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Your DuPont Benefit Resources

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# BeneFlex Vision Care Plan

July 2003

As of July 2003, participating employers in the BeneFlex Vision Care Plan include:

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

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



*The miracles of science™*

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## DETAILS OF THE PLAN

### Preface

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

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

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

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

### Introduction

The BeneFlex Vision Care Plan provides benefits to help you pay for covered eye exams, lenses and eye-glass frames following a defined schedule of benefits. Vision Care is provided through Vision Benefits of America (VBA). The Plan allows you the option of using either a VBA provider or a non-VBA provider. So, if you have an ophthalmologist with whom you are comfortable, you can enroll in the BeneFlex Vision Care Plan and be covered. You can also combine Vision Care and a Health Care Spending Account to cover your vision expenses.

Participation in the BeneFlex Vision Care Plan is voluntary.

### Eligibility

#### *Eligible employees*

You are eligible for the BeneFlex Vision Care Plan if you are:

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

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

Since January 1, 1992, the BeneFlex Flexible Benefit Plan has been offered to all DuPont U.S. Region employees. However, you are not eligible for the BeneFlex Vision 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.

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### ***Eligible dependents***

You can cover certain dependents under the BeneFlex Vision Care 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 BeneFlex Vision Care Plan coverage.

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

### ***Additional information regarding eligibility for your 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 BeneFlex Vision Care Plan coverage.
- If you are required by court order to provide vision 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 BeneFlex Vision Care 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 BeneFlex Vision Care Plan. Both of you cannot cover your child at the same time.
- It is your responsibility to remove children who no longer meet the BeneFlex Vision Care Plan eligibility requirements.

## Enrollment

### *Enrolling in the Plan*

You can enroll in Vision Care 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>

New employees hired before August 1 can enroll for the current year. Any new employee hired on August 1 or later must wait for the next BeneFlex Election Change Period to enroll. If you are a newly hired employee, you must call DuPont Connection or visit BeneFlex OnLine to make your benefit elections within 31 days of the date on your new hire package that is mailed to you. If you do not enroll, you will be defaulted to no coverage. In addition, you will not have coverage for your dependents, so it is important that you enroll in a timely manner.

Your benefit elections will stay in effect for the entire **Plan Year** (January 1–December 31).

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 BeneFlex Vision Care Plan for the following year with no change to your election.

### *When coverage begins*

Once enrolled, your and your eligible dependents' BeneFlex Vision Care Plan coverage will start on the first of the month following your election or on January 1st if you enroll during the BeneFlex Election Change Period.

### *Making changes*

You can not make changes to your BeneFlex Vision Care Plan coverage level (you only, you plus one, or you plus family) during the year due to any **Qualifying Life Events**. Changes to your coverage level are permitted only during the annual BeneFlex Election Change Period.

### *Changes during the annual BeneFlex Election Change Period*

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

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

- enroll to participate
- cancel your participation
- change the level of coverage (you only, you plus one, you plus family)
- add or drop one or more dependents from coverage

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

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### ***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. In addition, if you have a new dependent as a result of marriage, birth, adoption or placement for adoption, you may be able to enroll yourself and your dependents, provided that you request enrollment within 30 days after the marriage, birth, adoption or placement for adoption.

## **Cost**

### ***Cost of coverage***

You are responsible for the full cost of the BeneFlex Vision Care Plan coverage for both yourself and your covered dependents. You pay your portion of the cost through payroll deductions.

To help lower your cost, your premiums are deducted from your pay on a before-tax basis—that is, before any Federal, and most state and local, taxes are withheld. This reduces your taxable income and, consequently, reduces the amount of income tax you pay.

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

<b>Coverage Level</b>	<b>Monthly Premium</b>
You only	\$ 7.25
You plus one (you and one eligible dependent)	\$12.70
You plus family (you and two or more of your eligible dependents)	\$18.40

The premiums listed above are effective for the 2003 Plan Year. Your premiums are reviewed annually and are subject to change. Any adjustments to your deductions will be effective January 1 of the new Plan Year. You will be notified in advance of any rate changes.

## **Plan Benefit**

### ***Vision Care benefits coverage***

You have two levels of coverage under the BeneFlex Vision Care Plan. You receive a higher benefit when you use a Vision Benefits of America (VBA) network provider. If you use a provider who does not belong to the VBA network, you will still receive benefits, but they will be at a lower, out-of-network level.

The following chart outlines the differences between using a VBA provider and a non-VBA provider:

**Scheduled Reimbursements Once Every Plan Year**

<b>Service</b>	<b>VBA Provider</b>	<b>Non-VBA Provider</b>
Eye Examination	100%	Up to \$30
Eyeglass Lenses and/or Frames (once/Plan Year) Including: Polycarbonate Lenses, Scratch-Resistant Coatings, Optional Lens Tints	100% after \$20 copayment per person (covers frames with a wholesale value up to \$50)	Single vision: up to \$20 Bifocal: up to \$30 Trifocal: up to \$40 Lenticular: up to \$50 Frames: up to \$50
Cosmetic Contact Lenses (as an alternative to glasses, including eye exam)	Up to \$120 allowance toward the total cost	Up to \$120 allowance toward the total cost
VBA-Approved Medically Necessary Contact Lenses (as an alternative to glasses, including exam)	100% of reasonable and customary	Up to \$150

***About contact lenses (in lieu of glasses)***

When contact lenses are selected in lieu of glasses, a total allowance of up to \$120 is paid toward the cost of exams and cosmetic (elective) contact lenses, regardless of whether you purchase them through a VBA provider or not.

**NOTE: The standard vision exam (for spectacle eyewear) is fully covered by VBA at a reduced fee that is accepted by the VBA network doctors. The contact lens exam includes additional elements such as the evaluation (tear drop test, etc.) and fitting. Contact lens service (exam/evaluation/fitting/lenses) is in lieu of all other benefits for the Plan Year. If contact lens services are received through a VBA network provider, the provider will subtract the Plan allowance of \$120 from his or her usual and customary charge for these services, with the patient responsible for any difference over and above the \$120 allowance.**

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### ***Medically Necessary contact lenses***

Medically Necessary contact lenses, as determined by the Plan Administrator, are covered in full under the BeneFlex Vision Care Plan with prior approval from VBA for these conditions:

- due to eye disease (such as Kerataconus or Aphakia) or injury
- following cataract surgery
- to correct significant anisometropia or
- to correct extreme visual acuity problems

Refractive conditions (such as Myopia, Hyperopia, etc.) do not qualify for Medically Necessary contacts unless 20/40 acuity cannot be achieved with eyeglasses. Authorization for Medically Necessary contacts must be requested prior to services/coverage.

If you obtain Medically Necessary contact lenses from a VBA provider, the Plan pays 100%. If however, you receive Medically Necessary contact lenses from a non-VBA provider, the Plan **reimburses** you up to \$150 based on reasonable and customary charges.

### ***Options to add to lenses***

There are certain options that can be added to your eyeglass lenses:

- polycarbonate lenses
- scratch-resistant coatings (both Standard 1-Year and Premium 2-Year)
- solid and gradient lens tints

If you use a provider in the VBA network, there will be no additional charges for these fully covered lens options. If you receive these lens options out-of-network, the cost will be applied toward the scheduled lens allowance.

### ***VBA discount program***

A variety of non-covered lens options are available at cost-contained prices established by VBA. Discounts apply only when purchased in conjunction with covered lenses and/or frames. Discounts are not available on multiple pairs of lenses and/or frames.

You can receive a discount from VBA of 15% to 20% below typical retail costs on certain merchandise such as:

- a frame that costs more than the Plan allowance
- blended lenses
- contact lenses in excess of the Plan allowance
- photochromatic lenses
- progressive multifocal lenses
- rimless frames
- the laminating of a lens or lenses

Discounted prices represent a fair and reasonable cost that generally falls within this range.

### ***Combining Vision Care with your Health Care Spending Account***

When you contribute to a Health Care Spending Account, you may use funds from your account in combination with the BeneFlex Vision Care Plan benefits. The Health Care Spending Account reimburses you for expenses the BeneFlex Vision Care Plan does not cover, including your copayments.

#### ***Expenses not covered***

The Plan does not cover:

- orthoptics or vision training, subnormal vision aids or nonprescription lenses
- plano (non-prescription) lenses
- two pairs of glasses in lieu of bifocals
- medical or surgical treatment of the eyes
- any eye examination, or corrective eyewear, required by an employer as a condition of employment
- services or materials provided as a result of any Workers' Compensation law or similar legislation
- glasses and contacts during the same eligibility period
- replacement of lost or broken lenses and frames furnished under this Plan except at the normal intervals when services are otherwise available
- charges above the fees charged by a vision care provider affiliated with Vision Benefits of America (VBA) if a participant fails to obtain a VBA Benefit Form in advance and visits the provider as a private patient
- accessories for eyeglasses and vision care solutions such as lens cleaning cloths, repair kits and contact lens solution

### **Filing for Reimbursement**

#### ***How to use the Plan***

To receive Vision Care services, contact Vision Benefits of America (VBA) and request a Benefit Form. Upon verifying your eligibility, Vision Benefits of America (VBA) will send you a valid Benefit Form and a current list of all participating providers in your area. You have to make an appointment with any provider on this list within 90 days from the issue date on your Benefit Form in order to receive in-network benefits. On your first visit, sign and present your Benefit Form to the provider along with any necessary copayments.

You can get a VBA Benefit Request Form from:

- Vision Benefits of America  
1-800-432-4966  
[www.visionbenefits.com](http://www.visionbenefits.com)

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If you do not obtain a VBA Benefit Form in advance and visit a network provider as a private patient, the provider is not obligated to accept VBA fees as payment and may elect to charge a higher fee, and out-of-network benefits will apply.

If you don't go to a provider in the VBA network, you will need to pay for the services when you go and submit a claim for reimbursement using a VBA Benefit Form.

### ***How to file a claim***

If you use a provider that is part of the VBA network, you do not need to file a claim.

If you receive services out-of-network, you must submit a claim for reimbursement using the VBA Benefit Form. You have one year from the date of service to file a claim. You must also include supporting documentation for out-of-network claims as follows:

- exam amount paid
- lens type and amount paid
- frame amount paid

Failure to provide this information could result in incorrect payment.

Mail the completed VBA Benefit Form and your receipts to:

Vision Benefits of America  
300 Weyman Plaza, Suite 400  
Pittsburgh, PA 15236-1588  
Attn: Non-Preferred Claims

Make copies of all supporting documentation for your records.

Reimbursement checks are issued bi-weekly.

### ***Notification and explanation of benefits***

Vision Benefits of America will notify you in writing regarding a claim's benefit determination. You will receive a detailed statement called an **Explanation of Benefits**, or EOB. The EOB will explain what amounts have been reimbursed. The statement will explain the reason why a claim has not been paid. An EOB will be sent within a maximum of 30 days for **post-service claims**. If you send in a **pre-service claim** (such as a written request for consideration of Medically Necessary contact lenses), VBA will respond within a maximum of 15 days.

The decision-making timeframe may be extended by Vision Benefits of America on both the pre-service and the post-service claims 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 Vision Benefits of America expects to provide a benefit determination.

### *Revised notification timeframe*

If you are required to submit additional information, the initial notification deadline for your claim determination is suspended from the time you are contacted for such additional information and until you return the requested information. This is called the tolling period. The tolling period ends on the date the Plan receives your response to the notice, without regard to whether or not you have supplied all the necessary information to decide the claim or on the date such information was due if you did not respond. You must respond with the missing information within 45 days.

Once you respond, Vision Benefits of America will make a determination within 15 calendar days.

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

The Plan will notify you of a denied claim within a maximum of 30 days for post-service claims (or 15 days for pre-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 a resolution:

- Step 1: Contact Vision Benefits of America for a clearer explanation of the denial.
- Step 2: Provide additional information to VBA that may allow reconsideration of your claim.

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

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

The request for appeal should include:

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

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

You will receive information about the final decision from DuPont which will respond within 60 days for post-service claims (or 15 days for pre-service claims).

Special circumstances may cause the review to take longer. You will be notified if the review is extended and 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, your vision carrier. In deciding an appeal of any adverse benefit determination that is based in whole or 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.

### ***Coordination of benefits***

This Plan does not coordinate with other group plans.

## **About Your Coverage**

### ***If you leave the Company***

Your BeneFlex Vision Care Plan coverage ends at the end of the month in which you leave the Company for any reason, including retirement, and are no longer employed as an active Full-Service Employee. 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 BeneFlex Vision Care Plan coverage. You are responsible for continued payment of premiums if you are on an unpaid leave-of-absence.

***If you retire***

Pensioners and Survivors are not eligible for BeneFlex Vision Care Plan coverage. COBRA continuation coverage is available at the time of your retirement. Refer to the “COBRA” section for more information.

***If you are terminated due to lack of work***

If your employment with the Company is terminated due to lack of work, your coverage ends. COBRA continuation coverage is available at the time of your termination.

***If you die***

If you die while employed by the Company, your coverage ends. Your surviving dependents may be eligible for COBRA continuation coverage. Refer to the “COBRA” section for more information.

***When coverage ends***

BeneFlex Vision Care 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 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 BeneFlex Vision Care Plan coverage if it ends because of one of the following:

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

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

- your death
- your divorce, legal separation or annulment of your marriage
- your dependent child becomes ineligible for coverage

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COBRA coverage continues for up to 18, 29 or 36 months, depending on how you or your eligible dependents become ineligible. If you elect to continue coverage under COBRA, you are required to pay 102% of the cost of coverage in after-tax dollars.

If you are disabled as determined by the Social Security Administration, you may elect to continue COBRA for up to 29 months.

<b>Length of COBRA coverage</b>	<b>Reason coverage stops</b>
18 months	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	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)	You become entitled to Medicare. You die. You divorce, have your marriage annulled or legally separate. Your dependent stops being eligible for coverage.

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### ***Electing COBRA***

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

If you wish to elect COBRA coverage, you must do so no later than 60 days after the date your Company coverage ends or 60 days after the date of the notice of COBRA rights 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 within the initial 18 months of COBRA coverage so that you and your 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.

If you become entitled to Medicare benefits and then lose medical coverage within the next 18 months because your employment is terminated or your hours are reduced, your eligible dependents may purchase COBRA coverage for a maximum of 36 months from the date you become entitled to Medicare.

### ***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 paid on a timely basis
- the Company stops offering any group vision plan
- the person who elected COBRA becomes covered under another group medical plan and meets any pre-existing condition prohibitions or limitations
- the person who elected COBRA becomes entitled to Medicare after COBRA coverage has started

### **Future of the Plan**

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

## **ADMINISTRATIVE INFORMATION**

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

### ***Overpayments and other errors***

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

### ***Qualified Medical Child Support Order (QMCSO)***

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

### ***Conversion rights***

If you or your eligible 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 Vision Care Plan, you are entitled to certain rights and protections under ERISA. ERISA entitles you to:

- examine, at the Plan Administrator's office and other specified locations, including work sites and union halls if applicable, without charge, all Plan documents governing the Plan. These documents may include insurance contracts, collective bargaining agreements if applicable, and the latest annual report (Form 5500) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.

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- 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 Insurer**

Vision Benefits of America  
300 Weyman Plaza, Suite 400  
Pittsburgh, PA 15236-1588  
Phone: 1-800-432-4966

## **Plan Name**

This summary describes benefits for the BeneFlex Vision Care Plan.

## **Type of Plan and Administration**

The Plan is a welfare plan as defined by the Employee Retirement Income Security Act of 1974 (ERISA) that provides group health benefits. The Company contracts with an insurance company for the purposes of providing any benefits under this Plan.

## **Plan Administrator**

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 515.

## **Plan Year**

The Plan Year is January 1 through December 31.

## **Source of Benefits Funding**

You pay the entire cost.

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## **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**

Vision Benefits of America  
300 Weyman Plaza, Suite 400  
Pittsburgh, PA 15236-1588  
Phone: 1-800-432-4966

## **CONTACTS**

### **For Questions Regarding Eligibility or Enrollment**

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

### **For Sending a Reimbursement Request**

Vision Benefits of America  
300 Weyman Plaza, Suite 400  
Pittsburgh, PA 15236-1588  
Phone: 1-800-432-4966

### **For a Benefit Form**

Vision Benefits of America  
300 Weyman Plaza, Suite 400  
Pittsburgh, PA 15236-1588  
Phone: 1-800-432-4966

### **For Appealing a Denied Reimbursement**

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

## For COBRA Coverage

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

## DICTIONARY TERMS

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

### *Appeal*

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

### *BeneFlex Election Change Period* (annual enrollment, open enrollment)

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

### *COBRA* (Consolidated Omnibus Budget Reconciliation Act)

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

### *Company*

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

### *ERISA* (Employee Retirement Income Security Act of 1974)

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

### *Explanation of Benefits (EOB)*

A statement you receive from your carrier giving specific details about how and why benefit payments were or were not made. It summarizes the charges submitted and processed, the amount allowed, the amount paid and your balance, if any.

### *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 vision 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 an already-performed eye examination.

### ***Pre-service claim***

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

### ***Qualifying Life Event***

An event recognized by Section 125 of the Internal Revenue Code that entitles you to make a change in the benefit elections you made. No changes to Vision Care elections are permitted mid-year due to a Qualifying Life Event.

### ***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

### ***Reimburse***

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

### ***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.

