
Your DuPont Benefit Resources

BeneFlex Health Care Spending Account Plan and Health Care Spending Account Plan

July 2003

As of July 2003, participating employers in the BeneFlex Health Care Spending Account Plan and/or the Health Care Spending Account 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

A Health Care Spending Account (HCSA) allows you to pay, on a before-tax basis, for certain health care expenses not covered by other benefits plans or insurance.

If you enroll, your money will be deducted from your pay on a before-tax basis and credited to your individual spending account each month. Then, after submission of claim forms and supporting documentation, you will be **reimbursed** from your account for covered expenses you incur for health care (including medical, dental and vision care). Expenses for eligible care will be reimbursed only after the care is provided and cannot be claimed again as a deduction or credit on your federal income tax return.

You will need to satisfy the requirements described in this SPD to participate in the Health Care Spending Account.

Eligibility

Eligible employees

You are eligible for the BeneFlex Health Care Spending Account if you are:

- a Full-Service Employee of the DuPont U.S. Region, or
- a Full-Service Employee of a participating DuPont subsidiary or joint venture that has adopted this Plan.

You can also cover your spouse and dependents, if they are eligible.

Since January 1, 1992, the BeneFlex Flexible Benefit Plan has been offered to all DuPont U.S. Region employees. However, you are not eligible for the BeneFlex Health Care Spending Account 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 may use the Health Care Spending Account to reimburse eligible health care expenses for yourself, your spouse or your eligible dependents. According to the Internal Revenue Service (IRS) rules, an eligible dependent must meet all of the following requirements:

- lives with you for the entire year as a member of your household
- is claimed as an exemption on your federal income tax return
- receives more than half of his/her financial support from you

For more information on eligible dependents, refer to **IRS Publication 502**.

Enrollment

Enrolling in the Plan

You can enroll in the Health Care Spending Account Plan during the annual **BeneFlex Election Change Period** or when you first become eligible. Participation is voluntary. You enroll:

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

New employees hired before December 1 can enroll for the current year. Any new employee hired on December 1 or later must wait for the next BeneFlex Election Change Period to enroll. 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 no coverage, so it is important that you enroll in a timely manner.

Your benefit elections will stay in effect for the entire **Plan Year** (January 1–December 31), unless you have a **Qualifying Life Event**. Refer to the section titled “Making changes” for further 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 Health Care Spending Account Plan for the following year with no change to your contribution election.

When participation begins

Once enrolled, your Health Care Spending Account Plan participation will start on the first of the month following your election or on January 1 if you enroll during the BeneFlex Election Change Period.

Making changes

You may change your BeneFlex Health Care Spending Account Plan 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 changes must be consistent with and on account of your Qualifying Life Event and not for financial reasons.

For 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 a spouse or dependent child
- gain or loss of an eligible dependent
- the start or termination of your spouse's employment
- a change in your or your spouse's employment from part-time to full-time or vice versa
- unpaid leave of absence by your spouse

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

Changes you make after a Qualifying Life Event become effective the first day of the month following the day the event is reported and apply to reimbursements for expenses incurred on or after the effective date of the change. New payroll deduction amounts will also be effective in the month following the day the event is reported.

Changes during the annual BeneFlex Election Change Period

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

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

- enroll to participate
- increase your Health Care Spending Account contribution amount
- decrease your Health Care Spending Account contribution amount
- cancel your participation

All changes in the Health Care Spending Account made during the BeneFlex Election Change Period will become effective on the first day (January 1) of the new Plan Year.

Contributions

Contribution amounts

You select an amount to contribute to the Plan. You can contribute between \$10 per month and \$416.67 per month, a maximum of \$5,000 per year.

Since you will lose any amount you don't use, you should estimate your expenses carefully before deciding on an amount to contribute. Visit the Aetna website at www.aetna.com for a contribution estimation worksheet. You may be reimbursed for eligible expenses you incur during the Plan Year. You can't be reimbursed for services that are provided before your participation begins.

Once you make your selection for the year, you can't make any changes, unless you have a Qualifying Life Event.

The Health Care Spending Account Plan and the Dependent Care Spending Account Plan are separate. Money you set aside for your Health Care Spending Account cannot be used to pay for dependent care expenses. Similarly, any money set aside for the your Dependent Care Spending Account Plan cannot be used to reimburse any health care expenses. Furthermore, transferring money between the two accounts is not allowed.

Contribution limits for married couples

If you are married, you and your spouse may each contribute up to the maximum contribution amount allowed by your health care spending account plans. If you and your spouse both work for the Company and are each enrolled in the Health Care Spending Account, your combined contribution maximum cannot exceed \$10,000 (a monthly maximum of \$416.67 each).

If both you and your spouse contribute to health care spending account plans, you can only be reimbursed once for any eligible expense.

When contributions are credited

Your contributions will be deducted from your pay while you are an active employee and credited into your account on a monthly basis.

Account statements

Twice a year (usually in February and September), you will receive a statement showing your account activity, regardless of whether you have had any claims.

You can also contact:

- Aetna at 1-800-323-5479, or
- Aetna online at www.aetna.com

to receive information on your account activity.

Tax information

Your contributions to the Health Care Spending Account are deducted on a before-tax basis. This means that the money is deducted from your pay before federal, **Social Security** and most state and local income taxes are withheld. By contributing on a before-tax basis, you reduce your taxable pay and, as a result, you lower the amount of taxes you pay. The amounts reimbursed to you from the Plan are also tax-free.

In certain situations, IRS tax rules allow you to deduct some health care expenses on your federal income tax return. If you have significant medical expenses during the year that are in excess of 7.5% of your annual income, you will be able to deduct medical expenses on your tax return. The Health Care Spending Account Plan is a benefit to you because you may use it to pay on a before-tax basis for expenses that are not deductible to you because of the 7.5% threshold. However, if you are eligible for the deduction, you may use this tax deduction, choose to participate in the Health Care Spending Account Plan, or decide to use a combination of the two to pay for your health care expenses. If you choose to use both, you must subtract your annual Health Care Spending Account Plan contribution from the amount specified under IRS tax rules.

The IRS provides information about the tax deduction and qualifying expenses. You cannot, however, submit a claim for reimbursement to the Health Care Spending Account Plan and claim the same expenses on your federal income tax return.

Important considerations

Since no Social Security taxes are paid on the amount of your contributions, if your annual taxable pay is under the Social Security maximum taxable amount, your income for Social Security benefit purposes is less and your Social Security benefits at retirement or disability may be slightly reduced. Whether your Social Security benefits are affected depends on a number of factors, such as your current age, your pay before participating in the Health Care Spending Account Plan and your future pay levels.

Forfeiting unused contributions

Under Section 125 of the IRS tax code, you will **forfeit** any unused balances in your account at the end of the Plan Year. All claims for reimbursement of services in a Plan Year must be sent to Aetna/U.S Healthcare postmarked no later than April 15 of the subsequent year or you forfeit funds in your Health Care Spending Account.

You will lose any contributions left in your account after April 15; those funds will be used to offset administrative Health Care Spending Account Plan costs. Any remaining forfeited funds after administrative expenses are fully paid are then distributed per capita into all employee accounts existing at that time.

Plan Benefit

Eligible expenses

The Health Care Spending Account will reimburse eligible health care expenses incurred by you, your spouse or dependent(s), during your period of participation, which would generally be an eligible deduction on your tax return and in accordance with IRS Code 213. These expenses cannot be covered by any other benefit plan or insurance. Following is a partial list of examples of expenses which are reimbursable if they are not covered by a benefit plan or insurance:

- medical, dental or vision plan deductibles, copayments and coinsurance
- prescription copayments and coinsurance
- vision care and eyeglasses or contact lenses
- hearing care and hearing aids
- orthodontia
- costs in excess of dental plan limits
- dental care, excluding cosmetic treatment
- equipment for the mentally or physically disabled

IRS Publication 502 (“Medical and Dental Expenses”) can be used as a guide to eligible expenses. Some items are eligible on federal tax returns but NOT under the Health Care Spending Account (e.g., most premiums for health care coverage). For added clarification on eligible expenses, you can contact Aetna at 1-800-323-5479.

Ineligible expenses

You cannot be reimbursed for expenses:

- that do not qualify as a federal income tax deduction (without regard to exceeding 7.5% of your adjusted gross income)
- that are payable under any other benefit plan or insurance
- for services that occurred before or after your participation in the Plan

The following are some examples of expenses that are not eligible for reimbursement:

- custodial care in a nursing home
- elective cosmetic surgery
- dancing lessons, swimming lessons, etc. (even if your doctor recommends them for general improvement of your health)
- diaper service
- diet pills or appetite suppressants
- funeral expenses

- health club membership fees
- health plan premium contributions
- household help
- marriage or family counseling
- maternity clothes
- non-prescription drugs or vitamins
- orthodontia costs not associated with services received in the current year
- orthodontia costs that are strictly cosmetic
- premiums for life insurance policies, or policies that provide payment for loss of earnings or for an accidental loss of life, limb, sight, etc.

Filing for Reimbursement

How to file for reimbursement

When you have a health care expense that was not paid by a benefit plan or insurance, you submit the expense for reimbursement. First, make sure that you or your provider submits the expense to any other benefit plan that might pay it. Then, complete the DuPont Flexible Spending Account Health Care Reimbursement Form. You may obtain a claim form:

- by calling Aetna at 1-800-323-5479, or
- by visiting the Forms Central section of the DuPont Human Resources internal website at <http://www1.lvs.dupont.com/hr/>

You must also include supporting documentation as follows:

- a copy of the copayment receipt from the provider when the copayment is your only expense and you do not receive an **Explanation of Benefits (EOB)** statement
- an explanation of benefits statement if the claim is covered but not paid by any plan (for example, the amount you must pay or will pay because of deductibles or coinsurance)
- an itemized bill or receipt from the doctor, dentist or other supplier for expenses not covered by your medical, dental or vision plans

Documentation must include the provider's name and address, the patient's name, dates of service, a description of the service or supply, and the amount charged. A cancelled check is not sufficient documentation in the absence of an itemized bill.

Send your completed claim form to:

Aetna
FSA Middletown Unit
151 Farmington Avenue
Hartford, CT 06156-1301

All claims for reimbursement of services in a Plan Year must be sent to Aetna postmarked no later than April 15 of the subsequent year or you forfeit funds in your Health Care Spending Account.

You can submit a reimbursement request as frequently as you like. The minimum reimbursement is \$50, except for the final reimbursement at the end of the year.

You can be reimbursed before you pay your health care provider as long as the services have been received and you are legally required to pay for the care.

Reimbursement checks are issued daily, and Aetna will

- mail your reimbursement to your home address, or
- deposit your reimbursement check directly into your checking or savings account (if you have signed up with Aetna for automatic deposit)

Notification and explanation of benefits

Aetna will notify you in writing regarding a claim's benefit determination. You will receive a detailed statement called an explanation of benefits. The EOB will explain what amounts have been reimbursed. The statement will explain the reason why a claim has not been paid. An EOB will be sent within a maximum of 30 days.

The decision-making timeframe may be extended by Aetna 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 Aetna expects to provide a benefit 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.

Once you respond, Aetna will make a determination within 15 calendar days.

If a reimbursement is denied

If a claim for benefits is denied or reduced, you will be notified of the reason in writing for the denial within 60 days. The notice will include:

- the specific reason 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

Appealing a denied reimbursement

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 a resolution:

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

You also have the right to request, free of charge, access to and copies of all documents, records and other information relevant to your claim for benefits. If, after contacting Aetna 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 your claim.

Your final **appeal** is to DuPont. To appeal the denial, you should notify DuPont Connection in writing requesting a claim review. The request for the appeal should include additional 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 letter received from Aetna

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 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, Aetna.

About Your Participation

If you leave the company

Your Health Care Spending Account Plan participation ends at the end of the month in which you leave the Company for any reason, including retirement, and are no longer employed as an active Full-Service Employee.

If you leave the Company during the Plan Year (including retirement), you have three options for your Health Care Spending Account:

- You may authorize a one-time pre-tax deduction from your final pay to bring your account up to the total amount originally elected and continue to submit eligible claims incurred through December 31. You have up to April 15 of the subsequent year to mail claims to Aetna.
- You may continue your participation on an after-tax basis under **COBRA** at 102% of the current monthly deduction for up to 18 months. Refer to the “COBRA” section for more information.
- You may elect to terminate your account as of your date of termination and submit claims incurred on or before your date of termination. You have up to April 15 of the subsequent year to mail these claims to Aetna.

These three options will be explained in detail by DuPont Connection should you terminate or retire.

If you die

Participation in the Health Care Spending Account ends on the date of your death. Your surviving eligible dependents may continue to file claims for eligible expenses incurred while you were a participant in the Plan, until your account balances are used up. They have up to April 15 of the subsequent year to mail these claims to Aetna.

Your surviving eligible dependents may be eligible to continue coverage under the Health Care Spending Account by enrolling through COBRA and making after-tax contributions. Refer to the “COBRA” section below for more information.

COBRA

This section is intended to comply with the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) as amended, which requires continuation of 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 Health Care Spending Account 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

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
- your dependent child becomes ineligible for coverage

COBRA coverage for the Health Care Spending Account continues for up to 18 months. If you elect to continue coverage under COBRA, you are required to pay 102% of the cost of coverage in after-tax dollars.

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 becoming eligible 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.

When COBRA ends

COBRA coverage ends when one of the following events occurs:

- the COBRA period ends
- premiums are not paid on a timely basis
- the Company stops offering any group health care spending account plan
- the person who elected COBRA becomes covered under another group medical plan and meets any pre-existing condition prohibitions or limitations
- the person who elected COBRA becomes entitled to **Medicare** after COBRA coverage has started

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**).

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.

ERISA Rights

As a participant in the BeneFlex Health Care Spending Account Plan and/or the Health Care Spending Account 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 BeneFlex Health Care Spending Account Plan and the Health Care Spending Account 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 a choice between compensation and certain benefits. This Plan is administered by the Company.

Plan Administrator

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

Plan Sponsor Employer Identification Number (EIN)

The EIN is 51-0014090.

Plan Number

The Plans are part of Plan number 512.

Plan Year

The Plan Year is January 1 through December 31.

Source of Benefits Funding

You 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

Aetna
FSA Middletown Unit
151 Farmington Avenue
Hartford, CT 06156-1301
Phone: 1-800-323-5479

CONTACTS

For Sending a Reimbursement Request

Aetna
FSA Middletown Unit
151 Farmington Avenue
Hartford, CT 06156-1301
Phone: 1-800-323-5479

For a Reimbursement Form

Aetna
FSA Middletown Unit
151 Farmington Avenue
Hartford, CT 06156-1301
Phone: 1-800-323-5479

For Appealing a Denied Reimbursement

DuPont Connection
Dependent Care Spending Account Appeals
P.O. Box 1407
Lincolnshire, IL 60069-1407
Phone: 1-800-775-5955

For COBRA Coverage

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

DICTIONARY TERMS

The following terms are 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 plans.

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 timeframes 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 employees may generally make changes to their benefit elections.

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.

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 from your carrier 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 your balance, if any.

Forfeit

To lose money set aside in the Plan for expenses.

Internal Revenue Service Publication 502

Describes medical and dental expenses that qualify for deductions on your federal income tax return.

Plan Year

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

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.

Social Security

A federal program you can apply for that may pay disability benefits to you, your spouse and your dependent children if you become totally and permanently disabled.

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.

This document is printed on paper containing
DuPont™ RPS Vantage® titanium dioxide.



The miracles of science™