
Your DuPont Benefit Resources

BeneFlex Medical Care Plan and Medical Care Assistance Program

July 2003

As of July 2003, participating employers in the BeneFlex Medical Care Plan and/or Medical Care Assistance Program 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.



The miracles of science™

TABLE OF CONTENTS

DETAILS OF THE PLAN	1
PREFACE	1
INTRODUCTION	1
ELIGIBILITY	2
ENROLLMENT AND PREMIUM INFORMATION FOR EMPLOYEES	3
PARTICIPATION AND PREMIUM INFORMATION FOR PENSIONERS AND SURVIVORS	7
COST-SHARING PLAN DESIGN PROVISIONS	10
PLAN BENEFIT GENERAL INFORMATION	11
PLAN OPTIONS	15
MANAGED CARE GENERAL INFORMATION	15
CONSUMER CHOICE OPTION	17
POINT-OF-SERVICE OPTION AND PREFERRED PROVIDER ORGANIZATION OPTION	21
POINT-OF-SERVICE OPTION	22
PREFERRED PROVIDER ORGANIZATION OPTION	24
ALTERNATIVE COVERAGE OPTION	24
NON-MANAGED CARE BENEFIT INFORMATION	25
INDEMNITY OPTION/MEDCAP STANDARD	26
CATASTROPHIC OPTION	27
NO COVERAGE OPTION	27
COVERED SERVICES	27
EMERGENCY CARE	30
HOSPICE CARE	30
PREVENTIVE CARE SERVICES	31
PRESCRIPTION DRUGS	33
MATERNITY HOSPITAL STAY LIMIT	35
WOMEN’S HEALTH AND CANCER RIGHTS ACT	35
MENTAL HEALTH AND CHEMICAL DEPENDENCY TREATMENT	35
PRECERTIFICATION	37
SECOND SURGICAL OPINIONS	37
CENTERS OF EXCELLENCE	38
RESTRICTIONS AND EXCLUSIONS	38
FILING A CLAIM	40
ABOUT YOUR COVERAGE	43
COBRA	44
FUTURE OF THE PLAN	46
ADMINISTRATIVE INFORMATION	46
ERISA RIGHTS	47
PLAN SPONSOR	48
PLAN NAME	48
TYPE OF PLAN AND ADMINISTRATION	49
PLAN ADMINISTRATOR	49
PLAN SPONSOR’S EMPLOYER IDENTIFICATION NUMBER (EIN)	49
PLAN NUMBER	49
PLAN YEAR	49
SOURCE OF BENEFITS FUNDING	49
AGENT FOR SERVICE OF LEGAL PROCESS	49
CLAIMS ADMINISTRATOR	50
PHARMACY NETWORK	50
MENTAL HEALTH AND CHEMICAL DEPENDENCY (MH/CD) NETWORK	50
CONTACTS	50
FOR APPEALING A CLAIM	50
FOR CLAIM FORMS/ISSUES, PRECERTIFICATION INFORMATION OR NETWORK PROVIDER INFORMATION (WHERE APPLICABLE)	51
GETTING PREAPPROVAL FOR MENTAL HEALTH AND SUBSTANCE ABUSE	51
PRESCRIPTION PROGRAM	51
FOR COBRA COVERAGE	51
DICTIONARY TERMS	52

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 Medical Plan benefits reflect the Company's health care principles. The Medical Plan:

- encourages wellness, illness prevention and the wise use of health care dollars,
- provides you with prevention coverage and catastrophic financial protection, and
- allows for the appropriate sharing of costs between you and the Company.

If you are an employee, you can select from the BeneFlex Medical Care Plan options available in your area or elect no coverage for yourself and your eligible dependents. The BeneFlex Medical Care Plan options include a variety of managed care and non-managed care choices. Refer to your personal benefits enrollment materials for the BeneFlex Medical Care Plan options available to you.

If you are a Pensioner or Survivor, you receive the Medical Care Assistance Program (MEDCAP) coverage. Your benefit coverage varies, depending on where you live and whether you and your covered dependents are eligible for Medicare. If you and your covered dependents are not yet eligible for Medicare and you live in a managed care area, you will receive MEDCAP Network coverage (the Point-of-Service Option). All other Pensioners and Survivors will receive MEDCAP Standard coverage (the Indemnity Option). Participation is voluntary.

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

Eligibility

Eligible employees, Pensioners and Survivors

You are eligible for Medical 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 Medical 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 Medical 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 Medical Plan coverage, including prescription drug and mental health/chemical dependency benefits.

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

- To be eligible for secondary coverage under the Medical Plan, working spouses must enroll for primary medical care coverage with their employer if it is available and their out-of-pocket individual premium cost for the lowest priced coverage available is less than \$100.00 per month for 2003.
- If both you and your spouse work for a Company participating in the Medical 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 Medical 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 Medical Plan coverage.
- If you are required by court order to provide medical 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 Medical 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 Medical Plan. Both of you cannot cover your child at the same time.
- It is your responsibility to remove children who no longer meet the Medical Plan eligibility requirements.

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

If you are an employee, you can enroll in the Medical 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 either the Point-of-Service Option or Indemnity Option, depending on where you work and live. 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 Medical Plan options, depending on where you work and where you live. Options that may be available include:

Medical Plan options for employees

Managed Care Options:

- Consumer Choice
- Point-of-Service
- Preferred Provider Organization
- Alternative Coverage

Non-Managed Care Options:

- Indemnity
- Catastrophic
- No Coverage

Each Medical Plan option 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)**. See page 5 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 Medical Plan for the following year with no change to your elections.

End Stage Renal Disease

Even for an active employee or a covered dependent of an active employee, Medicare becomes primary at a certain point when the diagnosis of End Stage Renal Disease has been made and kidney dialysis begins. You and all your covered family members will be moved out of managed care and into a non-managed care option at that time. Call DuPont Connection to have your medical option changed if you are in this situation.

When coverage begins

Medical 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 BeneFlex Medical Care 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 change must be consistent with and on account of your Qualifying Life Event and not for financial reasons. Changes to Medical Plan options, such as switching from the Point-of-Service Option to the Consumer Choice Option, are only permitted mid-year if you move out of a managed care service area and can no longer participate in your existing Medical Plan option.

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 (such as a child who ages out of coverage)
- the start or termination of your spouse's employment
- moving into or out of a managed care service area
- a change in your spouse's employment from part-time to full-time or vice versa
- a significant change in your spouse's medical 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 BeneFlex elections within 31 days of the Event, your medical changes will be effective retroactive to the date of your Event. If you report your QLE after 31 days of the Event, your medical 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 Medical Plan.

Changes during the 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 Medical Plan 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 health insurance 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 as retroactive to the date you lost other coverage.

Premium costs

The Company bears a large part of the cost of your Medical Plan coverage. You pay your portion of the cost through payroll deductions (premiums) and cost-sharing benefit design features such as **copays**, **coinsurance** and **deductible** amounts. 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 medical coverage are based on the level of coverage you choose:

Medical Plan Options for Employees 2003 Monthly Employee Premium by Coverage Level

	You only	You plus one	You plus family
Managed Care Options:			
• Consumer Choice	\$38.50	\$ 77.00	\$115.50
• Point-of-Service	\$51.75	\$103.50	\$155.25
• Preferred Provider Organization	\$65.75	\$131.50	\$197.25
• Alternative Coverage	call**	call**	call**
Non-Managed Care Options:			
• Indemnity	\$51.75	\$103.50	\$155.25
• Catastrophic	\$ 0.00	\$ 0.00	\$ 0.00
• No Coverage	\$ 0.00	\$ 0.00	\$ 0.00

The premiums listed above are effective for the 2003 Plan Year. Your premiums are reviewed annually and are subject to change. You will be notified in advance of any premium changes.

*Note that coverage levels may vary for the Alternative Coverage Option.
 **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 medical benefits is prorated. Refer to the next section titled “About prorated premiums” for more information.

About prorated premiums

If you are approved to work part-time under Flexible Work Practices, the Company contribution to your Medical 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 medical 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 full-time employee premium amount.

Participation and Premium Information for Pensioners and Survivors

Participating in the Plan

If you are an eligible Pensioner or Survivor, you and your covered dependent(s) are automatically enrolled in the Medical Care Assistance Program (MEDCAP), which provides either:

- MEDCAP Network benefits (the Point-of-Service Option), or
- MEDCAP Standard benefits (the Indemnity Option)

depending on where you live and whether you and/or your covered dependent(s) are eligible for Medicare. Upon retirement, your coverage continues at the same coverage level (You only, You plus one, or You plus family) that you elected as an active employee. You may change your coverage level or decline medical coverage, as described on page 8, at any time.

Before you or your covered dependent(s) qualify for Medicare

If you live in a Point-of-Service Option network area, you will receive MEDCAP Network benefits (the Point-of-Service Option) until Medicare becomes the primary medical coverage for you or a covered family member. If you do not live in a Point-of-Service Option network area, you will receive MEDCAP Standard benefits (the Indemnity Option) unless you choose to enroll in MEDCAP Network benefits (the Point-of-Service Option). In that case, contact DuPont Connection at 1-800-775-5955.

When you or your covered dependent(s) become eligible for Medicare

Contact the Social Security Administration to enroll in parts A (hospital) and B (medical/surgical) of Medicare.

When Medicare becomes the primary medical coverage for Pensioners, Survivors or any of their covered family members, the entire family will no longer be eligible for MEDCAP Network benefits (the Point-of-Service Option). Instead, the entire family will be covered by MEDCAP Standard (the Indemnity Option) and coverage will be automatically transferred as long as the Plan Administrator knows about the Medicare primacy. Contact DuPont Connection at 1-800-775-5955 to report the change and have your future premiums adjusted. This change in coverage is effective the first of the month in which you or a covered family member become eligible for Medicare.

Medicare will be the primary coverage for those family members on Medicare. The Medical Plan will become secondary, using maintenance of benefits (described on page 13) to calculate any claim payment. If you choose to decline Medicare Part A or Part B coverage when eligible, the Medical Plan will not **reimburse** for that portion of hospital/medical/surgical services normally paid by Medicare.

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 medical coverage is permanent and irrevocable. If you decline medical coverage as a Pensioner or Survivor, you cannot later enroll in the Medical Plan unless you either:

- lose eligibility for coverage under another employer or a government plan. Loss of coverage cannot be due to non-payment of premiums; or
- decline coverage through the Company to enroll in a Medicare HMO (MHMO) and you are changing MHMO plans (with the same or different carrier) or terminating MHMO participation and returning to traditional Medicare coverage

Note that if you decline medical coverage, you will receive no medical, prescription, or mental health benefits from the Medical Plan.

Premium costs

The Company contributes toward the cost of Medical Plan coverage. Your premiums for medical coverage are based on the level of coverage you choose:

**Medical Plan Options
for Pensioners and Survivors**

**2003 Monthly Premium by Coverage Level
for Individuals Receiving a Full Pension Benefit**

	You only	You plus one	You plus family
Pre-Medicare			
• Point-of-Service Option (MEDCAP Network)	\$63.50	\$127.00	\$190.50
• Indemnity Option (MEDCAP Standard)	\$63.50	\$127.00	\$190.50
Medicare eligible (Pensioner, Survivor and/or Dependents)			
• Indemnity Option (MEDCAP Standard)			
— One Medicare (others non-Medicare)	\$43.50	\$107.00	\$170.50
— Two Medicare (others non-Medicare)	n.a.	\$ 87.00	\$150.50
— All Medicare	n.a.	n.a.	\$130.50

The premiums for your Medical Plan coverage are normally deducted from your pension payment, if possible. 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 1st of each month from your checking, savings, or investment account.

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

About prorated premiums

For DuPont Pensioners receiving less than a full pension benefit and their Survivors, the Company contribution to your medical coverage is prorated if you retired on or after January 1, 1994. The Company contribution to your Medical 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. This factor will not change for the Pensioner’s lifetime and will also be applied to any Survivor’s Medical Plan 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 medical 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

The deductible is the amount of money you must pay each Plan Year for covered medical care before the Plan pays additional benefits. Under the Medical Plan coverage, some benefits are subject to an annual deductible as described in the “Plan Options” section, beginning on page 15. The Medical Plan has both individual and family deductibles (except for the Consumer Choice Option, which has a combined deductible for all covered family members, and no separate individual deductible). Deductible amounts are based on your Medical Plan option and the level of coverage you elect. A new deductible applies each year.

Individual deductible

The individual deductible applies to each covered person. Once you meet the individual deductible, the Medical Plan begins paying benefits for that individual.

Family deductible

The family deductible limits the combined amount of individual deductibles that apply for you and your covered dependents in a Plan Year. To meet the family deductible, one family member must meet the individual deductible and the expenses of other family members can be combined to meet the balance of the family deductible.

Coinsurance

Coinsurance is the percentage of expenses that you are responsible for paying after you meet the deductible (when applicable). The Medical Plan pays a percentage of the expenses based on the type of service; you pay the remaining amount. Coinsurance differs by Medical Plan option. Refer to the “Plan Options” section for information on the coinsurance that applies to your Medical Plan option.

Copay

The copay is the flat dollar amount you pay for certain expenses, as shown in the “Plan Options” section, beginning on page 15.

Plan Benefit General Information

Medical ID cards

Appropriate ID cards will be mailed to your home address by your medical carrier. Your card will include information such as your name and your identification number. It will also include instructions on how to contact member services, a group of customer service representatives employed by your medical carrier who will answer your questions and respond to your concerns. You will receive a new ID card when changes to your personal information, carrier or Medical Plan option occur.

Remember to take your ID card with you whenever and wherever you go for health care services. It identifies you as a Medical Plan participant. If you need a second set of ID cards, contact your medical carrier.

Once all outstanding claims have been processed and resolved, destroy all ID cards you have from previous coverages.

Pharmacy ID cards

All eligible participants will receive prescription drug ID cards from Medco Health Solutions. If you present your ID card at a Medco Health Solutions participating network retail pharmacy, you can receive up to a 30-day supply of your prescription for a discounted price. You must show your ID card when you go to have your prescription filled in order to receive in-network pharmacy benefits. (Note that in-network pharmacy benefits are not applicable to participants in the Catastrophic Option, although discounts do apply.)

Reasonable and customary (R&C) amounts

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 (your medical carrier) reviews charges submitted by providers in your location.

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

- the usual fee which the doctor or facility most frequently charges the majority of patients for the particular service rendered or supply furnished; and
- the prevailing range of fees charged in the same geographical area by similar health care providers for similar services; or
- special circumstances or medical complications which require additional time, skill, experience or services to provide the necessary treatment.

Multiple surgical procedures performed during the same operative setting will have the reasonable and customary allowance for each secondary procedure reduced before benefits are paid.

Call your medical carrier with any questions about individual claims which are over R&C. Call in advance of receiving services to learn if proposed charges are within R&C. You will need to know the Current Procedural Terminology (CPT) medical procedure code (available from your provider) and the zip code of the provider in order to receive information regarding R&C in advance of receiving treatment.

If your doctor's charges for care covered by the Medical Plan are less than or equal to the reasonable and customary charges, benefits apply to the full billed charges. If your doctor charges more than what is reasonable and customary, you pay your share of the covered R&C amount plus any excess fees above R&C.

Under the managed care Medical Plan options, in-network charges are based on the pre-negotiated fee agreed to by the medical carrier and the providers, the Network Negotiated Rate, in lieu of R&C.

Annual medical stop-loss

The annual medical **stop-loss** is the maximum amount you pay for your share of covered expenses each year. Once you reach the individual or family stop-loss, the Medical Plan pays 100% of R&C or, if applicable, the Network Negotiated Rate, for the remainder of the Plan Year.

Expenses that count toward your annual medical stop-loss include:

- coinsurance for medical services
- coinsurance for mental health or chemical dependency services
- deductibles

These out-of-pocket expenses do not apply to the annual medical stop-loss:

- office visit copays
- Plan premiums
- charges above reasonable and customary when applicable
- prescription drug copays or coinsurance amounts (a separate \$1,500 per person stop-loss applies to covered prescriptions)
- expenses for services that are not **medically necessary** or are not covered by the Plan
- expenses for infertility treatment and in vitro fertilization procedures
- charges that exceed individual benefit maximums

The individual stop-loss applies to each covered person. To meet the family stop-loss, one family member must satisfy the individual stop-loss, and the expenses of other family members can be combined to satisfy the balance of the family stop-loss. (Note that the Consumer Choice Option has a combined stop-loss for all covered family members, and no separate individual stop-loss.)

Under the managed care Medical Plan options, a separate stop-loss applies to in-network and out-of-network amounts. In-network stop-loss amounts do not apply to the out-of-network stop-loss and vice versa.

Refer to the "Plan Options" section for information on the annual stop-loss amounts that apply to your Medical Plan option.

Example of how the stop-loss works

John is covered in the Indemnity Option. During the course of the year, John undergoes cancer treatment. His deductible plus his coinsurance share of the covered medical expenses are capped at the individual Indemnity Option stop-loss level of \$1,600 for 2003. His remaining covered expenses will be paid at 100% for the rest of the Plan Year.

Prescription drug annual stop-loss

The annual stop-loss for in-network prescription drugs is \$1,500 per person. Your Medical Plan prescription copays and coinsurance amounts (except for infertility medications) apply toward the prescription drug annual stop-loss each year. Once an individual meets the stop-loss, covered prescriptions for the rest of the Plan Year are paid at 100% of the discounted rate for that individual.

There is no stop-loss for prescription drugs received from a pharmacy or mail order program outside the Medco Health Solutions network.

Annual benefit maximum

The Medical Plan pays a benefit maximum of \$1.5 million for all covered medical expenses incurred on account of any one person in any one Plan Year.

Lifetime maximum benefit

The lifetime maximum benefit is the limit the Plan will pay in each covered person's lifetime. The Medical Plan has no general lifetime maximum benefit; however, a lifetime maximum benefit does apply to the following specific infertility treatment expenses:

- Infertility treatment and in vitro fertilization procedures shall not exceed a lifetime maximum of \$25,000 per family (including prescription drug benefit amounts). Expenses incurred under the lifetime infertility benefits are cumulative and continue to apply toward the lifetime maximum in cases of remarriage where additional covered infertility treatment and/or in vitro fertilization expenses are incurred or when coverage changes to a different Medical Plan option or medical carrier.

Maintenance of benefits

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

Maintenance of benefits allows two or more medical 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 medical plan, your Medical Plan will be secondary for him/her (if enrolled). Similarly, if you are also covered by your spouse's employer's medical 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 Medical Plan is secondary.
- If you have Medicare, that coverage is primary and this Medical 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 Medical Plan is the secondary payer, the Medical 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 Medical Plan would normally pay, then the Medical Plan won't pay any additional benefits. If the other plan pays less than the Medical Plan would pay, then the Medical Plan will pay the difference up to its normal benefit.

For example, if your spouse's primary plan (or Medicare) pays an 80% benefit, this Medical Plan will not pay additional benefits under the Indemnity Option unless you have exceeded the stop-loss. The Indemnity Option provides 80% benefits after satisfaction of the deductible, but you have already received 80% from your spouse's plan (or Medicare), so no secondary benefits will be paid.

The pharmacy program under the Medical Plan does not coordinate with other plans. If another prescription drug plan is used as primary, your Medical Plan pharmacy program will not coordinate or pay any additional benefits as secondary. You should, therefore, use your primary plan first even for prescriptions.

Contact your medical carrier with questions on how maintenance of benefits works with your coverages.

PLAN OPTIONS

Managed Care General Information

The Managed Care options offer a complete system of health care delivery aimed at providing quality care at negotiated prices. The options available differ by area. Each provide you with access to a network of providers and facilities managed by a medical carrier. Your managed care medical carrier prenegotiates treatment fees with network providers and facilities, which reduces costs to you and the Company.

The managed care benefit options are designed to encourage the use of network providers and facilities. Each time you need medical care, you choose the doctor you want to visit, in- or out-of-network. When using in-network providers and facilities, you receive care at network-negotiated fees, which are generally lower than normal charges. You get a higher level of benefits when you receive care in-network than when you go out-of-network for treatment.

The following Medical Plan options deliver managed care benefits:

- Consumer Choice Option
- Point-of-Service Option
- Preferred Provider Organization Option
- Alternative Coverage Option

Further information on both the specific provisions for each Plan option and the general provisions applicable to all Plan options is contained in the sections that follow.

Network of doctors, hospitals and ancillary service providers

The network consists of a group of health care providers, including physicians, hospitals, pharmacies, labs and other ancillary providers that have agreed to accept negotiated fees for their services. Each health care provider and facility in the network must meet the medical carrier's strict standards and agree to follow its guidelines. These guidelines ensure that you and your family will receive the right care in the right setting at the right price.

Use of network providers and facilities is optional yet most cost-effective. The network providers are selected by your medical carrier and may change at any time.

Doctors join networks for various reasons, including:

- to keep or attract patients who belong to managed care plans
- to receive faster payment and reduce patient bad debt
- to have “formal” and “informal” affiliations with other doctors who share similar credentials and philosophies on cost-effective, high-quality care
- to be part of the growing movement to managed care and help control health care costs
- to enjoy less paperwork

The providers and facilities in the network are listed in a provider directory. You can get a copy of the directory from your medical carrier. Note that any mental health/chemical dependency providers or facilities listed in the directory are not necessarily recognized as network providers for the Medical Plan.

There is a separate network of mental health/chemical dependency treatment providers. These providers and facilities are listed in a provider directory which you can obtain from ComPsych. If you are an employee, you must contact the Employee Assistance Program at 1-800-435-7266 before treatment to receive in-network benefits. If you are a Pensioner or Survivor, or a dependent of a Pensioner or Survivor, you must contact ComPsych at 1-800-435-7266 before treatment to receive in-network benefits. A dependent of an employee can receive in-network authorization from either the EAP or ComPsych.

There is also a separate network for prescription drug benefits.

Refer to the “Coverage” section of this SPD for further information.

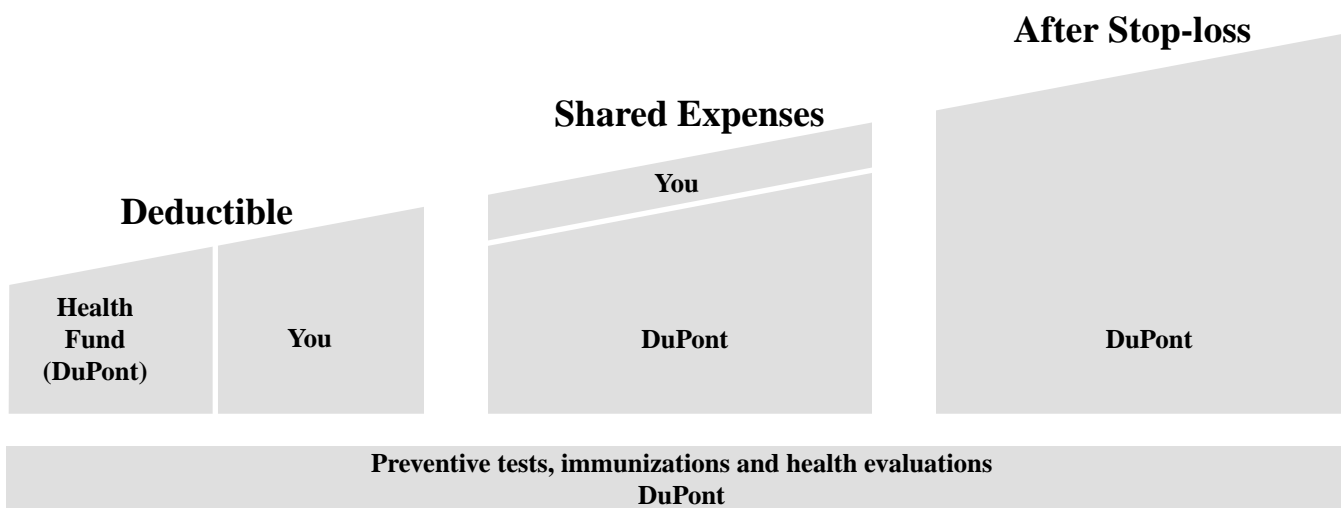
Consumer Choice Option

The Consumer Choice Option is a managed care option available to employees across the United States. This option is not available to Pensioners and Survivors.

Benefit amounts for the Consumer Choice Option are summarized in the chart on the next page. Refer to the “Plan Benefit General Information” and “Covered Services” sections for additional information applicable to all Medical Plan options.

The Consumer Choice Option blends the features of traditional managed care benefits with a unique health fund benefit. The option is specifically designed to give you more control in managing your care and your costs. You are not required to select a Primary Care Physician (PCP) or to obtain a referral to see a specialist. Plus, special tools are available to help you manage your benefits.

Benefit amounts change as your medical costs increase over the course of the Plan Year, as illustrated below.



Benefit amounts for some services do not reduce your health fund or deductible. Specifically:

- Preventive tests, immunizations and health evaluations. Covered prevention and wellness services are paid at 100% of the reasonable and customary (R&C) amounts or, if applicable, the Network-Negotiated Rate. Refer to page 31 for more information on your preventive care benefits
- Prescription drugs
- Services, supplies or charges not covered by the Medical Plan

In addition, your health fund does not apply to mental health and chemical dependency treatment expenses. Any out-of-network mental health or chemical dependency treatment does require satisfaction of the deductible.

Special tools developed and maintained by the medical carrier, Aetna, help you manage your benefits. In addition, when you use your Consumer Choice Option benefits, you receive a monthly statement from Aetna that reflects your prior month’s benefit activity. Contact Aetna for more information regarding these items.

Medical Plan Benefits—Consumer Choice Option*

Company-Provided Health Fund*	Coverage Level		
	You only	You plus one	You plus family
	\$500	\$750	\$1,000
Employee Deductible*	\$1,000	\$1,500	\$2,000
Total Deductible	\$1,500	\$2,250	\$3,000
	In-network	Out-of-network	
Covered Preventive Care: Tests, Immunizations and Health Evaluations	100% • health fund and employee deductible do not apply	100% R&C • health fund and employee deductible do not apply	
Mental Health/Chemical Dependency Covered Inpatient or Outpatient Care	90% when using the DuPont EAP • health fund and employee deductible do not apply	70% R&C, Deductible • health fund does not apply • precertification • licensed MH provider • use licensed facilities • no out-of-network outpatient benefits available for chemical dependency treatment	
Other Covered Services (after depletion of the health fund)	90%, Deductible	70% R&C, Deductible	
Annual Stop-loss** (based on coverage level)	\$3,500 you only \$5,250 you plus one \$7,000 you plus family	\$5,000 you only \$7,500 you plus one \$10,000 you plus family	

Prescription Drug Benefits***

(health fund and employee deductible do not apply)

Retail (up to a 30-day supply)	Generic: 30%, \$7 min.; Brand: 30%, \$20 min.
Mail Order (up to a 90-day supply)	Generic: \$16; Brand: \$45
Annual Prescription Stop-loss**	\$1,500/individual

*2003 Consumer Choice Health Fund and employees' share of the deductible amounts by coverage level are: \$750 You only; \$1,125 You plus one; \$1,500 You plus family. The Health Fund amounts shown reflect the annual Company benefit contribution. Unused amounts may be carried over from year to year up to the total deductible amount. Health Fund amounts carried over from prior years reduce the employee's share of the deductible.

**Stop-loss applies to medical and mental health/chemical dependency deductible and coinsurance amounts, excluding your share of infertility or in vitro fertilization treatments. A separate \$1,500/individual stop-loss applies to prescription drugs.

***Applies to participating retail pharmacies and mail service only. Benefits shown are per prescription.

The Company-provided health fund

The health fund gives you the incentive, and the opportunity, to gain a financial advantage by managing your costs effectively. You begin each year with an opening health fund balance provided by the Company. The annual Company-provided health fund amount varies depending on the coverage level you elect (You only, You plus one or You plus family) and applies jointly to you and your covered dependents. New employees hired mid-year receive the same Company-provided health fund contribution as existing employees who enroll during the annual BeneFlex Election Change Period.

You can use the health fund to pay benefits for covered medical services received from either an in-network or out-of-network provider during the Plan Year. If you use an in-network provider, you

NOTE: If you participate in both the Medical Plan and a Health Care Spending Account, you must submit your claims to the Medical Plan for payment prior to requesting reimbursement from the Health Care Spending Account. The IRS does not let you choose which claims you can have paid out of your Consumer Choice Option health fund and which ones can be paid from the Health Care Spending Account.

will be charged the Network-Negotiated Rate. Network-Negotiated Rates are generally lower than the Reasonable and Customary allowance. If you use an out-of-network provider, any portion of the charges that exceed the Reasonable and Customary allowance will not be paid from the health fund or applied towards satisfaction of your deductible.

The health fund is not used to pay benefits for: prescription drugs; mental health or chemical dependency treatment expenses; preventive care services; or services, supplies or charges not covered by the Medical Plan.

Health fund rollover amounts

You may roll over any unused health fund balance from year to year so long as your participation in the Consumer Choice Option continues uninterrupted. Rollover amounts reduce your share of the deductible. So, you can combine your annual Company-provided health fund amount with your health fund rollover amount to eliminate all or a portion of your deductible. You cannot, however, have a health fund that exceeds your total deductible. If you change coverage levels from year to year, you may still roll over any unused health fund balance from the prior year. However, if you leave the Consumer Choice Option, your remaining health fund balance is left unused and reverts to zero.

Rollover example: Suppose you had elected family coverage in year 1 and have \$700 left in your health fund at the end of the year. If you elect “You only” coverage for year 2, you will receive \$500 for your year 2 health fund from the Company plus your \$700 unused health fund dollars rolled over from year 1. Your beginning health fund for year 2 equals \$500 + \$700 or \$1,200. Since the total deductible for “You only” coverage equals \$1,500, your share of the deductible will be \$300 (which is the total deductible of \$1,500 less your \$1,200 health fund) for year 2.

Your deductible

The Consumer Choice Option has a combined deductible for all covered family members, based on the coverage level you elect. If you use your entire health fund balance and require additional medical care during the year, you will be responsible for your portion of the deductible and shared coinsurance expenses. Your deductible may be reduced by your health fund rollover amounts, if any.

The deductible applies to benefits for covered medical services received from either an in-network or out-of-network provider. If you use an in-network provider, you will be charged the Network-Negotiated Rate. If you use an out-of-network provider, any portion of the charges that exceed the Reasonable and Customary allowance will not be paid from the health fund or applied towards satisfaction of your deductible.

The deductible does not apply to benefits for prescription drugs, preventive care services, or services, supplies, or charges not covered by the Medical Plan.

Shared costs

The Consumer Choice Option also gives you the advantages of a managed care approach if you have expenses after you've used your health fund and satisfied your deductible. Each time you seek medical care, you decide whether to use a physician or facility that is in- or out-of-network. To receive in-network benefits, you must visit a network doctor. If you visit an out-of-network doctor, you will receive lower benefits.

In-network, after your health fund and deductible, the Consumer Choice Option pays benefits of 90% of the Network-Negotiated Rate for most covered medical services until you reach the annual stop-loss. Once you reach the annual stop-loss, the Plan pays covered expenses at 100% of the Network-Negotiated Rate for the rest of the Plan Year.

For services provided by a non-network doctor or hospital, after your health fund and deductible, the Plan pays benefits of 70% of Reasonable and Customary for covered medical services until you reach the annual stop-loss. After you reach the stop-loss, the Plan pays benefits of 100% of Reasonable and Customary of covered expenses for the rest of the Plan Year. You are responsible for charges above R&C.

Your Consumer Choice Option medical stop-loss varies based on your coverage level (You only, You plus one and You plus family). It is a combined stop-loss for all covered family members. A separate stop-loss applies to in-network and out-of-network charges. Note, however, that your deductible amounts apply toward both your in-network and out-of-network stop-loss. Plus, a separate \$1,500/individual stop-loss applies to prescription drugs.

More information

Refer to the "Coverage" section of this SPD for further information about your benefits, including information on precertification, prescription drug benefits, mental health/chemical dependency treatment, covered services, and limitations and exclusions.

Point-of-Service Option and Preferred Provider Organization Option

Benefit amounts for the traditional managed care Medical Plan options are summarized in the chart below. Refer to the “Plan Benefit and General Information” and “Covered Services” sections for additional information applicable to all Medical Plan options.

Point-of-Service Option/MEDCAP Network and Preferred Provider Organization Option

Medical Care Benefits		
	In-Network	Out-of-Network
Office Visit Copay/Deductible	\$20/Office Visit	\$500 individual; \$1,000 family
Covered Preventive Tests and Immunizations	100%	100% R&C
Mental Health/ Chemical Dependency Covered Inpatient or Outpatient Care	90% when using the DuPont EAP (or when using ComPsych if you are a Pensioner or Survivor)	70% R&C, Deductible • precertification • licensed MH provider • use licensed facilities • no out-of-network outpatient benefits available for chemical dependency treatment
Other Covered Services	90%	70% R&C, Deductible
Annual Stop-loss*	\$1,600 individual; \$3,200 family	\$4,000 individual; \$8,000 family
Prescription Drug Benefits**		
Retail (up to a 30-day supply)	Generic: 30%, \$7 min.; Brand: 30%, \$20 min.	
Mail Order (up to a 90-day supply)	Generic: \$16; Brand: \$45	
Annual Prescription Stop-loss**	\$1,500/individual	

*Stop-loss applies to medical and mental health/chemical dependency deductible and coinsurance amounts, excluding your share of infertility or in vitro fertilization treatments. A separate \$1,500/individual stop-loss applies to prescription drugs.

**Applies to participating retail pharmacies and mail service only. Benefits shown are per prescription.

Point-of-Service Option

The Point-of-Service Option combines the qualities of a network program with freedom of choice. Each time you seek medical care, you decide whether to use a physician or facility that is in- or out-of-network. To receive in-network benefits, you must first select and visit your Primary Care Physician (PCP), who will provide most of your care or refer you to an appropriate specialist, if necessary. Also, network providers will bill the Medical Plan for the service directly. If you seek medically necessary care out-of-network, or without first consulting your PCP, you will still receive benefits—but at a lower, out-of-network level. For out-of-network care, you pay the bill and file a claim for reimbursement of covered expenses.

Covered preventive tests and immunizations are paid at 100% of R&C or, if applicable, the Network-Negotiated Rate. Refer to page 31 for more information on your preventive care benefits.

In the Point-of-Service Option, there is no deductible for care that is provided or authorized by your PCP. In-network, a \$20 copay applies to each office visit. For most other covered in-network services, the Plan pays benefits of 90% of the Network Negotiated Rate until you reach the annual in-network stop-loss. After you reach this limit, the Medical Plan pays benefits of 100% of the Network-Negotiated Rate of covered expenses for the rest of the Plan Year.

Note that you must have all non-emergency hospitalizations arranged by your PCP (or the Network specialist your PCP referred you to) in order to receive in-network benefits. If not, you will get out-of-network level payments. Any hospitalization that is determined to be medically inappropriate or unnecessary will not be covered.

For services provided by a non-network doctor or not authorized by your PCP, the individual \$500 deductible under the Point-of-Service Option applies. The out-of-network family deductible under the Point-of-Service Option is \$1,000 per year. Out-of-network, after you meet the annual deductible, the Medical Plan pays benefits of 70% of Reasonable and Customary for most covered medical services until you reach the annual out-of-network stop-loss. After you reach this limit, the Medical Plan pays benefits of 100% of Reasonable and Customary of covered expenses for the rest of the Plan Year.

Primary Care Physicians

A Primary Care Physician (PCP) is a doctor you choose to manage all of your health care. Your PCP serves as the manager or advocate for all of your health care needs. Your PCP is trained to handle a wide variety of medical conditions, and to coordinate the care you receive from other providers. He/she provides preventive and routine care like office visits and diagnoses, and refers you to specialists and hospitals as needed. (Note that a separate referral process applies to mental health/chemical dependency care.)

A PCP can be an internist, a family or general practitioner, or a pediatrician for children. You choose your PCP for yourself and each of your covered dependents from the network of doctors maintained by your medical carrier. Each member of your family can have a different PCP. You can change your PCP at any time by calling your medical carrier. Your change will be effective following your call.

Some PCPs share a medical practice with other physicians. In this case, your specified PCP should still coordinate all of your care. If your PCP is on vacation or otherwise unavailable, you can see the doctor who is on call for your PCP.

If you need to be hospitalized in a non-emergency situation, your PCP, or the network specialist your PCP referred you to, will arrange it in advance. Your PCP (or the network specialist) will choose the most medically appropriate hospital for you, usually in-network. If your hospital stay is arranged by your PCP (or the network specialist) and approved by the medical carrier, it will be covered at the in-network level.

For a list of network PCPs, specialists, hospitals and other health care providers, contact your medical carrier.

Getting a referral to a medical specialist

To receive in-network benefits for treatment by a network specialist, your care has to be managed by your PCP who will authorize a referral when one is appropriate. If you don't get a referral from your PCP before treatment by a specialist, you will receive out-of-network benefits for the specialist's fees even if the specialist is in the network.

Make sure you understand the specific reason for the referral, and find out how many visits to the specialist your PCP has authorized. When the referral is authorized, make an appointment to see the specialist. If the specialist needs to see you more than your PCP has authorized, contact your PCP before the additional visits. Take along your ID card when you go for your appointment.

Occasionally, a PCP may need to refer you out-of-network. This must be pre-approved by your medical carrier and will only occur if the medically necessary services are not available within the network. Be aware that your carrier doesn't have a contract with out-of-network doctors. So, you and the Company will pay based on the out-of-network doctor's normal charges, which may be higher than an in-network doctor's normal charges.

A woman doesn't need her PCP to refer her to a gynecologist or obstetrician-gynecologist (Ob/Gyn) for her annual preventive checkup. You can refer yourself to any network Ob/Gyn for this service. If you go in-network, you will pay a \$20 office visit copay for your preventive examination. If you go to an out-of-network Ob/Gyn, out-of-network benefits will apply.

For mental health/chemical dependency care, your care must be authorized in order to receive in-network benefits. If you are an employee, contact the Employee Assistance Program (EAP) 1-800-435-7266 to precertify your care. If you are a Pensioner or Survivor, or a dependent of a Pensioner or Survivor, contact ComPsych at 1-800-435-7266. A dependent of an employee can receive in-network authorization from either the EAP or ComPsych.

Emergency care and care received away from home

When you receive **emergency** care, regardless of which hospital you use, call your Primary Care Physician or your medical carrier within 48 hours, or on the first business day following the start of your emergency care/admission. You can make the call, a family member can call or a person at the facility where you are being treated can call. Once you are stabilized and either released or admitted to the hospital, your PCP must coordinate all follow-up care for you to continue getting in-network level benefits.

Urgent care may be needed if you have sudden and severe symptoms that do not qualify as a medical emergency but require care to prevent the problem from becoming an emergency. Before you seek urgent care when away from home or after normal office hours, call your PCP. You might get advice or directions over the phone for appropriate treatment. Non-emergency situations that occur away from home are almost always covered at the out-of-network benefit level of 70% of Reasonable and Customary after the deductible. Contact your medical carrier to find out how the care you received will be covered.

In situations where a family member lives away from home for an extended period of time (e.g., a college student or a transferred employee whose family has not yet relocated), contact your medical carrier to see if a “reciprocity” or “guesting” arrangement is available. If your medical carrier has a network in the other area, guest privileges with a network PCP may be available for the family member who is temporarily living away from home.

For more information on emergency care, refer to the “Covered Services” section of this SPD.

More information

Refer to the “Covered Services” section of this SPD for further information about your benefits, including information on precertification, prescription drug benefits, mental health/chemical dependency treatment, covered services, and limitations and exclusions.

Preferred Provider Organization Option

The Preferred Provider Organization Option is available in a limited number of locations. It provides the same benefit coverage as the Point-of-Service Option; however, you are not required to select a Primary Care Physician (PCP) and you do not need a referral before visiting a specialist. Each time you need medical care, you choose the doctor you want to visit, in- or out-of-network. To receive in-network benefits, you must visit a network doctor. If you visit an out-of-network doctor, you will receive lower benefits.

This option is not available to Pensioners and Survivors.

Refer to the “Covered Services” section of this SPD for further information about your benefits, including information on emergency care, precertification, prescription drug benefits, mental health/chemical dependency treatment, covered services, and limitations and exclusions.

Alternative Coverage Option

If an Alternative Coverage Option (usually HMO coverage) is offered where you work, it will be listed as an option on your personal benefits enrollment materials, which you will receive prior to the BeneFlex Election Change Period. Each Alternative Coverage Option is fully insured (not self-insured by DuPont) with features that vary from carrier to carrier. You’ll need to contact the carrier directly for a summary of benefits specific to your option. Keep in mind that if you elect an Alternative Coverage Option, your prescription drug coverage is provided by the carrier. If you select an Alternative Coverage Option, you may need to complete a separate enrollment form for the carrier in addition to making your BeneFlex change elections.

This option is not available to most Pensioners and Survivors.

Non-Managed Care Benefit Information

Benefit amounts for the non-managed care Medical Plan options are summarized in the chart below. Refer to the “Plan Benefit and General Information” and “Covered Services” sections for additional information applicable to all Medical Plan options.

Medical Care Benefits

	Indemnity Option/ MEDCAP Standard	Catastrophic Option C	No Coverage Option
Deductible	\$500 individual; \$1,000 family	\$2,000 individual; \$4,000 family	None
Covered Preventive Tests and Immunizations	100% R&C	100% R&C	No Benefit
Other Covered Services	80% R&C, Deductible	60% R&C, Deductible	No Benefit
Mental Health/ Chemical Dependency In-Network Covered Inpatient or Outpatient Care	90% when using the DuPont EAP (or 80% when using Aetna if you are a Pensioner or Survivor)**	90% when using the DuPont EAP	90% when using the DuPont EAP
Mental Health/ Chemical Dependency Out-of-Network Covered Inpatient or Outpatient Care	80% R&C, Deductible • precertification • licensed MH provider • use licensed facilities • no out-of-network outpatient benefits available for chemical dependency treatment	60% R&C, Deductible • precertification • licensed MH provider • use licensed facilities • no out-of-network outpatient benefits available for chemical dependency treatment	No Benefit
Annual Stop-loss	\$1,600 individual; \$3,200 family*	\$5,000 individual; \$10,000 family	\$1,600 individual for EAP services

Rx Drugs Benefits

Retail (up to a 30-day supply)	Generic: 30%, \$7 min.; Brand: 30%, \$20 min.	60%, Deductible	No Benefit
Mail Order (up to a 90-day supply)	Generic: \$16; Brand: \$45	60%, Deductible	No Benefit
Annual Prescription Stop-loss***	\$1,500/individual	Included in medical stop-loss	Not Applicable

*Stop-loss applies to medical and mental health/chemical dependency deductible and coinsurance amounts, excluding your share of infertility or in vitro fertilization treatments. A separate \$1,500/individual stop-loss applies to prescription drugs.

**In-network mental health/chemical dependency benefits are available to all Full-Service Employees and their covered eligible dependents as well as to Pensioners and Survivors and their eligible dependents as long as no family member has Medicare as their primary coverage. If there is a Medicare-primary family member, the mental health/chemical dependency benefits are payable at 80% R&C subject to the deductible.

***Applies to participating retail pharmacies and mail service only. Benefits shown are per prescription.

Indemnity Option/MEDCAP Standard

The Indemnity Option is a non-managed care option that enables you to use any licensed provider you wish. You don't need to name a Primary Care Physician (PCP) or receive referrals to see a specialist.

The Indemnity Option covers preventive tests and immunizations at 100% of the reasonable and customary (R&C) amounts. (Refer to page 31 for more information on your preventive care benefits.) For most other services, you pay for all your health care costs until you reach your deductible. Then, the Company provides benefits of 80% R&C. The stop-loss protects you against high costs. After you reach this limit, the Plan pays covered expenses at 100% of Reasonable and Customary for the rest of the Plan Year.

Refer to the "Covered Services" section of this SPD for further information about your benefits including information on emergency care, precertification, prescription drug benefits, mental health/chemical dependency treatment, covered services, and limitations and exclusions.

How does Medicare fit in?

Traditional Medicare

If traditional Medicare is your primary coverage, it pays benefits first, and MEDCAP Standard (the Indemnity Option) is secondary.

Your secondary coverage under the Medical Plan will pay benefits only if traditional Medicare's payment is less than the MEDCAP Standard (the Indemnity Option) normal benefit. The Medical Plan's normal benefit is determined by the carrier, then Medicare's payment is subtracted. However, even if the Medical Plan pays zero as secondary to Medicare, you still get deductible and stop-loss credit based on the Medical Plan's normal benefit. Refer to the "Maintenance of benefits" section on page 13 for further information.

Other forms of Medicare

Medicare beneficiaries in many areas of the country can now choose Medicare plans that differ from the "traditional Part A/Part B" coverage. The most prevalent of these are Medicare HMOs. Medicare HMOs can be an attractive alternative to traditional Medicare. To find out what types of plans are available in your area, call the federal government's Medicare Hotline, 1-800-MEDICARE, or access their website: <http://cms.hhs.gov>. If you do choose one of these other forms of Medicare, you need to know how your Company medical benefits are affected.

A typical Medicare HMO will provide all of the coverage you need without any supplement from the Medical Plan, and the Medical Plan is not designed to coordinate with a Medicare HMO. However, here are some rules when you have a Medicare HMO and continue to carry Medical Plan coverage:

- You may not use the Medical Plan like a "point of service" plan. That is, you may not receive out-of-network services not covered by the Medicare HMO and submit the bills to this Medical Plan. If you do file claims for such out-of-network services, they will still be processed by "carving out" what Medicare would have paid if you were still enrolled.
- Your covered dependents who don't have other coverage (such as Medicare) may use the Medical Plan as primary coverage.

If all family members are Medicare-eligible and all choose to enroll in Medicare HMOs, you may decline Medical Plan coverage (and pay no premium). If you later decide to return all family members to traditional Medicare, you can be reinstated in the Medical Plan and begin paying the applicable premium.

Catastrophic Option

The Catastrophic Option is primarily designed to provide protection against high expenses. Its coverage for routine expenses is lower than those of most other options. This option is only available to employees.

The Catastrophic Option is a non-managed care option that enables you to choose any provider you wish. You don't need to choose a Primary Care Physician (PCP), or receive referrals to see a specialist.

The Catastrophic Option covers preventive tests and immunizations at 100% of the reasonable and customary (R&C) amounts. (Refer to page 31 for more information on your preventive care benefits.) For most other services, you pay for all your health care costs until you reach your deductible. Then, the Company provides benefits of 60% R&C for most other covered services including prescription drugs. The stop-loss protects you against high costs. After you reach this limit, the Plan generally reimburses covered expenses at 100% of Reasonable and Customary for the rest of the Plan Year.

Refer to the "Covered Services" section of this SPD for further information about your benefits including information on emergency care, precertification, prescription drug benefits, mental health/chemical dependency treatment, covered services, and limitations and exclusions.

No Coverage Option

If both you and your spouse work for a Company participating in the Medical Plan, or if your spouse has coverage through his or her employer, you can select the No Coverage Option and be covered under your spouse's medical plan as a dependent. Be sure to check your spouse's plan for any limitations before waiving medical coverage. Remember, the No Coverage Option provides only mental health/chemical dependency coverage for you, the employee. No other medical or prescription benefits are provided.

Covered Services

The following services are covered under the Medical Plan, subject to other Plan requirements such as copays, deductibles, coinsurance, etc. All care must be medically necessary. Plan limitations and exclusions apply.

- Allergy testing and treatment
- Chiropractic care by a licensed provider
 - services limited to X rays and manipulations of the spine, heat and ultrasound. Services must be medically necessary and "restorative" in nature. Charges for services specifically to maintain a level of well-being are not covered.
- Christian Science facility
 - out-of-network only
- Durable medical equipment

-
- Emergency care (see page 30 for more information)
 - in a doctor’s office
 - in a hospital emergency room or urgent care center
 - professional ambulance service to the nearest health care facility capable of providing needed care
 - Emergency dental treatment
 - related to the repair of sound natural teeth or other body tissues required as a result of an accidental injury
 - Extended-care facility
 - limited to medically necessary skilled-care needs related to a recent hospital confinement as approved in advance by your medical carrier
 - Gynecological care
 - Home health care
 - limited to medically necessary skilled-care services of an RN/LPN, excluding any custodial services and services by a nurse who is a member of the family or the spouse’s family or resides in the patient’s home, as approved in advance by your medical carrier
 - Hospice care in an approved hospice program (see page 30 for more information)
 - Hospital services
 - **outpatient** hospital services
 - **inpatient** room and board—coverage is for a semi-private room. If you stay in a private room, you pay the difference between its cost and the average cost of a semi-private room in that hospital.
 - inpatient operating and recovery room
 - inpatient ancillaries (supplies, tests, medications, therapies, etc.)
 - Human organ transplants (see page 38 for more information)
 - Infertility services
 - the patient must be a covered female employee or dependent wife with sperm provided by her husband unless the husband is sterile (not due to voluntary sterilization), and she must carry the embryo
 - requires advance approval; extensive coverage limitations and exclusions including \$25,000 lifetime maximum; call your medical carrier for details
 - Kidney dialysis
 - Medicare is primary for some End Stage Renal Disease patients. Check with your medical carrier on timing.
 - Laboratory services
 - Maternity care (see page 35 for more information)
 - hospital
 - physician
 - qualified, free-standing birthing centers
 - newborn infant care

- Mental health care and chemical dependency care (see page 35 for more information)
- Outpatient private-duty nursing
 - limited to medically necessary skilled-care services of a RN/LPN, excluding any custodial services and services by a nurse who is a member of the family or the spouse’s family or resides in the patient’s home, as approved in advance by your medical carrier
- Physician care
 - office visits
 - referral physician services
 - outpatient surgical services
 - inpatient surgical services
 - inpatient hospital visits
 - inpatient hospital consultant services
 - home/nursing home visits
 - second surgical opinions (see page 37 for more information)
- Prescription drugs (see page 33 for more information)
- Preventive care, as outlined on pages 31–33
- Prosthetic devices
- Radiation therapy, chemotherapy and electroshock therapy
- Short-term rehabilitation (physical, occupational and speech therapy)
 - limited to “restorative” therapy, except for certain developmental coverage for children or physical therapy for some neurological diseases such as Multiple Sclerosis, Cerebral Palsy, Polio, Spina Bifida, Amyotrophic Lateral Sclerosis, Muscular Dystrophy or Parkinson’s Disease; call your medical carrier for details. The therapy must be expected to result in significant improvement in body function lost or impaired by the disease or be aimed at slowing or preventing further deterioration of body function for the neurological diseases cited above. Charges for services specifically to maintain a level of well-being are not covered.
- Treatment for temporomandibular joint (TMJ) and associated muscles for chewing, subject to review for medical necessity
 - including, but not limited to: splints, physical therapy, trigger point injections and surgery. (Charges for the diagnosis of TMJ are covered by the Company dental plan.) See the “Restrictions and Exclusions” section of this SPD for exclusions.
- X rays and other diagnostic services

Certain rules and restrictions apply. Refer to the section titled “Restrictions and Exclusions” for further information.

Emergency Care

In the case of a life-threatening, sudden and serious medical emergency, get the care you need as soon as possible.

Examples of conditions that would typically be considered emergencies are:

- loss of consciousness
- poisoning
- stroke
- uncontrolled bleeding
- acute asthma attack
- convulsions
- heart attack

The Medical Plan covers emergency care provided in a hospital emergency room, urgent care center or physician's office. Ambulance expenses incurred for taking you to the nearest health care facility in an emergency are also covered.

If you are admitted to the hospital as a result of an emergency, you precertify your stay by calling your medical carrier. You, a family member, a friend or a person at the hospital can make the call. Call within 48 hours or on the first business day following your admission.

Normally, the facility will file a claim for your emergency treatment with your medical carrier. The facility will bill you for any balance not covered.

If you are traveling, working or living outside of the United States, you will normally need to pay the bill and then file a claim with your medical carrier. Be sure to get written details of your treatment to submit with your claim.

If you participate in the Point-of-Service Option, you should contact your PCP within 48 hours of receiving emergency treatment in order to have your treatment considered for in-network benefits. Refer to page 22 for further information.

Hospice Care

The Medical Plan covers hospice care for terminally ill patients. Hospice care is generally received when the patient, family and physician agree that palliative care is appropriate because the patient is in the final stage of an incurable illness and has a limited life expectancy. Services must be in an approved, licensed hospice facility or program. Call your medical carrier to precertify hospice care.

Refer to the "Precertification" section for more information.

Preventive Care Services

Preventive health benefits are screening tests, immunizations and/or examinations that are ordered by your physician before you have developed symptoms of a disease. These are differentiated from diagnostic tests, which your physician requests when you have developed possible symptoms or signs of disease.

Prevention and wellness benefits are important features of the Medical Plan. A healthy lifestyle can improve the quality of life for you and your family. It's also less costly to prevent an illness than to treat it later. The Company supports you and your family in living a healthy lifestyle by offering comprehensive preventive benefits.

The Company pays 100% of the cost for covered preventive tests and immunizations. **You are responsible for preventive office visit copays or deductibles/coinsurance, depending on your Medical Plan option** (except under the Consumer Choice Option, in which all preventive care is covered at 100%.)

Plan Option	Covered Tests and Immunizations	Preventive Examinations and Office Visits
Point-of-Service Option and Preferred Provider Organization Option	In-network = 100% Out-of-network = 100% R&C	In-network = \$20 copay Out-of-network = 70% R&C, Deductible
Consumer Choice Option	In-network = 100% Out-of-network = 100% R&C	In-network = 100% Out-of-network = 100% R&C
Indemnity Option	100% R&C	80% R&C, Deductible
Catastrophic Option	100% R&C	60% R&C, Deductible

The Preventive Health Benefits booklet serves as an easy-to-read guide to covered preventive care services. A copy of the booklet is available on the employee (<http://www1.lvs.dupont.com/hr/>) and retiree websites (<http://www.retiree.dupont.com>). You are encouraged to share the Preventive Health Benefits guide with your physician.

Covered preventive examinations:

- Adult Health Evaluation—starting at age 19, every three years
- Gynecology examination—for women once a year in addition to your adult health evaluation, beginning at age 18 or earlier if sexually active
- Clinical breast examination—for women, once a year, beginning at age 18
- Clinical testicular examination—for men, once a year, as recommended by your physician
- Well Baby Visits—total of 9 visits beginning at birth through age 2 (at birth; 1 month; 2 months; 4 months; 6 months; 8–10 months; 12–15 months; 18 months; and 2 years)
- Well Child Visit—three visits between ages 3 and 6 years, then every two years between 7 and 18 years

-
- Targeted nutritional counseling visits—as recommended for individuals with diabetes (type 1 or 2), high lipids (fats) or treatment for hyperlipidemia (high fat in the blood), hypertension (high blood pressure), obesity (more than 30% over ideal body weight), food allergies, osteoporosis (brittle bones), HIV/AIDS, anemia (low red blood cells or iron deficiency), renal (kidney) disease, emphysema (lung disease), cancer, gastroesophageal reflux disorder (GERD), diverticular disease, Crohn’s disease (small bowel inflammation) or a diagnosed eating disorder. Nutritional counseling services are available only in managed care areas and only as an in-network benefit for individuals enrolled in the Consumer Choice Option, Point-of-Service Option and Preferred Provider Organization Option. The benefit is not available out-of-network or for participants enrolled in the non-managed care Indemnity Option or Catastrophic Option.

Covered preventive tests and immunizations for adults:

- Blood glucose test—every 3 years, beginning at age 19
- Total lipid profile test—every 3 years, beginning at age 19
- Fecal occult blood test—annually, beginning at age 50
- Digital rectal exam—annually, beginning at age 40
- Colonoscopy test, sigmoidoscopy test, or double-contrast barium enema test—in addition to the fecal occult blood test, starting at age 50 (colonoscopy every 10 years; flexible sigmoidoscopy every 5 years; or double-contrast barium enema every 5 to 10 years)
- Influenza vaccine—beginning at age 2, once a year, at physician’s discretion
- Mammogram test—for women, a baseline mammogram test once between the ages of 35 and 40; every 2 years, beginning at age 40; and every year after age 50
- Pap smear test—for women once a year, beginning at age 18 or earlier if sexually active
- Prostate-Specific Antigen test (PSA)—for men, once a year, beginning at age 50
- Tetanus-diphtheria toxoid booster shot—once every 10 years after age 18
- Pneumococcal vaccine—once, on or after reaching age 65
- Hearing test—once, on or after reaching age 65
- Visual acuity/glaucoma test—every 3 years, beginning at age 65
- Urinalysis—annually, beginning at age 65

Covered preventive tests and immunizations for infants and children:

- Ophthalmic antibiotics—at birth
- Haemophilus Influenzae Type B (Hib) vaccine—a 4-dose series for infants (at 2 months; 4 months; 6 months; and 12 months). Note: Tetramune is a combination of the Hib and DPT vaccines and may be substituted.
- Diphtheria-Pertussis-Tetanus (DPT) vaccine—for infants and children (at 2 months; 4 months; 6 months; 12 months; and once between 4 and 6 years). Note: Tetramune is a combination of the Hib and DPT vaccines and may be substituted.

- Influenza vaccine—annually beginning at age 2, at physician’s discretion
- Measles, Mumps, Rubella Virus (MMR) vaccine—a 2-dose series (once between 12 and 15 months; and once between 4 and 6 years)
- Inactivated Poliovirus (IPV) vaccine—for infants and children (at 2 months; 4 months; 12 months; and once between 4 and 6 years)
- Tetanus-diphtheria (Td) booster—once between ages 14 and 16; every 10 years after age 18
- Hepatitis B (HBV) Series—series of 3 immunizations between ages 2 months and 15 months. The series can be obtained through age 18 if not previously completed.
- Chickenpox vaccine—once between the ages of 12 months and 13 years. Over the age of 13, a 2-dose series is recommended, 4–8 weeks apart.
- Hemoglobin and Hematocrit—once before age 2 years; then, between 24 months and 4 years; between 7 and 12 years; and between 13 and 18 years
- Urinalysis—recommended between ages 2 and 18 during Well Child Visit
- Tuberculosis test—once between ages 2 and 6 years
- Vision test (general test for the ability to see; not for eye prescriptions)—once between ages 7 and 12 years
- Hearing test—at birth; and once between ages 2 and 6 years
- Eye exam (screening for amblyopia and strabismus)—once between ages 2 and 6 years
- Phenylalanine, Thyroxine, Thyroid-Stimulating Hormone—within the first 3 to 6 days of life

Prescription Drugs

The Medical Plan covers both **brand-name** and **generic** prescription drugs. When purchased at a retail pharmacy, the Medical Plan benefits cover up to a 30-day supply of a prescription. When utilizing the network mail service program, the Medical Plan benefits cover up to a 90-day supply. Refer to the chart in the “Plan Options” section for benefit amount information.

Reminder: If you participate in the Alternative Coverage Option, you must contact your medical carrier for prescription benefit information specific to your option.

For prescription drugs to be covered by the Medical Plan, all of the following coverage criteria must be met:

- drugs must be medically necessary as determined by the Plan,
- prescribed by a licensed physician,
- not available over-the-counter,
- approved by the FDA, and
- not considered **experimental/investigational** in nature.

Contact Medco Health Solutions at 1-800-RxDuPont (1-800-793-8766) for more information about any other restrictions that may apply.

There is a pharmacy network associated with the Medical Plan maintained by Medco Health Solutions. You may have your prescription filled through a participating retail pharmacy or the mail service. When using network pharmacies, you reduce your out-of-pocket expense for your prescriptions, save time by eliminating claim paperwork and receive the advantage of safety checks for potential drug interactions. Present your Medco Health Solutions prescription drug ID card and your benefit is automatically calculated at the time of your purchase. You pay your copay and/or coinsurance share of the cost. You can get a list of network pharmacies from Medco Health Solutions at 1-800-793-8766.*

If you use a non-participating pharmacy, or if you do not show your ID card at a participating pharmacy, you will pay the full retail price for your prescription and you must file a paper claim with Medco Health Solutions, unless you are in Catastrophic Option, in which case the paper claim is filed with Aetna. You will be reimbursed the difference between the copay or coinsurance you would have paid at a participating pharmacy and the discounted price that would have been charged at a participating pharmacy. Any amount above the discounted price up to the full retail price you are charged at a non-participating pharmacy will be your responsibility.

The Medical Plan uses an open (voluntary) formulary to cover brand-name and generic prescription drugs. A formulary is a list of commonly prescribed, cost-effective, preferred prescription drugs that have been approved for coverage. However, you are not required to use the prescription drugs on the formulary list.

About generic drugs

By law, generic drugs contain the same active ingredients and are subject to Food and Drug Administration (FDA) standards for quality, strength and purity. The FDA is the government agency responsible for ensuring that medications in the United States are safe and effective.

The price of a generic medication is usually much lower than that of the original brand-name medication. Therefore, if you use generics whenever possible, you may reduce prescription medication costs to you and the Medical Plan and, in turn, receive the most value. Your out-of-pocket costs can be significantly lower when using generic drugs instead of brand-name drugs.

Mail service home delivery program

The mail service pharmacy program is designed to save you money on medications you know that you'll use on an ongoing basis, normally "maintenance drugs." Through this program, you can receive up to a 90-day supply of a drug for a single mail service copayment of either \$45 for brand-name drugs or \$16 for generic drugs, or the actual cost of the drug, if less. Keep in mind that the mail service pharmacy is not available if you elect Catastrophic Option.

When taking a newly prescribed drug, it's best to fill your first prescription at a network retail pharmacy for up to a 30-day supply. This allows you time to ensure that you don't have an adverse reaction to the medication prior to starting home delivery. Subsequent prescriptions can be filled for up to a 90-day supply through the mail service program.

*Note that the pharmacy network and mail order services do not apply to individuals in the Catastrophic Option. The Catastrophic Option participants receive a Medco Health Solutions identification card in order to take advantage of discount pricing at network retail pharmacies. Prescription claims for the Catastrophic Option must be submitted to the medical carrier for reimbursement following satisfaction of the deductible.

Each time you use the mail service, you will be charged the mail service copay regardless of the days supplied (up to 90). For mail service fills, ask your doctor to write the prescription for a 90-day supply with the appropriate number of refills. Submitting a prescription written for 30 days with two refills will get you only a 30-day supply for the full mail service copay. Contact Medco Health Solutions at 1-800-793-8766 (or online at www.medcohealth.com) to get instructions on how to use the mail service program.

Drug utilization review

Your drug benefit includes an important safety feature. Participating retail pharmacies and the mail service pharmacists access a computerized database to check each prescription against a record of other drugs you have purchased through this program. The system alerts the pharmacist to any potential drug interactions. It also provides an alert on the appropriateness of a limited number of specialized drugs. If there is a question, the pharmacist will work with your doctor before dispensing medication.

Maternity Hospital Stay Limit

The Medical Plan covers the stay for mother and child in a hospital at the normal benefit level (subject to a deductible and/or coinsurance according to your Medical Plan option) for up to 48 hours for a vaginal delivery and up to 96 hours for a cesarean section. Medical complications may require longer stays. In any event, authorization is not required for prescribing a length of stay that does not exceed 48 hours (or 96 hours).

Women's Health and Cancer Rights Act

The Medical Plan complies with the provisions of the Women's Health and Cancer Rights Act concerning coverage for reconstructive surgery in connection with mastectomies. Specifically, the Medical Plan covers: reconstruction of the breast on which the mastectomy has been performed; surgery and reconstruction of the other breast to produce a symmetrical appearance; and prostheses and treatment of physical complications of all stages of mastectomies, including lymphedemas.

Mental Health and Chemical Dependency Treatment

Inpatient/Outpatient

Under the Medical Plan, expenses for treatment of mental health/chemical dependency conditions are considered in-network only if pre-approved. The Medical Plan pays these in-network expenses at 90% of the Network-Negotiated Rate. Out-of-network treatment is covered at a lower percentage of Reasonable and Customary, subject to the deductible. Refer to the benefit charts in the "Plan Options" section for details.

In-network mental health/chemical dependency benefits are available to all Full-Service Employees and their covered eligible dependents as well as to Pensioner and Survivors and their eligible dependents, as long as no family member has Medicare as their primary coverage. If there is a Medicare-primary family member, the mental health/chemical dependency benefits are payable at 80% R&C subject to the deductible.

To receive full benefits for mental health or chemical dependency treatment, call to precertify your treatment. Emergency admissions for mental health or chemical dependency must be reported by calling 1-800-435-7266 (Medicare-eligible individuals and their covered family members call 1-800-445-7175) within 48 hours or on the first business day following the admission.

Mental health and substance abuse treatment benefits for both inpatient and outpatient are included in the Plan's \$1.5 million annual per person maximum. Plan deductibles, where applicable, apply.

Employee precertification for mental health/chemical dependency treatment

If you are an active employee, you must contact the Employee Assistance Program before treatment in order to receive the 90% in-network mental health/chemical dependency benefit. The EAP provides assessment, evaluation and pre-authorization for mental health and chemical dependency treatment for you and your dependents. When you call the EAP, you speak to a local Employee Assistance Consultant. The Consultant will confidentially assess your situation and, if necessary, authorize treatment by a network provider who will meet your needs. By using the EAP, you receive the highest level of coverage for these expenses. Your share of these costs will be applied to your stop-loss; however, you must forward the coinsurance information to your medical carrier. You will not have to meet a deductible in-network. You can reach a local Employee Assistance Consultant by calling the EAP at 1-800-435-7266.

For most Plan options, both you and your dependents may receive treatment through the EAP. However, if you participate in the No Coverage Option or are enrolled in an Alternative Coverage Option (usually an HMO) that may be available in your region, you as the Company employee can still receive mental health and chemical dependency treatment through the EAP, but none of your dependents may do so.

Covered dependents of employees have the choice of initiating care through the EAP or directly through ComPsych, the Medical Plan's mental health/chemical dependency administrator. ComPsych can be reached at 1-800-435-7266. The EAP may be in the best position to help your dependents because of their familiarity with, and expertise in using, the local network providers.

If you choose not to use the EAP or select an out-of-network provider not authorized by the EAP after consulting with the EAP, your share of the covered treatment charges will depend upon which Medical Plan option you have selected. Payment will be at the out-of-network level.

Retiree precertification for mental health/chemical dependency treatment

If you are a pre-Medicare Pensioner or Survivor, or a dependent of a Pensioner or a Survivor, you must contact ComPsych at 1-800-435-7266 to precertify mental health/chemical dependency treatment and receive in-network benefits.

If you choose not to use ComPsych or select an out-of-network provider after consulting with ComPsych, your share of the covered treatment charges will depend upon the Medical Plan option in which you participate.

Medicare-eligible individuals and their covered family members must contact Aetna at 1-800-445-7175 to discuss benefits.

Precertification

Precertification (for medical care other than mental health/chemical dependency treatment) is available for the following services:

- hospital admissions
- extended-care facility stays
- home health care
- hospice care in an approved hospice program
- infertility treatment and in vitro fertilization
- outpatient private-duty nursing

To obtain precertification, you or your treating physician should contact your medical carrier by phone at least five days before the service or admission is scheduled. This means that the admission or treatment will be reviewed in advance for medical necessity. (Note that hospital stays for Medicare-eligible participants do not need to be precertified.) The medical carrier's toll-free number is on your ID card.

If you are admitted to the hospital on an emergency basis, call your medical carrier within 48 hours or on the first business day following your admission—or have someone else call for you.

If you participate in the Point-of-Service Option, your PCP, or the network specialist to whom your PCP referred you, will normally call the medical carrier to precertify your care, when appropriate. If your care is arranged by your PCP (or the network specialist), it will be covered at in-network levels.

To request an extension of your ongoing treatment or your inpatient hospitalization beyond the length of time that was initially approved, you or someone on your behalf should contact your medical carrier at least 48 hours prior to the expiration of the initially approved period. If your request for an extension of your treatment or hospitalization involves **urgent care claims**, the Medical Plan will make a benefit determination as soon as possible. Your medical carrier will notify you of the benefit determination, whether favorable or not, within 24 hours after the receipt of the request.

Second Surgical Opinions

You don't need a second surgical opinion for covered surgery. However, a second opinion is covered and may help you determine whether surgery is really necessary. The second surgical opinion must be made by a surgeon capable of performing the surgery who is not associated with or in partnership with the first surgeon. If the first and second opinions conflict, the Medical Plan will cover a third opinion.

If you are in the Point-of-Service Option, your PCP must arrange the second surgical opinion visit with a network physician to receive in-network benefits.

Centers of Excellence

Certain highly complex surgical procedures—such as heart, kidney and bone marrow transplants—are best performed in specialized facilities. Many carriers contract with well-regarded medical facilities across the U.S. known for their specialized expertise and excellent results in performing these procedures. If you and your physician agree that your health needs would best be served by your entering one of these facilities (often called “Centers of Excellence” or “Institutes of Excellence”) your physician can request that you be considered for admission by the medical carrier. If your admission is approved in advance, the services performed will be paid based on your Medical Plan Option benefits. Participants in a managed care option will have these charges covered at an in-network level.

Restrictions and Exclusions

Expenses not covered

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

1. charges covered by any other plan of the Company
2. charges covered under any national or local law (except charges relating to a government group insurance plan for that government’s own civilian employees)
3. charges due to an occupational illness or injury
4. charges for any services performed by a resident physician or intern of a hospital when billed directly—their services are included in the hospital’s bill
5. charges for care rendered to a dependent child after his or her marriage or to any dependent once they cease to be eligible
6. charges for chiropractic care other than X rays, manipulations of the spine, heat and ultrasound treatment
7. charges for communication equipment such as augmentive speech devices
8. charges for cosmetic surgery, unless it is necessary for prompt repair of a nonoccupational injury or is related to a visible congenital defect of an eligible newborn child
9. charges for custodial care, regardless of who recommends or provides the care
10. charges for eyeglasses, contact lenses and hearing aids (or examinations for the prescription or fitting of them), except for one pair of eyeglasses or contact lenses following cataract surgery
11. charges for hospitalization primarily for diagnostic studies, X ray or laboratory examinations, electrocardiograms, electroencephalograms or physical therapy except when medical necessary
12. charges for immunizations required for personal international travel
13. charges for in-hospital physician visits for any day the physician does not visit the covered patient
14. charges for inpatient or outpatient hospitalization for dental care, unless confinement is due to accidental bodily injury, or when a physician other than a dentist certifies that the hospital setting is necessary to safeguard the life or health of a patient

15. charges for items available for purchase over the counter, regardless of who recommends the purchase
16. charges for missed appointments or copying medical records
17. charges for nonmedical equipment or items intended for the comfort/convenience of the patient, such as exercise cycles, hot tubs, stairway elevators, humidifiers
18. charges for orthopedic appliances (including orthotics) when they are primarily used as supportive devices for the feet
19. charges for personal services such as phone, TV, guest meals
20. charges for routine physical examinations outside the scope of the Basic Preventive Services Schedule
21. charges for services and associated expenses considered experimental or investigative
22. charges for services not widely accepted by the U.S. medical community as safe and effective treatment for illness or injury (e.g., most applications of acupuncture or non-abstinence based treatment for chemical dependency)
23. charges for services or supplies not medically necessary or appropriate for the diagnosis and treatment of the illness or injury, except for preventive procedures described herein
24. charges for services or supplies not recommended by a licensed physician or practitioner
25. charges for services or supplies not specifically defined as covered expenses
26. charges for services or supplies specifically to maintain a level of well-being
27. charges for services provided by an unlicensed physician or practitioner
28. charges for TMJ diagnosis, and for TMJ treatment involving the teeth, such as crowns, inlays/onlays, bridges, full and partial dentures, or orthodontics
29. charges for travel other than what may be authorized under “Centers of Excellence” Transplant Program
30. charges for treatment to a person after that person is no longer eligible for coverage under this Plan
31. charges for treatment to a person before that person becomes eligible for coverage under this Plan
32. charges in excess of carrier-negotiated fees or reasonable and customary charges
33. charges incurred for any medical observation or diagnostic study when no disease or injury is revealed, unless: the covered person had definite symptoms of illness or injury other than hypochondria; or the observation or studies were not part of a routine physical examination; or the request for benefit is in order in all other respects
34. charges not reported for more than two years
35. charges related to an act of war, declared or undeclared, if the injury or illness occurs after the person is covered under this Plan
36. charges related to dental treatment except charges for repair of natural teeth or other body tissues required as a result of accidental injury

-
37. charges relating to past or present military service
 38. charges resulting from any occupation or work outside the Company for compensation or profit
 39. charges which are associated with injuries suffered due to the act or omission of a third party
 40. charges which would not have been made had the patient not been covered under this Plan, or charges which the participant or his or her eligible dependents are not legally obligated to pay
 41. second or third opinions concerning procedures not covered by this Plan or required by a hospital

Pre-existing conditions

There are no exclusions or limitations for **pre-existing conditions**.

Filing a Claim

How to file a claim

If you participate in a managed care option, you do not need to submit a claim form for in-network treatment. Payment will be sent directly to your provider. For out-of-network services, you must get claim forms from your medical carrier by calling the phone number on your ID card and submit the claim forms to your medical carrier. In some cases, your provider or facility may submit the claim form on your behalf.

You may file a claim after you've received eligible health care services or after buying prescription drugs from a non-participating pharmacy. Normally, you pay the cost of these services when you receive them, then file a claim for reimbursements. Hospitals usually file your claim for you, then bill you directly for any balance.

These items must be submitted when filing a claim:

- a description of the service provided including the dates of service and diagnostic (IDC-9) and treatment (CPT) codes for treatment received in the U.S.
- proof of payment such as an original receipt or a cancelled check
- the name and identification number of the person receiving the services

Be sure to file a separate claim for each member of your family. Make copies of all itemized bills for your records.

You have two years from the date you receive care to file a claim.

You can get a claim form from your medical carrier.

Notification and explanation of benefits

Your medical carrier will notify you in writing regarding a claim's benefit determination. You will receive a detailed statement called an **Explanation of Benefits** (EOB). For the Consumer Choice Option, a monthly statement will be mailed to your home and an electronic EOB will be available online. 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 medical circumstances that require action but no later than 72 hours for pre-service urgent care claims (i.e., 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 54 for a definition of urgent care claims.)
- within 15 days for non-urgent **pre-service claims**
- within 30 days for **post-service claims**

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

For pre-service and post-service claims, your medical carrier 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 the Claims Administrator expects to provide a determination. If your claim is a pre-service urgent care claim, you will be notified orally with the circumstances requiring an extension and when your medical carrier expects to provide you 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. 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 pre-service 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 pre-service urgent care claims but no later than 72 hours
- 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 your medical carrier for a clearer explanation of the denial. If your appeal is concerning eligibility or enrollment, contact DuPont Connection at 1-800-755-5955.
- Step 2: Provide additional written information to your medical carrier or, in the case of eligibility or enrollment, to DuPont Connection 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 your medical carrier 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 Connection 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 letter(s) received from the carrier

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 pre-service 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 second level of post-service 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 by your medical carrier. In deciding an appeal of any adverse benefit determination that is based in whole or in part on a medical judgment, including determinations with regard to whether a particular treatment, drug or other item is experimental, investigational, or not medically necessary or appropriate, the Plan Administrator shall consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment.

About Your Coverage

If you leave the company

Your Medical Plan coverage ends at the end of the month in which you leave the company for any reason and are no longer eligible for coverage. 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 Medical 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 Medical Care Assistance Program, which provides Point-of-Service Option type benefits and Indemnity Option 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 medical coverage level or decline coverage, you may do so by calling DuPont Connection at 1-800-775-5955.

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

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 Medical Plan coverage (either the Point-of-Service Option type or the Indemnity Option type, depending on where you live) through the Medical Care Assistance Program for yourself and your covered dependents for up to 12 months. You will pay the active employee premium cost during this period, even if you are a Pensioner. If you elect to remain in another Medical Plan option other than the Point-of-Service Option or Indemnity Option, COBRA rates will apply.

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 for more information. If you have more than 15 years of service at the time of your death, coverage continues through the Medical Care Assistance Program for your specified Survivor and his/her eligible dependents.

When coverage ends

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

COBRA

This section is intended to comply with the Consolidated Omnibus Budget Reconciliation Act (COBRA) of 1985 as amended, which requires continuation of medical 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 medical 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
- a change in your employment status that results in a loss of benefits eligibility
- your dependent child becomes ineligible for coverage

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

COBRA coverage continues for up to 18, 29 or 36 months, depending on how you or your covered dependents become eligible. If you or one of your covered dependents 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 • 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, as described on the COBRA billing statement
- the Company terminates the Plan or amends the Plan to eliminate coverage and does not provide any other group medical plans to employees
- 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

HIPAA certification

The Health Insurance Portability & Accountability Act of 1996 (HIPAA) requires employers to provide certification showing evidence of your prior health coverage when you are no longer eligible for coverage. The certificate is included with the COBRA application package DuPont Connection sends you.

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 of 1974 (**ERISA**).

Qualified Medical Child Support Order (QMSCO)

You or your dependents can obtain a description of procedures for Qualified Medical Child Support Order determinations at no charge from the Plan Administrator.

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.

Subrogation

If you become ill or injured and another person is at fault or potentially responsible, notify the Plan Administrator immediately.

The Medical Plan reserves the “right of subrogation” in the event of a loss. The Plan Administrator or Plan Sponsor may choose to take action to recover the amount of a claim paid to you or your covered dependent if the loss was caused by a third party. The Plan shall be entitled to full reimbursement first from any payments by a potentially responsible party. If you have the right to receive such a payment

from a third party, the Medical Plan can claim the payment directly from the party. This means, for example, that the Medical Plan is entitled to reimbursement from you or your covered dependent for the expenses that it paid on account of the injury or illness.

The Plan is not required to participate in or pay attorney fees to the attorney hired by the Plan participant to pursue the Plan participant's damage claim.

Assignment of benefits

When you file a claim, you can direct your medical carrier, the Claims Administrator, to issue benefit payments to the service provider. When you assign benefits, your medical carrier pays your provider 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 provider will submit claims for you.

Assignment of benefits does not apply to in-network managed care services. When the network provider submits the claim on your behalf, he or she automatically receives the benefit payment from the medical carrier. For in-network managed care office visits, you pay your office visit copay and no explanation of benefits is produced.

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 Medical Care Plan and/or Medical Care Assistance Program, 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 Name

This summary describes benefits for the DuPont Medical Plan which includes the:

- BeneFlex Medical Care Plan
- Medical Care Assistance Program

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 DuPont.

Plan Administrator

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

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

Plan Sponsor's Employer Identification Number (EIN)

The EIN is 51-0014090.

Plan Number

The Plan number is 503.

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

Your medical carrier:

Consumer Choice Option: Aetna, Inc.—Dover, DE, 1-800-938-7668

Point-of-Service Option and Preferred Provider Option:

Aetna, Inc.—Dover, DE, 1-800-938-7668

Anthem BC/BS—Louisville, KY, 1-888-650-4047 or 1-502-261-0294

CIGNA—Columbus, OH, 1-800-203-1742

Companion HealthCare—Columbia, SC, 1-800-821-3023

Independent Health—Buffalo, NY, 1-800-257-2753

John Deere Health Care—Moline, IL, 1-800-287-1227

Indemnity Option and Catastrophic Option: Aetna, Inc.—Dover, DE, 1-800-445-7175

Mental Health/Chemical Dependency and Prescription benefit claims administrators are noted separately, below.

Pharmacy Network

Medco Health Solutions

Phone: 1-800-793-8766

Mental Health and Chemical Dependency (MH/CD) Network

MH/CD Administrator for employees:

DuPont Employee Assistance Program—Wilmington, DE, 1-800-435-7266

MH/CD Administrator for Pensioners, Survivors and their covered dependents:

ComPsych—1-800-435-7266 if you participate in the MEDCAP Network (Point-of-Service Option)

Or Aetna—1-800-445-7175 if you participate in MEDCAP Standard (Indemnity Option)

If you are a dependent of an active employee, you can either contact ComPsych or the DuPont Employee Assistance Program before treatment.

CONTACTS

For Appealing a Claim

DuPont Connection

Medical Appeals

P.O. Box 1407

Lincolnshire, IL 60069-1407

Phone: 1-800-775-5955

For Claim Forms/Issues, Precertification Information or Network Provider Information (where applicable)

Most issues about claims or benefits can be resolved informally by contacting Carrier Member Services. The toll-free number is on the member's medical ID card.

Your medical carrier:

Consumer Choice Option: Aetna, Inc.—Dover, DE, 1-800-938-7668

Point-of-Service Option and Preferred Provider Option:

Aetna, Inc.—Dover, DE, 1-800-938-7668

Anthem BC/BS—Louisville, KY, 1-888-650-4047 or 1-502-261-0294

CIGNA—Columbus, OH, 1-800-203-1742

Companion HealthCare—Columbia, SC, 1-800-821-3023

Independent Health—Buffalo, NY, 1-800-257-2753

John Deere Health Care—Moline, IL, 1-800-287-1227

Indemnity Option and Catastrophic Option: Aetna, Inc.—High Point, NC, 1-800-445-7175

Mental Health/Chemical Dependency and Prescription benefit carrier contacts are noted separately, below.

Getting Preapproval for Mental Health and Substance Abuse

MH/CD Administrator for employees:

DuPont Employee Assistance Program—Wilmington, DE, 1-800-435-7266

MH/CD Administrator for Pensioners, Survivors and their covered dependents:

ComPsych—1-800-435-7266 if you participate in the MEDCAP Network (Point-of-Service Option)

Or Aetna—1-800-445-7175 if you participate in MEDCAP Standard (Indemnity Option)

If you are a dependent of an active employee, you can either contact ComPsych at 1-800-435-7266 or the Employee Assistance Program before treatment.

Prescription Program

Medco Health Solutions

Phone: 1-800-793-8766

<http://www.medcohealth.com>

For COBRA Coverage

DuPont Connection—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 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 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.

Brand-name drug

Protected by a patent issued to the original company that invented or marketed the drug. Brand-name drugs are single or multisource brand drugs, but exclude those drugs billed as generics.

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.

Coinsurance

A percentage of expenses that you are responsible for paying after you meet your deductible.

Company

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

Copay

The flat dollar amount you pay for a certain type of health care expense.

Custodial care

Treatment of persons who have reached the maximum level of recovery which can reasonably be expected, or care primarily for purposes of meeting a person's needs which could be provided by persons without professional skill or training.

Deductible

The amount of out-of-pocket expenses you must pay for service before the Plan pays additional expenses.

Emergency

A life-threatening, sudden and serious medical problem such as a stroke, heart attack, serious injury, acute asthma attack, poisoning or convulsions.

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.

Experimental or investigational treatment

Health care procedures and drugs which have not been broadly accepted among the relevant medical community as a standard part of medical practice.

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.

Generic drug

A multisource drug that generally contains the same ingredients and has the same effect as a brand-name drug, but is manufactured by a company other than the one that manufactures the brand-name drug. In some instances, a generic drug may not have a brand-name counterpart.

Inpatient

When you are admitted to the hospital for treatment or observation.

Medically necessary

A service or supply which is reasonable and necessary for the diagnosis or treatment of an illness or injury, in view of the customary practice in the geographical area, and is given at the appropriate level of care.

Outpatient

When you visit a clinic, emergency room or health facility and receive health care without being admitted as an overnight patient.

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-existing condition

A health problem you had and received treatment for before your current benefit elections took effect.

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 medical care.

Primary care physician (PCP)

A doctor you choose who is responsible for coordinating your medical care, from providing direct care up to and including referring you to specialists and hospital care.

Qualified Medical Child Support Order (QMCSO)

A judgment, decree or order that meets all of the following criteria:

- is issued by a court pursuant to a domestic relations law or community property law
- creates or recognizes the right of an alternate recipient to receive benefits under a parent's employer's group or health plan
- includes certain information relating to the participant and alternate recipient

Qualifying Life Event

An event recognized by Section 125 of the Internal Revenue Code and the Plan 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.

Stop-loss

The maximum amount you have to pay toward the cost of your covered medical care expenses in the course of one year. After you have paid this amount, the Medical Plan will pay 100% of eligible health care expenses up to the calendar-year maximum of \$1.5 million.

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.

Urgent care

Sudden and severe symptoms that do not qualify as a medical emergency but require care to prevent the problem from becoming a medical emergency.

Urgent care claim

Claims for medical 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.

