a Medicare drug plan at that time.

In addition, if you otherwise lose other creditable prescription drug coverage (such as under an individual policy) through no fault of your own, you will be able to join a Medicare drug plan, again without penalty. These special enrollment periods end two months after the month in which your other coverage ends.

Compare Coverage
You should compare your current coverage, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare prescription drug coverage in your area. See the Plan’s summary plan description for a summary of the Plan’s prescription drug coverage. If you don’t have a copy, you can get one by contacting us at the telephone number or address listed at the beginning of the Required Notices section of this guide.

Coordinating Other Coverages with Medicare Part D
Generally speaking, if you decide to join a Medicare drug plan while covered under the Company Plan due to your employment (or someone else’s employment, such as a spouse or parent), your coverage under the Company Plan will not be affected. For most persons covered under the Plan, the Plan will pay prescription drug benefits first, and Medicare will determine its payments second. For more information about this issue of what program pays first and what program pays second, see the Plan’s summary plan description or contact Medicare at the telephone number or Web address listed at the end of this notice.
If you do decide to join a Medicare drug plan and drop your prescription drug coverage with Cigna, be aware that you and your dependents may not be able to get this coverage back. To regain coverage you would have to re-enroll in the Plan, pursuant to the Plan’s eligibility and enrollment rules. You should review the Plan’s summary plan description to determine if and when you are allowed to add coverage.

For more information about this notice or your current prescription drug coverage...

Contact the Plan Administrator for further information. Note: You’ll get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage through the Company changes. You also may request a copy.

For more information about your options under Medicare prescription drug coverage...

More detailed information about Medicare plans that offer prescription drug coverage is in the “Medicare & You” handbook. You’ll get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare drug plans.

For more information about Medicare prescription drug coverage:

- Visit www.medicare.gov
- Call your State Health Insurance Assistance Program (see the inside back cover of your copy of the “Medicare & You” handbook for their telephone number) for personalized help,
- Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

If you have limited income and resources, extra help paying for Medicare prescription drug coverage is available. For information about this extra help, visit Social Security on the Web at www.socialsecurity.gov, or call them at 1-800-772-1213 (TTY 1-800-325-0778).
## HSA ASSOCIATED ACCOUNT FEES & INTEREST (DI PREFERRED WITH STANDARD FEES)

<table>
<thead>
<tr>
<th>Description</th>
<th>Amount</th>
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<tbody>
<tr>
<td>HSA service fee (monthly account maintenance fee)</td>
<td>No charge to your account. Your employer covers this fee</td>
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</tbody>
</table>

### SERVICE FEES

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<thead>
<tr>
<th>Description</th>
<th>Amount</th>
<th>How to Avoid Fee</th>
</tr>
</thead>
<tbody>
<tr>
<td>Debit card issuance</td>
<td>$6.00</td>
<td>No charge for the first two Health Benefits Debit Cards on your account.</td>
</tr>
<tr>
<td>HSA returned item</td>
<td>$10.00</td>
<td>Check available account balance online before you withdraw funds.</td>
</tr>
<tr>
<td>HSA checkbook order (50 checks)</td>
<td>$10.00</td>
<td>Use your Health Benefits Debit Card or online transfers to access funds.</td>
</tr>
<tr>
<td>Printed HSA summary</td>
<td>$1.25</td>
<td>Elect to receive free e-statements through Internet Banking.</td>
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For details regarding the general terms and conditions that apply to your HSA, see the Deposit Account Agreement and Disclosures for Health Saving Accounts.

1. You may incur a lesser fee than that disclosed to you when your account has insufficient funds to cover the entire amount of the fee.

2. If your employment status changes, your HSA Service Fee may change.

3. Distributions from your Health Savings Account presented in the form of checks, ACH withdrawals or other electronic means will be returned unpaid if there are insufficient funds in your account to cover the amount of the withdrawal, and you will be charged a returned item fee.

### Investment Account

You have the option to invest in mutual funds. Complete your investment application through the online portal or visit mycigna.com. **Eligibility criteria:** A minimum balance of $2,000 must be in your HSA Bank cash account.

Investment accounts are not FDIC insured and they are not bank guaranteed. Investment accounts are not a deposit account, or an obligation of HSA Bank, and they may lose value.

**Minimum Account Balance and How Interest Rate is Determined**

There is no minimum account balance required to open a health savings account or to obtain the annual percentage yield disclosed. We use the daily balance method to calculate the interest on your account. The daily balance method applies a daily periodic rate to the principal in the account each day. Interest is compounded monthly and credited monthly. Interest begins to accrue no later than the business day that we receive credit for the deposit of non-cash items (for example, checks). The interest rate and annual percentage yield (APY) is based on the balance in your account. The interest rate and annual percentage yield available on your account is as follows, effective as of January 1, 2017.

**Daily Balance:** $0.01 or more / **Interest Rate:** 0.14% / **APY:** 0.14%. This interest rate is subject to change at HSA Bank’s discretion at any time. Fees may reduce your earnings.
Disclaimer:
Benefits are provided pursuant to a Plan Document on file at DynCorp International. The plans are also summarized in a Summary Plan Description (SPD). If there is a conflict involving the language provided in the Plan Document, the SPD or any communication regarding these benefits, the terms of the Plan Document will control, unless superseded by applicable law.

Please note not all DI employees are eligible to participate in the plans described. Eligibility is dependent on the terms of any applicable CBA, contract, service contract act, employee classifications and the operation of host country and/or US law. Please check with your HR Generalist if you have questions regarding the applicability of any of the plans described.