
Your DuPont Benefit Resources

BeneFlex Dental Care Plan and Dental Assistance Plan

July 2003

As of July 2003, participating employers in the BeneFlex Dental Care Plan and/or the Dental Assistance Plan include:

- E. I. du Pont de Nemours and Company
- DuPont Dow Elastomers L.L.C.
- Solae, L.L.C.
- DuPont Textiles & Interiors, Inc.
- DuPont Photonics Technologies, L.L.C.
- DuPont Protective Apparel Marketing Company

All references to “the Company” in this document pertain to the specific company that employs you.



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DETAILS OF THE PLAN

Preface

This **Summary Plan Description (SPD)** provides a concise description of Plan coverage available for you and your eligible dependents.

While this SPD contains detailed and important information about your benefit Plan, every attempt has been made to communicate that information clearly and in easily understandable terms.

While the **Company** intends to continue the benefits and policies described in this booklet, the Company reserves the right to change, modify or discontinue the Plan at its discretion at any time. This SPD does not constitute a contract of employment or guarantee any particular benefit.

In the event of a discrepancy between this SPD and the Plan document, the Plan document will govern.

Introduction

The Dental Plan assists you in maintaining good dental care for you and your family. It emphasizes preventive care and good dental habits. Under this Plan, preventive and diagnostic services are covered at 100% of the reasonable and customary allowance. Restorative and other covered dental procedure costs are shared with participants and are paid according to a regional fee schedule. Benefits for restorative and other covered dental procedures differ based on your Dental Plan option.

Most employees can select from two Dental Plan options or elect no coverage for themselves and their eligible dependents.

- **High Option (A)** pays restorative and other dental service charges at approximately 75% according to a regional fee schedule. An annual benefit maximum of \$2,000 per person applies.
- **Standard Option (B)** pays restorative and other dental services at approximately 50% according to a regional fee schedule. An annual benefit maximum of \$1,100 per person applies.

Eligible Pensioners and Survivors receive Standard Option (B) coverage unless they decline to participate in the Dental Plan.

You will need to satisfy the requirements described in this Summary Plan Description to receive Dental Plan coverage.

Eligibility

Eligible employees, Pensioners and Survivors

You are eligible for Dental Plan coverage if you are one of the following:

- a Full-Service Employee, Pensioner or Survivor of the DuPont U.S. Region or a Subsidiary Company Transferee (SCT) on assignment in the U.S.
- a Full-Service Employee of a participating DuPont subsidiary or joint venture that has adopted this Plan
- a Pensioner or Survivor of a participating DuPont subsidiary or joint venture that has adopted this Plan for Pensioners and Survivors

Coverage for a Survivor who is a minor child will end on the last day of the month in which the child becomes age 21. **COBRA** continuation is available.

Since January 1, 1992, the BeneFlex Flexible Benefits Plan has been offered to all DuPont U.S. Region employees. However, you are not eligible for the BeneFlex Dental Care Plan if you are an employee, or dependent of such employee, in a bargaining unit represented by a union for collective bargaining unless and until the site manager has authorized the benefit, collective bargaining on the subject has taken place, and any requisite obligations thereunder have been fulfilled.

Eligible dependents

You can cover certain dependents under the Dental Plan. Your eligible dependents are any of the following:

- your lawful spouse
- children who meet ALL these criteria:
 - unmarried
 - under age 25, and
 - claimed as dependents on your federal income tax return (except unmarried, full-time students age 24 who must meet only the first two criteria).

Only those eligible dependents you list as your covered dependents will have Dental Plan coverage.

You must promptly notify DuPont Connection at 1-800-775-5955 if an enrolled dependent no longer meets the Plan's definition of a dependent. Your dependent will be eligible for COBRA continuation coverage if you notify the Plan within 60 days of the date the dependent became ineligible. The Plan Administrator may take action to recover the value of any benefits provided while the dependent was ineligible.

Additional information regarding eligibility for your lawful spouse

- If both you and your spouse work for a Company participating in the Dental Plan, you can cover your spouse as a dependent, or your spouse can elect separate employee coverage. You or your spouse can't be covered as both employee and dependent in the Dental Plan.

Additional information regarding eligibility for your dependent children

- The age 25 limit does not apply to unmarried, dependent children who can't support themselves because of a physical or mental disability that existed and was certified by the DuPont Medical Plan carrier before the child reached age 25. The child must be claimed by you as a dependent for federal tax purposes. You must provide physical documentation from the child's primary care physician or specialist of the child's disability to the DuPont Medical Plan carrier at least 31 days before the child turns 25 and at reasonable intervals upon request to continue Dental Plan coverage.
- If you are required by court order to provide dental coverage for your children, your children are eligible for coverage if they are under age 25 and unmarried. The court order must meet the requirements of a Qualified Medical Child Support Order (QMCSO) and must be approved by the DuPont Legal Department. Contact DuPont Connection at 1-800-775-5955 for further information. A copy of the QMCSO procedures is available by contacting the Plan Administrator or visiting the DuPont Legal website at <http://legal.lvs.dupont.com>.
- Survivors can only cover as dependent children those children who were previously covered dependents of the deceased employee or Pensioner. The children and spouse of a Survivor's subsequent marriage cannot be covered.
- If both you and your spouse work for a Company participating in the Dental Plan and you both claim your eligible child as a dependent for federal tax purposes, only you or your spouse can cover your eligible child as a dependent under the Dental Plan. Both of you cannot cover your child at the same time.
- It is your responsibility to remove children who no longer meet the Dental Plan eligibility requirements.

Enrollment and Premium Information for Employees***Enrolling in the Plan***

If you are an employee, you can enroll in the Dental Plan during the annual **BeneFlex Election Change Period** or when you first become eligible. You enroll:

- by calling DuPont Connection toll-free at 1-800-775-5955
- by visiting BeneFlex OnLine at <http://resources.hewitt.com/dupont>

If you are a newly hired employee, you must call DuPont Connection or visit BeneFlex OnLine to make your benefit elections within 31 days of the date on your new hire package that is mailed to you. If you do not enroll you will be defaulted to single coverage in the Standard Option (B). In addition, you will not have coverage for your dependents, so it is important that you enroll in a timely manner.

You have a choice of two dental options, High Option (A) or Standard Option (B), or you can elect the No Coverage Option. Each of these options is described in this SPD.

Your benefit elections will stay in effect for the entire **Plan Year** (January 1–December 31) unless you have a **Qualifying Life Event (QLE)**. Refer to the section titled “Making changes” for information regarding Qualifying Life Events.

You do not have to re-enroll each year. If you do not make a change during the annual BeneFlex Election Change Period, you will remain enrolled in the Dental Plan for the following year with no change to your elections.

When coverage begins

Dental coverage is effective as of your date of hire. You must enroll your eligible dependents for their coverage to become effective.

Making changes

You may change your Dental Plan benefit elections mid-year only if you have a Qualifying Life Event; otherwise, you may only make changes during the annual BeneFlex Election Change Period.

Qualifying Life Events

You can change your benefit elections anytime during the year upon certain Qualifying Life Events. Your change must be consistent with and on account of your Qualifying Life Event and not for financial reasons. Changes to Dental Plan options, such as switching from the High Option (A) to the Standard Option (B), are not permitted mid-year.

For more information on Qualifying Life Events, contact:

- DuPont Connection at 1-800-775-5955

A Qualifying Life Event is:

- marriage or divorce
- birth or adoption of a child
- death of your spouse or dependent child
- gain or loss of an eligible dependent
- the start or termination of your spouse’s employment
- a significant change in your spouse’s dental coverage
- unpaid leave of absence by your spouse

All benefit changes related to the Qualifying Life Event must be made at the same time.

If you have a Qualifying Life Event and change your benefit elections within 31 days of the Event, your dental changes will be effective retroactive to the date of your Event. If you report your QLE after 31 days of the Event, your dental changes will be effective the date of your call. New payroll deduction amounts will be effective in the month following any change to elections.

Note that the date you report a Qualifying Life Event does not impact the date coverage ends for an ineligible dependent. For example, if you become divorced, your ex-spouse's coverage stops at the end of the month of your final divorce decree, regardless of whether or not you reported the event in a timely manner, as required by the Dental Plan.

Changes during annual BeneFlex Election Change Period

You may change your BeneFlex election once each year during the annual BeneFlex Election Change Period.

During the annual BeneFlex Election Change Period, you may do any of the following:

- elect coverage if previously waived
- elect a different dental option
- change the level of your coverage (You only, You plus one or You plus family)
- add or drop one or more named dependents from coverage
- drop your coverage

All changes in your benefit elections made during the annual BeneFlex Election Change Period will become effective on the first day (January 1) of the new Plan Year.

Special enrollment rules

If you are declining enrollment for yourself or your dependents (including your spouse) because of other dental coverage, you may in the future be able to enroll yourself or your dependents in this Plan, provided that you request enrollment within 30 days after your other coverage ends. Coverage will be effective retroactive to the date you lost other coverage.

Premium costs

For full-time employees, the Company pays the entire premium cost of Dental Plan Standard Option (B) coverage for you and your covered dependents.

If you elect to enroll in High Option (A), the Company still contributes an amount equal to the Standard Option (B) cost toward your coverage; you are responsible for the difference. You pay your portion of the cost through payroll deductions. To help lower your cost, your premiums are deducted from your pay on a before-tax basis—that is before any federal, and most state and local, taxes are withheld. This reduces your taxable income and, consequently, reduces the amount of income tax you pay.

Your premiums for dental coverage are based on the level of coverage you choose:

Medical Plan Options

2003 Monthly Premium by Coverage Level

	You only	You plus one	You plus family
High Option (A)	\$32.50	\$55.25	\$71.75
Standard Option (B)	\$0.00	\$0.00	\$0.00
Alternative Coverage Option*	call*	call*	call*

*Alternative Coverage Option prices (where offered) are available by calling DuPont Connection at 1-800-775-5955.

For employees who are approved to work part-time under Flexible Work Practices, the Company contribution to your dental benefits is prorated. Refer to the section titled “About prorated premiums” for more information.

The premiums listed above are effective for the 2003 Plan Year. Your premiums are reviewed annually and are subject to change. Any adjustments to your premiums will be effective January 1; you will be notified in advance of any changes. Refer to your personal benefit enrollment materials (which you receive prior to the annual BeneFlex Election Change Period) for further pricing information.

About prorated premiums

If you are approved to work part-time under Flexible Work Practices, the Company contribution to your Dental Plan benefits is prorated based on the number of part-time hours you work, divided by the number of hours in your normal work schedule.

For example, if you normally work a 40-hour weekly schedule and are approved to work a 20-hour-per-week Flexible Work Practices schedule, you will have the Company contribution of your dental benefit prorated on a 50-50 basis. Your premium will be 50% of what the Company would normally pay for the coverage if you were working full-time, plus the appropriate full-time employee premium amount.

If you are approved to work a 30-hour-per-week schedule, your Company contribution would be prorated on a 75-25 basis. Your premium will be 25% of what the Company would normally pay for the coverage if you were working full-time, plus the appropriate employee premium.

Participation and Premium Information for Pensioners and Survivors

Participating in the Plan

If you are an eligible Pensioner or Survivor, you are automatically enrolled in the Dental Assistance Plan, which provides Standard Option (B) type benefits unless you have declined to participate in the Dental Plan. Upon retirement, your Standard Option (B) coverage continues at the same coverage level (You only, You plus one or You plus family) that you elected as an active employee. If you wish to change your dental coverage level or decline coverage, you may do so by calling DuPont Connection at 1-800-775-5955.

Making changes

If you are a Pensioner or Survivor, you may change your benefit elections when necessary by contacting DuPont Connection at 1-800-775-5955. You may do any of the following:

- change the level of your coverage (You only, You plus one or You plus family)
- add or drop one or more named dependents from coverage
- drop your coverage

All changes in your benefit elections will become effective on the first day of the month following the date you report the change.

A decision to decline post-employment dental coverage is permanent and irrevocable. If you decline dental coverage as a Pensioner or Survivor, you cannot later enroll in the Dental Plan unless you lose eligibility for coverage under another employer or a government plan. Loss of coverage cannot be due to non-payment of premiums.

Premium costs

For DuPont Pensioners receiving a full pension benefit and their Survivors, the Company pays the entire cost of Dental Plan Standard Option (B) type coverage for you and your eligible dependents.

The premiums for your Dental Plan coverage are normally deducted from your pension payment. If your pension payment does not cover the amount of the premium, or if you have elected to defer your pension payments, you will be billed directly by State Street, the DuPont Pension Paying Agent. Payment is due in advance on the first of each month. A 30-day grace period applies. If you choose, you can have the amount you owe debited automatically on the first of each month from your checking, savings or investment account.

Dental Plan costs for Pensioners and Survivors of a participating DuPont subsidiary or joint venture that has adopted the Dental Plan may differ from those described above. Contact DuPont Connection at 1-800-775-5955 for information regarding your Dental Plan premiums.

About prorated premiums

For DuPont Pensioners receiving less than a full pension benefit and their Survivors, the Company contribution to your dental benefits is prorated if you retired on or after January 1, 1994. The Company contribution to your Dental Plan premium is based on the same age/service Pension Percentage Factor that is used to calculate the reduced pension. The difference will be paid by the Pensioner or Survivor in the form of an additional premium. Note that the actual cost to the Pensioner or Survivor could change each year depending upon changes in the Company contribution.

For example, if you are receiving a 25% reduced pension benefit, you will have the Company contribution of your dental benefit prorated on a 75-25 basis. Your premium will be 25% of what the Company would normally pay for the coverage if you were receiving an unreduced pension benefit, plus the appropriate Pensioner premium that applies to Pensioners receiving a full pension benefit.

For more information regarding your premium, contact DuPont Connection at 1-800-775-5955.

Cost-Sharing Plan Design Provisions

Deductible

Dental Plan coverage does not have a deductible.

Coinsurance

Coinsurance is the percentage of expenses that you are responsible for paying. The Dental Plan pays a percentage of the expenses based on the type of service; you pay the remaining amount. Coinsurance differs by Dental Plan option. Refer to the “Plan Benefit” section for information on the coinsurance that applies to your Dental Plan option.

Plan Benefit

Benefit amount

As a participant in the Dental Plan, you receive care from any dentist you choose. Benefits for High Option (A) and Standard Option (B) are summarized in the chart below.

Type of service	High Option (A)	Standard Option (B)
	<i>For employees and their covered dependents</i>	<i>For employees, Pensioners, Survivors and their covered dependents</i>
Preventive and Diagnostic	100% of R&C	100% of R&C
Restorative and Other Dental Care	75% based on the regional scheduled amount	50% based on the regional scheduled amount
Annual Maximum Benefit	\$2,000/individual	\$1,100/individual
Lifetime Orthodontic Maximum Benefit (for dependent children under age 19)	\$1,200/child	\$1,200/child

Reasonable and customary (R&C) amounts

Bills for diagnostic and preventive care—such as regular dental exams, teeth-cleaning and X rays—are paid in full if the charge falls within the reasonable and customary range.

Reasonable and customary (R&C) amounts are typical fees for services, treatments or supplies charged by most providers with similar training and experience in the same geographic area. To determine the R&C amount for a particular service, the Claims Administrator (MetLife Dental) reviews charges submitted by providers in your location.

The judgment on what are reasonable and customary charges is made by MetLife Dental as an agent for the Plan Administrator based on:

- the usual fee your dentist most frequently charges most patients for the service or supply
- the fees generally charged for the treatment by dentists in the same area
- any unusual circumstance or complications requiring more time, skill and experience

If your dentist’s charges are less than or equal to the reasonable and customary charges, the full amount of your diagnostic and preventive expenses will be paid. If your dentist charges more than what is reasonable and customary, you pay the difference.

Regional scheduled amount

Benefit payments for more than 400 restorative and other dental procedures—from common cavity fillings to more involved **root canal** therapy—are paid based on a regional scheduled amount. This schedule allows a specified number of dollars for each dental procedure. You pay the difference between what the regional schedule allows and what your dentist charges. It's important to keep in mind that the schedule has nothing to do with whether your dentist's bill is reasonable and customary. It simply defines what assistance the Dental Plan will provide. The regional schedule is updated from time to time to keep up with current dental practices and charges.

The Plan has a feature called an alternative course of treatment provision. Occasionally, accepted standards of dental practice may recognize more than one way of treating a dental condition. Under the Plan, if alternative methods of treatment are available to adequately treat your condition, the Dental Plan pays benefits based on the least expensive treatment. If you choose to have the more costly treatment, you will have to pay the additional cost.

Annual benefit maximum

The annual benefit maximum is the maximum dollar amount the Dental Plan will pay for expenses you incur during the Plan Year.

Expenses that do not count toward the annual benefit maximum include:

- charges for services not covered by the Plan
- charges over the reasonable and customary or regional scheduled amounts
- **orthodontia** benefits which are subject to a separate lifetime benefit maximum of \$1,200

Refer to the “Expenses not covered” and the “Reasonable and customary” sections for more information.

Lifetime orthodontia maximum

Orthodontia is subject to a lifetime benefit maximum of \$1,200. For all other services, no lifetime benefit maximum applies.

Maintenance of benefits

If you or a covered dependent is covered by another dental plan, benefits are coordinated to prevent duplication of benefits—a feature called maintenance of benefits.

Maintenance of benefits allows two or more dental plans to work together to cover eligible expenses. The plan that has the first obligation to pay is called “primary”; the other plan is called “secondary.” Typically, a secondary plan will pay any difference between what you receive from your primary plan and what you would have received if the secondary plan were your only coverage.

A participant may be covered under two or more plans. Certain rules govern which plan is primary and which is secondary; those rules follow this order:

- A plan that has no maintenance of benefits provision will be primary to a plan that does have a maintenance of benefits provision.
- A plan that covers a participant as an employee, Pensioner or Survivor will be primary to a plan that covers the person as a dependent. Thus, if your spouse is enrolled in his/her employer's dental plan, your Dental Plan will be secondary for him/her (if enrolled). Similarly, if you are also covered by your spouse's employer's dental plan, your spouse's plan is your secondary coverage.
- A plan that covers a participant as an employee will be primary to a plan that covers the person as a pensioner or survivor. Thus, if you are a Pensioner or Survivor and are employed by another company, that plan is primary and this Dental Plan is secondary.
- If children are covered by both parents' plans, the plan of the parent whose birthday falls earlier in the calendar year is primary before the plan of the parent whose birthday falls later that year (based on month and day only). If both parents have the same birthday, the plan covering the person for the longest time is considered primary before the plan that covers the other person.

Under maintenance of benefits, the primary plan pays benefits first. The secondary plan considers for payment any eligible amounts not **reimbursed** by the primary plan.

When the Dental Plan is the secondary payer, the Dental Plan will determine what benefits it would have paid if you didn't have other coverage, and then deduct the amount paid by the other plan. If the other plan pays more than the Dental Plan would normally pay, then the Dental Plan won't pay any additional benefits. If the other plan pays less than the Dental Plan would pay, then the Dental Plan will pay the difference up to its normal benefit.

For example, if your spouse's primary plan pays a 50% benefit for a restorative service (such as a root canal), this Dental Plan will not pay additional benefits under the Standard Option (B). The Standard Option (B) provides 50% benefits for restorative dental care, but you have already received 50% from your spouse's plan, so no secondary benefits will be paid.

Contact MetLife Dental with questions on how maintenance of benefits works with your coverages.

Covered Services

The Dental Plan covers the following services:

Preventive and diagnostic

The Dental Plan pays the full amount of reasonable and customary charges for diagnostic and preventive care. The idea is to encourage regular dental checkups. By seeing the dentist regularly, you can often avoid serious dental problems.

Services covered under the diagnostic and preventive category include:

- cleanings (dental prophylaxis)—two per person each Plan Year
- **fluoride** treatments—one topical application of stannous or acid fluoride each Plan Year for dependent children under age 14 only
- periodontal prophylaxis, but only where there is a diagnosed and previously treated periodontal condition—two per person each Plan Year
- routine oral exams—two per person each Plan Year
- **sealants**—once every 36 months on primary or permanent posterior teeth for dependent children under age 14 only
- **space maintainers**, for dependent children under age 19 only
- tests and laboratory examinations, when necessary for dental diagnosis, prevention and treatment
- X rays
 - full-mouth X rays, once per person every 36 months
 - supplementary **bitewing X rays**, twice per person each Plan Year
 - any dental X rays required to diagnose a specific condition needing treatment, as necessary

Example of how the Plan works—preventive and diagnostic care

A Company employee is enrolled in the Dental Plan. He visits the dentist for his semiannual checkup. The dentist examines and x-rays his teeth, charts their present condition, then scales and cleans them. For these services, the dentist charges \$110. MetLife Dental's records indicate that the \$110 charge falls within the definition of reasonable and customary; therefore, the claim is paid in full.

Restorative and other dental care

The Dental Plan pays a portion of other covered dental care expenses for you and your covered dependents. The amount that is paid for a particular service is determined by a regional benefit schedule. The regional benefit scheduled amount is not designed to show what a dentist should be charging. Its function is to let you know what part of the bill the Dental Plan pays. You can get information regarding the regional scheduled amount by calling MetLife Dental at 1-888-883-0052.

Over 400 dental procedures are covered. Services covered include:

- **bridges**

- initial installation of fixed bridgework, including **inlays** and **crowns** to form abutments, to replace one or more teeth (except wisdom teeth) lost or extracted while you are covered under the Dental Plan
- repair or recementing of bridgework
- replacement of an existing bridge, provided that it is at least five years old and cannot be made serviceable

- **crowns**

- initial installation of a crown to restore the structure of a tooth due to cavity or fracture
- repair or recementing of crowns

- **dentures**

- initial installation of removable dentures partial or full, including adjustments after the six-month period following installation, to replace one or more teeth (except wisdom teeth) lost or extracted while you are covered under the Dental Plan
- addition of teeth to an existing partial removable denture at least six months after installation
- repair of dentures
- relining of dentures after six months from the date of installation
- replacement of a temporary denture with a permanent full denture within 12 months of when it was installed
- replacement of an existing denture, provided that it is at least five years old and cannot be made serviceable

- emergency dental services, such as emergency palliative treatment of dental pain in the case of an infection

- endodontics—treatment for diseases of the dental pulp, such as root canal therapy

- general anesthesia—when medically necessary and administered for **oral surgery** in a doctor's office

- **inlays**

- initial installation of an inlay to restore the structure of a tooth due to cavity or fracture
- repair or recementing of inlays

- implantology (placing teeth or supports in a surgically prepared cavity) where medically necessary

- **oral surgery**

- surgical procedures in and around the mouth, including extractions of badly decayed or impacted teeth
- general anesthesia, when medically necessary in connection with covered oral surgery and administered in a dentist's office. When medical necessity dictates that oral surgery be done in a hospital (inpatient or outpatient), the anesthesia and facility charges may be covered by your medical plan.

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- orthodontics—teeth straightening or repositioning, for dependent children under age 19. The lifetime maximum is \$1,200 per child.
 - **periodontics**—treatment of gum diseases and the tissues surrounding the teeth (other than routine periodontal prophylaxis covered under diagnostic and preventive care)
 - restorations—treatment to restore the structure of a tooth or teeth because of cavities or fracture. This includes fillings, inlays, onlays and crowns, along with the necessary local anesthesia.
 - root planing

Refer to the “Dictionary Terms” section for a list of definitions for covered services.

Orthodontia

The Dental Plan will cover orthodontic expenses incurred for corrective treatment of maloccluded or mal-positioned teeth by means of an active appliance. Orthodontic benefits are limited to your eligible dependents who are under age 19. There is a \$1,200 individual lifetime maximum for orthodontic services.

Examples of some orthodontic services covered under this Plan are:

- complete orthodontic examination
- diagnostic casts (study models) for orthodontic evaluation
- surgical exposure of impacted or unerupted teeth for orthodontic purposes
- ongoing active and comprehensive orthodontic treatment
- orthodontic treatment that includes fixed or removable orthodontic appliances for tooth movement and/or guidance and the installation and monthly adjustments of the appliances

The Dental Plan generally pays orthodontia benefits for children’s braces as follows:

- \$300 benefit payment for the orthodontic banding
- \$900 remaining benefits paid out over the course of treatment, not to exceed 24 months

Benefits are paid quarterly at the end of the quarter.

If your dependent child is already in active orthodontia treatment prior to your coverage effective date, MetLife Dental will start issuing benefit payments from the date the patient becomes eligible under the Dental Plan. Monthly payments will be calculated based on the remaining months of treatment not to exceed \$900, assuming the banding was performed before the child became covered under the Plan.

Restrictions and Exclusions

Expenses not covered

Although the Dental Plan pays benefits for a wide range of dental services and procedures, there are certain exclusions. The Dental Plan does not cover the following:

- anesthesia, except general anesthesia when medically necessary in connection with oral surgery and administered in a doctor's office
- appliances, restorations and procedures to alter vertical dimension (changing the height of upper or lower teeth)
- charges (claims) submitted more than 24 months after services are rendered
- charges for sealants for dependents age 14 and over
- charges that would not normally be paid if you did not have insurance or charges you are not required to pay
- charges which, in the judgment of MetLife Dental, exceed the reasonable and customary charge for (or fair and reasonable value of) the service or supply provided
- completion of claim forms or filing of claims
- educational programs, such as training in plaque control or oral hygiene, or for dietary instructions
- experimental procedures or those not recognized by the dental profession
- extra sets of dentures or other appliances
- for job-related injuries or diseases paid by any Workers' Compensation or similar laws (refer to the Disability Summary Plan Description for more details)
- missed appointments
- periodontal **splinting** (temporary wiring or permanently bonding teeth together)
- replacement of lost or stolen prosthetic devices
- replacement of teeth removed or lost before coverage is effective, except in the following cases:
 - (1) when existing partial dentures, full removable dentures or fixed bridgework cannot be fixed and were installed five years before replacement, and
 - (2) when replacement or installation of a denture or bridgework is due to necessary additional extractions or loss of teeth while you are covered
- services or supplies not recommended by your dentist as necessary for proper dental treatment
- temporary procedures, services or appliances
- treatment of dental diseases or injuries resulting from declared or undeclared war, insurrection, participation in a riot or service in the armed forces of any government

-
- treatment of temporomandibular joint dysfunction (**TMJ**) (Note: An exam to diagnose TMJ is covered under the Dental Plan. Treatment may be covered under your medical plan.)
 - work done primarily for cosmetic or appearance purposes
 - work done while you are not covered under this Plan, except for certain procedures begun before you leave the Dental Plan and completed within two months. These include charges for installing a prosthetic device or a crown or for root canal therapy. If you are involved in the above procedures you need to consult MetLife Dental at 1-888-883-0052 for the appropriate guidelines.
 - work furnished or paid for because of service in the armed forces of any government
 - work furnished or paid for by any government—federal, state or local

Pre-existing conditions

The Dental Plan will not pay benefits for the following pre-existing conditions:

- completing a procedure that was started before you had coverage when the work is also covered by your former plan (see “Maintenance of benefits” rules on page 10 for more information)
- replacing a tooth that was missing before your coverage started

Filing a Claim

How to file a claim

To receive dental benefits, it is not necessary to show an identification card or get involved in elaborate paperwork. Simply take along a claim form when you visit your dentist. Forms are available from MetLife Dental at 1-888-883-0052. Use a separate form for each family member. Many dentists already stock claim forms. You can also obtain claim forms at BeneFlex OnLine at <http://resources/hewitt.com/dupont>.

You or your dentist must submit a completed claim form to receive Plan benefits. Each claim should include:

- the name of the person receiving the service
- a description of the service provided, including the dates of service

You have two years to file a claim after service has been provided.

Your dentist may submit bills directly to the Dental Plan if you choose to assign benefits. Refer to the “Assignment of benefits” section on page 23 for more information. If you prefer to pay the dentist yourself and have the Plan benefit sent to you, leave the box on the claim form that reads “I authorize payment directly to the below named dentist” blank. This tells MetLife Dental to send the payment directly to you.

Predetermination of benefits

You are strongly encouraged to file for a predetermination of benefits if the course of treatment can reasonably be expected to result in expenses of \$200 or more. A predetermination of benefits tells you in advance how much of your dental bill is covered and your coinsurance cost. Your dentist is likely to be familiar with the process. It is standard practice in most dental plans. Of course, in case of an emergency, do not delay getting the care you need. You or your dentist can file a claim after treatment.

Here's how to obtain a predetermination of benefits:

Essentially, the predetermination process involves submitting an advance claim.

You or an eligible family member visits the dentist—with Part I of the claim form filled out ahead of time. Your dentist outlines a treatment plan and lists the charges for each procedure. You or the dentist submits the form directly to the MetLife Dental claim office. Your dentist may have to send along X rays or other materials.

MetLife Dental reviews the treatment plan and issues an estimated **Explanation of Benefits** statement indicating how much of the bill will be paid. Both you and your dentist receive a copy of this statement.

The next step is for your dentist and you to review the form before doing the work. Once the services have been rendered, your dentist must indicate on the statement the date(s) the service(s) were performed, sign the statement and return it to MetLife for issuance of benefits.

Example of how the Plan works—predetermination of benefits

Employee Mary Jones visits her dentist for her semiannual checkup. She is enrolled in the Dental Plan Standard Option (B). After an examination and X rays, the dentist indicates that she needs to have two teeth extracted and replaced with a partial denture. Mary asks her dentist to file for a predetermination of benefits.

Mary's dentist will submit the planned treatment codes and cost information to MetLife for a predetermination of benefits. MetLife will inform the dentist of how much the Plan will pay, subject to eligibility at the time the procedure is performed. Mary's dentist will then discuss the procedure and Plan coverage with her prior to treatment.

Consultant review of planned treatment or claim

Once in a while, there is a question about the treatment selected by a dentist. That can happen because some dental problems may be treated several ways.

If there is a question, a dental consultant at MetLife reviews the claim. This consultant is a practicing dentist recommended by State Dental Society or Dental Association.

Generally the consultant okays the treatment and the benefits. However, sometimes the consultant contacts your dentist to discuss your treatment plan or an alternate method. If the consultant approves benefits based on an alternate method, he makes sure your dentist understands the reasons and the benefits payable. Then, it is up to you and your dentist. You can go ahead with any course of treatment, even a more expensive one, but MetLife Dental will base payment on what it considers to be adequate, reasonable and appropriate.

Notification and explanation of benefits

MetLife Dental will notify you in writing regarding a claim's benefit determination. You will receive a detailed statement called an explanation of benefits (EOB). The EOB will explain what amounts have been paid and what amounts have not been paid. The EOB will explain the reason why a claim has not been paid. An EOB will be sent within the following timeframes from the receipt of your claim:

- as soon as possible taking into account health care circumstances that require action but no later than 72 hours for pre-service **urgent care claims** (e.g., when you await treatment pending the outcome of the claim decision and your health would be severely jeopardized if the claim is not handled in an urgent manner. Refer to page 29 for a definition of urgent care claims.)
- within 15 days for **pre-service claims**
- within 30 days for **post-service claims**

For urgent care claims, MetLife Dental will contact you orally within 72 hours if circumstances require action, and follow up with written notice within a maximum of three days.

For pre-service and post-service claims, MetLife Dental may extend the decision-making timeframe for one additional period of 15 calendar days after the expiration of the initial notification period, if it is necessary for reasons beyond the control of the Plan. You will receive written notification indicating the circumstances requiring the extension and when MetLife Dental expects to provide a determination.

Revised notification timeframe

If you are required to submit additional information, the initial notification deadline for your claim determination is suspended from the time you are contacted for such additional information and until you return the requested information. This is called the tolling period. The tolling period ends on the date the Plan receives your response to the notice, without regard to whether or not you have supplied all the necessary information to decide the claim or on the date such information was due if you did not respond. You must respond with the missing information within the following timeframe:

- 45 days for post-service claims
- 45 days for pre-service claims
- as soon as possible but not later than 48 hours for urgent care claims

If a claim is denied or reduced

If your claim for benefits is denied or reduced, you will be notified in writing of the reason for the denial. The notice will include:

- the specific reasons for the denial
- references to the provisions of the benefit plan or practice involved
- a description of what additional information is necessary and why
- a copy of these procedures or comparable information about steps you need to take to resubmit it

Maximum timeframes for the Plan to notify you of a denied claim:

- as soon as possible for urgent care claims
- 30 days for pre-service claims
- 60 days for post-service claims

Appealing a denied claim

If the decision to deny or reduce the amount of the claim is not explained to your satisfaction or you have additional information that may change the decision, you should follow these steps to try to bring the claim denial to resolution:

- Step 1: Contact a MetLife Dental representative for a clearer explanation of the denial.
- Step 2: Provide additional written information to MetLife Dental that may allow reconsideration of your claim.

You also have the right to request, free of charge, access to copies of all documents, records and other information relevant to your claim for benefits. If, after contacting MetLife Dental and requesting additional information, you still have not received an adequate explanation concerning your claim for benefits under the Plan, you have a legal right to appeal the denial or partial denial of the claim.

Your final **appeal** is to DuPont. To appeal the denial, you should notify DuPont in writing requesting a claim review. The request for the appeal should include additional clinical documentation supporting the claim and the reasons why you disagree with the decision.

The request for appeal should include:

- the specific reasons why you think the claim should be reconsidered and approved
- any additional documentation that supports the approval of the claim
- an explanation of benefits statement for the denied claim
- a copy of the denial

You must make this request in a timely manner, preferably within 60 days after you receive the original claim decision or after you receive a claim denial.

You will receive information about the final decision from DuPont, which will respond within the following timeframes from when your appeal request is received:

- as soon as possible taking into account medical circumstances that require action but not later than 72 hours for urgent care claims
- 15 days for pre-service claims first level of appeal; if a second level of pre-service claim appeal is needed, then total response timeframe will not exceed 30 days
- 30 days for post-service claims first level of appeal; if a second level of post-service claim appeal is needed, then total response timeframe will not exceed 60 days

Special circumstances may cause the review to take longer. You will be notified if the review is extended and of the reason for the extension.

When you are notified of the final decision, the notice will provide the reason for the decision and the specific Plan provisions on which it is based. DuPont, as Plan Administrator, has full discretion and authority to interpret Plan provisions, resolve any ambiguities and evaluate claims. The decision made by DuPont is final and binding.

The exhaustion of the claim and appeal procedure is mandatory for resolving any claim arising under this Plan. Applicable law requires you to pursue all claim and appeal rights on a timely basis before seeking any other legal recourse regarding claims for benefits.

How the Plan will handle your appeal

In reviewing your appeal, all information that you submit, regardless of whether that information was considered at the time you submitted your initial claim, will be considered and a new review will be completed. The party reviewing your appeal will not have participated in the original claim determination and will not be a subordinate of the party who made the original claim determination, MetLife Dental. In deciding an appeal of any adverse benefit determination that is based in whole or in part on a medical or dental judgment, including determinations with regard to whether a particular treatment, drug, or other item is experimental, investigational, or not medically necessary or appropriate, shall consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical or dental judgment.

About Your Coverage

If you leave the company

Your Dental Plan coverage ends at the end of the month in which you leave the company for any reason and are no longer employed as an active Full-Service Employee. At that time, you will be eligible for COBRA continuation coverage (refer to the “COBRA” section for more information).

Coverage when you are not working

Taking a leave of absence does not affect your Dental Plan coverage. You are responsible for continued payment of premiums while you are on an unpaid leave of absence.

If you retire

When you retire as a Pensioner under the Age, Voluntary, Optional or Incapability provisions of the Pension and Retirement Plan, your coverage will continue through the Dental Assistance Plan, which provides Standard Option (B) type benefits. Your coverage continues at the same coverage level (You only, You plus one, You plus family) that you elected as an active employee. If you wish to change your dental coverage category or decline coverage, you may do so by calling DuPont Connection at 1-800-775-5955.

If you are terminated due to lack of work*

If your employment with the Company is terminated due to lack of work, you will continue to receive Dental Plan Standard Option (B) type coverage through the Dental Assistance Plan for yourself and your covered dependents for up to 12 months.

If you die*

If you die while employed by the Company and you have less than 15 years of service, your coverage ends. Your surviving dependents may be eligible for COBRA continuation of coverage, which allows your dependents to continue coverage for up to 36 months. Refer to the “COBRA” section below for more information. If you have more than 15 years of service at the time of your death, coverage continues through the Dental Assistance Plan for your specified survivor. If your specified survivor is your lawful spouse, coverage may also be continued for your dependent children.

When coverage ends

Dental Plan coverage ends at the end of the month in which you or your dependent(s) are no longer eligible for coverage.

If you or a dependent are in the middle of certain treatments, the Plan may pay additional benefits depending on how far along the treatments are. The types of work that are considered in process and covered are:

- dentures or bridges if the impression has already been taken
- restorations for teeth that are already prepared
- root canal therapy if the tooth was open while covered

Treatment must be completed within two calendar months after your coverage ends.

COBRA

This section is intended to comply with the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) as amended, which requires continuation of dental coverage to certain eligible employees whose coverage would otherwise terminate. If this section is incomplete or in conflict with the law, the terms of the law will govern.

Continuation of coverage

You and your covered dependents may continue your current dental coverage if it ends because of one of the following:

- you voluntarily leave the Company
- the Company ends your employment for any reason, unless you were fired because of gross misconduct
- the number of hours you are scheduled to work is reduced below that required for you to be eligible for benefits

*Coverage continuation described in this section applies to Full-Service Employees of DuPont. Coverage may differ for joint venture or affiliate company employees.

COBRA coverage also is available to your covered dependents if their coverage would otherwise end because of one of the following:

- your death
- your divorce, legal separation or annulment of your marriage
- a change in your employment status that results in a loss of benefits eligibility
- your dependent child becomes ineligible for coverage

COBRA coverage continues for up to 18, 29 or 36 months, depending on how you or your covered dependents become eligible. If you elect to continue coverage under COBRA, you are required to pay 102% of the cost of coverage in after-tax dollars. If you are disabled as determined by the Social Security Administration, you may elect to continue COBRA for up to 29 months.

Length of COBRA coverage	Reason coverage stops
18 months	<ul style="list-style-type: none">• Your employment with the Company ends for any reason other than gross misconduct• Your regularly scheduled work hours are reduced, making you ineligible for coverage
29 months	<ul style="list-style-type: none">• You or your dependent is disabled (as determined by the Social Security Administration) when your coverage ends or at any time during the first 60 days of COBRA continuation coverage.
36 months (for dependents)	<ul style="list-style-type: none">• You become entitled to Medicare while on COBRA• You die• You divorce, have your marriage annulled or legally separate• Your dependent stops being eligible for coverage

Electing COBRA

You and your covered dependents will receive election forms and more information about COBRA from DuPont Connection (1-800-775-5955). In the case of a divorce, legal separation or the ineligibility of a dependent child, you or your covered dependents must notify DuPont Connection within 60 days of the date coverage ends in order to elect COBRA.

If you wish to elect COBRA coverage, you must do so no later than 60 days after the date your company coverage ends or 60 days after the date of the notice of COBRA rights and your election is mailed to you, whichever is later. You must pay any cost necessary to avoid a gap in coverage within 45 days of the date you elect COBRA.

If you elect COBRA coverage and the Social Security Administration determines that you or your covered dependent was permanently and totally disabled at any time within the first 60 days of the date of continuation coverage, you or your covered dependent must notify DuPont within 60 days of the determination. The notice must be received by DuPont within the initial 18 months of COBRA coverage so that you and your covered dependents can qualify for an additional 11 months of coverage.

If a 36-month event happens while a dependent is covered under COBRA, COBRA coverage may be continued for the dependent for 18 months—up to a total of 36 months.

When COBRA ends

COBRA coverage ends when one of the following events occurs:

- the COBRA period—18, 29 or 36 months—ends
- premiums are not made on a timely basis
- the Company terminates the Plan or amends the Plan to eliminate coverage and does not provide any other group dental plans to employees
- the person who elected COBRA becomes covered under another group dental plan and meets any pre-existing condition prohibitions or limitations

Future of the Plan

While the Company intends to continue the benefits and policies described in this booklet, the Company reserves the right to suspend, modify, or terminate this Plan at its discretion at any time.

ADMINISTRATIVE INFORMATION

The information presented in this Summary Plan Description is intended to comply with the disclosure requirements of the regulations issued by the U.S. Department of Labor under the Employee Retirement Income Security Act of 1974 (**ERISA**).

Qualified Medical Child Support Order (QMSCO)

You or your dependents can obtain a description of Qualified Medical Child Support Order procedures by contacting the Plan Administrator or visiting the DuPont Legal website at <http://legal.lvs.dupont.com>.

Overpayments and other errors

If a benefit is paid that is larger than the amount allowed by the Plan, the Plan has a right to recover the excess amount from the person or agency who received it. Erroneous statements will not change the rights or obligations under the Plan and will not operate to grant additional benefits or coverage.

Assignment of benefits

When you file a claim, you can direct the Claims Administrator (MetLife Dental) to issue benefit payments to the service provider. When you assign benefits, MetLife Dental pays your dentist directly. At the same time, an explanation of benefits is mailed to you. If you assign benefits, you do not have to submit claims to the Plan for reimbursement. Instead, your dentist will submit claims for you.

Conversion rights

If you or your covered dependents do not elect COBRA, your coverage will end. You cannot convert the coverage to an individual policy.

ERISA Rights

As a participant in the BeneFlex Dental Care Plan and Dental Assistance Plan, you are entitled to certain rights and protections under ERISA. ERISA entitles you to:

- examine, at the Plan Administrator's office and other specified locations, including work sites and union halls if applicable, without charge, all Plan documents governing the Plan. These documents may include insurance contracts, collective bargaining agreements if applicable, and the latest annual report (Form 5500) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.
- obtain, after sending a written request to the Plan Administrator, copies of documents governing the operation of the Plan, including insurance contracts and collective bargaining agreements if applicable, and copies of the latest annual report (Form 5500 Series) and updated Summary Plan Description. You may be asked to pay a fee for the copies.
- receive a written summary of the Plan's annual financial report. The Plan Administrator is required by law to provide each participant with a copy of this summary annual report.

In addition to creating rights for Plan participants, ERISA imposes duties on the people responsible for the operation of the Plan. The people who operate your Plan, called "fiduciaries," have a duty to do so prudently and in the best 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.

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 several steps you can take to enforce your rights. For instance, if you request a copy of Plan documents or the latest annual report from the Plan and do not receive it within 30 days, you may file suit in 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 Plan Administrator's control.

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. In addition, if you disagree with the Plan's decision or lack of decision about the qualified status of a domestic relations order or medical child support order, you may file suit in federal court. If 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 sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees if, for example, it finds your claim is frivolous.

If you have any questions about your Plan, contact the Plan Administrator. If you have questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory. You may also contact the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

Plan Sponsor

E. I. du Pont de Nemours and Company
1007 Market Street
Wilmington, DE 19898
Phone: 1-302-774-1000

Other companies related to DuPont also adopt the Plan for the benefit of their employees from time to time. You can get a list of adopting employers and their addresses from the Plan Administrator.

Plan Names

This summary describes benefits for the Dental Plan which consists of the:

- BeneFlex Dental Care Plan
- Dental Assistance Plan

Type of Plan and Administration

The Plan is a welfare plan as defined by the Employee Retirement Income Security Act of 1974 (ERISA) that provides group health benefits. This Plan is administered by the Company.

Plan Administrator

The Plan Administrator has the authority to control and manage the operations and administration of each Plan. You can reach the Plan Administrator at:

E. I. du Pont de Nemours and Company
1007 Market Street
Wilmington, DE 19898
Phone: 1-302-774-1000

Employer Identification Number (EIN)

The EIN is 51-0014090.

Plan Number

The Plan number is 507.

Plan Year

The Plan Year is January 1 through December 31.

Source of Benefits Funding

You and the Company pay the cost.

Agent for Service of Legal Process

E. I. du Pont de Nemours and Company
1007 Market Street
Wilmington, DE 19898
Phone: 1-302-774-1000

Claims Administrator

MetLife Dental
P.O. Box 14093
Lexington, KY 40512-4093
Phone: 1-888-883-0052

CONTACTS

For Appealing a Claim

DuPont Connection
Dental Appeals
P.O. Box 1407
Lincolnshire, IL 60069-1407
Phone: 1-800-775-5955

For Claim Forms/Issues

MetLife Dental
P.O. Box 14093
Lexington, KY 40512-4093
Phone: 1-888-883-0052

For COBRA Coverage

DuPont Connection
Phone: 1-800-775-5955

DICTIONARY TERMS

The following terms were highlighted throughout the SPDs. In this section, you will find the definitions for these terms to help clarify their meaning and to provide information to better help you understand the provisions of your benefit Plan.

Appeal

A request for reconsideration of a denied claim. Either the Claims Administrator or the Plan Administrator reviews the appeal and decides if the claim's previous denial should be overturned. Certain appeals are governed by requirements set forth by the Employee Retirement Income Security Act of 1974 (ERISA), including how appeals are submitted and responded to, relevant time frames and responsibilities of the claimant, the Claims Administrator and the Plan Administrator.

BeneFlex Election Change Period (annual enrollment, open enrollment)

The period of time each year designated by the Company when you may generally make changes to their benefit elections.

Bitewing X ray

The dental X ray showing the crown portions of the upper and lower teeth.

Bridge

A strong connecting link between two or more teeth, replacing a missing tooth or teeth. It usually has a gold frame and porcelain that has the shape and color of the missing teeth.

COBRA (Consolidated Omnibus Budget Reconciliation Act)

Federal law that allows eligible people covered by a group health plan to temporarily extend coverage when their coverage would otherwise end, such as when they get divorced or leave a company.

Company

The association or organization you work for and that provides your benefit program.

Crown (cap)

A porcelain or gold tooth cover for a decayed, damaged, brittle or discolored tooth that has a strong base and roots.

Dentures

Removable, artificial teeth designed to help you chew, restore your bite and improve your appearance.

Endodontic treatment

The care of the pulp chambers and root canals of your natural teeth; it usually involves sterilization and filling.

ERISA (Employee Retirement Income Security Act of 1974)

This federal law requires employee benefit plans to disclose information about the Plan to participants and establish claims procedures.

Explanation of benefits (EOB)

A statement you receive whenever you file a claim, giving specific details about how and why benefit payments were or were not made. It summarizes the charges submitted and processed, the amount allowed, the amount paid and the subscriber balance, if any.

Fluoride

A natural substance found in minerals that works with your tooth or bone structure to make it stronger and more resistant to acid decay.

Gingivectomy

The surgical removal of the flaps of gum tissue that create pockets alongside teeth that have periodontal damage, designed to stop periodontal disease.

Inlay

A cast, precious metal filling to help restore and strengthen a tooth.

Oral surgery

Surgery of the oral mouth cavity, including teeth, tongue and throat. Dental oral surgery typically includes complex extractions and other surgical procedures in relation to the teeth and gums.

Orthodontia

The branch of dentistry that deals with detecting, preventing and correcting abnormalities between teeth.

Periodontics

The treatment of the supporting structure of the tooth—the gum and bone tissue.

Plan Year

The 12-month period, or policy or fiscal year on which the Plan's records are kept. The Plan Year runs from January 1 through December 31.

Post-service claim

A claim that involves only the payment or reimbursement of the cost of medical care that has already been provided, and any other claim for benefits that is not a pre-service claim; for example, a claim for reimbursement for already performed diagnostic tests.

Pre-service claim

Any claim for a benefit which, with respect to the terms of the Plan, conditions receipt of the benefit, in whole or in part, on approval of the benefit in advance of obtaining dental care.

Qualifying Life Event

An event recognized by Section 125 of the Internal Revenue Code that entitles you to make a change in the benefit elections you made.

Reimburse

When you are paid back for money you spend on approved expenses.

Root canal

A procedure to save an abscessed tooth by cleaning out the pulp chamber, disinfecting it and filling it with a permanent filling.

Sealant

The protective plastic coating applied over grooves in your teeth to prevent decay.

Space maintainer

An appliance children use in their mouths so their teeth do not drift or crowd new teeth.

Splinting

Splinting is connecting teeth with a fixed appliance. Periodontal splinting is not covered by the Dental Plan.

Summary Plan Description (SPD)

A legally required document intended to help you understand your benefits, how the Plan operates, how to file claims and your rights and responsibilities as a Plan participant. It does not describe every feature in the Plan and it is not intended to be a full statement of the Plan documents.

TMJ syndrome (temporomandibular joint syndrome)

A medical or dental problem related to the temporomandibular joint that links the jawbone and skull. TMJ treatment or applications are not covered by the Dental Plan.

Urgent care claim

Claims for dental care or treatment that if processed under normal claims decisions processes could seriously jeopardize the claimant's life or health, jeopardize claimant's ability to regain maximum function, or subject claimant to severe pain that cannot be managed without the care or treatment that is the subject of the claim.

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