YOUR BENEFIT SUMMARY

BeneFlex Employee Health, Insurance, and Other Benefits

September 2018

About this Summary

This Summary Plan Description (SPD) provides a concise description of the following Company Plans (the Plans):

- *The BeneFlex Medical Care Plan*
- *The BeneFlex Dental Care Plan*
- *The BeneFlex Vision Care Plan*
- *The BeneFlex Health Care Limited Purpose Flexible Spending Account*
- *The BeneFlex Dependent Care Flexible Spending Account*
- *The BeneFlex Employee Life Insurance Plan, which includes:*
  - *The BeneFlex Dependent Life Insurance Plan*
  - *The BeneFlex Accidental Death Insurance Plan*

These plans and programs are offered through the BeneFlex Flexible Benefits Plan, a "cafeteria plan", which enables you to pay the cost of some of these plans on a pre-tax basis.

This SPD is intended to help you understand your benefits, how the Plans operate, how to file claims, and your rights and responsibilities as a participant. While this SPD contains detailed and important information about your benefits, we've tried to make it clear and easy to understand.

To receive benefits, you will need to satisfy the requirements that are described in this summary.

The summary does not describe every feature in the Plans, and it is not intended to be a full statement of the official plan documents. In the event of a discrepancy between this SPD and the official plan documents, the applicable official plan document(s) will govern and the Plan Administrator has the full discretion to interpret those documents.

While the Company intends to continue the Plans and programs described in this summary, the Company reserves the right to change, modify or discontinue the Plans and any component of the Plans at its discretion at any time.

This summary does not constitute a contract of employment or guarantee any particular benefit.

See the Defined Terms *section on page 108 for the meanings of certain capitalized terms used in this summary.*

YOUR SUMMARY PLAN DESCRIPTION

BeneFlex Employee Health, Insurance, and Other Benefits

SEPTEMBER 2018

DuPont's health and insurance benefits for active employees offer comprehensive and robust programs to keep you healthy, save you money, and protect you and your family. The Company pays the majority of the cost for many of these benefits.

With BeneFlex, you can select from a broad range of benefit plan options and change your elections every year.

CONTENTS AT A GLANCE

Eligibility and Enrollment

The Plans described in this summary generally have the same rules covering participation. Where differences exist, they are noted in this section. Certain rules and processes only cover some plans, such as naming a beneficiary when you enroll for life insurance.

When Coverage Ends (and How Some Coverage Can Continue)

For details about when coverage ends, including some cases where you can continue or convert your Company coverage, see "When Coverage Ends" on page 102.

Questions?

If you have questions about the rules for eligibility and how to enroll, contact DuPont Connection at 1-800-775-5955.

SECTION CONTENTS

Who Is Eligible?

You are eligible if you are a Regular Employee of the Company.

If you are an employee in a bargaining unit represented by a union for collective bargaining, you will not be eligible unless and until the site manager has authorized the benefit, collective bargaining on the coverage has taken place, and any requisite obligations thereunder have been fulfilled.

Employees who are on temporary assignment in the U.S. are eligible only for the BeneFlex Medical Plan (with Dental coverage), not for the entire suite of BeneFlex Plans.

Eligible Dependents for Health Plans

For the medical, dental, and vision plans, you may cover:

- your legal spouse.
- your children who meet these criteria:
  - The child is either:
    - your biological child;
    - your stepchild from your current marriage;
    - your adopted child (including a child legally placed with you for adoption);
    - your foster child; or
    - your ward, where you are the court-appointed legal guardian.
  - The child also meets one of the following criteria:
    - Under age 26 (eligibility ends at the end of the month in which the child's 26th birthday occurs); or
    - Age 26 or older, provided that:
      - the child was certified as disabled by the medical Plan Claims Administrator before the child's 26th birthday and continues to be disabled. You will be required to periodically substantiate your dependent's continued eligibility by submitting documentation as requested by the Claims Administrator; and
      - you claim the child as your dependent on your federal income tax return.

If Your Spouse Is Eligible for Other Medical Coverage

If your spouse is eligible for medical coverage through their employer and their out-of-pocket individual premium cost for the lowest-priced coverage available is less than $100 per month, they must elect primary coverage through their employer. Spouse coverage under the BeneFlex Medical Plan will be secondary.

Note that grandchildren and stepchildren from a former marriage are not eligible for coverage unless you are the court-appointed legal guardian, even if they are your federal tax dependents. Also, former spouses and your spouse if you are legally separated are not eligible for coverage, even if you are ordered by the court to provide coverage.

Dependent coverage is not automatic, even if the dependent is eligible. When you enroll, you must specify the dependents you are covering, otherwise, they will not be covered. The Plans may require you to provide proof of dependents' eligibility (such as a birth certificate or marriage certificate).

You must notify DuPont Connection at 1-800-775-5955 if an enrolled dependent is no longer eligible. Your dependent may 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.

If Both You and Your Spouse Are Eligible for Coverage

If both you and your spouse are eligible for the Plans as Company employees, retirees or COBRA participants, you can cover your spouse as a dependent, or your spouse can elect separate employee coverage. You or your spouse can't be covered as both an employee and a dependent under the medical, dental, and vision plans.

Your Children

If both you and your spouse are eligible for the Plans as Company employees, retirees or COBRA participants, only one of you can cover your eligible child as a dependent under the Plan. You can't both cover your child at the same time.

QUALIFIED MEDICAL CHILD SUPPORT ORDERS

If a court order requires that you provide medical coverage for your children, your children are eligible if they meet the criteria described above.

The court order must meet the requirements of a Qualified Medical Child Support Order (QMCSO) and must be approved by the DuPont Legal Department or its designee. For a copy of the QMCSO procedure, contact the Plan Administrator or DuPont Connection at 1-800-775-5955.

Eligible Dependents for the Health Care Limited Purpose Flexible Spending Account (FSA) and the Dependent Care FSA

You don't enroll dependents for the Health Care Limited Purpose FSA and the Dependent Care FSA. You can use the accounts for your eligible federal tax dependents' qualifying expenses. For detail on whose expenses are eligible, see:

- "Whose Expenses Are Eligible?" on page 64 in the *BeneFlex Health Care Limited Purpose FSA* section, and
- "Whose Expenses Are Eligible?" on page 70 in the *BeneFlex Dependent Care FSA* section.

Eligible Dependents for Life and Accident Insurance

The Dependent Life Insurance Plan and the Accidental Death Insurance Plan give you the option to cover your legal spouse and your children up to age 26. Dependent children over age 26 are not covered, even if they have been certified as disabled. You may cover:

- your legal spouse.
- your children under age 26 who meet these criteria:
  - The child is either:
    - your biological child;
    - your stepchild from your current marriage;
    - your adopted child (including a child legally placed with you for adoption);
    - your foster child; or
    - your ward, where you are the court-appointed legal guardian.

For this benefit, child eligibility ends at the end of the month in which the child's 26th birthday occurs (even if the child has been certified as disabled for medical coverage).

Note that grandchildren and stepchildren from a former marriage are not eligible for coverage unless you are the court-appointed legal guardian, even if they are your federal tax dependents. Also, former spouses and your spouse if you are legally separated are not eligible for coverage, even if you are ordered by the court to provide coverage.

Evidence of Insurability

The BeneFlex Employee Life Insurance Plan and the BeneFlex Dependent Life Insurance Plan may require evidence of insurability (proof of your good health) before coverage takes effect for you and/or your spouse. (No evidence of insurability is required to cover your children.)

The requirement for evidence depends on when you enroll and how much coverage you apply for. If evidence is required, you will have to answer questions about your health, and you may have to have a paramedical exam (vital statistics, blood test, etc.) or provide a physician's statement to prove your insurability to the insurance company. If a paramedical exam is required, the cost will be covered by the insurance carrier.

You are required to provide acceptable Evidence of Insurability to the insurance company if:

- You are a newly eligible employee and you apply for more than three times of your Pay in total life insurance coverage for yourself.
- You are an existing employee applying to increase the amount of your coverage for yourself. The requirement for evidence is not waived for changes during Annual Enrollment or after a Qualifying Life Event.
- You apply for more than $10,000 in coverage for your spouse at your initial eligibility.
- You apply for an increase in coverage for your spouse after your initial eligibility (including adding coverage for a spouse if you previously declined coverage for).

Once you provide evidence of insurability and the insurance carrier has approved it, the increase in coverage will be effective the first day of the month following the approval.

Evidence of Insurability is not required to enroll or make changes to your BeneFlex Accidental Death Insurance Plan coverage amount.

Dependent Verification

The Company is committed to following Plan requirements and managing the cost of our health plans (Medical, Dental and Vision) by ensuring only eligible dependents are enrolled. For newly enrolled dependents, you will be asked to provide proof of eligibility (such as, a birth or marriage certificate, proof of shared finances, etc.). Ineligible dependents will be dropped from your coverage. The Company also reserves the right to verify eligibility periodically after the initial enrollment.

How to Enroll

There are three times when you can enroll for coverage or change your participation:

- when you first become eligible (generally as a newly hired, or rehired, employee);
- during the BeneFlex Annual Enrollment period, each fall; and
- if you have a Qualifying Life Event.

See "Changing Your Coverage" on page 10 for information about changes after Qualifying Life Events.

Newly Eligible Participants

DuPont Connection will mail an election kit to your home address when you are hired or rehired as a benefits-eligible employee, or when you become eligible if you are an existing employee who was not previously eligible. If you do not receive your enrollment kit promptly, please call DuPont Connection at 1-800-775-5955.

The kit will explain how to enroll. **The deadline to submit your benefit elections is 31 days from the date printed in your enrollment kit showing when the kit was mailed to you.** If you enroll within 31 days, the effective date for medical, dental and vision coverage is the date you became eligible for benefits (which is your date of hire if you are a new employee). See "When Coverage Begins" on page 9.

DEFAULT COVERAGE FOR NEWLY ELIGIBLE PARTICIPANTS

If you don't submit enrollment instructions, you will be automatically enrolled for:

- Medical—"you only" coverage in the Core Option
- Dental—"you only" coverage in the Standard Option
- Employee Life Insurance – basic coverage equal to one times your Pay
- Accidental Death Insurance – basic coverage equal to one times your Pay

Default coverage does not include the following:

- Vision
- Health Savings Account—no Company or employee contributions
- Health Care Limited Purpose FSA
- Dependent Care FSA
- Dependent Life Insurance

You will not have any coverage for your dependents.

In Hawaii or Puerto Rico, or on International Assignment?

If you live in Hawaii or Puerto Rico or are on international assignment, the default medical coverage if you do not enroll will be "You Only":

- *In Hawaii, HMSA*
- *In Puerto Rico, Triple S*
- *If on international assignment, Aetna International (for medical and dental)*

Annual Enrollment

During the Annual Enrollment period, you can make changes such as enrolling for coverage that you did not take before, or changing your coverage option, or adding new dependents, or dropping coverage.

DEFAULT ELECTIONS FOR ANNUAL ENROLLMENT

If you don't fully complete the enrollment process during Annual Enrollment, your coverage will be continued with the same options, the same levels of coverage, the same dependents, and the same Health Savings Account and flexible spending account contributions wherever possible, unless the Annual Enrollment materials specifically require a new enrollment for that year. After you enroll, review your Confirmation of Enrollment (available through DuPont Connection) prior to the end of the Annual Enrollment period to make sure your elected coverage is accurately recorded.

Naming a Beneficiary

When you enroll for life or accidental death insurance, you will need to name a beneficiary—the person or persons who receive benefits in case of your death. While your beneficiary designations carry forward from year to year, it's a good idea to review your beneficiary designation each year during the Annual Enrollment period to ensure the information is up to date. For details on this and on what happens if you don't name a beneficiary, see:

- "Naming a Beneficiary" on page 77 in the *BeneFlex Employee Life Insurance* section; and
- "Naming a Beneficiary" on page 89 in the *BeneFlex Accidental Death Insurance Plan* section.

Paying for Coverage

The Company pays the majority of the cost for many of the BeneFlex Plans.

For the benefits where you pay premiums, you pay your share through payroll deductions, whenever possible.

For most of the benefits, to help lower your cost, your premiums are deducted before any federal, and most state and local, taxes are withheld (except where not permitted by law). This saves you money because it reduces your taxable income, which reduces your income tax liability.

After-Tax Premiums for Dependent Life, Supplemental Employee Life, and Voluntary Accidental Death Insurance Options

If you enroll in Dependent Life, Supplemental Employee Life, and/or Voluntary Accidental Death insurance, your premiums will be paid through payroll deductions, but will be on an after-tax basis, deducted after all taxes have been withheld.

Paying Premiums When On an Unpaid Leave of Absence

If you are on an unpaid leave of absence, you must pay the premiums for your coverage directly, instead of through payroll deductions. DuPont Connection will coordinate the payment process with you while you are on leave.

When Coverage Begins

The date when coverage begins (or when changes in existing coverage take effect) depends on when you make your enrollment elections.

Newly Eligible Participants

As a newly eligible participant, your coverage becomes effective as shown on the chart below.

BeneFlex Plan	Effective Date for Newly Eligible Participants
▪ Medical, Dental and Vision	Default coverage begins on the date you become eligible. You are defaulted to you only medical and dental coverage. You will not have vision coverage. If you enroll within 31 days, the coverage you elect for you and your dependents is retroactive to the date you became eligible (e.g. your date of hire).
▪ Flexible Spending Accounts (FSAs), and Accidental Death Insurance	If you enroll within 31 days, coverage begins the first of the month following your enrollment.
▪ Employee and Dependent Life Insurance	Default coverage for you only begins on the date you become eligible. If you enroll within 31 days, the coverage you elect for you and your dependents begins on the later of: ▪ the first of the month following your enrollment; or ▪ the first of the month following the date the insurance company approves your coverage when evidence of insurability is required.

Any required payroll contributions will generally be retroactive to the first full pay period coincident with or following your coverage effective date.

Annual Enrollment

The Company normally conducts Annual Enrollment during the fall of each year. Any election changes made during Annual Enrollment will become effective as of January 1 of the following year. For example, if you make changes during Annual Enrollment in the fall of 2018, those changes are effective on January 1, 2019.

Changing Your Coverage

In most situations, you cannot change your coverage during the year, except as part of the Annual Enrollment process. The cases where you can make changes are when you have a Qualifying Life Event, such as if:

- You get married, divorced, or legally separated.
- You have or adopt a child, or otherwise gain a new eligible dependent.
- Your eligible dependent becomes ineligible (such as if a child reaches age 26 or you experience a divorce or legal separation).
- Your spouse starts a new job or becomes unemployed.
- Your spouse's employment changes in a way that affects their eligibility for benefits (such as changing from part-time to full-time).
- Your spouse takes an unpaid leave of absence.
- Your spouse's employer's medical coverage changes significantly.
- You move and are no longer in the same service area for one of the plan's network coverage.
- Your spouse or dependent child dies.
- For the Dependent Care FSA, you change caregivers or your caregiver has a significant change in costs.

When Eligibility Ends

When a dependent becomes ineligible, their coverage ends on the last day of the month in which they became ineligible. If a Company plan pays benefits for an ineligible dependent, you are responsible for reimbursing the Company for the benefits.

Any changes you make to your Company benefits must be consistent with and because of the Qualifying Life Event, and not changes made just for financial reasons.

When you make changes because of a Qualifying Life Event, you must make all the changes related to that event at the same time.

When the Change Is Effective

If you have a Qualifying Life Event and change your BeneFlex elections within 31 days of the Event, your change will be effective retroactive to the date of the event (unless evidence of insurability is required).

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

HIPAA Special Enrollment Rules

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance coverage, you may in the future be able to enroll yourself and your dependents in this Plan if you lose eligibility, provided that you request enrollment within 31 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 31 days after the marriage, birth, adoption or placement for adoption.

What Happens If …

You Become Eligible for Medicare or Reach Age 65

Medicare is the U.S. national health insurance program administered by the federal government. Medicare coverage generally begins upon reaching age 65. However, you can also qualify for Medicare because you are disabled or if you are diagnosed with End-Stage Renal Disease.

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 (ESRD). (See "Medicare Eligibility Due to End-Stage Renal Disease Diagnosis" on page 11, below, for details.)

Enrolling in Medicare is optional for active employees. Most people must pay premiums for Medicare. If you or a dependent covered under a Company medical plan is eligible for Medicare and you decide to waive Medicare coverage for yourself or your covered dependent, be sure to contact the Social Security Administration and sign up for Medicare when you retire or otherwise end your employment with the Company (you should contact Medicare prior to your retirement).

When Coverage Ends (and How Some Coverage Can Continue)

For details about when coverage ends, including some cases where you can continue or convert your Company coverage, see "When Coverage Ends" on page 102.

Please note that your enrollment in Medicare (as an active employee) will make you ineligible to contribute to (or receive Company contributions towards) a Health Savings Account (HSA). This includes Medicare Part A, which Medicare may automatically enroll you in when you reach age 65. You should discuss your Medicare enrollment options with the Social Security Administration at least three months prior to your Medicare eligibility.

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.

MEDICARE ELIGIBILITY DUE TO END-STAGE RENAL DISEASE DIAGNOSIS

If you or your covered dependent are eligible for Medicare solely because of ESRD and are not eligible for Medicare because 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.

You Become Ineligible

If you become ineligible, any coverage under the plans described in this summary will end for you and your covered dependents on the last day of the month in which you become ineligible.

A Covered Dependent Becomes Ineligible

If a covered dependent becomes ineligible (such as if a dependent child reaches age 26 or you become divorced), any coverage under the plans described in this summary will end for that participant on the last day of the month in which the participant becomes ineligible.

You must promptly notify DuPont Connection at 1-800-775-5955 if an enrolled dependent no longer meets the Plan's definition of an eligible 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.
- If a Company plan pays any benefits while your dependent was ineligible, the Plan Administrator may take action to recover the value of the benefits provided while the dependent was ineligible.

You or a Dependent's Other Employer Coverage Ends or Changes

If you or your spouse has coverage from another employer's plan and that coverage ends or changes significantly, you may change your coverage elections based on the Qualifying Life Event. See "Changing Your Coverage" on page 10.

You Go On Leave

Your Company coverage continues while you are on an approved leave of absence, with the exception of your Dependent Care FSA (if applicable) which is stopped.

- If your leave of absence is paid, premiums will be deducted from your pay during the leave as usual.
- If your leave of absence is unpaid, you will have to pay premiums for your coverage directly. DuPont Connection will coordinate the payment process with you once your leave begins. Your Dependent Care FSA contributions (if applicable) will be suspended during your unpaid leave and your payroll deductions will be adjusted accordingly when you return.

You Retire

If you retire or leave the Company for any reason and are no longer eligible for coverage, your Company coverage ends on the last day of the month in which you leave and your eligibility ends. At that time, you may be eligible for COBRA continuation coverage.

When you retire, you may be eligible for retiree medical, dental, and life insurance benefits. The requirements vary based on your Company. In general, you must have been hired or rehired before the date specified in your Company's plan and must meet age and/or service requirements. To find out if you are eligible for retiree medical and or dental coverage, contact DuPont Connection. For more information about the Company's retiree medical, dental, and life insurance coverage, see the separate summaries: *Retiree Medical and Dental Benefits*, and *Life Insurance Benefit for Retirees, LTD Participants, and All Participants with NCGLI/CGLI Coverages*.

If you are eligible for your Company's retiree medical and/or dental coverage, you can either:

- enroll in the Company retiree plan; or
- enroll for COBRA continuation coverage in the BeneFlex Medical Care Plan and/or the BeneFlex Dental Care Plan.

You can't enroll for both Company retiree plan and COBRA continuation coverage.

If you enroll for COBRA coverage instead of retiree plan coverage, you will lose your eligibility for retiree coverage. Be sure to understand your options and consult with a financial advisor. You can also discuss with DuPont Connection.

If you do not submit instructions when you retire and you are eligible for medical and/or dental coverage as a pre-Medicare retiree, DuPont Connection will automatically enroll you in the retiree medical and/or dental coverage at the same coverage level you had as an active employee. If you want to change your coverage or decline coverage, do so by calling DuPont Connection within 31 days of retirement.

If you are an eligible retiree when you reach age 65, or become eligible for Medicare because of a disability other than End-Stage Renal Disease, your medical coverage will change, depending on the coverage provided by your Company. See the separate summary, *DuPont Retiree Medical and Dental Coverage*.

You Resign

If you resign or leave the Company for any reason and are no longer eligible for coverage, your Company coverage ends on the last day of the month in which you leave and your eligibility ends. At that time, you may be eligible for COBRA continuation coverage.

You Are Terminated Due to Lack of Work

If your employment with the Company is terminated due to lack of work, you may be eligible for benefits through the Career Transition Program. The Program includes either:

- COBRA continuation coverage; or
- the retiree coverage described above under "You Retire" on page 12.

The Company currently subsidizes your medical and dental coverage premium for most coverage options (excluding the dental "High" option) so that you pay the active employee premium rates.

- The subsidized coverage will last for one month for every two years of service, subject to the following limits:
  - The minimum subsidy period is six months.
  - The maximum subsidy period is 12 months.

The premium subsidy does not apply to Medicare-eligible retirees or their covered dependents who are eligible to receive a Health Reimbursement Arrangement account from the Company. For more information, contact DuPont Connection.

You Die

If you die, your coverage ends on the date of your death.

Coverage for your covered dependents will end at the end of the month of your death. They may be eligible for COBRA continuation coverage for up to 36 months after your death.

In addition, medical coverage for your survivors may be available through your Company's retiree medical plan. Contact DuPont Connection for details.

Your Decision to Waive Retiree Coverage Cannot Be Changed

If you decline retiree coverage for yourself or your dependents, you cannot later enroll in the Medical or Dental Care Assistance Program unless you lose eligibility for coverage under another employer or a government plan. Loss of coverage cannot be because of nonpayment of premiums.

BeneFlex Medical Care Plan

The Company's medical coverage encourages preventive care, promotes overall wellness, and protects you from the high cost of medical and prescription drug expenses.

Most employees in the mainland U.S. choose between two options—the Core Option and the Premium Saver Option. Employees in Hawaii and Puerto Rico and employees on international assignment have other options, called Alternative Coverage. The options available to you will be listed in your personalized enrollment materials.

Questions?
If you have questions about your coverage that are not answered here, contact the carrier for the plan you are enrolled in. See the Contacts *section, on page 116.*

SECTION CONTENTS

Highlights

The Company provides U.S. mainland employees with two medical options: the Core and Premium Saver Options. An outline of these options is shown below. Read the full summary for more details.

Special plan options apply to employees in Hawaii, Puerto Rico and on international assignment. The options available will be listed in your personalized enrollment materials.

	Core Option		**Premium Saver Option**	
Medical Care Benefits	***In Network***	***Out-of-Network***	***In Network***	***Out-of-Network***
HSA Company Contribution for qualifying employees	$600 for you only coverage, or $1,200 for other coverage levels		$600 for you only coverage, or $1,200 for other coverage levels	
Deductible (annual amount, combined for medical and prescription drug claims)	$1,400 for you only coverage	$2,500 for you only coverage	$2,800 for you only coverage	$3,500 for you only coverage
	$2,800 for other coverage levels	$4,000 for other coverage levels	$5,600 for other coverage levels	$6,000 for other coverage levels
Preventive Care (see your medical carrier for a list of covered services)	100% paid, no deductible	100% paid based on R&C, no deductible	100% paid, no deductible	100% paid based on R&C, no deductible
Coinsurance for medical services ▪ Office visits ▪ Mental health care ▪ Chiropractic care ($1,000 annual limit) ▪ Labs and X-Rays ▪ Hospitalization ▪ Surgery	You pay 20% after deductible	You pay 40% after deductible	You pay 20% after deductible	You pay 40% after deductible
Prescription Cost Sharing ▪ The deductible is waived for medications on the preventive medication list (see "Preventive Medications" on page 34) ▪ Retail benefits apply to a single fill up to a 30-day supply; ▪ Mail-Order benefits apply to a single fill of up to a 90-day supply. ▪ Additional information regarding prescription drugs appears under "Prescription Drugs" on page 32.				
Generic	No charge after deductible		No charge after deductible	
Brand Formulary (Preferred)	You pay 25% after deductible; $125 maximum* per fill		You pay 25% after deductible; $125 maximum* per fill	
Brand Non-Formulary (Non-Preferred)	You pay 45% after deductible; $250 maximum* per fill		You pay 45% after deductible; $250 maximum* per fill	
Maintenance medications after second fill at retail pharmacies	You pay 45% after deductible; no maximum		You pay 45% after deductible; no maximum	
Out of Pocket Maximum (annual amount, combined for medical and prescription drug claims)				
▪ Each Person	$5,000	No limit	$6,000	No limit
▪ All Covered Family Members Combined	$10,000	No limit	$12,000	No limit

* Rx maximum coinsurance amounts are per prescription

Are You Eligible for the HSA?

The IRS allows you to participate in the HSA if you are covered by the Core or Premium Saver Option as your only source of medical and prescription drug coverage. Employees with other coverage, such as through a spouse or Medicare, may not be eligible. See "Who Is Eligible?" On page 42 for details.

Your Medical Care Plan Options

In the mainland U.S., you can choose between two options:

- Core Option
- Premium Saver Option

You also have the option to waive coverage.

Claims administration and preferred provider networks vary based on where you live.

- The medical Claims Administrators include Aetna and Highmark BCBS (administrator determined by zip code of residence).
- Prescription drug claims are administered through Express Scripts.
- Mental health and chemical dependency coverage is administered through ComPsych.

Working Spouse Rule

To be covered as a spouse under the BeneFlex Medical Plan, working spouses must take their own employer's health coverage as primary if it is available for less than $100 per month. Spouse coverage under the BeneFlex Plan, if they are enrolled, will be secondary.

ALTERNATIVE COVERAGE OPTIONS—HAWAII, PUERTO RICO, AND INTERNATIONAL ASSIGNMENTS

If you are an employee in Hawaii, Puerto Rico, or on an international assignment, Alternative Coverage options are available to you, such as the:

- International PPO, provided through Aetna International
- Hawaii PPO (HMSA)
- Puerto Rico PPO (Triple S).

The options available will be listed in your personalized enrollment materials. For an overview of these options, please see "Alternative Coverage Highlights" on page 39.

IF YOU WAIVE COVERAGE

If you waive medical coverage, you will still be eligible to receive six free Employee Assistance Program (EAP) visits, per issue, each year. You will not receive any other medical or prescription drug benefits.

Cost of Coverage

The Company pays the majority of the cost of your Company medical coverage.

Alternative Coverage Costs

If you are in Hawaii, Puerto Rico, or on international assignment, call DuPont Connection, 1-800-775-5955 for your costs.

YOUR MONTHLY* PREMIUMS FOR 2018

Not including the Healthy Incentive Credit or any applicable tobacco user surcharge.

Coverage Level	Core Option	Premium Saver Option
You Only	$80	$55
You + Spouse	$170	$110
You + Child(ren)	$130	$90
You + Family	$210	$150

* *If you are not paid monthly, the premiums will be allocated to fit your pay schedule.*

Healthy Incentive Credit—Save $40 a Month!

The Healthy Incentive credit program is designed to help you:

- Identify your health risks and
- Improve your health.

The Healthy Incentive credit is available to active, U.S. employees (not spouses or dependents) age 18 and over who participate in the BeneFlex Medical Plan.

If you are a new employee, you will automatically receive the credit for the remainder of the plan year in which you are hired, and you will need to complete the requirements to earn the credit for the following year. Employees hired on or after July 1 also automatically receive the credit for the following calendar year.

Viverae—Our Healthy Incentive Partner

The Company's Healthy Incentive credit and the tobacco cessation program are offered by our partner, Viverae. For information, call Viverae at 1-888-VIVERAE (1-888-848-3723), or visit www.myhealth.dupont.com.

By completing the Healthy Incentive program, you can earn a $40 monthly credit that reduces your premiums if you are enrolled in either the Core or Premiums Saver options. The value of the credit, along with the steps required to earn it are subject to change each year. For 2018, the program consists of completing an on-line health risk assessment and a health screening. Details on the Healthy Incentive Credit program requirements change each year and are communicated to all U.S. employees.

Note that the credit is not available if you are covered under the Alternate Coverage Options (Hawaii, Puerto Rico, or International Assignment). The Healthy Incentive Credit is already factored into the premium cost you pay for the Alternative Coverage Options.

When Healthy Incentive Credits End

The premium credit ends when you retire or terminate 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 rest of the Plan Year. Note that the premium credit does not apply to medical premiums for retirees, even if the employee retires because of a termination for lack of work.

Health Screening Is Confidential—By Law!

The information collected on the health risk assessment and through the health screening is confidential. Our screening partner, Viverae, does not share information with the Company. Your information is protected by the Health Insurance Portability and Accountability Act (HIPAA).

Tobacco User Surcharge

You must indicate if you use tobacco each year when you enroll in your benefits. If you are a tobacco user and enroll in medical coverage, you will have to pay a $50 monthly surcharge in addition to your monthly medical premiums. If your status has changed, you will need to update it during the Annual Enrollment period. Otherwise, your prior year's tobacco user status will be your default election for the plan year.

No Tobacco Surcharge for New Hires Hired After July 1

If you are hired after July 1, the tobacco user surcharge will not apply during your first calendar year of employment. But if you use tobacco, you are eligible for the coaching sessions!

The tobacco surcharge applies to U.S. Mainland, Expatriates, Puerto Rico, and Hawaii employees enrolled in active medical coverage. If you are a tobacco user, you can avoid paying the surcharge for the next plan year by contacting Viverae at 1-888-VIVERAE (1-888-848-3723) and completing the Tobacco Cessation program. For 2018, the program consists of three Tobacco Cessation Coaching sessions by phone between January 1 and October 31. In addition, the online Breaking Free from Tobacco targeted program must be completed by October 31.

Details on the Tobacco User Surcharge program requirements change each year and are communicated to all employees before the start of the plan year.

How Coverage Works

The Core and Premium Saver Options cover the same services, provide the same prescription drug benefits, and have the same limitations and exclusions. What differs is how much you pay in premiums, deductibles, and your out-of-pocket maximum:

Option	Premiums	Deductible	Out-of-Pocket Max.
Core Option	Higher	Lower	Lower
Premium Saver Option	Lower	Higher	Higher
Alternative Coverage Options for Hawaii, Puerto Rico, and International Assignments	Contact your carrier for plan design and coverage details.		

See the "Highlights" chart on page 15 for a comparison of the Core and Premium Saver Options.

Note that:

- There are separate benefits for in-network and out-of-network care. Your Claims Administrator/carrier manages the network and can provide you with a list of in-network providers (or you can search their provider directories online).
- You must satisfy the applicable annual deductible before coverage begins for most services. The deductible does not apply to covered preventive medical care and prescription drugs on the Preventive Medications list. See "Preventive Medications" on page 34 for more information.
- Once the annual deductible is satisfied, the Plan pays a share of covered expenses (the coinsurance) and you pay the remaining share. A separate deductible applies to in-network and out-of-network claims.
- An annual out-of-pocket amount helps protect you against catastrophic costs for care received in-network. There is no out-of-pocket maximum for out-of-network care. See "Out-of-Pocket Maximums" on page 22 for more information.
- See "What Is Covered" on page 25 for further information about your benefits including information on emergency care, covered services and limitations and exclusions.

Saving with a Health Savings Account (HSA)

Both the Core and Premium Saver Options are high deductible health plans (HDHPs), as defined by the IRS. Because of this, you can participate in a tax-favored Health Savings Account (HSA) that can save you money. You decide how to use the money in your HSA—to offset your current health care expenses or save for future healthcare needs.

There is more detail about HSAs later in this SPD.

If you are eligible, the Company makes the following annual contributions to your HSA (which are prorated if you start or change your medical coverage mid-year):

- If eligible, the Company makes the following annual contributions to your HSA (prorated monthly for mid-year elections):
  - $600 for you only coverage
  - $1,200 for other levels of coverage.
- You may contribute your own before-tax funds to the HSA, up to legal limits.
- If you don't use the money in your HSA, the unused balance rolls over and can be used in the future, even if you are no longer covered under the plan.
- The money in the HSA is yours to keep, even if your employment with the Company ends.

What Is a Health Savings Account?

A HSA is a special bank account available only to participants in high-deductible health plans like the Core or Premium Saver Options. When you enroll in the Core or Premium Saver Options, you can establish an HSA that is funded by both you and the Company. You can use your HSA funds to pay for eligible out-of-pocket health expenses now, including medical, dental, and vision expenses. Since your funds roll over from year to year, you can also save them for future expenses. The choice is yours! The Company's annual contribution is usually provided in January, based on your pay cycle.

USA Patriot Act & Account Closures

In compliance with the USA Patriot Act, the HSA custodian is required to obtain, verify, and record information that identifies each person who chooses to open an account. You may be requested by the custodian to provide additional information to verify your identity. If you do not provide the requested information within 90 days of the first contribution (employer or employee), your account will be closed, and all funding returned to the employer. Returned employee contributions will be refunded as taxable wages in your paycheck. Any scheduled contributions will be stopped. If, at a later date you provide the information requested to the HSA custodian and open your account you may restart your contributions provided you contact DuPont Connection by December 1st. If you do not complete this process by December 1st no employee or employer funding can be processed for that same plan year.

The Coverage Network

The Claims Administrators/carriers negotiate treatment fees with network providers and facilities. These negotiated fees reduce costs for you and the Company.

The providers and facilities in the network are listed in a provider directory. You can get a copy of the directory from your carrier (or search their online directories) for:

- the medical service network (other than mental health or chemical dependency providers);
- the mental health and chemical dependency network; and
- the prescription drug retail, mail and specialty pharmacy network.

Refer to the *Contacts* section on page 116 for a list of carriers and their contact information. Or, contact your carrier using the information printed on your medical and pharmacy ID cards.

Caution: The BeneFlex Medical Care Plan uses ComPsych for mental health and chemical dependency care. If you use specialists from your medical carrier's network for this type of care, instead of a ComPsych network provider, you will receive out-of-network benefits (even if your medical carrier considers the specialist to be part of their medical network).

Medical ID Cards

Your Medical ID cards will be mailed to your home address from your medical carrier. You will receive a new ID card when changes to your personal information, carrier, or 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 Plan participant. If you need an additional set of ID cards, contact your medical carrier.

Allowable Charge Amounts

The Plan pays benefits based on Allowable Charge Amounts determined by the Claims Administrator. Plan allowance is based on the type of provider who renders such services or as required by law.

NETWORK NEGOTIATED RATES

The coverage networks include physicians, hospitals, pharmacies, labs and other providers that have agreed to accept negotiated fees for their services. Each health care provider and facility in the carriers' networks must meet strict standards and agree to follow guidelines set by the applicable carriers. These guidelines ensure that you and your family will receive the right care, in the right setting, at the right price.

The network negotiated rate is the amount a network provider has agreed to accept for rendering services or providing prescription drugs or supplies to participants of the Plan.

REASONABLE AND CUSTOMARY (R&C) AMOUNTS (OUT-OF-NETWORK)

When you receive services from an out-of-network provider, benefits are based on an Allowable Charge Amount of Reasonable and Customary (R&C) charges as determined by the carrier (or their designate).

You are responsible for all amounts above the carrier's recognized R&C charge.

The determination of 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;
- the amount allowed by the Centers for Medicare and Medicaid Services (CMS);
- an amount that the carrier determines is enough to cover the facility provider's estimated costs for the service and leave the facility provider with a reasonable profit;
- the prevailing range of fees charged in the same geographical area by similar health care providers for similar services;
- special circumstances or medical complications that require additional time, skill, experience or services to provide the necessary treatment; and
- the educational level, licensure or length of training of the provider.

The Plan applies the carriers' reimbursement policies to all out-of-network services including non-elective services. Reimbursement policies may affect the recognized charge. These policies consider:

- the duration and complexity of a service;
- when multiple procedures are billed at the same time, whether additional overhead is required;
- whether an assistant surgeon is necessary for the service;
- if follow-up care is included;
- whether other characteristics modify or make a particular service unique;
- when a charge includes more than one claim line, whether any services described by a claim line are part of or related to the primary service provided.

How Are Out-of-Network Benefits Determined?

- *If your doctor's charges for covered services 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 considered reasonable and customary, you pay your share of the covered R&C amount plus any excess fees.*

Call your medical carrier, Aetna, Highmark BCBS, or ComPsych with any questions about individual claims that are over R&C amounts.

Pre-existing Conditions

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

Deductible

The deductible is how much you must pay each calendar year for covered care *before* the Plan pays benefits. The deductible is based on your Option and your level of coverage. A new deductible applies each year.

	Core Option		**Premium Saver Option**	
Medical Care Benefits	***In Network***	***Out-of-Network***	***In Network***	***Out-of-Network***
Deductible *(combined for medical and prescription drug claims)*	$1,400 for you only coverage $2,800 for other coverage levels	$2,500 for you only coverage $4,000 for other coverage levels	$2,800 for you only coverage $5,600 for other coverage levels	$3,500 for you only coverage $6,000 for other coverage levels

The annual deductible applies to most covered services, such as: office visits, prescription medications, mental health and chemical dependency care, and emergency care. The deductible is waived for covered preventive care (as described under "Preventive Care" on page 25) and prescription medications on the Preventive Medication list available from your prescription drug carrier.

The "you only coverage" deductible applies only if you have single coverage.

The deductible for "other coverage levels" applies if you cover yourself and one or more other eligible family members. The deductible can be satisfied by one individual or a combination of covered family members.

A separate deductible applies to in-network and out-of-network claims. The in-network deductible does not go toward meeting the out-of-network deductible and vice versa.

Coinsurance

Coinsurance is the percentage of allowed charges that you pay after you meet the deductible (when applicable). The Plan pays a percentage of the allowed charges based on the type of service; you pay the balance.

	Core Option		Premium Saver Option	
Medical Care Benefits	***In Network***	***Out-of-Network***	***In Network***	***Out-of-Network***
Coinsurance for medical services ▪ Office visits ▪ Mental health care ▪ Chiropractic care ($1,000 annual limit) ▪ Labs and X-Rays ▪ Hospitalization ▪ Surgery	You pay 20% after deductible	You pay 40% after deductible	You pay 20% after deductible	You pay 40% after deductible

Coinsurance is waived for covered preventive care, which is covered at a 100% benefit level.

Coinsurance also applies to prescription drugs, including those on the Preventive Medication List (even though the deductible is waived).

Prescription Cost Sharing	Core Option	Premium Saver Option
Generic	No charge after deductible	No charge after deductible
Brand Formulary (Preferred)	You pay 25% after deductible; $125 maximum per fill	You pay 25% after deductible; $125 maximum per fill
Brand Non-Formulary (Non-Preferred)	You pay 45% after deductible; $250 maximum per fill	You pay 45% after deductible; $250 maximum per fill
Maintenance medications after second fill at retail pharmacies	You pay 45% after deductible; no maximum	You pay 45% after deductible; no maximum
See "Prescription Drugs" on page 32 for additional information on prescription drug benefits.		

Out-of-Pocket Maximums

The annual medical out-of-pocket maximum is the most you pay for your share of in-network covered expenses each year.

Medical Care Benefits	Core Option		Premium Saver Option	
Out of Pocket Maximum (annual amount, combined for medical and prescription drug claims)	In Network	Out-of-Network	In Network	Out-of-Network
Each Person	$5,000	No limit	$6,000	No limit
All Covered Family Members Combined	$10,000	No limit	$12,000	No limit

An individual out-of-pocket maximum applies whether you have "you only" (single) coverage or "other coverage levels" (you plus one or more dependents). Once you or one of your covered dependents meet the individual out-of-pocket maximum, the Plan will pay 100% of that person's in-network covered care charges for the rest of the year.

No Max for Out-of-Network

The out-of-pocket maximum does not apply for out-of-network services.

The family out-of-pocket maximum can be met by any combination of family members. When the combined deductible and coinsurance for all covered family members reaches the out-of-pocket maximum ($10,000 for the Core Option or $12,000 for the Premium Saver Option), the Plan will pay 100% for all covered family members' in-network care for the rest of the year.

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

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

- 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 (e.g. chiropractic care expenses for which a $1,000 annual benefit maximum applies).
- Your coinsurance for prescription maintenance medications filled more than two times using a retail pharmacy in a 180-day period.

Annual and Lifetime Maximum Benefits

ANNUAL BENEFITS

The Plan pays unlimited benefits for most covered medical services incurred for any one person during any plan year.

The exceptions are:

- Chiropractic care. The maximum benefit for covered chiropractic care is $1,000 per person per year.
- Benefits for which an age or frequency limit may apply (such as certain preventive care services and exams). Contact your carrier using the number on your ID care for age and frequency limitations.

LIFETIME MAXIMUM BENEFITS

The lifetime maximum benefit is the limit the Plan will pay in each covered person’s lifetime. The Plan has no general lifetime maximum benefit; however, 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.

- If you use these services and later use them again, the earlier charges will continue to apply toward the lifetime maximum.
- If you change to a different medical plan option or a different carrier, earlier charges under the prior option or carrier will continue to apply toward the lifetime maximum.

Medically Necessary and Appropriate

The medical plan covers only medically necessary services, procedures and supplies. Generally, to be medically necessary, the expense must be for health care services that a physician, exercising prudent clinical judgement, would provide to a patient for the purpose of preventing, evaluating, diagnosing, or treating an illness, injury, disease or its symptoms. The services must be:

- in accordance with generally accepted standards of medical practice;
- clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for the patient's illness, injury or disease; and
- not primarily for the convenience of the patient, physician, or other health care provider, and not costlier than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that patient's illness, injury or disease.

For these purposes, "generally accepted standards of medical practice" means standards that are based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community and recognized by the carrier as medically necessary for treatment of the patient's condition.

Precertification

Precertification is required for the following services:

- infertility treatment and in-vitro fertilization (call your medical carrier for precertification); and
- Applied Behavioral Analysis (call ComPsych for precertification)

Precertification is recommended for the following services:

- all mental health and chemical dependency care (call ComPsych for precertification);
- inpatient hospital admissions (including for mental health or chemical dependency);
- extended-care-facility stays;
- home health care;
- hospice care in an approved hospice program;
- outpatient private-duty nursing; and
- gender reassignment treatment.

To have your care precertified, you or your treating physician should contact your medical carrier (or ComPsych for mental health/chemical dependency care) by phone at least 14 days before the service or admission is scheduled. 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 after 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 before the end of the initially approved period. Your medical carrier will notify you with a decision within 24 hours after the precertification request is made.

If you do not precertify your care, your claim will be reviewed for medical necessity. The Claims Administrator may determine that some or all of your care does not qualify as medically necessary. For example, if you have been hospitalized for a procedure that could have been performed on an outpatient basis, the hospital charges will be denied.

What Is Covered

The following services are covered under the Plan, subject to the Plan deductibles, coinsurance, etc. All care must be medically necessary. Certain rules and restrictions apply. See "What Is Not Covered" on page 37.

Help Getting the Best Care

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.

Preventive Care

Preventive benefits are offered in accordance with a predefined schedule based on age, gender and certain risk factors. The schedule of covered services is periodically reviewed based on the requirements of the Patient Protection Affordable Care Act of 2010, and advice from organizations such as the American Academy of Pediatrics, the U.S. Preventive Services Task Force, the medical carrier and medical consultants. Therefore, the frequency and eligibility of services is subject to change. Benefits include periodic physical examinations, well child visits, immunizations and selected diagnostic tests.

For a complete list of services (and age/frequency limits), contact your medical carrier.

The Plan pays 100% benefits for covered preventive care services. No deductible or coinsurance applies. Reasonable and customary limits apply for out-of-network preventive care.

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 deductible and coinsurance.

Preventive Care Services Covered at 100%

The Plan covers many preventive care services at 100% with no deductible or coinsurance. For a complete list of covered preventive care services, as well as age and frequency limits, contact your medical carrier.

Note: Reasonable and customary limits apply for preventive care received out-of-network.

PREVENTIVE SCREENINGS AND EXAMS

The Plan covers services recommended by the U.S. Preventive Services Task Force (in addition to other sources) and those required by the Affordable Care Act. Age, gender and frequency limits apply. This broad list generally includes:

- routine preventive physical exams given by a physician for a reason other than to diagnose or treat a suspected or identified illness or injury
- breast cancer and cervical cancer screenings
- colon cancer screenings, including a pre-screening consultation, removal of polyps, and the pathologic exam of a polyp biopsy
- lactation counseling and breastfeeding equipment
- screening for iron-deficiency anemia in pregnancy
- screenings for diabetes, high cholesterol and high blood pressure

Diagnostic testing will not be covered as a preventive care benefit. You will pay the cost sharing specific to eligible health services for diagnostic testing.

Gender-specific preventive care benefits are based on your gender at the time the services are received, regardless of the gender you were assigned at birth, your gender identity, or your recorded gender.

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. This includes regular pediatrician visits, vision and hearing screening, (performed in a pediatrician/PCP's office), developmental assessments, immunizations, and screening and counseling to address obesity.

Child Preventive Care Varies by Age and Gender

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 covered preventive care services.

Other Medical Care (Non-Preventive)

PROVIDERS COVERED

To be covered under the Plan, an eligible provider must render all health care services. For Plan purposes, an eligible provider is a hospital, ambulatory surgical facility, or other health care facility licensed or otherwise authorized by law, acting within the scope of its practice, or a health care practitioner licensed or certified in the state in which he or she is practicing and acting within the scope of his or her license. To be eligible a health care practitioner may not be a family member.

PHYSICIAN SERVICES

Covered services include:

- physician care
  - office visits
  - telephonic or technology enabled virtual doctor visits using the Teladoc service available through your medical plan carrier
  - outpatient surgical services
  - inpatient surgical services
  - inpatient hospital visits
  - inpatient hospital consultant services
  - home/nursing home visits
  - second surgical opinions (See "Second Surgical Opinions" on page 30 for more information.)
  - allergy testing and treatment

The Convenience of Teladoc

Teladoc provides access to a national network of U.S. board-certified doctors by phone (and online in certain locations), 24 hours per day, 7 days a week. The service is offered as part of your medical coverage.

Simply set up an account with Teladoc at www.teladoc.com/dupont. At $40 per visit, a Teladoc doctor is significantly less expensive than urgent care and emergency room visits.

- 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.
- gynecological care

Using a Walk-In Clinic

When you need to see a health care provider for urgent care, or treatment outside of regular office hours, a walk-in or urgent-care clinic is often a convenient option. A walk-in clinic may be used for:

- *unscheduled, non-emergency illnesses and injuries and*
- *the administration of immunizations administered within the scope of the clinic's license.*

Benefits are applied at the in-network or out-of-network rate based on the network status of the Walk-In Clinic. Call your medical carrier before you visit to confirm the Walk-In Clinic is in-network.

PREGNANCY AND MATERNITY CARE

The medical Plan covers pregnancy, childbirth and related medical conditions for the following covered individuals:

- covered female employees;
- covered dependent spouses; and
- covered female dependents of a covered employee enrolled in the medical Plan at the time of delivery. Note, however, that the newborn child of a dependent child is not covered under the Plan.

Pregnancy expenses for a surrogate mother who is not covered under the medical benefit are NOT covered.

The Plan covers the stay for the mother in a hospital at the normal benefit level (subject to a deductible and/or coinsurance according to your 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).

Maternity care includes expenses related to your pregnancy and delivery care, including:

- hospital stay;
- physician;
- qualified, free-standing birthing centers;
- newborn infant care, when included in the cost of the mother's room and board. For newborn medical care services (such as care in a hospital nursery, circumcision or other surgery, tests, labs, etc.), the eligible child must be specifically added to coverage; and
- lactation counseling.

Adding a Newborn to Your Coverage

New babies are not covered automatically, even if you have family coverage.

You must call DuPont Connection to add your newborn to coverage within 31 days of birth to receive benefits retroactive to the date of birth.

When you call within 31 days of birth, your newborn's coverage will begin on the child's date of birth. If you call after 31 days, your child's coverage will start on the first of the month following your call. After 31 days, if a new calendar year begins, you will need to wait for the next Annual Enrollment period to add your child to coverage.

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.

URGENT CARE AND EMERGENCY CARE

The Plan covers care received in an urgent care center or emergency room when your need for treatment is serious and immediate. For less critical care, you should visit your primary care physician. Urgent care centers and emergency rooms should not be used as an alternative to a physician office visit solely based on the patient's convenience.

The Plan covers in-network and out-of-network 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. Benefits for true emergency services are covered at in-network levels (subject to R&C). Benefits for non-emergency services are applied at the in-network or out-of-network level based on the network status of the provider (the physician, hospital, urgent care center, ambulance company, etc.)

Urgent Care

Urgent-care centers are appropriate when you require immediate care because of a sudden illness, injury or condition that:

- is severe enough to require prompt medical attention to avoid serious deterioration of the participant's health;
- includes a condition which would subject you to severe pain that could not be adequately managed without urgent care or treatment; and
- you cannot obtain a physician office visit appointment in time to reasonably receive care.

Emergency Care

Emergency rooms are appropriate for the treatment of a recent and severe medical condition that would lead a prudent layperson to reasonably believe that the condition, illness, or injury is of a severe nature. And that if you don't get immediate medical care it could result in:

- placing your health in serious danger;
- serious loss to bodily function;
- serious loss of function to a body part or organ; or
- serious danger to the health of a fetus.

Examples of emergencies are:

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

If you are admitted to the hospital because of an emergency, you, or a family member, should certify your stay by calling your medical carrier within 48 hours or on the first business day after your admission. The facility may bill you for any balance not covered.

Covered services include:

- emergency care
  - 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

If you are traveling, working or living outside of the United States, you will 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. In-network benefits apply to emergency care received outside the United States.

OUTPATIENT SURGERY AND TREATMENT

Covered services include:

- outpatient surgical services
- outpatient hospital services
- home health care and 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 family or resides in the patient's home, as approved in advance by your medical carrier.
- outpatient 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.

HOSPITALIZATIONS AND OTHER INPATIENT SERVICES

Covered services include the following when hospitalization as an inpatient qualifies as medically necessary:

- 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.)
- Christian Science facility—(in-network coverage may not be available in all areas)
  - Care must qualify as medically necessary, using the same standards applicable to other hospital care.
- extended-care facility
  - Limited to medically necessary skilled-care needs related to a recent hospital confinement as approved in advance by your medical carrier.
- inpatient 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.

LAB WORK, X-RAYS AND SUPPLIES

Covered services include:

- laboratory services
- X-rays and other diagnostic services
- durable medical equipment when medically necessary and prescribed by a physician for use in the home. The medical carrier determines whether equipment qualifies as medically necessary and determines whether coverage will be on a rental or purchase basis. Coverage is limited to one piece of equipment for the same purpose, using the most conservative appropriate type. Duplicate items for convenience or personal use are not covered. (For example, you can't receive a regular wheelchair and a special sport-related wheelchair.) Modifications to the home are not covered, and maintenance and repairs needed because of misuse or abuse are not covered.
- prosthetic devices
- radiation therapy, chemotherapy and electroshock therapy

SECOND SURGICAL OPINIONS

If you would like to receive a second opinion on a surgical procedure, a second-opinion office visit is covered by the Plan. 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 Plan will cover a third opinion. Remember to take any tests or images with you since duplicate tests, x-rays and other images may be denied.

INFERTILITY SERVICES

For infertility services to be covered, the patient must be a covered employee or a covered spouse. In other words, infertility services are not covered for your dependent children or surrogates, only for you and your spouse.

Your medical carrier must approve all infertility treatments in advance. Extensive coverage limitations and exclusions apply. Benefits are determined by the clinical policies of the carrier; call you medical carrier for details.

All treatments are subject to the per family lifetime infertility and in vitro fertilization maximums of $15,000 for medical services and $10,000 for prescription medications. Services considered to be medical in nature (e.g. endometriosis) are covered as medical expenses and do not apply to these maximums.

Plan coverage for the reversal of sterilization is limited to once per lifetime.

Covered services, when approved by your medical carrier, include:

- charges included as part of an artificial insemination program
- charges included as part of an in vitro fertilization program
- charges included as part of infertility treatment (as allowed by the Affordable Care Act)
- charges for services related to obtaining donor sperm or preserving sperm or eggs are excluded from coverage.

TRANSPLANT SERVICES AND CENTERS OF EXCELLENCE

Coverage for human organ transplants.

Centers of Excellence are well-regarded medical facilities across the U.S. known for their specialized expertise and excellent results in performing highly complex surgical procedures—such as heart, kidney and bone marrow transplants.

Participants must use a Center of Excellence designated by their medical carrier to receive in-network coverage for a human organ transplant and associated care. If admission is approved in advance, the services performed will be paid based on plan benefits. Care received at network facilities that are not identified as Centers of Excellence by the carrier will be considered out-of-network and the out-of-network benefit levels will be applied.

TRANSGENDER HEALTH CARE

Covered services for the treatment of gender dysphoria include:

- gender reassignment services when medically necessary for the treatment of gender dysphoria, including:
  - counseling (see mental health and chemical dependency benefit section for coverage details),
  - pre- and post-surgical hormone therapy through the pharmacy benefit and
  - gender reassignment surgery for participants age 18 and older, including mastectomy, gonadectomy, and genital reconstructive surgery.

Call your carrier in advance of receiving care to review coverage and precertify your treatment. Extensive coverage limitations and exclusions apply; call you medical carrier for details. Related cosmetic procedures and surgeries and prosthetic devices are excluded from coverage. Examples of cosmetic procedures include laser hair removal or electrolysis, voice surgery, facial reconstruction and other items.

Hospice Care

The Plan covers hospice care for terminally ill patients in the final stage of an incurable illness. Services must be in an approved, licensed hospice facility or program. Call your medical carrier to precertify hospice care. See "Precertification" on page 24 for more information.

Covered services include:

- hospice care in an approved hospice program when all of the following 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 (that is, 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.

Examples of items not covered by the 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) instead of home care, except for periods of pre-approved short-term respite care.
- Charges for home modifications (for example, ramps, stair lifts, grab bars, etc.) or non-medical equipment items, or personal services (for example, 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.

DENTAL SERVICES

Covered services include:

- Emergency dental treatment related to the repair of sound natural teeth or other body tissues required because of an accidental injury.
- 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.)

Non-Medical Dental Coverage

For information on the dental coverage available through the dental plan, see BeneFlex Dental Care Plan on page 45.

Prescription Drugs

The BeneFlex Medical Care Plan includes prescription drug coverage administered through a pharmacy Claims Administrator. What you pay will vary depending on if you choose retail or mail order and the category of drug according to the Claims Administrator's Preferred Drug List (formulary).

Covered prescription drugs must meet the following criteria:

- drugs must be medically necessary as determined by the Plan;
- prescribed by a licensed physician or nurse practioner;
- not be available over-the-counter, in the same or lower dosage;
- approved by the FDA, and
- not considered experimental or investigational in nature.

Drugs not on the formulary will only be covered by exception, when a formulary medication cannot be taken by the patient and the non-formulary medication is medically necessary.

Pharmacy ID Cards

Aetna and Highmark 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 to receive in-network pharmacy benefits.

Rx for Alternative Coverage

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

HOW PRESCRIPTION COVERAGE WORKS

Express Scripts is the Claims Administrator/carrier for the Plan's prescription drug benefit for the Core and Premium Saver Options. The following section references Express Scripts and their specialty medication subsidiary, Accredo. If you participate in an Alternative Coverage Option (for Hawaii, Puerto Rico and International Assignments), contact your medical carrier for prescription coverage information. In the event that the Plan changes prescription drug carriers, you will be notified and this summary will be updated.

Express Scripts maintains a network of pharmacies that offer retail services at negotiated rates. You may have your prescription filled through a participating retail pharmacy or the Express Scripts mail service. You must present your Express Scripts prescription drug ID card and your benefit will be automatically calculated at the time of your purchase. If you use a nonparticipating pharmacy (out-of-network), you will need to submit a paper claim and Reasonable and Customary limits will apply.

Most prescription drug expenses are subject to the Plan deductible. Contact Express Scripts to find out if your medication will be subject to the deductible.

- No deductible applies to the following drugs:
  - Free preventive care prescription medications that are required by the Affordable Care Act, such as generic contraceptives, smoking cessation medications, and colonoscopy bowel preparations.

- Medications on the Preventive Medication List. These are medications prescribed 1) for a person who is at risk of having a particular disease or condition but who doesn't yet have any symptoms; and 2) to prevent a disease from returning in someone recovered from it.

Other important information about your prescription drug coverage:

- You can receive up to a 30-day supply of most prescription medications at a retail pharmacy or a 90-day supply using the mail order service. For some medications, a shorter day supply may apply. Examples include antibiotics, opioids (which may be limited to a 7-day supply) and drugs with a high initial patient rejection rate (which may be dispensed in an initial 7-day trial supply).
- If a generic equivalent is available and you choose a Preferred Brand or Non-Preferred Brand drug, you will pay the difference in cost between the generic and brand price. The cost difference will not be applied to your deductible or out-of-pocket maximum.
- When using a retail pharmacy for maintenance medications, a 45% coinsurance will apply to the third and subsequent fill and no maximum will apply to your share of the cost. While in the deductible phase and filling a maintenance medication three or more times at retail 55% of your cost will be applied to your deductible and out of pocket accumulators. The remaining 45% is considered coinsurance applied due to your third or more fill at retail and will not apply to your deductible or out of pocket accumulators. Even if you've reached your deductible and out-of-pocket maximum, the 45% coinsurance will still apply. To save money, switch to mail order through Express Scripts.
- Specialty medication will only be covered when purchased through the Plan's specialty medication provider. See "Specialty Medications" on page 35 for additional information.
- When taking a newly prescribed medication, 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 before starting home delivery. Subsequent prescriptions can be filled for up to a 90-day supply through the mail service program.

MAIL ORDER SERVICE HOME DELIVERY PROGRAM

The mail order service home delivery program is designed to save you money on medications you know that you'll use on an ongoing basis, normally "maintenance medications." Through this program, you can receive up to a 90-day supply of a drug for a single mail service copayment.

To start purchasing medications through mail order, ask your doctor to write you a prescription for up to a 90-day supply plus refills for up to one year. You can then place your order in one of three ways.

1. Mail your original prescription(s) with the Express Scripts Pharmacy order form and required coinsurance. You can receive mail order forms by calling 1-800-793-8766, or through www.express-scripts.com/dupontactive.
2. Ask if your doctor has electronic ordering capabilities with Express Scripts Pharmacy. Your doctor may need your member ID number (which is on your DuPont prescription plan ID card)
3. Ask your doctor to call 1-888-327-9791 for instructions on how to fax the 90-day prescription to Express Scripts. Your doctor must have your member ID number to fax your prescription.

WHAT YOU PAY FOR PRESCRIPTION DRUGS

Type of Medication	Amount You Pay For up to a 30-day supply at retail or a 90-day supply at mail order
Preventive Medications designated by the Affordable Care Act, including: ▪ Generic Contraceptives ▪ Smoking cessation medications ▪ Colonoscopy bowel preps	Free
Preventive Medication List	No deductible applies. Co-insurance may apply depending upon type of drug dispensed.
Generic	Free after meeting the deductible
Brand Formulary (Preferred)	25% coinsurance after deductible; $125 maximum
Brand Non-Formulary (Non-Preferred)	45% coinsurance after deductible, $250 maximum
Maintenance medications filled more than two times at retail pharmacies	45% coinsurance after deductible; no maximum

GENERIC DRUGS

Generic medications are covered at 100% after meeting your deductible when purchased through Express Scripts or a participating pharmacy. You are responsible for the deductible, unless the medication is listed on the Express Scripts Preventive Medications List.

By law, generic drugs contain the same active ingredients as their brand-name equivalents 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.

BRAND-NAME DRUGS

Brand-name medications include:

- Brand Formulary (Preferred)—These are brand-name drugs which are preferred by the claims administrator due to their efficiency and cost. They usually cost more than generics, but less than non-preferred brand-name drugs.
- Brand Non-Formulary (Non-Preferred)—Generally, these are higher-cost medications. In most cases, an alternative generic or preferred medication is available.

How Financial Assistance Impacts Cost-Sharing

When you receive financial assistance (such as a manufacturer's coupon for prescription drugs), the amount of financial assistance may be applied towards the total allowed cost.

For example, if you use $500 coupon to purchase a $600 specialty medication, the cost of the drug is reduced to $100 after the coupon. The $500 coupon value does not apply to your deductible or your out-of-pocket maximum.

PREVENTIVE MEDICATIONS

The Core and Premium Saver Options provide benefits for covered preventive medications that are not subject to the plan's deductible. To see if your medication is classified as preventive, go to the Express Scripts website at www.express-scripts.com/dupontactive. Click "GO" under the Open Enrollment Information tab and choose your medical plan type. The most up to date preventive medications list is available here to confirm your medication's classification. It is recommended you always reference the website for current information as the list will change over time.

Note: Medications may be added to or removed from the list of preventive medications (based on review of clinical experts), depending on different factors, including the intended purpose of the medication and its availability.

SPECIALTY MEDICATIONS

Specialty medications are drugs that are used to treat complex conditions, such as anemia, growth hormone deficiency, hemophilia, hepatitis C, high cholesterol, multiple sclerosis and rheumatoid arthritis. Express Scripts manages specialty medications through Accredo. To confirm whether your medications are considered specialty medications, contact Accredo at 1-800-803-2523.

You will pay the full retail cost for any specialty medication not purchased through Accredo. It is your responsibility to ensure your physician orders specialty medications to be administered on an outpatient basis through Accredo. If your physician does not accept outside medications for outpatient care, contact Accredo for additional assistance.

Accredo can deliver to outpatient facilities for medication administration, or assist you in locating an administration facility that accepts deliveries from Accredo. Specialty medications administered while you are an inpatient are processed as medical (rather than pharmacy) claims by your medical claims administrator.

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 you 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 you 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.
- **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 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 you 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.

Mental Health and Chemical Dependency Care (MH/CD)

ComPsych is the Claims Administrator/carrier for Plan's MH/CD benefit for the Core and Premium Saver Options. The following section references ComPsych. If you participate in an Alternative Coverage Option (for Hawaii, Puerto Rico or International Assignments), contact your medical carrier for MH/CD coverage information. In the event that the Plan changes MH/CD carriers, you will be notified and this summary will be updated.

To receive mental health and chemical dependency care, you should contact the MH/CD Claims Administrator, ComPsych at 1-800-435-7266 for assistance before you receive treatment. ComPsych will confidentially assess your situation and help you choose a ComPsych in-network provider who will meet your needs. If you choose not to use a ComPsych network provider, coverage will be at the out-of-network level.

Emergency admissions for mental health or chemical dependency must be reported by calling ComPsych within 48 hours or on the first business day after the admission. Failure to report may result in claims payment issues, including claim denial.

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 benefits until you reach the out-of-pocket maximum and begin receiving 100% benefits in-network. For out-of-network care, the Plan provides 60% benefits after the deductible with no out-of-pocket maximum.

Be Sure to Use a Provider in the ComPsych Network

Because mental health and chemical dependency (MH/CD) care benefits are administered by ComPsych, you will generally receive the highest benefit when you use a ComPsych network provider. If you use a Highmark BCBS or Aetna MH/CD provider who is not in the ComPsych network, the benefit will be paid at the out-of-network rate.

Covered services include:

- inpatient (when medically necessary) care at a hospital or specialized treatment center approved by ComPsych
- office visits and outpatient mental health care and chemical dependency care
- Applied Behavioral Analysis (ABA) therapy for the treatment of autism spectrum disorder. Call ComPsych at 1-800-435-7266 to review medical necessity and identify network providers. All ABA treatment must be pre-approved by ComPsych.

Note that intensive outpatient treatment is considered an inpatient service for benefit purposes.

Need Additional Support?

ComPsych Guidance Resources offers support, resources, and information for personal and work-life issues such as confidential counseling, financial information and resources, legal support and resources, and work-life solutions.

Keep in mind, you and your family members are eligible for six free Employee Assistance Program (EAP) counseling sessions through ComPsych, per issue, each year, even if you chose to waive medical coverage.

To schedule an EAP session, call ComPsych at 1-800-435-7266. If additional or more intensive mental health or chemical dependency care is required, the Plan benefits apply.

What Is Not Covered

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

- charges covered by any other plan of the Company
- charges covered under any national or local law (except charges relating to a government group insurance plan for that government's own civilian employees)
- charges due to an occupational illness or injury
- 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
- charges for care rendered to any dependent once they cease to be eligible
- charges for chiropractic care other than X-rays, manipulations of the spine, heat and ultrasound treatment, therapeutic procedures and activities, traction and electrical stimulation
- charges for communication equipment such as augmentive speech devices
- charges for cosmetic surgery, unless it is necessary for prompt repair of a non-occupational injury or is related to a visible congenital defect of an eligible newborn child
- charges for custodial care, regardless of who recommends or provides the care
- charges for eyeglasses, contact lenses and +s (or examinations for the prescription or fitting of them), except for one pair of eyeglasses or contact lenses after cataract surgery
- charges for hospitalization primarily for diagnostic studies, X-ray or laboratory examinations, electrocardiograms, electroencephalograms or physical therapy except, when medically necessary
- charges for immunizations required for personal international travel
- charges for in-hospital physician visits for any day the physician does not visit the covered patient
- 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
- charges for items available for purchase over the counter, regardless of who recommends the purchase.
- prescription medication available in the same or lower dosage over the counter, unless it is considered preventive care by the Affordable Care Act.
- charges for missed appointments or copying medical records
- charges for nonmedical equipment or items intended for the comfort/convenience of the patient, such as exercise cycles, hot tubs, stairway elevators, humidifiers
- charges for orthopedic appliances (including orthotics) when they are primarily used as supportive devices for the feet
- charges for personal services such as phone, TV, guest meals
- charges for routine physical examinations outside the scope of the Basic Preventive Services Schedule
- charges for services and associated expenses considered experimental or investigative
- charges for services not widely accepted by the U.S. medical community as safe and effective treatment for illness or injury (for example, most applications of acupuncture or non-abstinence-based treatment for chemical dependency)
- 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

- charges for services or supplies not recommended by a licensed physician or practitioner
- charges for services or supplies not specifically defined as covered expenses
- charges for services or supplies specifically to maintain a level of well-being
- charges for services provided by an unlicensed physician or practitioner
- charges for TMJ diagnosis and for TMJ treatment involving the teeth, such as crowns, inlays/onlays, bridges, full and partial dentures, or orthodontics
- charges for travel other than what may be authorized under "Centers of Excellence" Transplant Program
- charges for treatment to a person after that person is no longer eligible for coverage under this Plan
- charges for treatment to a person before that person becomes eligible for coverage under this Plan
- charges in excess of carrier-negotiated fees or Reasonable and Customary charges
- 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
- charges not reported, benefits not claimed, or payments not cashed for more than two years
- charges related to an act of war, declared or undeclared, if the injury or illness occurs after the person is covered under this Plan
- charges related to dental treatment except charges for repair of natural teeth or other body tissues required because of accidental injury
- charges relating to past or present military service
- charges resulting from any occupation or work outside the Company for compensation or profit
- charges that are associated with injuries suffered due to the act or omission of a third party
- 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
- second or third opinions concerning procedures not covered by this Plan or required by a hospital
- charges for the cost difference between a brand-name medication and its generic equivalent
- charges for prescription vitamin and mineral products, unless the prescription is considered preventive care by the Affordable Care Act.

Alternative Coverage Highlights

INTERNATIONAL PPO, PROVIDED THROUGH AETNA INTERNATIONAL

The following table summarizes the 2018 medical plan benefits. Contact your medical plan carrier for updated benefit information and coverage details, as well as terms and conditions specific to your medical option.

	U.S. Expatriate Option		Option for International Employees on Assignment in the U.S.	
Medical Care Benefits	***Outside the U.S.***	***In-Network* in the U.S.***	***Outside the U.S.***	***In-Network* in the U.S.***
Deductible (annual amount, combined for medical and prescription drug claims)	$800 for you only coverage $1,600 for other coverage levels		None (A $2,500 individual and $4,000 family deductible for U.S. care received out-of-network applies)	
Preventive Care (see your medical carrier for a list of covered services)	100% paid, no deductible		100% paid	
Coinsurance for medical services ▪ Office visits ▪ Mental health care ▪ Chiropractic care ($1,000 annual limit) ▪ Labs and X-Rays ▪ Hospitalization ▪ Surgery	You pay 20%, after deductible		100% paid (You pay 60% for U.S. care received out-of-network)	
Prescription Cost Sharing				
Generic	You pay 20%, after deductible	Free, after deductible	Free (Prescriptions filled in the U.S. out-of-network are subject to coinsurance and deductible amounts.)	
Brand Formulary (Preferred)		You pay 25% ($125 max per fill)		
Brand Non-Formulary (Non-Preferred)		You pay 45% ($250 max per fill)		
Specialty Drugs				
Out of Pocket Maximum (annual amount, combined for medical and prescription drug claims)				
▪ Each Person	$5,000		Not applicable	
▪ All Covered Family Members Combined	$10,000			

* *Different benefits apply to care received out-of-network while in the U.S. Contact your carrier for details.*

HAWAII AND PUERTO RICO MEDICAL OPTIONS

The following table summarizes the 2018 medical plan benefits. Contact your medical plan carrier for updated benefit information and coverage details, as well as terms and conditions specific to your medical option.

	Hawaii HMSA Comprehensive PPO		*Puerto Rico Triple S Plan*	
Medical Care Benefits	***In Network***	***Out-of-Network***	***In Network***	***Out-of-Network***
Deductible *(annual amount, combined for medical and prescription drug claims)*	$300 per person $900 per family		$50 per person (major medical) $100 per family (major medical)	
Preventive Care *(see your medical carrier for a list of covered services)*	100% paid, no deductible		100% paid, no deductible	You pay 20% after deductible
Coinsurance for physician services ▪ Office visits—PCP ▪ Office visits—Specialist office visits—mental health/chemical dependency	$17 copay after deductible		$10 PCP copay; $12 specialist copay; $15 subspecialist copay; $10 podiatrist, optometrist and audiologist copay; MH/CD $5 group therapy copay; $12 individual therapy copay	You pay 20% after deductible
Coinsurance for medical services ▪ Urgent care/ER ▪ Labs and X-Rays ▪ Hospitalization ▪ Surgery	$17 urgent care/ER copay You pay 20% after deductible for other care		$20 urgent care/ER copay for illness; $0 urgent care/ER copay for accident; You pay 20% after deductible for labs and X-rays No charge for hospitalization or surgery	$20 urgent care/ER copay for illness; $0 urgent care/ER copay for accident You pay 20% after deductible for other services

	Hawaii HMSA Comprehensive PPO		*Puerto Rico Triple S Plan*	
Medical Care Benefits	***In Network***	***Out-of-Network***	***In Network***	***Out-of-Network***
Prescription Cost Sharing				
Generic	Tier 1 Retail: $7 copay Tier 1 Mail Order: $11 copay	Tier 1 Retail: $7 copay Tier 1 Mail Order: Not Covered	Retail: You pay 20% coinsurance; Mail Order or Flex 90: You pay 10% coinsurance	US or territories: Reimbursement up to 75% of Triple-S Salud established fees, less the applicable drug co-payment or coinsurance.
Brand Formulary (Preferred)	Tier 2 Retail: $30 copay Tier 2 Mail Order: $65 copay	Tier 2 Retail: $30 copay Tier 2 Mail Order: Not Covered	Retail: You pay 20% coinsurance; Mail Order or Flex 90: You pay 10% coinsurance	US or territories: Reimbursement up to 75% of Triple-S Salud established fees, less the applicable drug co-payment or coinsurance.
Brand Non-Formulary (Non-Preferred)	Tier 3 Retail: $30 copay Tier 3 Mail Order: $65 copay	Tier 3 Retail: $30 copay Tier 3 Mail Order: Not Covered	Retail: You pay 20% coinsurance; Mail Order or Flex 90: You pay 10% coinsurance	US or territories: Reimbursement up to 75% of Triple-S Salud established fees, less the applicable drug co-payment or coinsurance.
Specialty Drugs	Tier 4 Retail: $100 copay Tier 5 Retail: $200 copay Mail Order: Not Covered	Tier 4 Retail: Not Covered Tier 5 Retail: Not Covered Mail Order: Not Covered	Retail: You pay 20% coinsurance; Mail Order or Flex 90: You pay 10% coinsurance	US or territories: Reimbursement up to 75% of Triple-S Salud established fees, less the applicable drug co-payment or coinsurance.
Out of Pocket Maximum (annual amount)				
Each Person	$3,000 (medical); $3,600 (Rx)		$1,500 (major medical)	
All Covered Family Members Combined	$9,000 (medical); $4,200 (Rx)		$3,000 (major medical)	

Using a Health Savings Account (HSA)

When you first enroll for the Core Option or Premium Saver Option, if you are eligible, the Company opens a Health Savings Account (HSA) for you through Bank of America, and contributes to it! An HSA is a separate bank savings account that is not part of your medical plan. As of January 1, 2018, each year that you participate, the Company contributes*:

- $600 for you only coverage
- $1,200 for other levels of coverage.

* *Note: Company contributions are prorated for mid-year elections.*

The HSA is available because both the Core and Premium Saver Options qualify as High Deductible Health Plans (HDHPs), according to IRS rules.

The HSA is a tax-advantaged account that you own. You can set aside money in the account through before-tax payroll deductions. You can use the money in the HSA to pay for future out-of-pocket health care expenses for you and your tax dependents. And once your account balance is more than $1,000, you can invest it in mutual funds.

Helping Get Your Account Established

Bank of America may request information from you directly when you first open an HSA. This is because of U.S. Patriot Act requirements described on page 19.

Not providing the information can prevent the Company from providing its HSA contributions. Your account could also be closed and your payroll contributions could be returned to you.

WHO IS ELIGIBLE?

To participate in the HSA, you must meet these IRS requirements:

- 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.
- You cannot be covered by a full-purpose Health Care Spending Account (also known as a Flexible Spending Account, or FSA) or Health Reimbursement Account (for example, through a previous employer or spouse's FSA or HRA) that pays or reimburses medical expenses during the same time period. It's okay to be in the Company's Health Care Limited Purpose FSA, though.
- Another individual cannot claim you as a tax dependent.

HSA PLAN LIMITS

With either the Core or the Premium Saver Option, you can make before-tax contributions to your HSA, up to the annual IRS combined maximum (includes employer and your contributions). For 2018, the HSA contribution limits will be as follows:

- single—$3,450
- family—$6,900
- If you are age 55 or older, you may make additional catch-up contributions of up to $1,000 annually.

You always own the money in your HSA, including contributions from DuPont. You can take the account with you if you retire or leave the Company.

Triple Tax Savings

*In addition to the Company contribution, you benefit from a **triple tax savings:***

- *You pay **no payroll taxes** on your money when it goes in*
- ***No taxes** as it grows, and*
- ***No federal taxes** when you use it to pay eligible expenses.*

ELIGIBLE HSA EXPENSES

HSAs may be used for qualified healthcare expenses that are not reimbursed by your health plan, such as:

- doctor's office visits (non-preventive care)
- dental care and orthodontia
- eyeglasses, contacts and LASIK surgery
- prescription medications
- acupuncture
- chiropractic services
- hearing aids (including batteries)
- long-term care medical expenses and insurance premiums
- tobacco cessation programs
- physical therapy
- psychiatric care
- psychological counseling
- nursing home care

For a full list of eligible health care expenses and more information on the HSA, visit www.irs.gov (Publication 502).

PAYING FOR CARE USING THE HSA

There are three ways to access and use the money in your HSA:

- The Bank of America Visa debit card: Use your card at most pharmacies and physician's offices (where Visa is accepted) and select Credit or Debit at the register for automatic deduction;
- Health care provider payments: When you receive an invoice, use the Bank of America website or mobile app to request that your provider is paid directly from your account (similar to online bill payment—and once the claim is approved, the provider will receive a check within 7 – 10 business days); and
- Reimbursement requests: If you pay out-of-pocket for health care services, you can request reimbursement for yourself through the Bank of America website either electronically (direct to your personal checking or savings account) or by receiving a check.

THE HSA AND THE HEALTH CARE LIMITED PURPOSE FSA ARE SEPARATE!

The Health Savings Account and the Health Care Limited Purpose FSA are similar, but separate, and subject to different rules:

- You can't pay for medical expenses, including prescription drugs, with the Health Care Limited Purpose FSA. For those expenses, you have to use the HSA.
- With the Health Care Limited Purpose FSA, if you don't use up the money you contribute each year, the money is forfeited. With the HSA, you don't have to use the money in your account at all (some people use it as another tax-advantaged way to save for the future). Your HSA money rolls over each year, even if you change to another medical plan or end your Company medical coverage. And if you have an HSA balance when you end your employment, you keep the HSA funds.

Help Prevent Fraud, Waste and Abuse

Fraud increases the cost of health care for everyone and increases your medical plan premium. Practice good ethical behavior and protect yourself from fraud.

- *Do not give your plan identification (ID) number over the telephone or to people you do not know. If you need to give your ID number to your medical provider or carrier, verify their identity first.*
- *Do not share medications or supplies with other individuals who you know.*
- *Never use a prescription drug coupon or financial assistance for a medication that has an equally effective, lower cost alternative. What may seem like a "free" medication to you is very likely being billed to the Plan at a high cost.*
- *Safely dispose of unused opioid medications immediately and help reduce the national opioid addiction crisis. Contact Express Scripts for disposal information.*
- *For short-term prescriptions, ask your physician to only give you a supply that will reasonably cover your need. Getting a 30-day supply when you only need a 7-day supply creates waste and the unused medication could pose a safety issue to yourself and others if not properly disposed.*
- *Avoid using providers who say that an item or service is not usually covered, but they know how to bill the insurer to get it paid.*
- *Carefully review your explanation of benefits (EOBs) statements. Report any suspicious billing errors to the Claims Administrator.*
- *Do not ask your provider to make false entries on certificates, bills or records to get payment for an item or service.*
- *Remove ineligible dependents as soon as they no longer qualify for coverage (such as upon legal separation or divorce).*

BeneFlex Dental Care Plan

Good dental care is an important part of overall health. The BeneFlex Dental Care Plan encourages good preventive care to help you maintain healthy teeth and gums.

The Plan offers two options for coverage—and the Company pays the full cost of the Standard Option!

Questions?
If you have questions about the dental coverage, call MetLife at 1-888-883-0052 or visit www.metlife.com/mybenefits.

SECTION CONTENTS

Highlights

Type of Service	Standard Option Plan Benefits	High Option Plan Benefits
Annual Deductible for Restorative Care	$50 per person, up to a maximum of $150 per family	$50 per person, up to a maximum of $150 per family
Preventive and Diagnostic Care ▪ 2 regular or 4 periodontal cleanings per year (with diagnosed condition) ▪ 2 routine exams per year ▪ Dental X-Rays: ▫ 1 set of Bitewing X-Rays per year ▫ 1 set of whole mouth X-rays every 5 years	100%*	100%*
Restorative and Other Dental Care *Includes bridges, crowns, fillings, and other covered dental services*	50%*	75%*
Annual Maximum Benefit	$1,100 per person	$2,000 per person
Lifetime Orthodontic Maximum Benefit	100%, up to $1,200 per child under age 19	100%, up to $1,500 per person (adult or child)

** The Plan pays the percentage shown for the allowable charge. For services received from a MetLife PDP dentist, the allowable charge is based on the MetLife PDP Plus network negotiated rate. For out-of-network dentists, the allowable charge is based on the 90th percentile of the reasonable and customary area rates, which means that 90% of dentists in the geographic area normally charge no more than the allowable amount.*

Your Plan Uses the MetLife PDP Plus Network

The BeneFlex Dental Care Plan is administered by MetLife. When you use dentists in the MetLife Preferred Dentist Program Plus (PDP Plus) network, your charges are usually lower than what the dentist would otherwise charge.

Find PDP Plus dentists by visiting www.mybenefits.metlife.com, or by calling MetLife at 1-888-883-0052. Using network dentists is recommended, but not required.

Your Dental Care Plan Options

The Dental Care Plan has two options:

- The Standard Option is provided at no cost to you—the Company pays the full cost.
- The High Option provides more generous benefits, but you pay the additional cost, over the cost of the Standard Option.

You can also waive coverage.

Dental Coverage While You Are on International Assignment

Eligible employees who are on international assignment are not covered under the MetLife PDP Plus Dental Care Plan. Instead, your dental coverage is provided through your Aetna International Health Plan. Information about this coverage is provided to you during the Annual Enrollment period. For questions, contact Aetna International.

The MetLife Preferred Dental Program (PDP) Plus Network

There are over 400,000 participating PDP Plus dentist locations nationwide, including over 95,000 specialist locations. You can get a list of these participating PDP Plus dentists online at www.metlife.com/mybenefits, and search for DuPont, or call 1-888-883-0052 to have a list faxed or mailed to you.

A participating dentist is a general dentist or specialist who has agreed to accept MetLife's negotiated fees through the PDP Plus network. Benefits are paid based on the negotiated fees, helping to keep costs down for both you and DuPont. Also, PDP Plus participating dentists agree not to balance bill you any amount over the negotiated fee.

You can use any dentist you choose, but you'll generally pay less when you use a participating network dentist.

Cost of Coverage

The Company pays the full cost of the Standard Option, not only for your coverage but also for any eligible dependents that you enroll.

If you elect to enroll in the High Option, the Company still contributes an amount equal to the cost of the Standard Option, and you pay the difference.

Here are the monthly employee premiums for 2018, which depend on how many dependents you cover:

Coverage Level	Standard Option	High Option
You only	$0	$18
You plus spouse	$0	$33
You plus child(ren)	$0	$35
You plus family	$0	$55

If you are not paid on a monthly schedule, your premiums will be allocated to fit your pay schedule.

How Coverage Works

The benefits you receive are based on the plan option you elected. Benefits are determined based on the allowable charge (either the MetLife PDP negotiated rate or, for out-of-network care, the amount billed up to a reasonable and customary amount).

- The **Standard Option:**
  - Covers 100% of the allowable charge for preventive and diagnostic care.
  - For restorative care and other covered services, the Standard Option covers 50% of the allowable charge after a $50 per person annual deductible (which is limited to $150 per family).
  - Benefits are limited to a maximum of $1,100 per person per year (not including orthodontic care).
  - Orthodontic care is covered only for children under age 19 and is subject to a lifetime benefit limit of $1,200 per child.
- The **High Option:**
  - Covers 100% of the allowable charge for preventive and diagnostic care.
  - For restorative care and other covered services, the High Option covers 75% of the allowable charge after a $50 per person annual deductible (which is limited to $150 per family).
  - Benefits are limited to a maximum of $2,000 per person per year (not including orthodontic care).
  - Orthodontic care is covered for both children and adults, up to a lifetime benefit limit of $1,500 per person.

Alternative Treatment

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

Note that the lifetime orthodontia benefit limit includes any orthodontia benefit received under either the Standard or High Option. This means that if your child received $1,200 in orthodontia benefits under the Standard Option, only an additional $300 in orthodontia benefits would be available for your child if you later elect the High Option coverage.

Benefits are based on the date that a service is actually performed, or the date a supply or material (like a crown) is actually ordered by the dentist.

- Charges for root canal therapy are based on the date the tooth is opened.
- Charges for a crown are based on the date the tooth is prepared for the crown.
- Charges for a prosthetic device (such as a bridge or denture) are based on the date the impressions are taken and/or the abutment teeth are fully prepared.

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.

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

- the usual fee your dentist most frequently charges most patients for the service or supply;
- the fees generally charged for the treatment by 90% of dentists in the same area; and
- any unusual circumstance or complications requiring more time, skill and experience.

If your dentist's charges are less than or equal to the reasonable and customary charges, the full charge will be used to calculate your plan benefit. If your dentist charges more than what is reasonable and customary, the reasonable and customary charge will be used to calculate your plan benefit. In addition, you will be responsible for any amount that exceeds the reasonable and customary charges.

Determining R&C Amounts

MetLife's claim payment system uses data accumulated through internal claims processing to establish specific customary allowances for each type of procedure within a geographic area. To determine the R&C amount for a particular service, the Claims Administrator reviews charges submitted by providers in your location.

Allowable Charge Amounts

The Plan pays benefits based on allowable charge amounts determined by the Claims Administrator.

- In-network: For services received from a MetLife PDP dentist, the allowable charge is based on the MetLife PDP Plus network negotiated rate.
- Out-of-network: When you use a dentist that is not in the MetLife PDP Plus network, the allowable charge is based on the area R&C amount.

Pre-existing Conditions

The Dental Care Plan will not pay benefits for completing a procedure that was started before you had coverage, when the work is also covered by your former plan.

Deductibles

An annual deductible of $50 per person, up to a maximum of $150 per family, applies to restorative and other dental care (including bridges, crowns, fillings, and other major care and emergency care). You must satisfy the annual deductible before the Plan provides coverage for restorative and other dental care services.

No deductible applies to the preventive and diagnostic care or orthodontia care.

Coinsurance

Coinsurance is the percentage you pay after you meet the deductible (if applicable). The Plan pays a percentage of the expenses based on the type of service, and you will pay the balance.

- Preventive care does not have a coinsurance. The Plan pays 100% of the allowable charge. Frequency and benefit limits apply.
- For restorative and other dental care:
  - Under the Standard Option, the Plan pays a 50% benefit and you pay a 50% coinsurance based on the allowable charge. Frequency and benefit limits apply.
  - Under the High Option, the Plan pays a 75% benefit and you pay a 25% coinsurance based on the allowable charge. Frequency and benefit limits apply.

- For Orthodontia, The Plan pays 100% up to the lifetime orthodontia maximum of $1,200 per child under age 19 in the Standard Option and $1,500 per person (adult or child) under the High Option. Coinsurance does not apply, but you are responsible for charges over the lifetime orthodontia maximum.

Annual Benefit Maximum

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

- $1,100 per person under the Standard Option, and
- $2,000 per person under the High Option.

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

- charges for services not covered by the Plan
- charges over the reasonable and customary amounts
- orthodontia benefits which are subject to a separate lifetime benefit maximum

See "What Is Covered" on page 51 and "What Is Not Covered" on page 53 for more information.

Lifetime Orthodontia Maximum Benefits

The maximum the Plan pays for orthodontia care is a lifetime limit:

- $1,200 for the Standard Option
- $1,500 for the High Option.

The Options differ in terms of whose orthodontia care can be covered:

- The Standard Option only covers orthodontia for children under age 19
- The High Option covers orthodontia for adults and children.

If a covered person receives orthodontic benefits under both the Standard Option and the High Option (such as if you change coverage from one year to the next), the maximum lifetime orthodontic care benefit from both Options is $1,500.

No Lifetime Limits, Except for Orthodontia

Orthodontic care is the only dental care that has a lifetime maximum benefit. All other care is subject to annual maximums, which reset each year.

Predetermination of Benefits

To avoid being surprised by expensive care, or by lower reimbursements than you expect, be sure to use the Dental Care Plan's predetermination of benefits process for any significant care. A predetermination of benefits tells you in advance how much of your dental bill is covered and your coinsurance cost.

HOW TO GET A PREDETERMINATION OF BENEFITS

1. You or an eligible family member visits the dentist—with Part I of the claim form filled out ahead of time (claim form available at www.metlife.com/mybenefits).
2. Your dentist outlines a treatment plan and lists the charges for each procedure.
3. You or the dentist submits the form directly to the MetLife Dental claim office. Your dentist may have to send along X-rays or other materials.
4. MetLife Dental reviews the treatment plan and issues an estimated Explanation of Benefits (EOB) statement indicating how much of the bill will be paid. Both you and your dentist receive a copy of this statement.
5. Once the services have been rendered, your dentist must indicate on the statement the date(s) the service(s) were performed, sign the statement and return it to MetLife for issuance of benefits.

Predetermination Example

Mary is enrolled in the Standard Option and visits her dentist for her semiannual checkup. After an examination and X-rays, her dentist recommends that she needs to have two teeth extracted and replaced with a partial denture. Mary asks her dentist to file for a predetermination of benefits.

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

What Is Covered

The Dental Care Plan covers these services:

Preventive and Diagnostic Care

The Dental Care Plan provides 100% benefits for diagnostic and preventive care. Services covered under the diagnostic and preventive category include:

- routine oral exams—two per person each plan year
- cleanings (dental prophylaxis)—two per person each plan year
- fluoride treatments—one topical application of stannous or acid fluoride every plan year for dependent children under age 14 only
- periodontal maintenance, but only where there is a diagnosed and previously treated periodontal condition—four per person each plan year, two of which are instead of the two standard dental cleanings (dental prophylaxis) covered each plan year
- sealants—once every 36 months on primary or permanent posterior teeth for dependent children under age 19 only
- space maintainers for prematurely lost or extracted teeth, for dependent children under age 19 only
- tests and laboratory examinations, when necessary for dental diagnosis, prevention and treatment
- emergency palliative treatment of dental pain
  - subsequent follow-up care may be considered restorative
- X-rays
  - full-mouth X-rays, once per person every 60 months (5 years)
  - supplementary bitewing X-rays, once per person each plan year
  - any dental X-rays required to diagnose a specific condition needing treatment, as necessary

What if my dentist recommends bitewing X-rays every six months?

Coverage for preventive dental X-rays includes a limited frequency. If your dentist takes preventive X-rays more often than the Plan covers, the extra X-rays will not be covered.

Restorative and Other Care

The Dental Care Plan pays a portion of other covered dental care expenses for you and your covered dependents. Some of the services covered include:

- bridges
  - initial installation of fixed bridgework, including inlays and crowns to form abutments, to replace one or more teeth (except wisdom teeth)
  - repair or recementing of bridgework
  - replacement of an existing bridge, provided that it is at least five years old and cannot be made serviceable
- crowns
  - initial installation of a crown to restore the structure of a tooth due to cavity or fracture
  - repair or recementing of crowns
- dentures
  - initial installation of removable dentures, partial or full, including adjustments after the six-month period after installation, to replace one or more teeth (except wisdom teeth)
  - addition of teeth to an existing partial removable denture at least six months after installation
  - repair of dentures
  - relining of dentures after six months from the date of installation
  - replacement of a temporary denture with a permanent full denture within 12 months of when it was installed
  - replacement of an existing denture, provided that it is at least five years old and cannot be made serviceable. The five-year replacement limitation does not apply if you have experienced documented, substantial changes to the dimensions of your oral cavity, or have lost or extracted teeth while covered by the Plan.
- periodontics—treatment for diseases of the structures surrounding and supporting the teeth, such as the gums
- endodontics—treatment for diseases of the dental pulp, such as root canal therapy
- inlays
  - initial installation of an inlay to restore the structure of a tooth due to cavity or fracture
  - repair or recementing of inlays
- implantology (placing teeth or supports in a surgically prepared cavity) where medically necessary
- oral surgery
  - surgical procedures in and around the mouth, including extractions of badly decayed or impacted teeth
  - general anesthesia, when medically necessary in connection with covered oral surgery and administered in a dentist's office. When medical necessity dictates that oral surgery be done in a hospital (inpatient or outpatient), the anesthesia and facility charges may be covered by your medical plan.
- restorations—treatment to restore the structure of a tooth or teeth because of cavities or fracture. This includes fillings, inlays, onlays and crowns, along with the necessary local anesthesia.

Orthodontia

The Dental Care Plan will cover orthodontic expenses incurred for corrective treatment of malocclusion or malpositioned teeth by means of an active appliance. This includes teeth straightening and repositioning.

Examples of some orthodontic services covered under this Plan are:

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

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

- 25% of the allowable maximum benefit for the orthodontic banding.
- Remaining benefits paid out over the course of treatment, not to exceed 24 months.
- Orthodontia benefits apply to services received up to the day before the child's 19th birthday under the Standard Option (there is no age limit under the High Option).
- Benefits are paid quarterly at the end of the quarter.

Standard Option Covers Orthodontia for Children Only

Keep in mind, under the Standard Option, orthodontic benefits are only provided for your eligible dependents under age 19.

Consider using the Health Care Limited Purpose FSA or your HSA funds to pay for non-covered, non-cosmetic orthodontia expenses.

Transition of Care

If your dependent child is already in active orthodontia treatment before your coverage effective date, MetLife Dental will start issuing benefit payments from the date the patient becomes eligible under the Dental Care Plan. Monthly payments will be calculated based on the remaining months of treatment (not to exceed the lifetime benefit maximum) less the benefit payment for the orthodontic banding, assuming the banding was performed before the child became covered under the Plan.

What Is Not Covered

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

- anesthesia, except general anesthesia when medically necessary in connection with oral surgery and administered in a doctor's office
- appliances, restorations and procedures to alter vertical dimension (changing the height of upper or lower teeth)
- charges (claims) submitted more than 24 months after services are rendered
- charges for sealants for dependents age 19 and over
- charges that would not normally be paid if you did not have insurance or charges you are not required to pay
- charges which, in the judgment of the Claims Administrator, exceed the reasonable and customary charge for (or fair and reasonable value of) the service or supply provided
- completion of claim forms or filing of claims
- educational programs, such as training in plaque control or oral hygiene, or for dietary instructions
- experimental procedures or those not recognized by the dental profession
- extra sets of dentures or other appliances

- for job-related injuries or diseases paid by any Workers' Compensation or similar laws (See the disability benefits summary, *Disability Benefits*, for more details)
- missed appointments
- periodontal splinting (temporary wiring or permanently bonding teeth together)
- replacement of lost or stolen prosthetic devices
- services or supplies not recommended by your dentist as necessary for proper dental treatment
- temporary procedures, services or appliances
- treatment of dental diseases or injuries resulting from declared or undeclared war, insurrection, participation in a riot or service in the armed forces of any government
- treatment of temporomandibular joint dysfunction (TMJ) (Note: An exam to diagnose TMJ is covered under the Dental Care Plan. Treatment may be covered under your medical plan.)
- work done primarily for cosmetic or appearance purposes
- work done while you are not covered under this Plan, except for certain procedures begun before your coverage ends and completed within two months. These include charges for installing a prosthetic device or a crown or for root canal therapy. If you are involved in the above procedures, you need to consult MetLife Dental at 1-888-883-0052 for the appropriate guidelines.
- work furnished or paid for because of service in the armed forces of any government
- work furnished or paid for by any government—federal, state or local

When Coverage Ends

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

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

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

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

For more information about when coverage ends, see the detailed *When Coverage Ends* section on page 102.

BeneFlex Vision Care Plan

Your vision is an important part of your overall health. Whether or not your vision is 20/20, it's essential to receive regular eye exams. The BeneFlex Vision Care Plan helps you pay for covered eye exams as well as lenses, frames, and contact lenses.

Questions?
If you have questions about the vision coverage, contact VBA at 1-800-432-4966 or visit www.vbaplans.com

SECTION CONTENTS

Highlights

Here's a look at what the Plan covers:

Coverage (Once per Plan Year)	VBA Provider*	Non-VBA Provider*
Routine Vision Exam	100%	Up to $40
Eyeglass Lenses and/or Frames (one time per plan year) Including: Single, Bifocal, Blended Bifocal, Progressive, Trifocal, Lenticular, Polycarbonate, one-year Scratch-Resistant Coatings, UV 400 and Optional Lens Tints	100% after $20 copayment per person (covers frames with a wholesale value up to $60)** *Note: Digital Progressives available at additional cost.*	Prescription Lenses: ▪ Single Vision: up to $40 ▪ Bifocal: up to $50 ▪ Trifocal: up to $75 ▪ Progressive: up to $75 ▪ Lenticular: up to $100 Frames: up to $50
Cosmetic Contact Lenses (in lieu of glasses, including vision exam)	Up to $175 allowance toward the total cost of exam, fitting fees and materials	Up to $175 allowance toward the total cost
VBA-Approved Medically Necessary Contact Lenses (in lieu of glasses, including vision exam)	100% of R&C (Reasonable and Customary)	Up to $300

** Note: Out-of-Area benefits are available at the network provider level when a VBA provider is not located within 35 miles of a participant's home address and a non-VBA provider is used. For participants living in Puerto Rico, a 20-mile radius applies. Contact VBA Member Services prior to your visit to confirm availability of these enhanced benefits.*

*** The $20 copay applies to lenses or frames but not both; the frames are covered with a wholesale value of up to $60 (approximately $150-$180 retail value).*

VBA's Network

VBA has a nationwide network of over 16,000 vision care providers. Find a VBA provider by visiting www.vbaplans.com or by calling 1-800-432-4966.

Cost of Coverage

Coverage Level	2018 Monthly Premium
You only	$8.46
You + Spouse	$14.70
You +Child(ren)	$14.70
You + Family	$21.78

How Coverage Works

The BeneFlex Vision Care Plan provides coverage through VBA for routine vision exams, prescription eyeglasses (lenses and frame) and contact lenses (in-lieu of eyeglasses). You can visit any vision care provider you want, but there are advantages to using VBA's network of participating providers:

- You will usually receive a higher level of benefits when you use a VBA network provider.
- VBA network providers will file your claim electronically, with no paperwork for you.

- VBA has a large national network of providers including participating retail chains and eyewear providers to choose from.
- Routine vision exams are covered at 100% through VBA network providers if you do not use your coverage for Contact Lenses.

For more information, refer to "Highlights" on page 56.

The VBA Network

The VBA network includes over 16,000 providers for your convenience, with the flexibility to choose their preferred labs. VBA Vision partners with licensed, practicing Doctors of Optometry and Ophthalmology as well as retail locations. All VBA Vision doctors adhere to comprehensive exam standards. A list of participating VBA providers is available on www.vbaplans.com under 'I am a Member—Provider Finder.'

When using a VBA network provider, the provider will contact VBA to verify your eligibility via their online system and will process your covered services electronically. You must advise your provider that you have coverage through VBA before you receive services or materials at your visit. So inform your VBA provider both when you schedule your exam and when you go there. If you do not, you will be treated as a private patient and out-of-network benefits will apply.

Be sure to check to see if your provider is part of the VBA network before your visit.

Out-of-Network Coverage

If you use a provider that is out-of-network, you will still receive benefits, but they will be at the out-of-network level. You will need to pay for the services and materials, and then submit a claim for reimbursement using a VBA Out-of-Network Reimbursement form. You can get this form online at www.vbaplans.com under 'Forms' or by calling 1-800-432-4966.

Out-of-network coverage also applies when you use a VBA network provider for an exam or materials without first informing the VBA provider that you are using your VBA coverage.

VBA issues out-of-network benefit payments on a bi-weekly basis after receiving and processing your out-of-network claim.

Out-of-Area Coverage

Here's how out-of-area coverage works if there is no VBA provider within 35 miles of your home zip code:

Coverage (Once per Plan Year)	Non-VBA Provider
Routine Vision Exam	100%
Eyeglass Lenses and/or Frames (one time per plan year) Including: Single, Bifocal, Blended Bifocal, Progressive, Trifocal, Lenticular, Polycarbonate, one-year Scratch-Resistant Coatings, UV 400 and Optional Lens Tints	▪ Plan pays 100% after $20 copay per person for the materials ▪ Frames will be reimbursed up to $130 ▪ Additional Lens Options such as: 1 Yr. Scratch, UV Coatings, Polycarbonate Lenses, Progressives and Tints will be reimbursed in full ▪ Digital Progressives available at extra cost
Cosmetic Contact Lenses (in lieu of glasses, including vision exam)	Up to $175 allowance toward the total cost
VBA-Approved Medically Necessary Contact Lenses (in lieu of glasses, including vision exam)	100% of R&C (Reasonable and Customary)

Scheduled Benefits/Plan Year

The Plan provides benefits for covered services once per calendar year for each covered person.

Plan Allowances

The Plan allowance, less copays, is the maximum amount the Plan will pay for vision care within the coverage period as noted by the chart under "Highlights" on page 56. You will be responsible for paying any costs above the plan allowances.

Providers in the VBA network have agreed to accept the Plan's allowance for in-network services (e.g., routine vision exams and medically necessary contact lenses).

Here's how it works: If your provider charges less than the Plan's allowance after the copay has been deducted for a specific service, you'll be reimbursed only up to the actual charges. If your provider charges more than the Plan's allowance, you'll have to pay the difference between your provider's fee and the Plan's allowance.

Save Even More on Your Vision Expenses

When you contribute to the Health Care Limited Purpose FSA or the Health Savings Account (HSA), you may use funds from your account to help pay your vision care expenses, including your copayments. And, you'll benefit from tax savings!

Copayments

A copayment is a fixed fee charged for certain services. For example, when you pay a $20 copayment for eyeglass lenses from a VBA provider and the Plan pays the rest.

VBA Discounts

A variety of non-covered lens options may be available to you at reduced prices through VBA network providers. Discounts apply only when purchased in conjunction with covered lenses and/or frames. Discounts are not available on multiple pairs of lenses and/or frames.

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

- a frame that costs more than the Plan allowance;
- contact lenses in excess of the Plan allowance;
- photochromatic lenses;
- rimless frames; and
- the laminating of a lens or lenses.

What Is Covered

Eyeglass Lens Options

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

- polycarbonate lenses
- scratch-resistant coatings (Standard one-year)
- solid and gradient lens tints
- blended bifocals
- non-digital progressive lenses (digital progressives available at additional cost)
- ultraviolet coating

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

Contact Lenses

When contact lenses are selected instead of glasses, a total allowance of up to $175 is paid toward the cost of exams and cosmetic (elective) contact lenses, regardless of whether you purchase them through a VBA provider or not.

CONTACT LENS COVERAGE INSTEAD OF REGULAR COVERAGE

Contact lens benefits (routine exam, evaluation, fitting, lenses) can be taken instead of all other benefits for the Plan Year. Because contact lens services vary from provider to provider and include additional elements such as the evaluation, (tear drop test, etc.) fittings, and follow-up visits, your allowance may not provide you 100% coverage for all costs incurred

If contact lens services are received through a VBA network provider, the provider will subtract the Plan allowance of $175 from his or her usual and customary charge for these services, and the patient will be responsible for any difference over and above the $175 allowance.

Medically Necessary Contact Lenses

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

- due to eye disease (such as Keratoconus or Aphakia) or injury;
- after cataract surgery;
- to correct significant anisometropia; or
- to correct extreme visual acuity problems.

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

If you get Medically Necessary contact lenses from a VBA provider, the Plan pays 100%.

If, however, you receive Medically Necessary contact lenses from a non-VBA provider, the Plan will reimburse you up to $300, so long as your request for Out-of-Network reimbursement is accompanied by a letter of medical necessity from your selected provider in compliance with VBA's established Medically Necessary criteria (as described above).

What Is Not Covered

The Plan does not cover:

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

BeneFlex Health Care Limited Purpose FSA

The Health Care Limited Purpose FSA provides a way for you to save money on your dental and vision expenses. It's called "limited" because the types of expenses that can be reimbursed are limited to qualified out-of-pocket dental and vision costs.

It's a benefit plan that lowers your taxes, helping you save money on your dental and vision expenses. But be careful! The Health Care Limited Purpose FSA has a "use it or lose it" rule. Unused money in your account at the end of the year is forfeited.

Important note: Medical, prescription, or other health care items that are not primarily for dental or vision care **are not eligible** to be reimbursed through the Health Care Limited Purpose FSA.

FSA stands for Flexible Spending Arrangement, a term used by the Internal Revenue Service (IRS) to describe plans like the Health Care Limited Purpose FSA that qualify for tax savings. Refer to IRS publication 969 "Health Savings Accounts and Other Tax-Favored Health Plans" for additional information.

Questions?
If you have questions about the Health Care Limited Purpose FSA, contact Bank of America at 1-877-319-8115, or visit https://healthaccounts.bankofamerica.com/DuPont and click on the FSA resources tab.

SECTION CONTENTS

Highlights

This table highlights key features of the Health Care Limited Purpose FSA. Read the full summary for more details.

How the Account Works	You contribute before-tax dollars to pay for eligible dental and vision expenses throughout the year.
Contributions	▪ From $120 to $2,600 annually ▪ Contributions prorated over the number of pay periods in the year
Eligible Expenses	Eligible expenses include, but are not limited to: ▪ Dental and vision plan deductibles, coinsurance and copays; and ▪ Amounts not covered by a benefit plan or insurance, including costs for: ▫ Eye exams, eye care and Lasik surgery; ▫ Eyeglasses or contact lenses; ▫ Dental care, dentures, exams, extractions, fillings, teeth cleaning, X-rays, but not including cosmetic treatment; ▫ Orthodontia care and devices (braces, retainers, etc.).
Expenses Not Eligible	▪ Medical care ▪ Prescriptions that are not for dental or vision care ▪ Cosmetic care (care that is not medically necessary) ▪ Any expenses that you reimburse using a Health Savings Account (HSA) or claim as deductions when you file your income taxes
Reimbursement	▪ Pay with the Health Care Limited Purpose FSA debit card you receive when you enroll, or ▪ Pay using cash, check, or another card and file a claim for reimbursement—see the row for the Health Care Limited Purpose FSA in the table under "How to File a Claim" on page 93 in the *Claiming Benefits and Other Information* section. ▪ You may be reimbursed up to your full annual contribution amount at any time during the year.
Deadlines ▪ December 31 ▪ April 15	▪ Expenses must be for services received during the plan year in which you make the contributions—so the deadline for receiving services is December 31. ▪ You must file all claims within 105 calendar days of the following plan year (typically April 15th). ▪ Unused money in your account at the end of the claim filing period will be forfeited.

How the Plan Works

You use the Health Care Limited Purpose FSA to reimburse yourself for eligible out-of-pocket dental and vision expenses not covered by any benefit plan.

- Contributions are deducted from your pay on a before-tax basis, before federal, Social Security and most state taxes are taken out. This means that by contributing, you reduce your total taxable income and end up paying lower taxes.
- When you submit a claim or use your Bank of America debit card, the funds come out of your account tax-free.

How You Save Money

The Health Care Limited Purpose FSA allows you to pay for qualified dental and vision expenses with before-tax dollars. By saving money on taxes, you have more money to use.

Here's an example.

- *Mark is planning to get braces for his child next year. He estimates that he will need to pay $1,500 during the year as his dental plan deductible and coinsurance amounts.*
- *He elects to contribute $1,500 to a Health Care Limited Purpose FSA.*
- *His current payroll tax rate is 22% federal taxes and 7.5% FICA taxes.*
- *Using Bank of America's Health FSA Savings Calculator, at https://healthaccounts.bankofamerica.com/DuPont, he sees that he should save approximately $442 in tax dollars.*

Account Statements

Quarterly account activity statements are available online within two business days after the quarter closes. Statements will be available even if you have had no claims.

For information on your account activity, contact:

- *Bank of America at 1-877-319-8115, or*
- *Bank of America online at https://healthaccounts.bankofamerica.com/DuPont.*

Choosing How Much to Contribute

You can contribute from a minimum of $120 to a maximum of $2,600 for the year.

If you and your spouse both work for the Company and are each enrolled in the Health Care Limited Purpose FSA, your combined contribution maximum cannot exceed $5,200.

Each year during enrollment, you decide how much to contribute for the upcoming plan year.

If you're currently contributing, your contributions will continue at the same level, automatically; there's no need to re-enroll each year.

Your enrollment decision will remain in effect for rest of the plan year. The only time you can make a change during the year only is if you have a Qualifying Life Event.

Estimate Your Expenses Carefully

Use the online tool to estimate your annual expenses at https://healthaccounts.bankofamerica.com/DuPont and click on the FSA Resources tab and choose Calculate how much you can save with an FSA. Enter figures into the calculator for eligible vision and dental expenses only which are listed as eligible for reimbursement under the Health Care Limited Purpose FSA.

When Your Account Funds Are Accessible

The full amount of your annual contribution will be available starting January 1. You can access the total amount, less any payments already taken, at any time, regardless of how much you have contributed. If you are newly hired and elect a Health Care Limited Purpose FSA, your contribution election will be available the first of the month following your election.

Forfeiting Unused Contributions

When you choose your contribution amount during enrollment, you should consider carefully your estimated dental and vision costs for the plan year. Under Section 125 of the IRS tax code, you will forfeit the unused balance in your account at the end of the plan year.

You must have submitted all claims for reimbursement to Bank of America, postmarked no later than 105 days from the end of the plan year to avoid forfeiting the unused funds.

Bank of America Visa® Debit Card

When you first start contributing to a Health Care Limited Purpose FSA, you will receive a Bank of America Visa debit card. This card will be loaded every January 1 with the full amount you will contribute for the year. You can use this card to pay for eligible expense directly, instead of paying the provider and then filing a claim for reimbursement. If you have also elected an HSA and/or the Dependent Care FSA you will receive one card for all accounts. The merchant code recognized when you swipe your card will determine which eligible account will be deducted for the expense.

Note: Eligible dental and vision expenses will automatically be deducted from your Health Care Limited Purpose FSA first prior to deducting from your HSA.

Effect on Social Security

Because no Social Security taxes are paid on the amount of your contributions, if your annual taxable pay is less than the Social Security maximum taxable amount, your income for Social Security benefit purposes is less and your Social Security benefits at retirement or disability may be slightly reduced.

Whether your Social Security benefits are affected depends on a number of factors, such as your current age, your pay before participating in the Health Care Limited Purpose FSA and your future pay levels.

Federal Tax Credit

In certain situations, IRS tax rules allow you to deduct some health care expenses on your federal income tax return. If you have significant health care expenses during the year that are in excess of 10% of your annual income, you will be able to deduct the expenses on your tax return. The Health Care Limited Purpose FSA is a benefit to you because you can use it to pay on a before-tax basis for expenses that are not deductible to you because of the 10% threshold. However, if you are eligible for the deduction, you can use this tax deduction, choose to participate in the Health Care Limited Purpose FSA, or decide to use a combination of the two to pay for your health care expenses. If you choose to use both, you must subtract your annual Health Care Limited Purpose FSA contribution from the amount specified under IRS tax rules.

The IRS provides information about the tax deduction and qualifying expenses. You cannot submit a claim for reimbursement to the Health Care Limited Purpose FSA and claim the same expenses on your federal income tax return.

Whose Expenses Are Eligible?

You can use your Health Care Limited Purpose FSA to cover eligible health care expenses for:

- you;
- your spouse;
- your son, daughter, stepchild, foster child, brother, sister, stepbrother, stepsister, half-brother, half-sister or descendant of the (for example, your grandchild, niece, or nephew) who:
  - is under age 19 at the end of the calendar year and younger than you (or your spouse, if filing jointly);
  - is under age 24 at the end of the calendar year, a full-time student, and younger than you (or your spouse, if filing jointly); or
  - is any age and permanently and totally disabled; and
  - lives with you for more than half the year
  - doesn't provide over half of his or her own support; and
  - didn't file a joint return other than to claim a refund
- anyone else that you claim as a dependent on your tax return, and
- any person you *could have claimed* as a dependent on your return, but did not, because:
  - the person filed a joint return;
  - the person had gross income of $3,900 or more, or
  - you, or your spouse if filing jointly, could be claimed as a dependent on someone else's most recent tax return.

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

Not for Dependent Care

The Health Care Limited Purpose FSA and the Dependent Care FSA are separate.

- *Money you set aside for your Health Care Limited Purpose FSA can't be used to pay for dependent care expenses.*
- *Similarly, any money set aside for a Dependent Care FSA can't be used to reimburse any health care expenses.*
- *Finally, you can't transfer money between these accounts.*

Eligible Expenses

The IRS determines which expenses are eligible for reimbursement. You can use the Health Care Limited Purpose FSA for eligible dental and vision expenses that are not covered by any benefit plan (such as your Company dental or vision coverage, if enrolled), including:

- dental and vision plan deductibles, coinsurance and copays;
- amounts not covered by a benefit plan or insurance, including costs for:
  - eye exams, eye care, and Lasik surgery;
  - eyeglasses or contact lenses;
  - dental care, dentures, exams, extractions, fillings, teeth cleaning, X-rays, but not including cosmetic treatment; and
- orthodontia; and devices (braces, retainers, etc.).

Filing Claims

For more details on filing claims for the Health Care Limited Purpose FSA and using your debit card, see the row for the Health Care Limited Purpose FSA in the table under "How to File a Claim" on page 93 in the Claiming Benefits and Other Information *section.*

If you are generally able to deduct a dental or vision expense from your federal tax return, under IRS Code 213, you will likely be able to reimburse it using your Health Care Limited Purpose FSA.

You can deduct some items, like premiums for health care coverage, from your federal tax returns that you can't reimburse with the Health Care Limited Purpose FSA. For added clarification on eligible expenses, contact Bank of America at 1-877-319-8115.

Ineligible Expenses

You can't use the Health Care Limited Purpose FSA for an expense that:

- relates to medical care, including prescriptions;
- can't be deducted from your federal tax return (except if it can't be deducted because it is more than 10% of your gross income);
- can be reimbursed by another benefit or insurance plan; or
- is from before or after you participated in the Plan.

Ineligible expenses include, but are not limited to:

- teeth bleaching/whitening;
- cosmetic dental surgery;
- dental hygiene products (toothpaste, floss, mouthwash, etc.);
- cosmetic glasses or sunglasses;
- orthodontia costs not associated with services received in the current year;
- orthodontia costs that are strictly cosmetic;
- premiums for benefit or insurance plans of any kind; or
- medical, prescription, mental health, chemical dependency or other expenses that are not primarily dental or vision in nature.

Filing Claims for Reimbursement

You can access your Health Care Limited Purpose FSA by paying for eligible expenses using your account debit card. Alternatively, you can pay using another method and then submit a claim for reimbursement.

For more information, see the row for the Health Care Limited Purpose FSA in the table under "How to File a Claim" on page 93 in the *Claiming Benefits and Other Information* section.

BeneFlex Dependent Care FSA

The Dependent Care FSA provides an easy way to save money on the cost of caring for your loved ones, so you and your spouse (if married) can work.

When you enroll, you begin making pre-tax payroll contributions to your personal account. You can use your account to reimburse the cost of care for your child under age 13, or a disabled older dependent such as a parent, spouse, or child. Reimbursable expenses include: child and adult day care, before and after-school care, summer day camps, and preschool.

It's a benefit plan that lowers your taxes, helping you afford the cost of dependent day care.

Questions?

If you have questions about the Dependent Care FSA, contact Bank of America at 1-877-319-8115, or visit https://healthaccounts.bankofamerica.com/DuPont and click on the DCFSA resources tab.

Caution! The Dependent Care FSA Is Not for Health Care Expenses!

The Dependent Care FSA cannot be used to reimburse health care expenses for your dependents. It is for day care expenses during the hours when you are working.

The Health Care Limited Purpose FSA is a separate BeneFlex plan that can be used to reimburse dental and vision care expenses, for you and for your eligible dependents.

The two accounts cover different types of expenses. You can't transfer money between the accounts. So when you enroll, be sure you are enrolling for the right account for the right expenses.

SECTION CONTENTS

Highlights

This table highlights key features of the Dependent Care FSA. Read the full summary for more details.

How the Account Works	You contribute before-tax dollars to pay for eligible dependent care expenses throughout the year.
Contributions	▪ From $120 to $5,000 annually ▪ If you're married, your contribution limits depend on how you and your spouse file your taxes.
Whose Care Is Eligible	Only care for children under age 13 and disabled dependents is eligible.
Eligible Expenses	If you're married, your spouse must work, attend school full time or be physically or mentally unable to provide self-care, for your expenses to be eligible. Eligible expenses include: ▪ Child day care centers; ▪ Nursery school; ▪ Adult day care centers; ▪ Summer day camp; ▪ Baby sitters; ▪ Au pairs; ▪ After-school programs; and ▪ Elder care.
Expenses Not Eligible	Ineligible expenses include but are not limited to: ▪ Expenses for services received when you or your spouse were not working or attending school full-time; ▪ Expenses you claim as a tax credit on your tax return; ▪ Expenses for services received while you are away from work because of an illness or leave of absence; ▪ Expenses for a caretaker who you claim or could claim as a dependent; and ▪ Expenses for tuition (kindergarten and up) or activity fees, field trips, late fees, food, medical care, registration fees, overnight camp, or transportation.
Reimbursement	▪ Pay with the Dependent Care FSA debit card you receive when you enroll, or ▪ You can pay using cash, check, or another card and file a claim for reimbursement—see the row for the Dependent Care FSA in the table under "How to File a Claim" on page 93 in the *Claiming Benefits and Other Information* section. ▪ You can only be reimbursed up to the amount of money that has been deposited into your account.
Deadlines ▪ December 31 ▪ April 15	▪ Expenses must be for services received during the plan year in which you make the contributions—so the deadline for receiving services is December 31. ▪ You must file all claims within 105 calendar days of the following plan year (typically April 15th). ▪ Unused money in your account at the end of the claim filing period will be forfeited.

How the Account Works

- You use the Dependent Care FSA to reimburse yourself for eligible dependent care expenses you have so that you and your spouse (if married) can work or attend school full-time or if your spouse is physically or mentally unable to provide self-care.
- Contributions are deducted from your pay on a before-tax basis, before federal, Social Security and most state taxes are taken out. This means that by contributing, you reduce your total taxable income and end up paying lower taxes.
- When you submit a claim, the funds come out of your account tax-free.

How You Save Money

The Dependent Care FSA allows you to pay for dependent care expenses with before-tax dollars. By saving money on taxes, you have more money to spend on your dependent's care.

Here's an example:

- *Casey is married and her husband works full-time. They pay over $5,000 a year for their two-year-old son's day care.*
- *She elects to contribute $5,000 to a Dependent Care FSA.*
- *Her current payroll tax rate is 22% federal taxes and 7.5% FICA taxes.*
- *Using Bank of America's Dependent Care FSA Savings Calculator, at https://healthaccounts.bankofamerica.com/DuPont, she sees that she should save approximately $1,475 in tax dollars.*

Account Statements

Quarterly account activity statements are available online within two business days after the quarter closes. Statements will be available even if you have had no claims. For information on your account activity, contact:

- *Bank of America at 1-877-319-8115, or*
- *Bank of America online at https://healthaccounts.bankofamerica.com/DuPont and click on the DCFSA resources tab*

Contribution Limits

You can contribute from a minimum of $120 to a maximum of $5,000 for the year.

Some restrictions apply:

- If you're married:
  - And you file a joint federal tax return, you can contribute up to of $5,000 per year to the Dependent Care FSA. Note: if your spouse's employer has a similar dependent care assistance program, the combined total of contributions to your Dependent Care FSA and to your spouse's program is $5,000.
  - And you file separate federal tax returns, you can contribute up to $2,500 per year to the Dependent Care FSA.
  - You can't contribute more than the lesser of your earned income or your spouse's earned income.
- If you're considered a highly compensated employee, as defined by the IRS, your contributions may be limited or suspended during the year so the Plan can comply with IRS non-discrimination requirements. You will be notified if this applies to you.

Choosing How Much to Contribute

Each year during Annual Enrollment, you decide how much to contribute for the upcoming plan year.

If you are currently contributing, your contributions will continue at the same level automatically; there's no need to re-enroll each year.

Your enrollment decision will remain in effect for rest of the plan year. The only time you can make a change during the year only is if you have a Qualifying Life Event.

Note: Expenses must be for the care of a dependent who is eligible according to IRS rules. Before enrolling each year, be sure to review these rules to confirm that your dependent will be considered eligible for the entire year and that you take this into consideration when making your contribution election. See IRS publication 503 "Child and Dependent Care Expenses" for the dependent eligibility rules.

Estimate Your Expenses Carefully

Use the online tool to estimate your annual expenses at https://healthaccounts.bankofamerica.com/DuPont for guidance. Don't over estimate; you are not able to change your contribution amount during the year unless you experience a Qualifying Life Event (QLE) such as a change in caregivers or a significant change in your caregiver costs. See "Changing Your Coverage" on page 10 for information on QLEs.

When Your Account Funds Are Accessible

Your contributions will be deducted from your pay and credited to your account shortly after each pay date.

Unlike the Health Care Limited Purpose FSA, which can reimburse you for eligible expenses even if the funds haven't been deposited in your account yet, with the Dependent Care FSA, you can only be reimbursed up to the amount of the funds deposited in your account.

Forfeiting Unused Contributions

When you choose your contribution amount during enrollment, you should consider carefully your estimated dependent care costs for the plan year. Under Section 125 of the IRS tax code, you will forfeit the unused balance in your account at the end of the plan year.

You must have submitted all claims for reimbursement to Bank of America, postmarked no later than 105 days from the end of the plan year (usually April 15th) to avoid forfeiting the unused funds.

Bank of America Visa® Debit Card

When you first start contributing to a Dependent Care FSA, you will receive a Bank of America Visa debit card. You can use this card to pay for eligible expenses directly up to the amount available in your account, instead of paying the provider and then filing a claim for reimbursement. If you have also elected a Health Savings Account (HSA) and/or the Health Care Limited Purpose FSA, you will receive one card for all accounts. The merchant code recognized when you swipe your card will determine which eligible account will be deducted for the expense.

Effect on Social Security

Because no Social Security taxes are paid on the amount of your contributions, if your annual taxable pay is less than the Social Security maximum taxable amount, your income for Social Security benefit purposes is less and your Social Security benefits at retirement or disability may be slightly reduced.

Whether your Social Security benefits are affected depends on a number of factors, such as your current age, your pay before participating in the Dependent Care FSA and your future pay levels.

Dependent Care Tax Credit

In certain situations, IRS tax rules allow you to deduct some dependent care expenses on your federal income tax return. You can either:

- use this tax deduction,
- participate in the Dependent Care FSA, or
- use a combination of the two to pay for your dependent care expenses.
  - If you use both, you must subtract your annual Dependent Care FSA contribution from the amount specified under IRS tax rules.

The IRS provides information about the tax deduction and qualifying expenses. You cannot submit a claim for reimbursement to the Dependent Care FSA and claim the same expense on your federal income tax return.

Whose Expenses Are Eligible?

To be eligible for reimbursement, expenses must be for the care of your:

- child (biological, legally adopted or placed for adoption)*:
  - who is under age 13;
  - who spends at least eight hours a day in your home; and
  - whom you claim as a dependent on your tax return*; or
- spouse or dependent family member (such as your parent, grandparent, or sibling):
  - who is not physically or mentally able to provide self-care and lives with you for more than 50% of the current calendar year;
  - who spends at least eight hours per day living in your home; and
  - whom you claim as a dependent on your tax return.

For more information on eligible dependents, refer to IRS Publication 503 "Child and Dependent Care Expenses."

** In the case of divorced or separated parents, your child may be considered to meet these requirements if you are the custodial parent and all other requirements to claim the child as a dependent on your tax return are met. Contact your tax advisor to see if your child can qualify.*

Eligible Expenses

Eligible expenses include:

- licensed child day care centers or nursery schools;
- a caretaker who provides care in your home or another location and provides you with their Social Security Number for tax purposes;
- preschool (up to kindergarten);
- adult day care centers;
- summer day camp for dependent children under age 13;
- baby sitters (work related);
- au pairs;
- after-school programs;
- elder care; and
- sick child care.

All Dependent Care FSA claims must be substantiated with supporting documentation, including the Taxpayer Identification Number (TIN) or Social Security Number of your care giver. Bank of America will contact you about providing the necessary documentation to support the debit card charge. You will be able to submit documentation via the online portal for both debit card charges and reimbursement requests for eligible expenses paid using cash, check, or another card.

Not for Health Care

The Dependent Care FSA and the Health Care Limited Purpose FSA are separate.

- *Money you set aside for a Dependent Care FSA can't be used to reimburse any health care expenses.*
- *Similarly, any money you set aside for your Health Care Limited Purpose FSA can't be used to pay for dependent care expenses.*
- *Finally, you can't transfer money between these accounts.*

Only expenses for care that enables you to work are eligible. And, if you're married, your spouse must either work, attend school full time, or be physically or mentally unable to provide self-care for your expenses to be eligible.

If you are generally able to deduct a dependent care expense from your federal tax return, you will likely be able to reimburse it using your Dependent Care FSA.

For more information on eligible expenses, refer to IRS Publication 503 "Child and Dependent Care Expenses."

Expenses That Can't Be Reimbursed

You can't use the Dependent Care FSA for any expenses that do not qualify for reimbursement based on IRS guidance, including, expenses that:

- are not for care that enables you (and your spouse if you are married) to work or attend school full-time or because your spouse is physically or mentally unable to provide self-care;
- could be reimbursed by another benefit or insurance plan;
- was for services received before or after you participated in the Dependent Care FSA;
- is claimed as a tax credit on your income tax return;
- doesn't qualify for an income tax credit on your tax return; or
- is from another plan year than the one for which contributions are made.

Ineligible expenses include, but are not limited to:

- expenses while you are away from work because of illness or leave of absence;
- payments to a caretaker that you could claim as a dependent on your (or your spouse's) tax return;

- tuition charges for kindergarten (and higher grades);
- activity fees;
- food expenses;
- medical expenses;
- transportation to and from a dependent care location (unless provided by the day care); and
- care provided in a full-time residential institution.

Filing Claims for Reimbursement

For information on submitting claims for reimbursement, see the row for the Dependent Care FSA in the table under "How to File a Claim" on page 93 in the *Claiming Benefits and Other Information* section.

Note: a claim will be reimbursed ONLY if the expense was for services received in the same calendar year in which the contribution to the Dependent Care FSA was made. You cannot be reimbursed for services received before your participation begins or after your participation ends.

BeneFlex Employee Life Insurance

Providing a Legacy of Financial Protection

Life insurance can provide you with peace of mind. Your loved ones depend on you.

Whether you're young and single or middle age with a family, life insurance can help pay your final expenses and debts, and give your survivors some financial support following your death.

SECTION CONTENTS

Active Employees Participating in the Noncontributory Group Life Insurance (NCGLI)/Contributory Group Life Insurance (CGLI) Plans

Some active employees have continuously participated in the Noncontributory and Contributory Group Life Insurance Plans (NCGLI/CGLI) since before the plans closed to new participants in 1992. If you are an active employee covered under the NCGLI/CGLI Plans, the Life Insurance Benefits Summary Plan Description contains information about your coverage.

Basic Coverage Paid for by the Company

The Company provides Basic Life Insurance automatically, if you are eligible, and the coverage begins on your first day of active employment.

No Tax on Benefits

Your beneficiary does not pay federal income taxes on the death benefit he or she receives.

Coverage	You have a choice of coverage levels: ▪ 1× your Pay, up to a maximum of $1 million; ▫ Coverage that is not a multiple of $1,000 will be rounded up to the next $1,000. ▪ $10,000; or ▪ $50,000.
Cost	▪ The Company pays the premiums for this coverage. ▪ If you choose $10,000 or $50,000 of coverage, and the premium cost is less than premium cost of the 1× Pay coverage, the difference will be returned to you in your paycheck.
Imputed Income	▪ Federal law requires you to pay income taxes on the value of any Company-provided life insurance coverage over $50,000. ▪ This value is referred to as "imputed income" and will be considered taxable income to you. ▪ If you want to avoid imputed income, you can limit your coverage to $10,000 or $50,000.
Occupational Accidental Death Coverage	▪ The Plan includes a special benefit in case you die as a result of an accident on the job with the Company. ▪ The benefit is 3× your Pay, with a minimum benefit of $10,000 and a maximum of benefit of $3 million. ▪ See "Occupational Accidental Death Coverage" on page 79.

If Your Pay Changes

The amount of coverage shown on your personalized enrollment worksheet will change throughout the year as your Pay changes. Your new coverage amount becomes effective the first of the month on or after your Pay change.

Conversion and Portability for Life Insurance

When your Company coverage ends, you may have options to continue employee and dependent coverage, through conversion and/or portability. See "Converting Employee Group Life Coverage to Individual Coverage on page 107 and "Portability of Employee and Dependent Life Coverage on page 107.

Supplemental Coverage Available for Purchase

You can purchase Supplemental Life Insurance if you want additional coverage.

Coverage	▪ You can purchase coverage of an additional 1× to 7× your Pay, to a maximum of $7 million of supplemental coverage. ▫ Coverage that is not a multiple of $1,000 will be rounded up to the next $1,000. ▪ EOI is required before coverage begins. You must provide EOI for: ▫ Initial enrollments for supplemental life amounts over 2× Pay (total employee life insurance coverage of 3× Pay or greater); and ▫ Any increase in coverage thereafter.
Cost	The cost depends on: ▪ Your age (premiums vary by age); and ▪ The amount of coverage.

Depending on the coverage option you select, you may need to provide Evidence of Insurability (EOI) to the insurance company before coverage takes effect. EOI is required for an initial enrollment of over 3× Pay (Basic plus Supplemental coverage combined) and any subsequent increase in insurance. See "Evidence of Insurability" on page 7 in the *Eligibility and Enrollment* section for more information.

Supplemental Coverage will begin:

- on the first of the month after you enroll (if no EOI is required) or
- after any required EOI is approved.

Maximum Life Benefit: $8 Million

The maximum combined death benefit for Basic and Supplemental coverage is $8 million.

Coverage Options

When you elect employee life insurance coverage, your options will show both the Basic and Supplemental options together, along with the cost of each option. You select the total combined amount of Basic plus Supplemental coverage that you want. This streamlines the coverage election process, saving you from needing to make separate elections for Basic and Supplemental coverage.

Coverage amounts that are higher than 1× Pay include Basic coverage of 1× Pay that is paid for by the Company.

You can select one of the following coverage amounts:

- $10,000
- $50,000
- 1× Pay
- 2× Pay
- 3× Pay
- 4× Pay
- 5× Pay
- 6× Pay
- 7× Pay
- 8× Pay

You must elect a minimum of $10,000 in coverage.

You can change your coverage option each year during Annual Enrollment and during the year if you have a Qualifying Life Event, as explained in "Changing Your Coverage" on page 10 in the *Eligibility and Enrollment* section.

Examples of Coverage Amounts

Kari's annual Pay is $80,300 and she elects Basic coverage of 1× Pay and Supplemental coverage of 2× Pay, for total coverage of 3× Pay. Her Basic coverage will be rounded up to $81,000 and her Supplemental coverage will be $160,000, for total coverage of $241,000, as shown below.

1× Pay Basic Coverage ($80,300 rounded up to $81,000)	$81,000
2× Pay Supplemental Coverage (3 × $80,300 = $240,900 rounded up to $241,000; $241,000 – $81,000 = $160,000)	$160,000
Total Coverage (3× $80,300, rounded up to the next $1,000)	$241,000

George's annual Pay is $50,700 and he elects Basic coverage of 1× Pay and Supplemental coverage of 3× Pay*, for total coverage of 4× Pay. His Basic coverage will be rounded up to $51,000, and his Supplemental coverage will be $152,000, for total coverage of $203,000.

1× Pay Basic Coverage ($50,700 rounded up to $51,000)	$51,000
3× Pay Supplemental Coverage (4 × $50,700 = $202,800 rounded up to $203,000; $203,000 – $51,000 = $152,000)	$152,000
Total Coverage (4× $50,700 = $202,800, rounded up to the next $1,000)	$203,000

** EOI is required for an initial enrollment of over 3× Pay (total Basic plus Supplemental coverage combined) and any subsequent increase in insurance. See "Evidence of Insurability on page 7 in the Eligibility and Enrollment section for more information.*

Cost of Coverage

The Company pays the premium costs of Basic coverage. If you choose $10,000 or $50,000 in coverage, and the premium cost for that coverage is less than the premium cost of the 1× Pay coverage option, the difference will be returned to you in your paycheck.

You pay the premium costs of any Supplemental coverage on an after-tax basis. The premium costs depend on your age as of December 31st of the year for which you are enrolling, the coverage level you choose, and your Pay. Your eligible Pay as of October 1 of each year is used to estimate your cost as of January 1, however Pay changes after October 1 will impact your coverage level and cost.

Age as of 12/31 of the Current Year	Monthly Premiums per $1,000 of Coverage
Under 25	$0.015
25 – 29	$0.018
30 – 34	$0.027
35 – 39	$0.041
40 – 44	$0.055
45 – 49	$0.098
50 – 54	$0.170
55 – 59	$0.281
60 – 64	$0.439
65 – 69	$0.788
70 – 74	$1.369
75 – 79	$2.042
80 – 84	$2.042
85 – 89	$2.042
90+	$2.042

When Premium Costs Change

The premium costs shown are for the 2018 Plan year. Unless indicated differently, premium costs are reviewed and subject to change annually at the beginning of a Plan year (January 1). You will be notified in advance of any changes.

If your coverage amount increases or decreases during the year, your cost will be adjusted to reflect the changes. Your cost will change based on your Pay cycle, on or after the date your:

- your Pay and coverage amount changes; or
- you change your coverage election because of a Qualifying Life Event; or
- you retire.

For example, if your Pay increases by $5,000, your coverage will increase by $5,000 for each 1× Pay amount that you have purchased, and your cost will increase accordingly.

When possible, your payments will be made through payroll deduction. If you take an unpaid leave of absence or your Pay does not cover the cost of coverage, the Plan may directly bill you for the cost.

Examples of Cost of Coverage

Peter is 43 years old and his annual Pay is $74,600. He elects Supplemental coverage of 2× Pay. His monthly cost of coverage will be $8.20.

Supplemental coverage amount (3 × $74,600 = $223,800 – $75,000 of Basic coverage = $148,800, rounded up to $149,000)	$149,000
Monthly cost per $1,000 of coverage for a 43-year-old	$0.055
Monthly cost of coverage ($0.055 × $149,000/$1,000 = $8.20)	$8.20

June is 32 years old and her annual Pay is $47,700. She elects Supplemental coverage of 1× Pay. Her monthly cost of coverage will be $1.30.

Supplemental coverage amount (2 × $47,700 = $95,400 – $48,000 of Basic coverage = $47,400 rounded up to $48,000)	$48,000
Monthly cost per $1,000 of coverage for a 32-year-old	$0.027
Monthly cost of coverage ($0.027 × $48,000/$1,000 = $1.30)	$1.30

Naming a Beneficiary

The beneficiary is the person or persons entitled to Basic and Supplemental Life Insurance benefits if you die.

- You can name more than one beneficiary, and you can specify the percentage of the total benefit each beneficiary should receive.
- You can name primary beneficiaries and contingent (alternate) beneficiaries. Contingent beneficiaries receive benefits only if all primary beneficiaries die before you.
- You can name a trust or charitable organization instead of people, if desired. Make sure you keep the trust documents with your important papers, since your estate will be required to submit the trust documents at your death.

All Plan participants are encouraged to keep their life insurance beneficiary information up to date. Contact DuPont Connection at 1-800-775-5955 to change your beneficiaries at any time.

Is Your Beneficiary Designation Up to Date?

It's a good idea to review your beneficiary designation to be sure it is up to date, especially if you have a life event such as a marriage. Contact DuPont Connection at 1-800-775-5955 to change your beneficiaries at any time.

The Beneficiary for Assigned Benefits

You cannot name a new beneficiary if you have already assigned your benefits, transferring ownership of your benefits to someone else (such as to a trust). The assignee may make an Assignee Beneficiary Designation, if they choose to do so. Otherwise, the assignee will be the beneficiary for your coverage.

As of January 1, 2014, no benefits under the Plans in this SPD can be assigned.

If No Beneficiary Is Named

If you do not have a valid beneficiary designation on file with the Plan Administrator at your death, or if your named beneficiary dies before you, your benefits will be paid out in the following order of survival:

- to your legal spouse at the time of your death;
- equally among your biological or legally adopted children;
- equally among your parents;
- equally among your siblings; and then
- to your estate.

If You Assigned Your Benefits

When you assign your rights to a benefit, you legally and irrevocably transfer ownership of your Plan benefit to someone else. Once coverage has been assigned, the new "owner" has all the rights you once had. Assignment of benefits under the Plan is irrevocable.

Effective January 1, 2014, you can no longer assign benefits.

See "Assignment of Benefits" on page 96 in the *Claiming Benefits and Other Information* section for more information.

When Benefits Are Paid

Plan benefits are distributed to your beneficiaries upon your death. If a Trust has been named as a beneficiary, at the time of your death, a copy of the trust, including all amendments, must be provided to DuPont Connection before your life insurance claim can be paid. If proper documentation is not provided, the Plan Administrator may treat your designation of the Trust as invalid.

If you assigned your life insurance benefit before January 1, 2014, benefits are payable to the assignee or to the beneficiary designated by the assignee on record with the Company.

The Plan has a minimum $10,000 death benefit for active employees. The maximum death benefit is $8 million.

Claiming Your Benefits

See the Claiming Benefits and Other Information *section on page 92 for details on how to file a claim for benefits.*

If You Are Terminally Ill

If you have a terminal illness, you may be eligible to receive an accelerated benefit, in advance, while you are still alive. You are not eligible to receive an accelerated benefit if you previously assigned your benefit.

Accelerated benefits pay up to one-half the value of your life insurance coverage, to a maximum of $1 million. The amount payable will take into account anticipated future changes in coverage as a result of age reductions. You must have at least $5,000 of coverage to be eligible for an accelerated benefit. Any benefit payments made in advance of death will be deducted from the death benefit paid to your beneficiaries.

To receive this benefit, a licensed physician must certify that your life expectancy is less than 12 months; the request must be approved by the insurance carrier.

To apply for an accelerated death benefit, contact DuPont Connection.

Occupational Accidental Death Coverage

If you die as a result of an injury that was caused by sudden, external, and purely accidental means, sustained while in the course of your employment with the Company, the Plan will pay your beneficiary an occupational accidental death benefit. Your death must occur within 90 days of having sustained these injuries to be covered.

The benefit is three times your Pay, with a minimum benefit of $10,000 and a maximum of benefit of $3 million.

This benefit is in addition to any other benefits that apply.

Restrictions and Exclusions

- There are no restrictions or exclusions related to the cause of death, except under the Plan's Occupational Accidental Death provision.
- The Assignment of Benefits provision contains restrictions on who can be named as an assignee. See "For Life and Accident Insurance" on page 97 under "Assignment of Benefits" on page 96 for more information.
- The portability feature of the Plan is subject to restrictions imposed by the insurer. Contact the life insurance company for further details.

The Occupational Accidental Death Benefit does not pay benefits if you die as a result of the following:

- Infections (except infections caused by pyogenic organisms which shall occur with and through an accidental cut or wound) or disease or illness of any kind
- Participation in or in consequence of having participated in the commission of a felony
- Self-destruction or self-inflicted injury while sane or insane
- War or act of war in which the United States is a participant at the time of injury.

Portability Restrictions, and the Conversion Option

The Portability feature of the Plan is subject to restrictions imposed by the insurer. Contact the life insurance company for further details. See "Portability of Employee and Dependent Life Coverage on page 107, and contact the insurer for further details.

Also see the conversion of coverage option, under "Converting Employee Group Life Coverage to Individual Coverage" on page 107.

BeneFlex Dependent Life Insurance Plan

Let's hope your family stays safe and healthy for many years to come. But tragic loss may happen. To lessen the financial burden of such a loss, the Company provides you with group term life insurance that you can purchase through payroll deduction.

Conversion and Portability for Life Insurance

When your Company coverage ends, you may have options to continue employee and dependent coverage, through conversion and/or portability. See "Converting Employee Group Life Coverage to Individual Coverage on page 107 and "Portability of Employee and Dependent Life Coverage on page 107.and

Life Insurance for Your Spouse and Children

SECTION CONTENTS

Spouse Life Insurance

You can purchase dependent life insurance for your spouse. In some cases, Evidence of Insurability (EOI) will be required. Coverage will begin:

- on the first of the month after you enroll (if no EOI is required) or
- after any required EOI is approved.

EOI is required if you purchase more than $10,000 of Spouse Life Insurance when you are a new hire or when your spouse first becomes eligible. EOI is always required if coverage is purchased later and for any increases in coverage. See "Evidence of Insurability" on page 7 in the *Eligibility and Enrollment* section for more information.

Coverage	Ten levels of spouse life insurance are available: ▪ $10,000 ▪ $25,000 ▪ $50,000 ▪ $100,000 ▪ $150,000 ▪ $200,000 ▪ $250,000 ▪ $300,000 ▪ $350,000 ▪ $400,000
Cost	You pay the full cost of spouse life insurance. The cost is based on: ▪ Your spouse's age (premiums are based on age); and ▪ How much coverage you choose.

Child Life Insurance

You can purchase dependent life insurance for your child(ren) up to age 26. If you purchase Child Life Insurance, all of your children are automatically covered, including newborns.

Coverage begins the first of the month after you enroll. No EOI is required.

Coverage	Three levels of child life insurance are available: ▪ $5,000 ▪ $10,000 ▪ $20,000
Cost	You pay the full cost of child life insurance.

If both you and your spouse participate in the Plan, you can each purchase up to $20,000 of child life insurance.

Newborn coverage

The amount of coverage for a newborn depends on when you elect Child Life Insurance coverage.

The Plan will automatically provide $5,000 of coverage for the first 31 days following live birth. Coverage applies only for your first eligible newborn, not subsequent children. To continue the coverage on the first child, you must elect child coverage within those 31 days, otherwise the coverage shall terminate at the end of the 31-day period.

- You can elect Child Life Insurance during the Annual Enrollment period before your child's birth. Following the live birth, your newborn will have life insurance equal to the amount you elected—$5,000, $10,000, or $20,000.
- You can wait and elect coverage within 31 days after your child's birth. The amount of coverage you elect will become effective the first of the month following your enrollment. Please see "Changing Your Coverage" on page 10 in the *Eligibility and Enrollment* section for more information.
- You can choose not to enroll in coverage.

Once you have elected Child Life Insurance coverage and remain enrolled, any subsequent newborn children are automatically covered following live birth.

Enrolling for Child Life Insurance

When you elect Child Life Insurance, you do not need to specify your children by name. All your eligible children are covered automatically for as long as the coverage is in effect.

Cost of Coverage

When possible, your payments will be made through payroll deduction. If you take an unpaid leave of absence or your Pay does not cover the cost of coverage, the Plan may directly bill you for the cost.

When Premium Costs Change

The costs shown are for the 2018 Plan year. Unless indicated differently, premium costs are reviewed and subject to change annually at the beginning of a Plan year (January 1). You will be notified in advance of any changes.

Spouse Life Insurance

The cost of spouse coverage depends on your spouse's age and how much coverage you choose.

Age as of 12/31 of the Prior Year	***Monthly Premiums per $1,000 of Coverage***
Under 25	$0.020
25 – 29	$0.024
30 – 34	$0.035
35 – 39	$0.054
40 – 44	$0.073
45 – 49	$0.128
50 – 54	$0.224
55 – 59	$0.374
60 – 64	$0.584
65 – 69	$1.049
70 – 74	$1.823
75 and older	$2.472

Child Life Insurance

The cost of child coverage depends on how much coverage you choose. The monthly premium is $0.037 per $1,000 of coverage. The number of children you cover does not affect the cost.

You Are the Beneficiary

For both Spouse and Child Life Insurance coverage, you are the beneficiary. In the event that your covered spouse or child dies, the benefits will be paid directly to you.

When Benefits Are Paid

The Plan will pay a benefit to you if your covered spouse or child(ren) dies for any reason. Payments are not reduced because of any other life insurance.

If Your Spouse Is Terminally Ill

If your spouse has a terminal illness, you may be eligible to receive an accelerated death benefit, in advance, while he or she is still alive.

Accelerated death benefits pay up to one-half the value of your spouse life insurance coverage, to a maximum of $200,000. Any benefit payments made in advance of death will be deducted from the death benefit paid to you upon your spouse's death.

To receive this benefit, a licensed physician must certify that your spouse's life expectancy is less than 12 months and the request must be approved by the insurance carrier.

To apply for an accelerated death benefit, contact DuPont Connection.

Exclusions and Limitations

There are no exclusions or limitations under BeneFlex Dependent Life Insurance coverage.

Claiming Your Benefits

See the Claiming Benefits and Other Information *section on page 92 for details on how to file a claim for benefits.*

BeneFlex Accidental Death Insurance Plan

We've been trained to value safety, but accidents can still happen. Thanks to DuPont, you've got insurance that will give you some financial support following an accidental death or dismemberment. This coverage is in addition to your Company-paid Basic life insurance. Plus, you can purchase the same insurance for your spouse and/or children too, at group rates.

SECTION CONTENTS

Accidental Death Insurance—Basic

The Company provides Basic Accidental Death coverage automatically, at no cost to you. Coverage begins as of your first day of active employment.

Coverage equals 1× your Pay, rounded up to the next $1,000 if not a multiple of $1,000. The maximum benefit is $1 million.

Benefits Based on Pay

For purposes of determining coverage, your Pay is your base Pay.

In addition, for DuPont and any Company that adopted this plan before January 1, 2013, Pay is the same as "Normal Annual Earnings" which includes such pay as shift differential, regular scheduled overtime and Sunday premium pay.

Additional Benefits

The Plan pays additional benefits under certain circumstances. See "Additional Benefits" on page 87 for more information.

Accidental Death Insurance—Voluntary

You can purchase Voluntary Accidental Death coverage for yourself, your spouse and/or your child(ren). There are four coverage options available:

	Option A	Option B	Option C	Option D
You Only	$500,000	$250,000	$100,000	$50,000
You and Your Spouse	▪ You: $500,000 ▪ Spouse: $300,000	▪ You: $250,000 ▪ Spouse: $150,000	▪ You: $100,000 ▪ Spouse: $50,000	▪ You: $50,000 ▪ Spouse: $25,000
You and Your Children	▪ You: $500,000 ▪ Children: $100,000	▪ You: $250,000 ▪ Children: $50,000	▪ You: $100,000 ▪ Children: $25,000	▪ You: $50,000 ▪ Children: $10,000
You, Your Spouse and Your Children	▪ You: $500,000 ▪ Spouse: $300,000 ▪ Children: $100,000	▪ You: $250,000 ▪ Spouse: $150,000 ▪ Children: $50,000	▪ You: 100,000 ▪ Spouse: $50,000 ▪ Children: $25,000	▪ You: $50,000 ▪ Spouse: $25,000 ▪ Children: $10,000

If both you and your spouse participate in the Plan, each of you can purchase up to $100,000 of Voluntary Accidental Death Insurance for your children, for a total of $200,000 of coverage.

Plan Benefits

If you're in an accident, the Plan pays a percentage of your coverage, up to the Plan maximum. The benefit depends on the type of loss or injury. The Plan follows state and federal law requirements.

Loss	The percentage of benefit paid for you, your covered spouse, or your covered children
Life	100%
▪ Both feet or both hands ▪ One foot and sight of one eye ▪ One hand and one foot ▪ One hand and sight of one eye ▪ Sight of both eyes ▪ Speech and hearing in both ears ▪ Quadriplegia, triplegia, paraplegia or hemiplegia	100%

Loss	The percentage of benefit paid for you, your covered spouse, or your covered children
▪ Speech or hearing in both ears ▪ One hand or one foot ▪ All four fingers of one hand ▪ Sight of one eye ▪ Uniplegia	50%
▪ Thumb and index Finger (of the same hand)	25%

Accidental Death Insurance Defined Terms

LOSS OF HAND OR FOOT
Complete severance through or above the wrist or the ankle joint.

LOSS OF THUMB OR INDEX FINGER
Complete severance at or above the metacarpophalangeal joints.

LOSS OF SIGHT
Total and permanent loss of vision, which cannot be corrected to any functional degree by aid or device.

LOSS OF HEARING
Total and permanent deafness in both ears such that it cannot be corrected to any function degree by aid or device.

QUADRIPLEGIA
The complete and irreversible paralysis of both upper limbs (from the shoulder down, including total paralysis of both hands) and both lower limbs (from the waist down, including total paralysis of both feet).

TRIPLEGIA
The complete and irreversible paralysis of three limbs (from the shoulder down including total paralysis of both hands if claiming an upper limb and from the waist down including total paralysis of both feet if claiming a lower limb).

PARAPLEGIA
The complete and irreversible paralysis of both lower limbs (from the waist down, including total paralysis of both feet).

HEMIPLEGIA
The complete and irreversible paralysis of both the upper limb (from the shoulder down, including total paralysis of both hands) and lower limb (from the waist down, including total paralysis of both feet) on one side of the body.

UNIPLEGIA
The complete and irreversible paralysis of one limb (from the shoulder down, including total paralysis of the hand if claiming an upper limb and from the waist down, including total paralysis of the foot if claiming a lower limb).

Additional Benefits

Under certain circumstances, the Plan will pay additional benefits.

Additional Benefits Paid from Both Basic and Voluntary Accidental Death Insurance

Seat Belt Benefit	▪ 10% of the benefit amount, up to a maximum of $10,000 for both the Company-paid and the Voluntary coverage (for a total of $20,000). ▪ Paid if a covered individual dies while wearing a seatbelt in a private passenger car accident in which the driver was licensed and not intoxicated, impaired or under the influence. ▪ Must be verified in an official report or certified in writing by investigation officials.
Airbag Benefit	▪ 10% of the benefit amount, up to a maximum of $10,000 for both the Company-paid and the Voluntary coverage (for a total of $20,000). ▪ Paid if a covered individual dies in a private passenger car accident while driving or riding in a seat equipped with a factory-installed airbag that went off. ▪ Covered individual must be wearing a seatbelt and the driver was licensed and not intoxicated, impaired or under the influence. ▪ Must be verified in an official report or certified by investigation officials.

Additional Benefits Paid Only if Voluntary Accidental Death Insurance Purchased

Spouse Tuition Reimbursement Benefit	▪ Reimburses tuition at an accredited educational institution or an institution of vocational training to prepare your spouse for full-time work if you die in a covered accident. ▪ Benefit is the actual tuition within the first year following the date of your death, 1% of the benefit amount or $5,000, whichever is the least. ▪ Spouse must not be working in any capacity for profit on the date of the accident and must enroll in program within 12 months of your death.
Child Tuition Reimbursement Benefit	▪ Reimburses tuition at an accredited post-secondary educational institution for dependent child if you or your covered spouse dies in a covered accident. ▪ Benefit is the actual tuition, 1% of coverage or $5,000 per year, and is paid for up to four years, whichever is the least. ▪ Dependent child must be under age 23 and a full-time student in an accredited post-secondary educational institution. ▪ Dependent child must be enrolled in an accredited post-secondary school or in high school and enrolls within 180 days of the covered individual's death. ▪ Paid to individual incurring the cost if child is under age by state law.
Child Care Expense Benefit	▪ Pays a benefit for child care expenses for a dependent child under age 13 if you or your covered spouse dies in a covered accident. ▪ Benefit is the annual child care center cost, 1% of benefit amount or $3,000, whichever is the least. ▪ Paid to the surviving parent, the child's legal guardian, or an adult caretaker when permitted under state law for up to four consecutive years or until the child reaches age 13. ▪ Child must be enrolled in a licensed or certified day care center at the time of or within 90 days of the covered individual's death.
Felonious Assault Benefit	▪ 5% of the benefit amount or $5,000, whichever is less. ▪ Paid if a covered individual dies or suffers a covered loss as a result of bodily harm caused by physical attack by another person (excluding immediate family member or coworker).

Additional Benefits Paid Only if Voluntary Accidental Death Insurance Purchased

Return of Remains Benefit	▪ Cost of return of remains or $2,500, whichever is less. ▪ Paid if a covered individual dies as the result of an accident at least 250 miles away from home. ▪ Covered expenses include embalming, cremation, a coffin and/or transportation of the remains to a mortuary.
Exposure and Disappearance Benefit	▪ Pays a benefit if a covered individual experiences a loss because of exposure to the elements as the result of an accident. ▪ Pays a death benefit if after one year the covered individual's body is not found after disappearance, stranding, sinking, explosion or wrecking of any vehicle in which the covered individual was an occupant.
Loss Due to Coma Benefit	▪ 1% of the benefit amount or $500, whichever is less, paid monthly for up to 12 months. ▪ Paid if you or a covered dependent remains in a coma as the result of an accident. ▪ Coma must be total, continuous and permanent, beginning within 30 days of accident and lasting continuously for at least six months.
Bereavement and Trauma Counseling Benefit	▪ Paid to the covered individual if you, your spouse or your child dies or suffers a covered loss. ▪ Benefit for bereavement and trauma counseling, up to $50 a session for 20 sessions, for the covered individual. ▪ Sessions must be held within one year after the date of the accident causing the covered loss.
Carjacking Benefit	▪ 1% of the benefit amount or $2,500, whichever is less. ▪ Paid if a covered individual has a covered loss of life as the result of a stranger taking unlawful possession of the individual's automobile by means of force or threats. ▪ Must be verified in a police report.
Permanent Disfigurement Benefit	▪ 5% of the benefit amount or $10,000, whichever is less. ▪ Paid if a covered individual is critically burned and disfigured to the point of requiring reconstructive or cosmetic surgery as a result of a covered accident. ▪ Burns must be classified as being more severe than second-degree burns and must result in permanent disfigurement over 50% of the body and which can be corrected only by cosmetic surgery.
Home Alteration and Vehicle Modification	▪ Cost of the alteration or modification, 1% of the full benefit amount, or $5,000, whichever is least. ▪ Paid if a covered individual suffers a loss that requires a home alteration or vehicle modification. These one-time alteration expenses must be incurred within two years from the date of the accident.
Monthly Mortgage Payment Benefit	▪ Monthly mortgage payment or $2,500, whichever is less, for up to 12 months or until the mortgage is paid in full or the house is sold. ▪ Paid if you die within 60 days as the result of injuries from a covered accident. ▪ Paid to surviving spouse who is co-borrower on the mortgage.

Cost of Coverage

The Company pays for the cost of Basic coverage.

For Voluntary coverage, you pay the cost of the coverage on a before-tax basis through payroll deduction or, if necessary, through direct billing.

The cost of coverage depends on the option you choose and whom you cover.

Monthly Cost of Voluntary Accidental Death Coverage

	Option A	***Option B***	***Option C***	***Option D***
You Only	$8.50	$4.25	$1.70	$0.85
You and Your Spouse	$13.60	$6.80	$2.55	$1.28
You and Your Children	$11.70	$5.85	$2.50	$1.17
You, Your Spouse and Your Children	$16.80	$8.40	$3.35	$1.60

2018 Costs

The cost information shown is for the 2018 Plan year. Unless indicated differently, premium costs are reviewed and subject to change annually at the beginning of a plan year (January 1). You will be notified in advance of any changes.

Naming a Beneficiary

A beneficiary is the person or persons entitled to benefits if you die.

- You are the beneficiary for your spouse and children.
- For your own coverage, you can name:
  - More than one beneficiary, and you can specify the percentage of the total benefit each beneficiary should receive.
  - Primary beneficiaries and contingent beneficiaries. Contingent beneficiaries only receive benefits if all primary beneficiaries die before you (unless you have designated otherwise).
  - A trust or charitable organization instead of people, if desired.

All Plan participants are encouraged to keep their life insurance beneficiary information up to date. Contact DuPont Connection at 1-800-775-5955 to change your Beneficiaries at any time.

Is Your Beneficiary Designation Up to Date?

It's a good idea to review your beneficiary designation to be sure it is up to date. During Annual Enrollment, take the time to review your beneficiary designation and make any necessary changes.

The Beneficiary for Assigned Benefits

You cannot name a new beneficiary if you have already assigned your benefits, transferring ownership of your benefits to someone else (such as to a trust). The assignee may make an assignee beneficiary designation, if they choose to do so. Otherwise, the assignee will be the beneficiary for your coverage.

As of January 1, 2014, no benefits under the Plans in this SPD can be assigned.

Different Beneficiaries for Different Plans

You can make different beneficiary designations for Basic and Supplemental Life Insurance, Basic and Voluntary Accidental Death Insurance, and Occupational Accidental Death Insurance.

If No Beneficiary Is Named

If you do not name beneficiary or if your beneficiary dies before you, your benefits will be paid out in the following order of survival:

- to your legal spouse;
- equally among your biological or legally adopted children;
- equally among your parents;
- equally among your siblings; and then
- to your estate.

If You Assigned Your Benefits

When you assign your rights to a benefit, you legally and irrevocably transfer ownership of your Plan benefit to someone else. Once coverage has been assigned, the new "owner" has all the rights you once had. Assignment of benefits under the Plan is irrevocable.

Effective January 1, 2014, you can no longer assign benefits.

See "Assignment of Benefits" on page 96 in the *Claiming Benefits and Other Information* section for more information.

When Benefits Are Paid

When you or your covered spouse or child suffers a loss or injury because of an accident, the Plan will pay the beneficiary.

If one accident causes multiple losses, the Plan will pay the highest of all applicable benefits. The Plan will only pay one benefit if a single accident causes multiple losses.

The loss must occur within 365 days of the accident.

The maximum Basic AD&D benefit is $1 million.

The Plan does not have a Basic AD&D minimum benefit.

Claiming Your Benefits

See the Claiming Benefits and Other Information *section on page* 92 *for details on how to file a claim for benefits.*

Examples

Sam purchased Option C of Voluntary Accidental Death coverage for himself and his wife ($100,000 of coverage for himself and $50,000 of coverage for his wife). If they both die in a car accident, his beneficiaries would receive the basic 1× Pay coverage plus his voluntary coverage of $100,000 for him and $50,000 for his spouse. The Plan would also pay up to $20,000 in additional benefits if they were both wearing seatbelts and up to $20,000 if both of their airbags deployed.

Doris only has the Company-provided basic coverage. She is severely injured in an accident, resulting in the loss of both hands. She dies 90 days after the accident. The Plan will pay the 100% benefit, not both the 100% dismemberment and the 100% death benefit.

Exclusions and Limitations

BeneFlex Accidental Death Insurance does not pay a benefit for a loss resulting from:

- serving on full-time active duty in any Armed Forces for more than 30 days (Reserve or National Guard active duty for training is not excluded);
- commission of or attempt to commit an assault or a felony by the insured;
- taking part in any insurrection;
- declared or undeclared war or act of war;
- participation in these hazardous sports: scuba diving; bungee jumping; skydiving; parachuting; hang gliding; paragliding; paramotoring; parascending or ballooning;
- intentionally self-inflicted injuries or any attempt to inflict such injuries, including suicide;
- being legally intoxicated or voluntary ingestion of any narcotic drug, poison, gas or fumes unless prescribed or taken under the direction of a physician and taken in accordance with the prescribed dosage;
- riding as a passenger in any aircraft not licensed to carry passengers for hire (employees traveling on Company business in any licensed civil aircraft are not excluded);
- serving as a pilot, crew member or student taking flying lessons (employees who are employed by the Company as pilots, aircraft mechanics or crew members are not excluded when flying in aircraft on Company business);
- any bacterial or viral infection, sickness, disease or bodily infirmity except when a direct result of a covered accident;
- travel in aircraft used by or for any military authority (aircraft flown by U.S. Military Airlift command not excluded); or
- travel in aircraft used for test or experimental purposes or designed for use beyond the Earth's atmosphere.

Claiming Benefits and Other Information

This section explains how you get your benefits. It also explains how to file an appeal if you feel that the Plan has incorrectly denied you eligibility or has not provided the correct coverage or benefits.

SECTION CONTENTS

If You Have Alternative Medical Coverage

If you have Alternative Medical Coverage because you are in Hawaii, Puerto Rico, or are on international assignment, your carrier can provide details on how to file claims.

How to File a Claim

Using Your HSA for Eligible Healthcare Expenses

Remember that you can pay for your share of medical, prescription drug, mental health and chemical dependency care, dental and vision care with your Health Savings Account (HSA), using the account's debit card. Alternatively, you can pay for your share of these claims out-of-pocket and save your HSA for future qualifying expenses, including those incurred when you are retired.

Need a New ID Card?

Have you lost your medical or prescription ID card, or do you need a new one for a covered family member? Contact the carrier for your plan, or visit their website. See the Contacts *section on page 116.*

Type of Care/Claim	How to File
Medical Care (Core and Premium Saver Options) ***From an in-network provider***	▪ You don't need to file claims if you use a network provider. Your network provider will file the claim for you. ▪ Your provider may ask you to pay your share of the claim costs when you receive the care or they may bill you. ▪ Don't forget that some care must be pre-certified.
Medical Care (Core and Premium Saver Options) ***From an out-of-network provider***	▪ For out-of-network services, the best method is to bring a claim form with you when you need care. In some cases, your provider or facility may submit the claim form on your behalf. You can get claim forms from the carrier website. ▪ Alternatively, you can file a claim after you've received the care. In this case, you would you pay your provider for the cost of your care, and then file a claim with the carrier for reimbursement. The claim form has instructions on what you will need to provide.
Prescription Drugs	▪ When you use a pharmacy in the Express Scripts network, you will not need to file claims. The pharmacy will charge you your share of the cost. ▪ Some prescriptions may have to be reviewed with your doctor by Express Scripts before it is covered. ▪ If you are not able to use your Express Scripts card at a pharmacy, you may print a paper claim form or submit a claim online at the Express Scripts website (detailed pharmacy receipt is required).
Mental Health/Chemical Dependency (MH/CD) Care From an in-network provider	▪ You are encouraged to contact ComPsych at 1-800-435-7266 before you need care, for assistance in finding a network provider. ▪ If you visit a ComPsych network provider, they will file claims on your behalf. You may be asked to pay your share of the claim costs when you receive the care or they may bill you. ComPsych will notify you and the provider of the contracted rate and the amount you are responsible for paying the provider (if deductible/coinsurance has been satisfied).
Mental Health/Chemical Dependency (MH/CD) Care From an out-of-network provider	▪ If you receive care from an out-of-network provider, it is common for the providers to ask you to pay the full amount and file a claim for reimbursement with ComPsych yourself. ▪ Claim forms can be obtained from ComPsych by calling 1-800-435-7266. The claim form has instructions on what you will need to provide.
Dental Care ***From an in-network provider***	▪ You don't need to file claims if you use a MetLife PDP Plus network provider. The Plan will reimburse the provider for the share of the cost it pays. ▪ Your provider may ask you to pay your share of the claim cost when you receive the care or they may bill you. ▪ For more complex procedures, take advantage of the pre-treatment estimate so you are not surprised by the cost.

Type of Care/Claim	How to File
Dental Care ***From an out-of-network provider***	▪ For non-PDP Plus dentists, the best method is to bring a claim form with you when you need care. In some cases, your dentist may submit the claim form on your behalf. You can get claim forms from the MetLife website, at www.metlife.com/mybenefits. ▪ Alternatively, you can file a claim after you've received care. In this case, you would pay your dentist for the cost of your care, and then file a claim with the carrier for reimbursement. The claim form has instructions on what you will need to provide. ▪ For more complex procedures, take advantage of the pre-treatment estimate so you are not surprised by the cost.
Vision Care ***From an in-network provider***	▪ See "The VBA Network" on page 57 for details on using the network and filing claims. ▪ Your VBA participating provider will contact VBA to verify your eligibility via their online system and will process your covered services electronically. ▪ If you do not advise your provider that you have coverage through VBA in advance of receiving services or materials at your visit, you will be treated as a private patient, and out-of-network benefits will apply.
Vision Care ***From an out-of-network provider***	▪ For non-VBA providers, you will need to pay for the services and materials you have selected out-of-pocket, and then submit a claim for reimbursement using a VBA Out-of-Network Reimbursement form. This form and others are available on www.vbaplans.com under "Forms."
Health Care Limited Purpose FSA	▪ The simplest way to access your account is to use the debit card that you will receive from Bank of America. ▫ When you use the debit card, be sure to save receipts and documentation that show the purchase was for a qualified expense (such as an itemized receipt, EOB, etc.), in case you are asked to substantiate your claim. ▪ Instead of using your debit card, you can file claims for reimbursement. ▫ You can file claims online, at www.bankofamerica.com/benefitslogin. ▫ You can also get a claim form at the website and print it and mail in your claim. The claim form has instructions on what you need to provide. If you can't use the website, you can call 1-877-319-8115 to get a form. ▪ You can submit a reimbursement request as frequently as you like. ▪ **Remember, the deadline for filing claims for the previous calendar year is April 15 of the next calendar year. Any funds not claimed will be forfeited.**
Dependent Care FSA	▪ You can file claims online, at www.bankofamerica.com/benefitslogin. ▪ You can also get a claim form at the website and print it and mail in your claim. The claim form has instructions on what you need to provide. If you can't use the website, you can call 1-877-319-8115 to get a form. ▪ **Please note that you will need to provide the care provider's name, address, and Social Security Number or Taxpayer Identification Number when you file your claim.** ▪ **Remember, the deadline for filing claims for the previous calendar year is April 15 of the next calendar year. Any funds not claimed will be forfeited.**
Life Insurance or Dependent Life Insurance	▪ Contact DuPont Connection at 1-800-775-5955 to begin the claim process. Your claim will be filed with the Life Insurer. ▪ A death certificate and other information will need to be provided, as may be requested by the insurance company.
Accidental Death or Dismemberment	▪ If you or a covered dependent experience an injury that qualifies for accidental death or dismemberment benefits, contact DuPont Connection at 1-800-775-5955 to file your claim. ▪ You will need to provide an accident report, a physician's statement, and X-rays and/or other information as may be requested by the insurance company.

Be Prepared When You Use an Out-of-Network Provider

Be sure to visit your carrier's website and print a claim form to bring with you when you use an out-of-network provider. You can find the name of the carrier (for example, Aetna or Highmark BCBS) and their web address on your ID card.

If You Have Other Coverage

If you or a covered dependent is also enrolled in another group medical, dental and/or vision plan (in addition to the Company's plan), benefits are coordinated to prevent duplication of benefits. This process is called "coordination of benefits" (COB). The type of COB used by the Plan is also referred to as "maintenance of benefits."

Coordination of benefits allows two or more 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."

- The primary plan pays your claims as if there is no other health plan involved.
- The secondary plan calculates payment as if the primary plan did not exist and then compares that benefit to the primary plan's benefit. If the primary plan's benefit is equal to or more than the secondary plan benefit, no payment is made (or deductible applied). If the primary plan's benefit is less than the secondary plan benefit, the secondary plan pays the difference between the primary and secondary plans benefits (or applies the amount to the deductible).

Coordination of Benefits with Medicare

When you or a dependent is covered by Medicare, the Medicare coverage is secondary to a Company plan. However, if you or your dependent has Medicare coverage due to End Stage Renal Disease (ESRD), Medicare becomes the primary plan after the first 30 months of eligibility for Medicare.

HOW TO DETERMINE WHICH PLAN IS PRIMARY AND WHICH IS SECONDARY

Here are the rules that determine which plan is primary and which is secondary:

- A plan that has no coordination of benefits provision will be primary to a plan that does have a coordination of benefits provision.

Employee or Dependent

- A plan that covers a participant as an employee will be primary to a plan that covers the person as a dependent. Thus, if your spouse is enrolled in his/her employer's medical plan, for example, your medical plan will be secondary for him/her (if enrolled). Similarly, if you are also covered by your spouse's employer's medical plan, your spouse's plan is your secondary coverage.
- A plan that covers a participant as an employee will be primary to a plan that covers the person as a retiree 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.

Dependent Children

- Parents who are married or living together:
  - If children are covered by both parents' plans, primary and secondary coverage is based on the "birthday rule." 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.
- Parents separated, divorced, not living together, or have a court-order:
  - The plan of the parent whom the court said is responsible for health coverage is primary. But if that parent has no coverage then the other spouse's plan is primary.

- Parents separated, divorced, not living together, or have a court-order that states both parents are responsible for coverage or have joint custody:
  - Primary and secondary coverage is based on the birthday rule. 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.
- Parents separated, divorced, or not living together and there is no court-order:
  - The order of benefit payments is:
    - The plan of the custodial parent pays first.
    - The plan of the spouse of the custodial parent (if any) pays second.
    - The plan of the noncustodial parents pays next.
    - The plan of the spouse of the noncustodial parent (if any) pays last.

Medicare Eligible Due to ESRD

The Company plan is primary to Medicare only during the first 30 months of eligibility for Medicare. 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.

After the 30-month period, the Company 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

Active or Inactive Employees

The plan covering you as an active employee (or as a dependent of an active employee) is primary to a plan covering you as a laid off or retired employee (or as a dependent of a former employee).

COBRA or State Continuation

The plan covering you as an employee or retiree or the dependent of an employee or retiree is primary to COBRA or state continuation coverage.

Longer or Shorter Length of Coverage

If none of the above rules determine the order of payment, the plan that has covered the person longer is primary.

When Other Rules Don't Apply

If none of the above rules apply, the plans share expenses equally

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

Assignment of Benefits

For Medical, Dental, and Vision Care Coverage

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 carrier pays your provider directly. The carrier will provide you with an Explanation of Benefits statement shortly after your claim is processed.

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 carrier (according to their network contract with the carrier).

You are not allowed to assign your right to appeal a benefit determination. However, you may provide written authorization to allow a provider to submit an appeal on your behalf.

For Life and Accident Insurance

Assigning your benefits transfers the ownership of your Plan benefit to someone else. Once coverage has been assigned, the new "owner" has all the rights you once had. An assignment of benefits under the Plan is irrevocable.

- Since January 1, 2014, none of the life and accident insurance plans allows benefits to be newly assigned.
- Before January 1, 2014, you could assign your benefits under the BeneFlex Employee Life Insurance Plan, but not under the Dependent Life Insurance Plan and the Accidental Death Insurance Plan. The following restrictions applied:
  - Assignment is recognized only if it is made in writing to the Company and it is made, without consideration, to one or more of the following persons or their estates, or to a trustee of a trust under which any such person is one of the beneficiaries:
    - your spouse;
    - brothers or sisters of you or your spouse;
    - lineal ascendants or descendants of you, your spouse, or the brothers or sisters of you or your spouse; or
    - brothers or sisters of lineal ascendants of you or your spouse.
  - Assignment of benefits to a viatical settlement company was not (and is not) permitted under the Plan.
  - The Plan Administrator has final discretion in determining the validity of any assignment, and its decision is final and binding.

Claims Review Notification and Explanations of Benefits

Timing for Notification of Claims

Your insurance 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:

	Medical and Dental	Vision	Health Care Limited Purpose and Dependent Care Flexible Spending Accounts
Pre-service urgent care claims (when you await treatment pending the outcome of the claim decision and your health would be severely jeopardized if the claim were not handled in an urgent manner)	As soon as possible, taking into account the health circumstances that require action. Your carrier will contact you orally within 72 hours and will follow-up with a written notice.	Not Applicable	Not Applicable
Pre-service non-urgent claims	Within 15 days	Within 15 days	Not Applicable
Post-service claims	Within 30 days	Within 30 days	Within 30 days

For pre-service and post-service claims, the 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 carrier expects to provide you a benefit determination.

IF ADDITIONAL INFORMATION IS REQUIRED

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:

	Medical and Dental	Vision	Health Care Limited Purpose and Dependent Care Flexible Spending Accounts
Pre-service urgent care claims	As soon as possible, but not later than 48 hours	Not Applicable	Not Applicable
Pre-service non-urgent claims	Within 45 days	Within 45 days	Not Applicable
Post service claims	Within 45 days	Within 45 days	Within 45 days

IF A CLAIM IS DENIED OR REDUCED

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

- the specific 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; and
- a copy of these procedures or comparable information about steps you need to take to resubmit it.

The maximum timeframes for the Plan to notify you of a denied claim are:

	Medical and Dental	Vision	Health Care Limited Purpose and Dependent Care Flexible Spending Accounts
Pre-service urgent care claims	As soon as possible, but not later than 72 hours	Not Applicable	Not Applicable
Pre-service non-urgent claims	Within 30 days	Within 15 days	Not Applicable
Post service claims	Within 60 days	Within 30 days	Within 60 days

Overpayments and Other Errors

If a benefit is paid that is larger than the amount payable under one of the Plans, the Plan has a right to recover the excess amount from the person or agency that received it. Erroneous payments or 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 and dental Plans reserve 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.

Claims Appeals

Please see the Contacts for Appeals section on page *118* for contact information.

Before beginning the appeal process, contact your carrier or vendor for a clearer explanation of the denial and provide additional information that may allow reconsideration of your claim. If, after contacting the appropriate carrier or vendor and requesting or providing additional information, you still have not received an adequate resolution concerning your claim for benefits under the Plan, you have a legal right to appeal the denial or partial denial of the 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.

You may appeal an adverse benefit determination by submitting an appeal to the carrier or vendor. This is considered a first level appeal (Level 1) and is performed by the carrier or vendor. To appeal the denial, you should notify the carrier in writing requesting a claim review. Medical appeals may be submitted verbally. The request for the appeal should include additional clinical documentation, if applicable, 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; if applicable; and
- a copy of the denial letter(s) received from the carrier, Bank of America or DuPont Connection.

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.

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. For Level 1 appeals, 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 carrier or vendor. In deciding a medical, Rx, or dental Level 2 appeal of any adverse benefit determination that is not enrollment or eligibility related, the Plan Administrator shall refer the appeal 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 including determinations whether a particular treatment, drug or other item is experimental, investigational or not medically necessary or appropriate.

For appeals involving eligibility or enrollment, a Level 2 appeal will be reviewed by the DuPont Benefit Plans Appeals Committee. The Committee will make a determination and notify you in writing. The Committee's decision is final and binding.

You will receive a response to your appeal within the following timeframes from when your appeal is received:

Type of Appeal	Level 1 Appeal Response Time
Eligibility and Enrollment	▪ Within 30 days
Medical	▪ As soon as possible, taking into account the medical circumstances that require action, but not later than 72 hours for pre-service urgent-care claims; ▪ Within 15 days for pre-service claims; ▪ Within 30 days for post-service claims.
Rx	▪ As soon as possible, taking into account the medical circumstances that require action, but not later than 72 hours for pre-service urgent-care claims; ▪ Within 15 days for pre-service claims; ▪ Within 30 days for post-service claims.
Dental	▪ As soon as possible, taking into account the circumstances that require action, but not later than 72 hours for pre-service urgent-care claims; ▪ Within 15 days for pre-service claims; ▪ Within 30 days for post-service claims.
Vision	▪ Within 15 days for pre-service claims; ▪ Within 60 days for post-service claims. ▪ The decision will be final and binding
Health Care Limited Purpose and/or Dependent Care Flexible Spending Accounts	Within 60 days
Life and Accident Insurance	Within 90 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 (or your beneficiary, if the appeal is related to life and accident insurance) 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.

If the first level appeal decision still results in a full or partial claim denial, you may have the right to request an additional appeal, known as a Level 2 appeal. The process for submitting a Level 2 appeal will be contained in the letter explaining the Level 1 claim decision. The Level 2 appeal will be reviewed by an independent firm or appeal board outside the organization that made the original claim and appeal decisions. The decisions made on the Level 2 appeal are final and binding.

You will receive a response to your Level 2 appeal within the following timeframes from when your appeal is received:

Type of Appeal	Level 2 Appeal Response Time
Eligibility and Enrollment	▪ The Benefit Plan Appeals Committee will respond within 60 days
Medical	▪ Within 72 hours for pre-service urgent-care claims; ▪ Within 30 days for pre-service claims; ▪ Within 30 days for post-service claims.
Rx	▪ Within 72 hours for pre-service urgent-care claims; ▪ Within 15 days for pre-service claims; ▪ Within 30 days for post-service claims.
Dental	▪ Within 72 hours for pre-service urgent-care claims; ▪ Within 15 days for pre-service claims; ▪ Within 30 days for post-service claims.
Vision	▪ Not Applicable
Health Care Limited Purpose and/or Dependent Care Flexible Spending Accounts	▪ Within 60 days
Life and Accident Insurance	▪ Within 90 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 (or your beneficiary, if the appeal is related to life and accident insurance) are notified of the final decision, the notice will provide the reason for the decision and the specific Plan provisions on which it is based.

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.

When Coverage Ends

In general, coverage ends on the last day of the month in which you drop your coverage, or you or your covered dependent becomes ineligible. See "What Happens If …" on page 11 in the *Eligibility and Enrollment* section for more details.

- If you or your dependent(s) lose health coverage (for the Medical, Dental, Vision, and Health Care Limited Purpose FSA plans), you may have the option to continue coverage, under COBRA, as described under "Continuing Coverage Under COBRA" on page 103.
- If you go on a military leave, you may be able to continue coverage under USERRA, as described under "Continuing Coverage While on Military Leave" on page 106.
- For life insurance, you may have options to continue your coverage.

SECTION CONTENTS

Continuing Coverage Under COBRA

This section is intended to comply with the Consolidated Omnibus Budget Reconciliation Act (COBRA) of 1985 as amended, which allows you and your covered dependents to temporarily extend health coverage (medical, dental, vision, and Health Care Limited Purpose FSA) in certain situations where coverage would otherwise end. If this section is incomplete or in conflict with the law, the terms of the law will govern.

Keep Your Plan Informed of Address Changes

To protect your family's rights, keep the Plan Administrator informed of any changes in the addresses of family members.

Also, keep a copy, for your records, of any notices you send to the Plan Administrator.

To report an address change, contact DuPont Connection at 1-800-775-5955.

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 employee covered under the Plan, the employee will become a qualified beneficiary with respect to the bankruptcy. The 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 DuPont Connection has been notified that a qualifying event has occurred. DuPont Connection will be automatically notified of the following qualifying events:

- The end of employment or reduction of hours of employment.
- Commencement of a proceeding in bankruptcy with respect to the employer.

YOU MUST GIVE NOTICE OF SOME QUALIFYING EVENTS

For the other qualifying events listed below, you must notify DuPont Connection within 60 days after the qualifying event occurs.

- Divorce or legal separation of the employee and spouse.
- A dependent child's losing eligibility for coverage as a dependent child.
- Death of the employee.
- The employee's becoming entitled to Medicare benefits (under part A, Part B or both)

How Is COBRA Coverage Provided?

Once DuPont Connection 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.

Reason Regular Coverage Ends	How Long COBRA Coverage Can Last
▪ 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	▪ 18 months
▪ You or your dependent is disabled (as determined by the Social Security Administration) before the 60th day of COBRA continuation coverage and continues to be disabled at least until the end of the 18-month period of COBRA continuation coverage.	▪ 29 months
▪ You become entitled to Medicare ▪ You die ▪ You divorce, have your marriage annulled or legally separate ▪ Your dependent stops being eligible for coverage	▪ 36 months (for dependents)

COBRA continuation coverage is a temporary continuation of coverage that generally lasts for 18 months due to employment termination or reduction of hours of work. Certain qualifying events, or a second qualifying event during the initial period of coverage, may permit a beneficiary to receive a maximum of 36 months of coverage.

There are also ways in which this 18-month period of COBRA continuation coverage can be extended:

DISABILITY EXTENSION OF 18-MONTH PERIOD OF COBRA CONTINUATION COVERAGE

If you or anyone in your family covered under the Plan is determined by Social Security to be disabled and you notify DuPont Connection within 60 days of the disabled individual's receipt of a Social Security Disability award, you and your entire family may be entitled to get up to an additional 11 months of COBRA continuation coverage, for a 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 COBRA continuation coverage. If the Social Security determination occurred before COBRA coverage started, you're required to notify DuPont Connection within the first 60 days of COBRA coverage.

SECOND QUALIFYING EVENT EXTENSION OF 18-MONTH PERIOD OF CONTINUATION COVERAGE

If your family experiences another qualifying event during the 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 DuPont Connection is notified within 60 days about the second qualifying event. This extension may be available to the spouse and any dependent children getting COBRA continuation coverage if the employee or former employee dies; becomes entitled to Medicare benefits (under Part A, Part B, or both); gets divorced or legally separated; or if the dependent child stops being eligible under the Plan as a dependent child. This extension is only available if the second qualifying event would have caused the spouse or dependent child to lose coverage under the Plan had the first qualifying event not occurred. To notify DuPont Connection of the additional qualifying event, call 1-800-775-5955.

ARE THERE OTHER COVERAGE OPTIONS BESIDES COBRA CONTINUATION COVERAGE?

Yes. Instead of enrolling in COBRA continuation coverage, there may be other coverage options for you and your family through the Health Insurance Marketplace, Medicaid, or other group health plan coverage options (such as a spouse's plan) through what is called a "special enrollment period." Some of these options may cost less than COBRA continuation coverage. You can learn more about many of these options at www.healthcare.gov.

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

If You Have Questions

Questions concerning your Plan or your COBRA continuation coverage rights should be addressed to DuPont Connection at 1-800-775-5955. 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.)

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.

Continuing Coverage While on Military Leave

If you take a military leave of absence—whether for active duty or for training—you are entitled to continue your medical, dental, vision, Health Care Limited Purpose FSA and Dependent Care FSA coverage for you and your dependents during your leave.

This continuation is accordance with the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA).

- You must give the Company notice of your leave as soon as practical (advance notice, if possible).
- Your premium contributions will be made through payroll deduction while you are on paid leave, if possible, or you will be billed directly. You may work with DuPont Connection to set up automatic checking account withdrawal, if desired.
- You will be charged the same premium contribution rates that apply to other active employees while you are on military leave.
- If you are a reservist called to active military duty for more than 179 days, you are entitled to receive a taxable distribution of your Health Care Limited Purpose FSA balance (contributions less the amount reimbursed) if you request a distribution by the last day of the calendar year in which you made such contributions.

Continuation of Coverage during Military Leave

The Company provides continuing coverage during your full military leave, which exceeds the USERRA 24-month continuation requirement. For additional details, contact DuPont Connection.

The start of a military leave is considered a Qualifying Life Event. As a result, you may stop any coverage or you can enroll for coverage, as long as the change is consistent with the event.

If you do not contact DuPont Connection to change your coverage, your benefit elections will continue in effect while you are on a military leave.

During your leave, you can participate in any Annual Enrollment periods that occur. If you are unable to make elections or do not make any changes during Annual Enrollment, your elections will continue for the next calendar year, until you return from your leave.

When you return from leave, the end of the leave is another Qualifying Life Event. So when you return you can make new benefit elections.

The Plan Administrator may take other steps to administer the Plans in accordance with USERRA and Department of Labor regulations.

If you are on a military leave for fewer than 24 months and you do not return to work at the end of your leave, you may be entitled to purchase COBRA continuation coverage. Your eligibility for COBRA will begin on the date your leave ends. Call the HR Service Center for more information about a military leave.

Converting Employee Group Life Coverage to Individual Coverage

The only plans described in this booklet that include a conversion option are the Employee Life Insurance Plan and the Dependent Life Insurance Plan.

With conversion, you can transfer the coverage to non-group whole life coverage without having to meet any eligibility requirements.

To convert your coverage to an individual policy, you must:

- be covered under the Plan on the date you lose coverage; and
- contact the insurance company within 31 days of your coverage ending.

You can convert the entire amount of your current coverage. The insurance company will determine the cost of the new policy based on the amount of coverage, your age, and plan type.

Portability of Employee and Dependent Life Coverage

The only plans described in this booklet that include a portability option are the Employee Life Insurance Plan and the Dependent Life Insurance Plan.

The portability feature allows you to continue your coverage after it ends, under a separate group policy with group rates. Keep in mind that when employee coverage ends, spouse and dependent coverage will also end.

To port coverage, you must:

- be covered under the Plan on the date the Company group coverage is lost;
- contact the insurance company within 31 days of the Company coverage ending and request a portability application;
- complete and return the application within 31 days of the date it is mailed to you;
- be under age 80; and
- your coverage must NOT have ended because you:
  - failed to pay premiums when due; or
  - requested that your coverage be reduced or cancelled.

You can port any amount of employee coverage between:

- a minimum of $20,000;
- a maximum of $1 million up to the age of 65; or
- a maximum of $650,000 at age 65 or older. The maximum for an insured age 65 or older on his/her portability date will not be more than 65% of the amount in force on the insured's portability date.

For dependent coverage, you can port a maximum of:

- $150,000 of coverage for your spouse.
- $1,000 of coverage for each of your eligible children.

You may not port your coverage if you:

- are confined for medical care or treatment the day your coverage ends; or
- have assigned your benefits. (Note that an assignee may be able to port coverage).

Additional restrictions may apply. Contact the insurance company for further details.

Defined Terms

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

"DuPont" and the "Company"

- Where we use "DuPont" in this summary, we mean E. I. du Pont de Nemours and Company.
- Where we refer to the "Company" in this summary, we mean the DuPont affiliated organization that has adopted or participates in the BeneFlex Health and Insurance Benefits Plans and employs you.

Pay

For purposes of this plan, your pay is your regular rate of base pay computed on a payroll periodbasis without considering occasional or temporary variations from normal working hours, awards under special compensation plans or payments for relocation, severance, or other special payments.

For DuPont and any Company that adopted this plan prior to January 1, 2013, pay is the same as "Normal Annual Earnings" which includes such pay as shift differential, regular scheduled overtime and Sunday premium pay.

For Pioneer Hi-Bred, Inc. and subsidiary companies, pay excludes regular scheduled overtime and Sunday premium pay.

Qualifying Life Event

Qualifying Life Event that may impact your coverage and allows you to change benefits mid-year include:

- You get married or divorced.
- You have or adopt a child, or otherwise gain a new eligible dependent.
- Your eligible dependent becomes ineligible (such as if a child reaches age 26 or you experience a divorce or legal separation).
- Your spouse starts a new job or becomes unemployed.
- Your spouse's employment changes in a way that affects their eligibility for benefits (such as changing from part-time to full-time).
- Your spouse takes an unpaid leave of absence.
- Your spouse's employer's medical coverage changes significantly.
- You move and are no longer in the same service area for one of the plan's network coverage.
- Your spouse or dependent child dies.
- For the Dependent Care FSA, you change caregivers or your caregiver has a significant change in costs.

REGULAR EMPLOYEE

A "Regular Employee" is an individual who is classified as a "regular" (non-temporary) employee by the Company (generally defined as an employee who regularly works at least 20 hours per week), or who is designated in the sole discretion of the Plan Administrator as an "employee" for purposes of the Plan."

You are not a Regular Employees if you are classified by the Company as:

- a part-time employee regularly scheduled to work less than 20 hours per week;
- a leased employee or an independent contractor;
- an intern, co-op, or seasonal employee;
- someone who is receiving severance pay, a retainer, or other fees under a contract that does not provide for your eligibility;
- a Temporary Employee hired to complete a special project of limited duration or to fill the vacancy of an employee who is on a leave of absence; or
- someone who is not a Company employee.

Administrative Information

This section provides some facts required to be included in Summary Plan Descriptions by law, and describes your rights.

SECTION CONTENTS

ERISA Rights

As a participant in any of the plans described in this summary (except for the BeneFlex Flexible Benefits Plan and the Dependent Care Flexible Spending Account), you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA entitles you to:

- Examine, without charge, at the Plan Administrator's office and other specified locations, including work sites and union halls if applicable, all documents governing the Plans. These documents may include insurance contracts, collective bargaining agreements if applicable, and the latest annual report (Form 5500) filed by the Plans 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 Plans, including insurance contracts and collective bargaining agreements if applicable, and copies of the latest annual reports (Form 5500 Series) and updated Summary Plan Descriptions. You may be asked to pay a reasonable 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 the Plans, 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 can 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 can 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 court order, you can file suit in a federal court. If Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you can seek assistance from the U.S. Department of Labor, or you can file suit in a 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 can also contact the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, DC 20210. You can also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

HIPAA Privacy and Security

The Health Insurance Portability and Accountability Act (HIPAA) requires employer health plans to maintain the privacy and security of your health information. HIPAA also requires the health plans subject to HIPAA to provide you with a notice of the Plans' legal duties and privacy practices with respect to your health information. The notice will describe how the Plans may use or disclose your health information and under what circumstances they may share your health information without your authorization (generally, to carry out treatment, payment or health care operations). In addition, the notice will describe your rights with respect to your health information. Please see the "Notice of HIPAA Privacy Practices" available from DuPont Connection.

Governing Law

The Plans will be construed and enforced according to the provisions of the Employee Retirement Income Security Act of 1974 (ERISA), as amended, which sets forth the minimum requirements concerning participation, vesting and other matters that an employee benefit plan must satisfy, and provides rules regarding the manner in which an employee benefit plan is to be administered. ERISA also requires that an employee benefit plan prepare periodic reports and provide or make available other information to the participants in the plan. For additional information concerning your rights under ERISA, see "ERISA Rights" on page 111.

Agent for Service of Legal Process

Legal process may be served on:

E. I. du Pont de Nemours and Company
Chestnut Run Plaza
974 Centre Road
P.O. Box 2915
Wilmington, DE 19805

Administrative Plan Details

The Plan Sponsor for all the plans covered in this summary is:

E. I. du Pont de Nemours and Company
974 Centre Road
Wilmington, DE 19805

Phone: 1-302-774-1000

The Plan Sponsor's EIN is 51-0014090.

The Plan Administrator for all the plans covered in this summary is:

The Benefit Plans Administrative Committee
974 Centre Road
Wilmington, DE 19805

Phone: 1-302-774-1000

The Plan Administrator has full discretion and authority to interpret Plan provisions, resolve any ambiguities and evaluate claims.The plan year for all the plans covered in this summary is January 1 to December 31.

The BeneFlex Medical Care Plan

Plan Name	The DuPont Medical Care Plan (which includes the BeneFlex Medical Care Plan)
Plan Number	503
Type of Plan	The Plan is a welfare plan as defined by the Employee Retirement Income Security Act of 1974 (ERISA) that provides group health benefits.
Claims Administrator	The Claims Administrators vary by location. For the Core and Premium Saver Options, the Claims Administrators are: Aetna, Inc. P. O. Box 14079 Lexington, KY 40512 1-800-938-7668 Highmark BCBS Delaware P.O. Box 1991 Wilmington, DE 19899-1991 1-888-431-4650 Other Claims Administrators are: Triple S P.O. Box 363628 San Juan, PR 00936-363628 1-877-357-9777 Aetna International P.O. Box 981543 El Paso, TX 79998-1543 1-800-231-7729 or 1-813-775-0190 HMSA P.O. Box 860 Honolulu, HI 96808 1-808-948-6111
Source of Benefits Funding	You, the employee, and the Company pay the cost.

The BeneFlex Dental Care Plan

Plan Name	Dental Assistance Plan (which includes the BeneFlex Dental Care Plan)
Plan Number	507
Type of Plan	The Plan is a welfare plan as defined by the Employee Retirement Income Security Act of 1974 (ERISA) that provides group health benefits.
Claims Administrator	MetLife Dental P.O. Box 981282 El Paso, TX 79998-1282 1-888-883-0052
Source of Benefits Funding	You, the employee, and the Company pay the cost.

The BeneFlex Vision Care Plan

Plan Name	Vision Care Plan (which includes the BeneFlex Vision Care Plan)
Plan Number	515
Type of Plan	The Plan is a welfare plan as defined by the Employee Retirement Income Security Act of 1974 (ERISA) that provides group health benefits. The Company contracts with an insurance company for the purposes of providing any benefits under this Plan. The Plan insurer is: Vision Benefits of America 400 Lydia Street, Suite 300 Carnegie, PA 15106 1-800-432-4966
Claims Administrator	VBA 400 Lydia Street, Suite 300 Carnegie, PA 15106 1-800-432-4966
Source of Benefits Funding	You, the employee, pay the entire cost.

The Flexible Spending Account (FSA) Plans

Plan Name	The BeneFlex Health Care Limited Purpose FSA Plan (this Summary also describes the BeneFlex Dependent Care Flexible Spending Account, which is not covered by ERISA)
Plan Number	512
Type of Plan	The Plan is a welfare plan as defined by the Employee Retirement Income Security Act of 1974 (ERISA) that provides a choice between compensation and certain benefits.
Claims Administrator	Bank of America P.O. Box 2203 Fargo, ND 58108 Phone: 1-877-319-8115 Fax: 1-844-590-0919 www.bankofamerical.com/benefitslogin
Source of Benefits Funding	You, the employee, pay the entire cost.

The Employee Life Insurance Plan (which includes The BeneFlex Employee Life Insurance Plan, The BeneFlex Dependent Life Insurance Plan, and The BeneFlex Accidental Death Insurance Plan)

Plan Name	Employee Life Insurance Plan (which includes the BeneFlex Employee Life, Dependent Life and Accidental Death Insurance Plans)
Plan Number	501
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 certain group life insurance benefits. The Company has contracts with one or more insurance companies for the purpose of providing any benefits under this Plan.
Plan Administrator	Benefit Plans Administrative Committee 974 Centre Road Wilmington, DE 19805 Phone: 1-302-774-1000
Plan Insurer	Securian Financial Group, Inc. 400 Robert Street North St. Paul, MN 55101-2098 Phone: 1-866-365-4304
Source of Benefits Funding	The benefits payable under this Plan are fully insured. The Company pays the entire premium cost for Basic Coverage under the Plan. Active employees and retirees pay the premium cost of Supplemental Coverage under the BeneFlex Life Insurance program.

Contacts

Service/Resource	Contact Details
DuPont Connection	http://digital.alight.com/dupont 1-800-775-5955
Medical (U.S. Mainland)	Aetna, Inc. P. O. Box 14079 Lexington, KY 40512 1-800-938-7668 www.aetna.com Highmark BCBS Delaware P.O. Box 1991 Wilmington, DE 19899-1991 1-888-431-4650 www.highmarkbcbsde.com
Healthy Incentive Program	Viverae 1-888-VIVERAE (848-3723) www.myhealth.dupont.com
Choosing Providers	Castlight 1-855-572-2172 www.mycastlight.com/dupont
Pharmacy Network	Express Scripts 1-800-793-8766 www.express-scripts.com/dupontactive
Specialty Medications	Accredo 1-800-803-2523
Employee Assistance Program and Mental Health/Chemical Dependency	ComPsych 1-800-435-7266 www.guidanceresources.com
Telephone medical consultation for minor illness or injury	Teladoc 1-800-835-2362 www.teladoc.com/dupont
Health Savings Account	Bank of America P.O. Box 2203 Fargo, ND 58108 1-877-319-8115 www.bankofamerica.com/benefitslogin
Medical (Hawaii)	HMSA Blue Cross Blue Shield of Hawaii P.O. Box 860 Honolulu, HI 96808 1-808-948-6111 www.hmsa.com
Medical (Puerto Rico)	Triple S 1-787-774-6060 www.ssspr.com

Service/Resource	Contact Details
Medical (International)	Aetna International P.O. Box 981543 El Paso, TX 79998-1543 1-800-231-7729 1-813-775-0190 www.aetnainternational.com
Dental	MetLife Dental P.O. Box 981282 El Paso, TX 79998-1282 1-888-883-0052 www.metlife.com/mybenefits
Vision	VBA 400 Lydia Street, Suite 300 Carnegie, PA 15106 1-800-432-4966 www.vbaplans.com
Health Care Limited Purpose FSA **Dependent Care FSA**	Bank of America P.O. Box 2203 Fargo, ND 58108 1-877-319-8115 www.bankofamerica.com/benefitslogin
COBRA Coverage	DuPont Connection Prior to 1/1/2019: DuPont Connection 4 Overlook Point P.O. Box 1462 Lincolnshire, IL 60069-1462 On or After 1/1/2019: DuPont Connection 1000 S. Perimeter Road P.O. Box 7101 Rantoul, IL 61866-7101 http://digital.alight.com/dupont 1-800-775-5955
Life and Accidental Death Insurance	Securian Life Insurance Company 400 Robert Street North St. Paul, MN 55101-2098 1-866-365-4304 www.lifebenefits.com

Contacts for Appeals

Type of Appeal	Contact Details
Eligibility and Enrollment	**DuPont Connection:** Benefit Determination Review Team P.O. Box 1407 Lincolnshire, IL 60069-1407
Dependent Verification	**DuPont Connection:** Dependent Verification Center P.O. Box 1415 Lincolnshire, IL 60069-1415
Medical	**Aetna:** **For standard appeals:** Aetna Customer Resolution Team P.O. Box 14463 Lexington, KY 40512 **For pre-service appeals:** Aetna Customer Resolution Team P.O. Box 14001 Lexington, KY 40512 **Highmark:** Highmark Blue Cross Blue Shield Delaware Attention: Customer Service Appeals Team P.O. Box 8832 Wilmington, DE 19899-8832 Fax: 1-877-710-1513 **ComPsych:** ComPsych Appeals Coordinator 455 N Cityfront Plaza Drive, 13th Floor Chicago, IL 60611 **HMSA:** HMSA P.O. Box 860 Honolulu, HI 96808 **Triple S:** Claims and Appeals P.O. Box 363628 San Juan, PR 00936-363628 disputedclaims@opm.gov

Type of Appeal	Contact Details
Rx	**ESI:** **Clinical Appeal requests:** Express Scripts Attn: Clinical Appeals Department P.O. Box 66588 St. Louis, MO 63166-6588 Fax: 1-877-852-4070 **Administrative appeal requests:** Attn: Administrative Appeals Department P.O. Box 66587 St Louis, MO 63166-6587 Fax: 1-877-328-9660 **Urgent clinical appeal requests:** Phone: 1-800-753-2851 Fax: 1-877-852-4070 **Urgent administrative appeal requests:** Phone: 1-800-946-3979 Fax: 1-877-328-9660 **External review:** MCMC LLC Attn: Express Scripts Appeal Program 300 Crown Colony Drive, Suite 203 Quincy, MA 02169-0929 Fax: 1-617-375-7683
Dental	MetLife Group Claims Review P.O. Box 14589 Lexington, KY 40512
Vision	VBA Attn: Claims and Appeals 400 Lydia Street, Suite 300 Carnegie, PA 15106
Health Care Limited Purpose and/or Dependent Care Flexible Spending Accounts	Bank of America c/o Health Account Services Fargo, ND 58108 Attn: Appeals Department **Appeals may also be initiated by:** Phone: 1-877-319-8115 Fax: 1-844-590-0919
Life and Accident Insurance Appeals	Securian Financial Claims P.O. Box 64114 St Paul, MN 55164-0114

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