Your DuPont Benefit Resources

BeneFlex Medical Care Plan

July 2014

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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 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.

As an active employee or COBRA participant, you may select from the BeneFlex Medical Care Plan options available in your area or elect no coverage for yourself and your eligible dependents. Refer to your personal benefits enrollment materials for the BeneFlex Medical Care Plan options available to you.

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

Helpful Resources

Put the CastLight Consumer Tool to work for you!

Because charges vary from provider to provider, even for in-network care, the Company provides you with a free CastLight health services comparison tool. CastLight can help you compare charges of local providers based on the service you need. Plus, CastLight includes quality data and customer ratings to help you select the best care at the best price. CastLight is available online or as a mobile app. Go to www.mycastlight.com to use the CastLight Consumer Tool.

Need information about	Where to go:	DuPont employees	Pioneer, Danisco, Solae and other legal-entity employees
Your benefits package and to enroll or make changes to your elections	HR Service Center	MyInfo Service Center 1-877-694-6364 www.myinfo.dupont.com	DuPont Connection 1-800-775-5955 Your Benefit Resources www.resources.hewitt.com/dupont

Your medical plan	Highmark BCBS	Highmark BCBS 1-888-431-4650 www.highmarkbcbsde.com
	Aetna	Aetna, Inc. 1-800-938-7668 www.aetna.com
	Cigna	Cigna 1-800-203-1742 www.CIGNA.com

Need information about	Where to go:	DuPont employees	Pioneer, Danisco, Solae and other legal-entity employees
Your medical plan	Independent Health	Independent Health 1-800-445-7175 www.aetna.com	
	Hawaii BCBS	HMSA BCBS of Hawaii 1-808-948-6111 www.hmsa.com	
	Aetna International	Aetna International 1-888-212-3689 www.aetnainternational.com	
	Puerto Rico	Triple S 1-877-357-9777 www.ssspr.com	
Prescription Drug Benefits	Regular medications	Express Scripts 1-800-793-8766 www.express-scripts.com/dupontactive	
	Specialty medications	Accredo 1-800-803-2523	
Employee Assistance Program	Counseling	ComPsych Employee Assistance Program 1-800-435-7266 in U.S. 1-800-981-5070 Lucy Lopez—Puerto Rico www.guidanceresources.com	
Mental health and chemical dependency care	Extended Counseling and Treatment	ComPsych Employee Assistance Program 1-800-435-7266 www.guidanceresources.com	Highmark BCBS 1-888-431-4650 www.highmarkbcbsde.com
The Health Savings Account	HSA	Bank of America 1-877-319-8115 www.bankofamerica.com/benefitslogin	
Healthy Incentive Program	Wellness	Health Fitness 1-888-211-2411 www.myhealth.dupont.com	
	Shopping for Care	CastLight www.mycastlight.com/dupont	

Eligibility

Eligible employees

- a Full-Service Employee 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, including: Pioneer, Danisco, Solae and other DuPont legal-entity companies.

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 or
- Your same-sex domestic partner if you live in a state that does not recognize same-sex marriage;
- Children who meet ALL these criteria:
  - — Your natural child, stepchild, adopted child (including a child legally placed with you for adoption), or foster child
  - — under age 26 or certified as disabled by the Plan's medical carrier prior to reaching age 26.

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 may be required to provide proof that your dependent(s) are eligible for coverage. Copies of your marriage certificate, child's birth certificate, and federal tax forms are examples of the types of proof that you may be required to provide in order to cover or continue covering your dependent.

You must promptly notify the HR Service Center 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 becomes 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/same-sex partner

- Spouses/partners who work 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. Coverage under the Medical Plan will be secondary and their employer's medical plan will be primary.
- If both you and your spouse/partner work for a Company participating in the Medical Plan, you can cover your spouse/partner as a dependent, or your spouse/partner can elect separate employee coverage. You or your spouse/partner can't be covered as both an employee and a dependent in the Medical Plan.
- You may cover your same-sex partner while you are actively employed, provided that you have completed and filed an Affidavit of Domestic Partnership with the HR Service Center. If you live in a state that recognizes same-sex marriage, you must be legally married in order to cover your same-sex domestic partner.

Additional information regarding eligibility for your dependent children

- Children who do not meet the eligibility criteria (such as grandchildren, stepchildren from a former marriage and children for whom the employee is the legal guardian) are not eligible for coverage, regardless of the child's dependence on the employee.
- Your children are eligible for coverage under the Plan through the end of the month in which they turn age 26, regardless of marital status, student status, residency or financial dependency, provided they meet the eligibility requirements.
- The age-26 limit does not apply to eligible 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 26. The child must be claimed by you as a dependent for federal tax purposes in order to be covered after reaching age 26. 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 26 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 meet the eligibility criteria described on page 5. The court order must meet the requirements of a **Qualified Medical Child Support Orde**r (QMCSO) and must be approved by the DuPont Legal Department. Contact the HR Service Center for further information. A copy of the QMCSO procedure is available by contacting the Plan Administrator or HR Service Center.
- If both you and your spouse/partner work for a Company participating in the Medical Plan, only you or your spouse/partner can cover your eligible child as a dependent under the Medical Plan. Both of you cannot cover your child at the same time.

Enrollment and Premium Information for Employees

Enrolling in the Plan

You may enroll in the Medical Plan when you first become eligible and during the annual **BeneFlex Election Change Period**.

If you are a newly hired employee, you must call the HR Service Center to make your benefits elections within 31 days of the date on your new-hire package that is mailed to you. If you do not enroll, you will be defaulted to single coverage in the Standard PPO. 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

National Options:

- Standard PPO
- Health Savings PPO
- No Coverage

Alternative Coverage Options available in specific locations, including:

- International PPO
- Hawaii PPO (HMSC)
- Puerto Rico PPO (Triple S)

Each Medical Plan option is described in this SPD.

Your benefits elections will stay in effect through the end of the **Plan Year** (January 1–December 31) unless you have a **Qualifying Life Event** (**QLE**). See page 8 for information regarding Qualifying Life Events.

You do not have to re-enroll each year unless you are instructed to do so. 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.

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.

How Medicare eligibility impacts your coverage

Medicare is the U.S. national health insurance program administered by the federal government. Medicare coverage generally begins upon reaching age 65. However, adults under age 65 may also qualify for Medicare due to a disability or diagnosis of End-Stage Renal Disease (ESRD). Participation in Medicare is optional and may require the payment of premiums. In the event that you elect to waive Medicare coverage for yourself or your covered dependent while you are participating in the BeneFlex Medical Care Plan, it is important to contact the Social Security Administration and sign up for Medicare prior to retiring or leaving the Company.

As an active employee, your BeneFlex Medical Care Plan coverage is primary to Medicare for you and your covered dependents, unless the Medicare eligibility is due to a diagnosis of End-Stage Renal Disease. Contact the Social Security department to discuss your Medicare coverage and enrollment options. Information regarding Medicare is also available on the internet at www.Medicare.gov.

If you or your covered dependent are eligible for Medicare solely on the basis of ESRD and are not eligible for Medicare by reason of age or another disability, the BeneFlex Medical Care Plan is primary to Medicare only during the first 30 months of such eligibility for Medicare benefits. This 30-month period generally begins on the earlier of:

- The first day of the fourth month during which a regular course of renal dialysis starts; or
- If you receive a kidney transplant, the first day of the month during which you become eligible for Medicare.

Following the 30-month period, the BeneFlex Medical Care Plan will provide secondary benefits to what Medicare paid or should have paid, assuming the individual enrolled or could have enrolled in Medicare Parts A and B as their primary coverage. Therefore, even though you are an active employee, it is important to enroll in Medicare coverage for the individual with ESRD.

How enrollment in a individual health insurance plan impacts your coverage

DuPont intends for your coverage to be affordable; however, you may still be eligible for a premium discount through the public health insurance marketplace. If the lowest-cost Medical Plan option for You Only coverage is more than 9.5% of your household income for the year, you may be eligible for a tax credit. The tax credit is only available to individuals who elect No Coverage from the Medical Plan and purchase individual coverage through the public health insurance marketplace. For more information, contact your HR Service Center.

Qualifying Life Events

You can change your benefits 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 the Medical Plan's national options, such as switching from the Standard PPO Option to the Health Savings PPO Option, are not permitted mid-year. If you move out of a managed-care service area and can no longer participate in your existing Medical Plan option (such as in the case of an employee who goes on an international assignment, to Hawaii or to Puerto Rico), you will be switched to the Alternative Plan options.

For more information on Qualifying Life Events, contact your HR Service Center.

A Qualifying Life Event is:

- marriage or divorce
- start or termination of your domestic partnership
- birth or adoption of a child
- death of your spouse/partner 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/partner's employment
- moving into or out of a managed-care service area
- a change in your spouse's/partner's employment from part-time to full-time or vice versa, impacting eligibility for benefits
- a significant change in your spouse's/partner's medical coverage
- unpaid leave of absence by your spouse/partner

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 Qualifying Life Event after 31 days of the Event, your medical changes will be effective on the date of your call.

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 former spouse/partner is no longer eligible for coverage as of 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. You will be responsible for reimbursing the Plan for any claims paid for an ineligible dependent.

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 spouse/partner, You plus child[ren] or You plus family)
- add or drop one or more named dependents from coverage
- drop your coverage

All changes in your benefits 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/partner) 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 retroactive to the date you lost other coverage. 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.

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 coinsuance and deductible amounts. To help lower your cost, your premiums are deducted from your pay on a before-tax basis (except where not permitted by law) — 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. If you are on a leave without pay, you will be responsible for making premium payments.

2014 Medical Plan Options and Employee Premiums

	Standard PPO and International PPO	Health Savings PPO	Alternate Coverage (e.g., Hawaii or Puerto Rico)
You Only	$90	$50	Call*
You + Spouse/Partner	$190	$105	Call*
You + Child(ren)	$145	$80	Call*
You + Family	$255	$135	Call*

The premiums listed are effective for the 2014 Plan Year. Your premiums are reviewed annually and are subject to change. You will be notified in advance of any premium changes. Refer to your personal benefit enrollment materials (which you receive prior to the annual BeneFlex Election Change Period) for further pricing information.

***Alternative Coverage Option prices (where offered) are available by calling the HR Service Center.**

Healthy Incentive reward

Each year, the Company determines whether wellness incentives will be offered to employees. The Healthy Incentive reward program is designed to help you identify your health risks and improve your health. All individual health information is kept confidential, as required by HIPAA.

For 2014, you can earn a monthly medical premium credit by participating in the Healthy Incentive rewards program. Note that the credit is not available to employees in the No Coverage or Alternate Coverage options which are fully insured (e.g., Hawaii and Puerto Rico).

Details on the Healthy Incentive medical premium credit are communicated to employees during the Annual Enrollment period. The information includes the amount of the credit, when and how to earn it, and contact information for assistance.

The premium credit ends when an employee retires or terminates employment with DuPont for any reason other than termination for lack of work, as recognized through a Company severance plan such as the Career Transition Plan (CTP). Employees who are terminated for lack of work may continue to receive the premium credit for the remainder of the Plan Year. Note that the premium credit does not apply to medical premiums for retirees, even if the employee retires as a result of a termination for lack of work.

Cost-sharing Plan Design Provisions

Deductible

The deductible is the amount of money you must pay each Plan Year for covered care before the Plan pays additional benefits. Under the BeneFlex Medical Care Plan coverage, some benefits are subject to an annual deductible.

Type of Covered Care	Deductible Applies?
Preventive Care as set forth by the Patient Protection and Affordable Care Act *(see your medical carrier for a list of covered services)*	**No**
Preventive Medications on the Plan's list maintained by Express Scripts	**No** (Medications are subject to coinsurance)
Employee Assistance Program counseling sessions *(six per person per year)*	**No**
Other Non-Preventive Care, including: • Office visits • Prescription medications, other than those on the Preventive Medications List • Emergency care • Lab or medical tests • Hospital care • Surgery • Mental health or chemical dependency treatment	**Yes**

The Medical Plan deductible amounts are shown in the chart on page 15. Deductible amounts are based on your Medical Plan option and the level of coverage you elect. A new deductible applies each year.

In-network and out-of-network deductible amounts

A separate deductible applies to in-network and out-of-network covered medical services. If you use an in-network provider, you will be charged the Network-Negotiated Rate and the in-network deductible will apply. In-network care costs include medical care received from a preferred provider in your carrier's network and medications purchased through the Express Scripts pharmacy program. If you use an out-of-network provider, the out-of-network deductible will apply. Out of network, any portion of the charges that exceed the Reasonable and Customary allowance will not be applied toward satisfaction of your deductible.

Individual and Family deductible limits, by plan option

The Health Savings PPO Option has a combined deductible for all covered family members. There is no individual deductible. For example, if you have Employee Plus Family level coverage in the Health Savings PPO Option, all covered family members' claims will go toward meeting the deductible, regardless of whether the claims are all for one person or for a few family members. The IRS requires qualifying high-deductible health plans to use a combined deductible with no underlying individual deductible.

The Standard PPO and Alternative PPO options have both individual and family deductibles. The individual deductibles apply to each covered person. Once a covered individual meets the individual deductible, the Medical Plan begins paying benefits for that individual. The family deductible limits the combined amount of individual medical deductibles that apply in a Plan Year when coverage is elected for more than one person. The family deductible can be met regardless of whether any one covered family member has reached the individual deductible. Alternative PPO participants (e.g., Hawaii and Puerto Rico participants) should refer to the plan materials provided by the insurer for further details.

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.

Annual medical in-network stop-loss (also called an out-of-pocket maximum)

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

Expenses that count toward your annual medical stop-loss include in-network deductible and in-network coinsurance amounts for medical, prescription, or mental health/chemical dependency care, except as noted below.

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

- all out-of-network expenses, including deductible and coinsurance amounts
- Plan premiums
- charges above reasonable and customary or network-negotiated amounts, when applicable
- expenses for services that are not medically necessary or are not covered by the Plan

- expenses for infertility services and in-vitro fertilization procedures
- charges that exceed individual benefit maximums

The individual stop-loss applies to each covered person. (Note that the Health Savings PPO Option has a combined stop-loss for all covered family members, and no separate individual stop-loss.)

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

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 Express Scripts. If you present your ID card at an Express Scripts 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.

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 that 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 that 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.

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 benefit maximum

The Medical Plan pays unlimited benefits for covered medical expenses incurred on account of any one person in any one Plan Year.

An annual maximum of $1,000 applies to covered chiropractic care benefits.

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 services and in-vitro fertilization procedures shall not exceed a lifetime family maximum of $15,000 for infertility medical treatments and $10,000 for infertility prescription drugs. 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 services 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/partner 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/partner's employer's medical plan, your spouse's/partner'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. A plan that covers a participant as an employee or the covered dependent of an employee will be primary to Medicare, except in cases of End-Stage Renal Disease that qualify for Medicare primary coverage.
- 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/partner's primary plan pays an 80% benefit, this Medical Plan will not pay additional benefits under the Standard PPO Option unless you have exceeded the stop-loss. The Standard PPO Option provides 80% benefits after satisfaction of the deductible, but you have already received 80% from your spouse's/partner's plan, so no secondary benefits will be paid.

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

Plan Options

General Information

Medical Plan options:

- Standard PPO
- Health Savings PPO

The Medical Plan offers a choice of options so that you can elect the best option for you and your dependents.

The Standard PPO and Health Savings PPO are self-insured by the Company, meaning the Company pays the actual claim costs. These two options share the same list of covered services, prescription drug benefits, and limitations and exclusions. What differs between these two options is the amount of cost you pay in premiums, deductibles, and your ability to save through a Health Savings Account (HSA). The
Standard PPO has higher premiums, a lower deductible and no HSA. The Health Savings PPO has lower premiums, a higher deductible, and an HSA. The Company contributes to the HSA, providing funds which may be used to help reimburse your deductible and coinsurance amounts. An HSA may also be used to reimburse out-of-pocket dental and vision expenses.

Employees living in Hawaii, Puerto Rico, or on an international assignment receive alternative coverage. Details on your insurance coverage, including benefit amounts, limitations and exclusions, and administrative rules will be provided by your medical carrier.

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

Your medical carrier prenegotiates treatment fees with network providers and facilities, reducing cost for you and the Company. 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.

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 Aetna, CIGNA or Independent Health directories are not necessarily recognized as network providers for the Medical Plan. If Aetna, CIGNA or Independent Health is your carrier, the in-network mental health/chemical dependency treatment providers are listed in a provider directory that you can obtain from ComPsych.

Express Scripts maintains the network of retail pharmacies and administers the prescription drug coverage. A list of network pharmacies is available from Express Scripts.

Health Savings PPO Option

The Health Savings PPO (HSPPO) provides comprehensive health care coverage, both in-network and out-of-network, along with a Company contribution into a Health Savings Account for you.

BeneFlex 2014: Medical Plan Options and Prices

	Standard PPO		Health Savings PPO	
Health Savings Account Company Contribution	**None**		**$600 / Single; $1,200/ with dependents covered.** *You automatically receive a Company contribution into your personal Health Savings Account (HSA) on January 1. An HSA is a tax-free investment account. Use it to pay for your out-of-pocket health costs now or save it for future years.*	
Benefits for Preventive Care *Coverge follows the standard preventive care guidelines of the Patient Protection and Affordable Care Act. Includes 6 free EAP sessions per unique short-term counseling need.*	**In-Network:** 100%, no deductible.	**Out-of-Network:** 100% R&C, no deductible	**In-Network:** 100%, no deductible.	**Out-of-Network:** 100% R&C, no deductible
Annual Deductible - Medical and Prescription Expenses	$500 per individual up to $1,000 per family	$1,000 per individual up to $2,000 per family	$1,250 You Only or $2,500 with Dependents	$2,500 You Only or $4,000 with Dependents
Benefits for Sick Care:	**After Deductible:**		**After Deductible:**	
Office Visits *(Includes mental health counseling approved by ComPsych)*	**In-Network:** 80%	**Out-of-Network:** 60%	**In-Network:** 80%	**Out-of-Network:** 60%
Chiropractic Care, ($1,000 annual limit applies)	80%	60%	80%	60%
Labs/Xrays	80%	60%	80%	60%
Hospitalization/Surgery	80%	60%	80%	60%
Prescriptions: Retail: up to a 30-day supply Mail: up to a 90-day supply	**After Your Annual Deductible for all medications except those on the Express Scripts Preventive Medications List, You Pay:** Generic: No Charge Preferred Brand: 25% ($125 max.) Non-Preferred Brand: 45% ($125 max.) Retail Maintenance Rx: 45% (no max) (after 2 fills at retail)		**After Your Annual Deductible for all medications except those on the Express Scripts Preventive Medications List, You Pay:** Generic: No Charge Preferred Brand: 25% ($125 max.) Non-Preferred Brand: 45% ($125 max.) Retail Maintenance Rx: 45% (no max) (after 2 fills at retail)	
Out-of-Pocket Maximum (Stop Loss)	$3,000 per individual up to $6,000 per family	not applicable	$3,000 You Only or $6,000 with dependents	not applicable

The Health Savings PPO option is a managed-care option that covers the same medical services described in this SPD as the Standard PPO option, including preventive care and prescription drugs. A network of preferred providers, maintained by the carrier, supplies services in-network at negotiated rates. Out-of-network, benefits are based on reasonable and customary (R&C) amounts. You don't need to choose a Primary Care Physician (PCP), or receive referrals to see a specialist.

The HSPPO benefits are outlined on page 15. The benefit design includes:

- 100% benefits for preventive care;
- deductibles for in-network and out-of-network care, based on your coverage level;
- coinsurance for office visits, lab tests, surgery, hospitalization, medications and other non-preventive care; and
- a stop-loss to limit your out-of-pocket expenses for in-network care, based on your coverage level.

The HSPPO features deductible and stop-loss amounts that are based on your coverage level. All covered family members together must satisfy the amounts. For example, an employee with *Family*-level coverage has a combined deductible of $2,500 for all covered family members. The deductible can be satisfied by one individual or a combination of family members. The stop-loss works the same way.

The HSPPO qualifies as a high-deductible health plan, which allows participants to receive special tax savings that are not available to employees in the other BeneFlex Medical Care Plan options. Specifically, employees in the HSPPO receive a tax-favored Health Savings Account to go along with their BeneFlex Medical Care Plan coverage. The Company contributes to your HSA, providing you with money you can use to reimburse out-of-pocket health expenses, such as your medical or dental deductible and coinsurance amounts. You can also save the HSA and use it to pay for future out-of-pocket health care expenses for yourself and your tax dependents. Plus, you can reduce your taxable income by making your own HSA contributions. Details on the HSA are available in the BeneFlex annual enrollment communications. IRS rules governing HSAs may be found in IRS publication 969.

Because active employees participating in the Health Savings PPO receive an HSA contribution from DuPont, you must meet all of the following criteria set forth by the IRS in order to participate in this medical plan option:

– You cannot be covered by another medical plan that is not a qualifying high-deductible plan, either as an individual or as a participant. (Your covered dependents may have other medical coverage.)
– You cannot be enrolled in Medicare.
– Another individual cannot claim you as a tax dependent.

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

Standard PPO Option

The Standard PPO provides comprehensive health care coverage, in-network and out-of-network. The plan benefits are outlined on page 15. The benefit design includes:

- 100% benefits for preventive care;
- deductibles for in-network and out-of-network care;
- coinsurance for office visits, lab tests, surgery, hospitalization, medications and other non-preventive care; and
- a stop-loss to limit your out-of-pocket expenses for in-network care.

The Standard PPO option is a managed-care option that covers the same medical services described in this SPD as the Health Savings PPO option, including preventive care and prescription drugs. A network of preferred providers, maintained by the carrier, supply services in-network at negotiated rates. Out-of-network, benefits are based on reasonable and customary (R&C) amounts.

You don't need to choose a Primary Care Physician (PCP), or receive referrals to see a specialist.

The Standard PPO features individual and family deductible and stop-loss amounts. Because the deductible and stop-loss amounts are limited for any one family member, this plan may be attractive to families who have one person who requires high-cost medical care.

Here's how the individual and family deductible and stop-loss amounts work. The individual amounts are a subset of the family amounts. When one covered family member satisfies their individual deductible, they move into the coinsurance portion of the benefit. That same individual's deductible and coinsurance amounts go toward meeting their individual stop-loss. Once their individual stop-loss is satisfied, they receive 100% in-network benefits for the remainder of the year. (Note that a separate deductible and no stop-loss applies to out-of-network care.)

The individual deductible amounts of all covered family members apply toward satisfying the family deductible. Once the family deductible is met, no further individual deductibles apply for the remainder of the year. The stop-loss also has a family amount which works the same way; i.e., once the family stop-loss is met, all covered family members receive 100% in-network benefits for the remainder of the 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.

Alternative Coverage Option

This option is only available to employees in Hawaii, Puerto Rico, or on an international assignment as a U.S. Expatriate or Inpatriate.

If an Alternative Coverage option applies where you work or live, 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 Alternative Coverage, your prescription drug coverage is provided by the carrier. If you select Alternative Coverage, you may need to complete a separate enrollment form for the carrier in addition to making your BeneFlex change elections.

No Coverage Option

The No Coverage option provides only six free Employee Assistance Program visits 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, therapeutic procedures and activities, traction and electrical stimulation. Services must be medically necessary and "restorative" in nature. Charges for services specifically to maintain a level of well-being are not covered. Benefits are limited to a maximum of $1,000 per person per plan year.

- Christian Science facility — out-of-network only
  — Care must qualify as medically necessary, using the same standards applicable to other hospital care
- Durable medical equipment
- Emergency care (See page 20 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/partner'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 20 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 27 for more information.)
- Infertility services
  — the patient must be a covered female employee or a covered dependent wife/same-sex domestic partner and she must carry the embryo. The Plan does not cover the purchase of sperm.
  — the patient must have been unable to conceive following frequent, unprotected sexual intercourse with a fertile male partner or have received a minimum of six cycles of artificial insemination (or equivalent infertility treatment procedures such as IVF) without achieving conception during the 12 months preceding infertility treatment.
  — requires advance approval; extensive coverage limitations and exclusions including $15,000 lifetime maximum for infertility medical services and $10,000 lifetime maximum for infertility prescription drugs apply; 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 25 for more information.)
  - — hospital
  - — physician
  - — qualified, free-standing birthing centers
  - — newborn infant care
- Mental health care and chemical dependency care (See page 25 for more information.)
- Outpatient private-duty nursing
  - — 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/partner'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 27 for more information.)
- Prescription drugs (See pages 22-25 for more information.)
- Preventive care, as outlined on page 21
- 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 slowing 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 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.

Emergency care is covered at the in-network or out-of-network benefit level applicable to the facility and providers.

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.

DuPont medical plan participants are eligible for hospice care coverage when all of the following indications are met:

- The individual is terminally ill and expected to live six months or less, as certified by the patient's primary care physician;
- Potentially curative treatment for the terminal illness is not part of the prescribed plan of care;
- The individual or appointed designee has formally consented to hospice care (i.e., care which is directed mostly toward palliative care and symptom management); and
- The hospice services are provided by a certified/accredited hospice agency with a hospice nurse and doctor on-call 24 hours a day, 7 days a week.

Coverage is limited to care for acute symptom management and palliative care.
Examples of items not covered by the DuPont medical plan include:

- Inpatient hospice care that is primarily custodial in nature (including room and board charges for care in a nursing home, long-term-care center, skilled nursing facility, or similar facility) in lieu of home care, except for periods of pre-approved short-term respite care.
- Charges for home modifications (e.g., ramps, stair lifts, grab bars, etc.) or non-medical equipment items, or personal services (e.g., humidifiers, air conditioners, TV, meals, etc.).
- Services to primarily aid in the performance of activities of daily living, including home health aide services that are provided outside of the approved hospice treatment program.

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.

The Plan provides 100% benefits for covered preventive care services. No deductible or coinsurance applies.

At times, you may receive both preventive care and non-preventive care at the same time. For example, if you visit your doctor to treat back pain and you have not yet received a flu vaccine, your doctor may give you a flu shot during your office visit. The flu shot would be covered at 100%. However, the office visit would be subject to the benefit deductible and coinsurance.

Medically necessary preventive tests used to diagnose or treat an illness are covered at the standard medical benefit rate for your option. For example, a diagnostic mammogram for a 30-year-old woman would be subject to the deductible and coinsurance for her medical plan option. The diagnostic codes submitted with your claim are used to determine whether your care qualifies for preventive or non-preventive benefits.

Evidence-based preventive services:

The Plan covers services recommended by the U.S. Preventive Services Task Force. Age, gender and frequency limits apply. This broad list generally includes:

- Breast cancer and cervical cancer screenings
- Colon cancer screenings
- Screening for iron-deficiency anemia in pregnancy
- Screenings for diabetes, high cholesterol and high blood pressure

Routine vaccinations:

The Plan covers a list of immunizations recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention. They are considered routine preventive care for use with children, adolescents and adults, and range from childhood immunizations to periodic tetanus shots for adults.

Preventive care for children:

The Plan covers preventive care services for children following guidelines developed by the Health Resources and Services Administration with the American Academy of Pediatrics. Services include regular pediatrician visits, vision and hearing screening, developmental assessments, immunizations, and screening and counseling to address obesity.

Important Note: Covered tests, immunizations and exams vary by age and gender. Covered services and age-based frequencies are subject to change, based on national recommendations set forth by the U.S. Affordable Care Act. Contact your medical carrier for a list of preventive care services covered.

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, in the same or lower dosage,
- approved by the FDA, and
- not considered experimental/investigational in nature.

Contact Express Scripts 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 Express Scripts. You may have your prescription filled through a participating retail pharmacy or the mail service. Present your Express Scripts prescription drug ID card and your benefit is automatically calculated at the time of your purchase.

If you use a nonparticipating 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 Express Scripts. 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 nonparticipating pharmacy will be your responsibility.

The Medical Plan uses a 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. If your physician prescribes a non-formulary medication, Express Scripts will assist you in requesting your physician to prescribe a formulary medication.You may request a formulary exception from Express Scripts.Generally, a formulary exception will only be approved if the alternative medication on the formulary list would not be as effective in treating your condition and/or would cause you to have adverse medical effects.

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.

Contact Express Scripts at 1-800-793-8766 (or online at www.express-scripts.com) to get instructions on how to use the mail service program.

About brand-name drugs

Brand-name medications are categorized as follows:

- Preferred – These are drugs for which generic equivalents are not available. They have been on the market for a time and are widely accepted. Express Scripts has arranged a significant discount on these drugs. They usually cost more than generics, but less than non- preferred brand-name drugs.
- Non-Preferred – Generally, these are higher-cost medications that have recently come on the market. In most cases, an alternative preferred medication is available.

The Plan provides benefits of 25% for preferred or 45% for non-preferred brand-name medications, up to a $125-per-fill maximum, after the deductible. The deductible is waived for medications on the Express Scripts Preventive Medication List. Once the stop-loss is satisfied, benefits of 100% apply.

Additional information regarding brand-name drug benefits:

Many brand-name drugs are also available in generic form. If you buy a brand-name drug when there is a generic-equivalent medication to the brand-name drug available (even if your physician has written "dispense as written" or "no substitution allowed"), then you are responsible for payment of the difference between the cost of the two drugs plus the copay. If you are unable to take the generic-equivalent medication due to an allergy, etc., an appeal to Express Scripts would be required. Some brand-name medications have several lower-cost alternatives available that could save you money. However, the alternatives may not contain the same active ingredients as the brand-name drug. These drugs are not considered equivalent medications, and you will not be required to pay the difference in price between the brand-name medication and the lower-cost alternative.

- Maintenance medications are prescriptions that are taken over a long period of time with frequent refills. These drugs can be purchased at a lower cost through the Express Scripts By Mail service compared to retail pharmacies. To account for the higher retail drug costs, individuals electing to fill a prescription more than two (2) times at a retail pharmacy within a 180-day period will pay a greater share of the drug cost each time the drug is subsequently filled using a retail pharmacy. In addition, the prescription drug stop-loss does not apply to maintenance medications filled at a retail pharmacy.

About generic drugs

Generic medications are covered at 100% when purchased through Express Scripts. A deductible applies, unless the medication is listed on the Express Scripts Preventive Medications List.

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.

About preventive medications—no deductible applies

The Health Savings PPO and Standard PPO medical plan options provide benefits for covered preventive medications without having to satisfy the deductible. A list of preventive medications is available by contacting Express Scripts at 1-800-793-8766. Medications on the preventive list help prevent, treat and manage several health conditions as defined by the IRS. Coverage prior to the deductible being met may not be provided for every dosage form of a listed medication. Medications may be added to or removed from the list (based on review of clinical experts), depending on different factors, including the intended purpose of the medication and its availability. Coinsurance applies.

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.

Mail service home delivery program for Specialty Medications

Specialty medications are typically injectable medications administered either by you or a health care professional, and they often require special handling. These medications treat complex conditions, such as anemia, hepatitis C, multiple sclerosis, asthma, growth hormone deficiency, and rheumatoid arthritis. You can obtain these prescriptions through Accredo Health Group (1-800-793-8766), a subsidiary of Express Scripts.

Coverage Management Programs—These programs help ensure the appropriateness of coverage for specific drugs and specific amounts of drugs. The following programs are included under Coverage Management:

- Prior Authorization—Requires the member to obtain approval through a coverage review. A coverage review is performed to determine whether the use of the medication qualifies for coverage.
- Preferred Drug Step Therapy Program—Requires the member to use the generic or preferred brand before a non-preferred brand is covered. Selected non-preferred brands must undergo a coverage review and be approved before the non-preferred brand is covered.
- Qualification by history—For some medications, a set of rules, called Qualification by History, is implemented to determine if the member qualifies for coverage. By applying factors that are on file with Express Scripts®, such as the member's drug history, age or gender, Qualification by History rules can often eliminate the need for a coverage review. If the claim is rejected, a coverage review can be initiated.
- Dose Duration—Dose duration rules encourage appropriate dosing over the course of therapy. Coverage is determined based on drug history. A prescription that exceeds the dosage allowed within a given time period will require a coverage review.
- Quantity Duration—Quantity duration rules limit coverage for certain quantities of medications within a defined time period. A prescription that exceeds the quantity allowed will require a coverage review (if available) and approval in order to obtain the excess amount.
- Dispensing Quantity—Dispensing quantity rules allow up to a maximum quantity per copayment. A prescription that exceeds the quantity allowed per copayment will require a coverage review, or the member may pay another copayment for the additional medication.

- Dose Optimization—Dose optimization rules focus on switching those members currently taking two tablets or capsules a day to taking one a day of the higher strength. A coverage review is required (if available) to determine whether taking one tablet or capsule each day of the higher strength is right for the member.

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

The Employee Assistance Program

Employees and their covered dependents are eligible for six free Employee Assistance Program (EAP) counseling sessions through ComPsych, including those employees who elected No Coverage or Alternate Coverage. No deductible applies to the free EAP sessions. To schedule an EAP session, call ComPsych at 1-800-435-7266 or access the website at www.guidanceresources.com. If additional or more intensive mental health or chemical dependency care is required, the Medical Plan benefits apply.

Benefits for Other Treatment

Like all other non-preventive-care services covered by the Plan, expenses for the treatment of mental health and chemical dependency are subject to the deductible. Once the deductible is satisfied, the Plan provides 80% in-network and 60% out-of-network benefits until you reach the stop-loss and begin receiving 100% benefits in-network. Expenses for treatment of mental health/chemical dependency conditions are considered in-network only if pre-approved. Refer to page 26 for information on the precertification process.

Outpatient

To receive full benefits for mental health or chemical dependency treatment, call to precertify your treatment. No coverage is available for outpatient chemical dependency treatment received out-of-network.

Benefits vary by coverage option, as shown in the chart on page 15. Note that intensive outpatient treatment is considered an inpatient service for benefit purposes.

Inpatient

Inpatient benefits are provided for both mental health and chemical dependency treatment, when medically necessary. Emergency admissions for mental health or chemical dependency must be reported by calling within 48 hours or on the first business day following the admission. Employees with medical coverage administered by Highmark BCBS must call 1-888-431-4650. All other employees should call ComPsych at 1-800-435-7266.

No benefit will be paid for care that is not precertified. Refer to the benefits table on page 15 for further information on out-of-network benefits.

Precertification for mental health/chemical dependency treatment

Precertification applies to both in-network and out-of-network care. Precertification is required to receive mental health and chemical dependency treatment benefits.

You must contact your mental health/chemical dependency carrier before treatment in order to receive the in-network mental health/chemical dependency benefit. Your carrier provides assessment, evaluation and pre-authorization for mental health and chemical dependency treatment for you and your dependents. Your carrier will confidentially assess your situation and, if necessary, authorize treatment by a network provider who will meet your needs. By using in-network care through your carrier, you receive the highest level of coverage for these expenses.

If you choose not to use a provider authorized as in-network by your carrier, 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 if treatment was pre-approved.

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.

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 office visit 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.

Medical consultations performed by phone, mail, e-mail or similar methods

The Plan only covers physician care provided in an office setting. It does not cover charges for medical consultations performed by phone, mail, e-mail, or similar methods. Charges for these services will be considered expenses not covered by the Plan.

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. Participants must use a Center of Excellence designated by their medical carrier in order to receive in-network coverage for a human organ transplant and associated care. If your admission is approved in advance, the services performed will be paid based on your Medical Plan option benefits.

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 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, therapeutic procedures and activities, traction, and electrical stimulation
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 medically 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 puchase, including prescription medication available in the same or lower dosage over the counter
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, benefits not claimed, or payments not cashed 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 that are associated with injuries suffered due to the act or omission of a third party
40. charges that would not have been made had the patient not been covered under this Plan, or charges that 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
42. charges for the cost difference between a brand-name medication and its generic equivalent
43. charges for prescription vitamin and mineral products

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 nonparticipating 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 canceled 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)**. 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 43 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 the HR Service Center.
- Step 2: Provide additional written information to your medical carrier or, in the case of eligibility or enrollment, to the HR Service Center 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.

You may appeal adverse benefit determination on medical claims to DuPont and on prescription claims to Express Scripts. To appeal the denial, you should notify DuPont or Express Scripts 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 a response to your appeal within the following timeframes from when your appeal 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 decision on your appeal, the notice will provide the reason for the decision and the specific Plan provisions on which it is based. The Plan Administrator has full discretion and authority to interpret Plan provisions, resolve any ambiguities and evaluate claims. The decisions made on the appeal by the Plan Administrator are 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 refer the appeal of any adverse benefit determination (other than one involving eligibility) to an external Independent Review Organization for review. The external review will be conducted by an independent health care professional who has appropriate training and experience in the field of medicine involved.

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

Eligibility for retiree medical benefits varies based on your Company. In general, to be eligible for retiree medical coverage, you need to have been hired prior to the date specified in your Company's plan and meet minimum age and/or service requirements. To find out if you are eligible for retiree medical, contact your HR Service Center.

If you are eligible for your Company's retiree medical coverage, you may elect to enroll in either your retiree medical plan or COBRA continuation coverage in the BeneFlex Medical Care Plan, but not both. Electing COBRA instead of retiree medical may permanently and irrevocably end your right to retiree medical plan coverage. Therefore, it is important to discuss your options with the HR Service Center. If you do nothing, the HR Service Center will automatically enroll you in retiree medical coverage at the same coverage level (You only, You plus spouse/partner, You plus child[ren], 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 the HR Service Center. Upon turning age 65 or becoming eligible for Medicare before age 65 due to a disability other than End-Stage Renal Disease, your medical coverage will be replaced by a Health Reimbursement Arrangement account. (Refer to your Company's retiree medical plan summary for details.)

If you are terminated due to lack of work

If your employment with the Company is terminated due to lack of work, you will be eligible for COBRA continuation coverage in the BeneFlex Medical Care Plan. Employees who are eligible for retiree medical coverage may elect either COBRA or retiree medical, as described in the previous section titled "*If you retire*." Depending on your Company, you may receive a subsidy for your COBRA or retiree medical coverage premium. Contact your HR Service Center for details.

If you die

COBRA continuation coverage is available for your covered dependents for up to 36 months following your death. In addition, medical coverage may be available through your Company's retiree medical plan. Contact your HR Service Center for details.

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.

What is COBRA continuation coverage?

COBRA continuation coverage is a continuation of Plan coverage when coverage would otherwise end because of a life event known as a "qualifying event." Specific qualifying events are listed later in this section. After a qualifying event, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." You, your spouse and your dependent children could become qualified beneficiaries if coverage under the Plan is lost because of the qualifying event. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

If you are an employee, you will become a qualified beneficiary if you lose your coverage under the Plan because either one of the following qualifying events happens:

- Your hours of employment are reduced, or
- Your employment ends for any reason other than your gross misconduct.

If you are the spouse of an employee, you will become a qualified beneficiary if you lose your coverage under the Plan because any of the following qualifying events happens:

- Your spouse dies;
- Your spouse's hours of employment are reduced;
- Your spouse's employment ends for any reason other than his or her gross misconduct;
- Your spouse becomes entitled to Medicare benefits (under Part A, Part B or both); or
- You become divorced or legally separated from your spouse.

Your dependent children will become qualified beneficiaries if they lose coverage under the Plan because any of the following qualifying events happens:

- The parent-employee dies;
- The parent-employee's hours of employment are reduced;
- The parent-employee's employment ends for any reason other than his or her gross misconduct;
- The parent-employee becomes entitled to Medicare benefits (Part A, Part B or both);
- The parents become divorced or legally separated; or
- The child stops being eligible for coverage under the Plan as a "dependent child."

Sometimes, filing a proceeding in bankruptcy under Title 11 of the United States Code can be a qualifying event. If a proceeding in bankruptcy is filed with respect to the Company and that bankruptcy results in the loss of coverage of any retired employee covered under the Plan, the retired employee will become a qualified beneficiary with respect to the bankruptcy. The retired employee's spouse, surviving spouse and dependent children will also become qualified beneficiaries if bankruptcy results in the loss of their coverage under the Plan.

When is COBRA coverage available?

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred. When the qualifying event is the end of employment or reduction of hours of employment, death of the employee, commencement of a proceeding in bankruptcy with respect to the employer or the employee's becoming entitled to Medicare benefits (under Part A, Part B or both), the employer must notify the Plan Administrator of the qualifying event.

You must give notice of some qualifying events

For the other qualifying events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), you must notify the Plan Administrator within 60 days after the qualifying event occurs. You must provide this notice to the HR Service Center.

How is COBRA coverage provided?

Once the Plan Administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered employees may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation coverage on behalf of their children.

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 elects 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.

COBRA continuation coverage is a temporary continuation of coverage. When the qualifying event is the death of the employee, the employee's becoming entitled to Medicare benefits (under Part A, Part B or both), your divorce or legal separation or a dependent child's losing eligibility as a dependent child, COBRA continuation coverage lasts for up to a total of 36 months. When the qualifying event is the end of employment or reduction of the employee's hours of employment, and the employee became entitled to Medicare benefits less than 18 months before the qualifying event, COBRA continuation coverage for qualified beneficiaries other than the employee lasts until 36 months after the date of Medicare

Length of COBRA coverage	Reason coverage stops
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

entitlement. For example, if a covered employee becomes entitled to Medicare eight months before the date on which his employment terminates, COBRA continuation coverage for his spouse and children can last up to 36 months after the date of Medicare entitlement, which is equal to 28 months after the date of the qualifying event (36 months minus 8 months). Otherwise, when the qualifying event is the end of employment or reduction of the employee's hours of employment, COBRA continuation coverage generally lasts for only up to a total of 18 months. There are two ways in which this 18-month period of COBRA coverage can be extended.

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.

Disability extension of 18-month period of continuation coverage

If you or anyone in your family covered under the Plan is determined by the Social Security Administration to be disabled and you notify the Plan Administrator in a timely fashion, you and your entire family may be entitled to receive up to an additional 11 months of COBRA continuation coverage, for a total maximum of 29 months. The disability would have to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of continuation coverage. You must notify the HR Service Center within 60 days of the determination. The notice must be received by the HR Service Center within the initial 18 months of COBRA.

Second qualifying event extension of 18-month period of continuation coverage

If your family experiences another qualifying event while receiving 18 months of COBRA continuation coverage, the spouse and dependent children in your family can get up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if notice of the second qualifying event is properly given to the Plan. This extension may be available to the spouse and any dependent children receiving continuation coverage if the employee or former employee dies, becomes entitled to Medicare

benefits (under Part A, Part B or both), or gets divorced or legally separated, or if the dependent child stops being eligible under the Plan as a dependent child, but only if the event would have caused the spouse or dependent child to lose coverage under the Plan had the first qualifying event not occurred.

If you have questions

Questions concerning your Plan or your COBRA continuation coverage rights should be addressed to the HR Service Center. For more information about your rights under ERISA, including COBRA, the Health Insurance Portability and Accountability Act (HIPAA) and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit the EBSA website at www.dol.gov/ebsa. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.)

Keep your Plan informed of address changes

In order to protect your family's rights, you should keep the Plan Administrator informed of any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Plan Administrator. To report an address change, contact the HR Service Center.

HIPAA certification

The Health Insurance Portability and 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 the HR Service Center 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 Act of 1974 (**ERISA**).

Qualified Medical Child Support Order (QMCSO)

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.

The Medical Plan does not allow a participant to assign his/her right to appeal a benefit determination. All appeals must be filed directly by the participant.

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, 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

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:

- Aetna, Inc.—High Point, NC, 1-800-445-7175
- CIGNA—Columbus, OH, 1-800-203-1742
- Independent Health—Buffalo, NY, 1-800-257-2753
- HighMark BCBS – Wilmington, DE, 1-888-431-4650
- Aetna International, 1-888-212-3689
- HMSA Blue Cross Blue Shield of Hawaii, 1-808-948-6111
- Triple S, Puerto Rico, 1-877-357-9777

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

Pharmacy Network

Express Scripts
Phone: 1-800-793-8766

Mental Health and Chemical Dependency (MH/CD) Network

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

MH/CD Administrator for employees:

- For DuPont employees: ComPsych—1-800-435-7266
- For Legal Entity employees: Highmark BCBS—1-888-431-4650

CONTACTS

For Appealing a Claim

DuPont Human Resources—Employee Benefits Appeals D-6150
1007 Market Street
Wilmington, DE 19898

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.

- Aetna, Inc.—High Point, NC, 1-800-445-7175
- CIGNA—Columbus, OH, 1-800-203-1742
- Independent Health—Buffalo, NY, 1-800-257-2753
- HighMark BCBS—Wilmington, DE, 1-888-431-4650
- Aetna International, 1-888-212-3689
- HMSA Blue Cross Blue Shield of Hawaii, 1-808-948-6111
- Triple S, Puerto Rico, 1-877-357-9777

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:

- For DuPont employees: ComPsych—1-800-435-7266
- For Legal Entity employees: Highmark BCBS—1-888-431-4650

Prescription Program

Express Scripts
Phone: 1-800-793-8766
http://www.express-scripts.com

For COBRA Coverage

For COBRA coverage, contact the HR Service Center.

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 help you better 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 benefits 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
All references to "the Company" in this document pertain to the specific company that employs you.

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 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.

Full-service Employee
Any person designated by the Company as a full-time employee.

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 benefits 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 benefits 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.

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.

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