

Your Benefit
Summary



Employee Health, Insurance, and Other Benefits



Effective January 1, 2026

About this Summary

This Summary Plan Description (SPD) provides a concise description of the following Company Plans (the Plans), all of which are part of the DuPont Consolidated Health and Welfare Plan:

- *Medical Plan*
- *Hospital Indemnity Plan*
- *Critical Illness Plan*
- *Accident Plan*
- *Infertility/Family Planning Program*
- *Behavioral Health Plan*
- *Dental Plan*
- *Vision Plan*
- *Limited Purpose Health Care Flexible Spending Account*
- *Traditional Health Care Flexible Spending Account*
- *Dependent Daycare Flexible Spending Account*
- *Employee Life Insurance Plan, which includes:*
 - *Dependent Life Insurance Plan*
 - *Accidental Death Insurance Plan*
- *Legal Plan*
- *Identity Protection Program*
- *Commuter Benefits Program*

These plans and programs are offered through the 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 describes certain benefits, including the Flexible Benefits Plan, the Dependent Daycare Flexible Spending Account, Health Savings Accounts, Identity Protection Program and Commuter Benefits Program, which are not subject to ERISA, and their inclusion in this SPD does not serve to subject such benefits to ERISA or its requirements.

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 document. In the event of a discrepancy between this SPD and the official plan document, the applicable official plan document 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. If the Plans are terminated, only benefits accrued through the effective date of the termination will be paid. There is no guarantee of lifetime benefits under the Plans. No person has or will have a vested or nonforfeitable right to receive benefits under the Plans.

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

See "Defined Terms" on page 128 for the meanings of certain capitalized terms used in this summary.

YOUR SUMMARY PLAN DESCRIPTION

Employee Health, Insurance, and Other Benefits

JANUARY 2026

DuPont de Nemours, Inc.’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.

You can select from a broad range of benefit plan options and change your elections every year.



CONTENTS AT A GLANCE

- Eligibility and Enrollment..... 2*
- Medical Plan 13*
- Dental Plan 54*
- Vision Plan 63*
- Health Care Flexible Spending Accounts..... 69*
- Dependent Daycare FSA..... 77*
- Employee Life Insurance..... 83*
- Dependent Life Insurance Plan 90*
- Accidental Death Insurance Plan..... 94*
- Legal Plan 102*
- Identity Protection Program 104*
- Commuter Benefits Program 105*
- Claiming Benefits and Other Information 106*
- When Coverage Ends 122*
- Defined Terms 128*
- Administrative Information 130*
- Contacts..... 137*
- Premium Assistance Under Medicaid and the Children’s Health Insurance Program (CHIP) 141*

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 122.



Questions?

If you have questions about the rules for eligibility and how to enroll, contact DuPont Connection at 1-833-253-7719.

SECTION CONTENTS

Who Is Eligible? 3

How to Enroll 6

Paying for Coverage 8

When Coverage Begins 8

Changing Your Coverage 9

What Happens If 10

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 (unless waived), and any requisite obligations thereunder have been fulfilled.

Employees whose home country are outside of the United States who are on temporary assignment in the U.S. are eligible only for the Medical Plan benefits (with Dental coverage), not for the entire suite of benefits.

Eligible Dependents for Health Plans

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

- your legal spouse/domestic partner*
- your children who meet these criteria:
 - The child is either:
 - your or your domestic partner’s biological child;
 - your stepchild from your current marriage;
 - your or your domestic partner’s adopted child (including a child legally placed with you or your domestic partner for adoption);
 - your or your spouse’s or domestic partner’s foster child; or
 - your or your spouse’s or domestic partner’s ward, where you or your spouse or domestic partner are the court-appointed, permanent 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 is a federal tax dependent of you or your domestic partner and 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 or your domestic partner claim the child as your dependent on your federal income tax return.

Note that grandchildren and stepchildren from a former marriage are not eligible for coverage unless you are the court-appointed, permanent legal guardian, even if they are your federal tax dependents. Also, former spouse/domestic partners and your spouse/domestic partner 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, affidavit of domestic partnership, or marriage certificate).

You must notify DuPont Connection at 1-833-253-7719 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.

ELIGIBILITY AND ENROLLMENT

Your domestic partner is your same-sex or opposite-sex domestic partner; provided, however, that the domestic partnership must satisfy all of the following criteria:

- You and the domestic partner have lived in a committed relationship for at least 12 consecutive months and intend to remain each other's domestic partner indefinitely;
- You and the domestic partner reside together in the same permanent residence;
- You and the domestic partner are financially interdependent and jointly responsible for the common welfare and financial obligations of the household or your domestic partner is chiefly dependent upon you for care and financial assistance;
- You and the domestic partner are at least 18 years of age;
- You and the domestic partner are not married to anyone else and are not the domestic partner or common law spouse of anyone else;
- You and the domestic partner are not related by blood to an extent that would prohibit marriage under applicable law of the state in which you reside; and
- You and the domestic partner are not in the relationship solely for the purpose of obtaining benefit coverage.

To qualify for domestic partner coverage, you and the domestic partner will be required to submit an affidavit to certify that the domestic partner is eligible for coverage.

Tax Implications for Domestic Partners

Your taxes may be affected when you enroll your domestic partner in the benefits program. If your domestic partner and his or her child(ren) qualify as your dependents under section 152 of the Tax Code, your contributions for domestic partner coverage will be taken before taxes are withheld and there will be no tax implications for you. However, if your partner and his or her child(ren) do not qualify as dependents under section 152 of the Tax Code, the value of any coverage for your domestic partner and/or his or her child(ren) is considered "imputed income" and will be shown on your pay statement and Form W-2. You will pay taxes on the amount of imputed income. The value is calculated by determining the excess of the fair market value (FMV) of the coverage over the after-tax amount you paid for the coverage.

Note too that in general, state income tax treatment of domestic partner benefits is the same as the federal income tax treatment. However, certain benefits for domestic partners and their children who are not your federal tax dependents may be eligible for special state income tax treatment in a few select states. Contact your personal tax advisor for more information.

If Both You and Your Spouse/Domestic Partner Are Eligible for Coverage

If both you and your spouse/domestic partner are eligible for the Plans as Company employees or COBRA participants, you can cover your spouse/domestic partner as a dependent, or your spouse/domestic partner can elect separate employee coverage. You or your spouse/domestic partner 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/domestic partner are eligible for the Plans as Company employees 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 1-833-253-7719.

ELIGIBILITY AND ENROLLMENT

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

You don't enroll dependents for the Limited Purpose Health Care FSA, the Traditional Health Care 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 73 under *Health Care Flexible Spending Accounts*,
- "Eligible Expenses – Traditional Health Care FSA" on page 75 under *Health Care Flexible Spending Accounts*, and
- "Whose Expenses Are Eligible?" on page 81 under *Dependent Daycare FSA*.
- Note: You can only claim health care or dependent care expenses for a domestic partner or a domestic partner's child(ren) through your FSA if they are considered to be your dependents by the IRS.

Eligible Dependents for Life and Accident Insurance and the Legal Plan

The Dependent Life Insurance Plan, the Accidental Death Insurance Plan, and the Legal Plan give you the option to cover your legal spouse/domestic partner 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/domestic partner.
- your children under age 26 who meet these criteria:
 - The child is either:
 - your or your domestic partner's biological child;
 - your stepchild from your current marriage;
 - your or your domestic partner's adopted child (including a child legally placed with you or your domestic partner for adoption);
 - your or your spouse's or domestic partner's foster child; or
 - your or your spouse's or domestic partner's ward, where you or your spouse or domestic partner are the court-appointed, permanent 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, permanent legal guardian, even if they are your federal tax dependents. Also, former spouse/domestic partners and your spouse/domestic partner 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 Employee Life Insurance Plan and the Dependent Life Insurance Plan may require evidence of insurability (proof of your good health) before coverage takes effect for you and/or your spouse/domestic partner. (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, and provide any other necessary information. If a paramedical exam is required, the cost will be covered by the insurance carrier.

ELIGIBILITY AND ENROLLMENT

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/domestic partner at your initial eligibility.
- You apply for an increase in coverage for your spouse/domestic partner after your initial eligibility (including adding coverage for a spouse/domestic partner 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 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 Annual Enrollment period, each fall; and
- if you have a Qualifying Life Event.

See "Changing Your Coverage" on page 9 for information about changes after Qualifying Life Events.

Newly Eligible Participants

DuPont Connection will send you an email letting you know when you're able to enroll and how to enroll. If you do not receive an email within one week of becoming eligible to enroll, please call DuPont Connection at 1-833-253-7719.

The deadline to submit your benefit elections or waive coverage is 30 days from your date of hire or when you first become eligible to enroll. If you enroll within 30 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 8.

DEFAULT COVERAGE FOR NEWLY ELIGIBLE PARTICIPANTS

If you don't submit enrollment instructions or waive coverage, 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 1.5 times your Pay
- Accidental Death Insurance – basic coverage equal to 1.5 times your Pay

ELIGIBILITY AND ENROLLMENT

Default coverage does not include the following:

- Vision
- Health Savings Account—no Company or employee contributions (until you attest that you are eligible for HSA contributions)
- Supplemental Healthcare Benefits
- Limited Purpose Health Care FSA
- Traditional Health Care FSA
- Dependent Care FSA
- Dependent Life Insurance
- Legal Plan
- Identity Protection Program
- Commuter Benefits Program

You will not have any coverage for your dependents.

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 contribution 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 87 under *Employee Life Insurance*; and
- "Naming a Beneficiary" on page 99 under *Accidental Death Insurance Plan*.

Paying for Coverage

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

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.

After-Tax Premiums for Supplemental Healthcare Benefits, Supplemental Employee Life Insurance, Dependent Life Insurance, the Legal Plan, and Identity Protection Program.

If you enroll in Supplemental Healthcare Benefits, Supplemental Employee Life Insurance, Dependent Life Insurance, the Legal Plan and/or the Identity Protection Program, your premiums will be paid through payroll deductions, but will be on an after-tax basis, deducted after all taxes have been withheld.

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.

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 30 days, the coverage you elect for you and your dependents is retroactive to the date you became eligible (e.g., your date of hire). However, in order to pay for premiums for retroactive coverage on a pre-tax basis (if applicable), you must enroll within 30 days of your date of hire.
Supplemental Healthcare Benefits	If you enroll within 30 days, coverage begins the first of the month following your enrollment.
Flexible Spending Accounts (FSAs), and Accidental Death Insurance	If you enroll within 30 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 30 days, the coverage you elect for you and your dependents begins on the later of: <ul style="list-style-type: none"> ▪ 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.
Legal Plan	If you enroll within 30 days, coverage begins the first of the month following your enrollment.
Identity Protection Program	If you enroll within 30 days, coverage begins the first of the month following your enrollment.

ELIGIBILITY AND ENROLLMENT

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 2024, those changes are effective on January 1, 2026.

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/domestic partner starts a new job or becomes unemployed.
- Your spouse/domestic partner's employment changes in a way that affects their eligibility for benefits (such as changing from part-time to full-time).
- Your spouse/domestic partner takes an unpaid leave of absence.
- Your spouse/domestic partner'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/domestic partner 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 Plan elections within 30 days of the Qualifying Life Event, your medical, dental, and vision changes, if applicable, will generally be effective prospectively. However, if you gain a new dependent through birth, adoption or placement for adoption, such election changes will be retroactive to the date of the Qualifying Life Event. Changes to life insurance, accidental death insurance, flexible spending accounts, the legal plan, and the identity protection program will be effective on the first of the month following the date of your call to DuPont Connection at 1-833-253-7719 or by making the change online (unless evidence of insurability is required). Your flexible spending account may not be reduced to an amount lower than the total amount of claims already reimbursed to date. If you discontinue your flexible spending account, you will not be able to be reimbursed for claims incurred after the end of the month in which you report the Qualified Life Event.

If you report your Qualifying Life Event after 30 days, but within 90 days of the Qualifying Life Event by calling DuPont Connection, your medical, dental, and vision changes, if applicable, will be effective on the date of your call. Changes to life insurance, accidental death insurance, flexible spending accounts, the legal plan and the identity protection program will be effective on the first of the month following the date of your call (unless evidence of insurability is required). Your flexible spending account may not be reduced to an amount lower than the total amount of claims already reimbursed to date. If you

ELIGIBILITY AND ENROLLMENT

discontinue your flexible spending account, you will not be able to be reimbursed for claims incurred after the end of the month in which you report the Qualifying Life Event.

In no event may an election change be made later than 90 days following the Qualifying Life Event.

HIPAA Special Enrollment Rules

If you are declining enrollment for yourself or your dependents (including your spouse/domestic partner) because of other health insurance coverage, you may in the future be able to enroll yourself and your dependents in the medical, dental, and vision plan components of this Plan if you lose eligibility, provided that you request enrollment within 30 days after your other coverage ends. Coverage will be effective prospectively.

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 90 days after the marriage, birth, adoption, or placement for adoption. If you are adding a new dependent as a result of birth, adoption or placement for adoption, and you request enrollment within 30 days of such event, coverage will be effective retroactive to the date of 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 Medical 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 10, 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).

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 Medical 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.

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 122.

ELIGIBILITY AND ENROLLMENT

Following the 30-month period, the Medical 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 1-833-253-7719 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. Contact DuPont Connection at 1-833-253-7719 if you have questions.
- 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/domestic partner 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 9.

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 benefits through a previous employer. You should contact that employer to confirm your eligibility and carefully consider if it would be better to elect those benefits after you leave the Company, or if it would be better for you to elect COBRA continuation coverage. If you decide to enroll in retiree coverage through a previous employer, you must do so within the time limits provided by that previous employer.

Former employees of Danisco hired before January 1, 2012 who retire from the Company on or after age 62 with 10 years of service after participating in the Medical Plan as active employees for at least 5 years will be allowed to continue coverage in the Medical Plan, Dental Plan and Vision Plan at active employee rates, until the earlier of the following occurs: (1) the former employee reaches age 65 or (2) the former employee becomes eligible for Medicare. Notwithstanding the foregoing, no such former Danisco employee will receive this coverage if he or she retires from the Company after November 30, 2018, unless he or she reached age 50 on or before November 30, 2018. To find out if you are eligible, contact DuPont Connection at 1-833-253-7719.

ELIGIBILITY AND ENROLLMENT

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 COBRA continuation coverage.

The Company currently subsidizes your medical and dental coverage premiums 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.

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.

Your Work Unit Is Divested

If your work unit is divested and you are part of the divestiture, all coverage ends on the date of the divestiture.

Medical 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 U.S. choose between three options—the Core Option, the Premium Saver Option, or the Traditional Copay PPO. 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 Aetna One Advisor (A1A) if you are enrolled in the Core, Premium Saver, or Traditional Copay PPO Option, or your medical carrier if you are enrolled in Alternative Coverage. See "Contacts" on page 137.

SECTION CONTENTS

Highlights	14
Hinge Health	17
2nd.MD	18
Your Medical Care Plan Options	18
Cost of Coverage	19
How the Core and Premium Saver Options Work	20
Saving with a Health Savings Account (HSA)	21
How the Traditional Copay PPO Works	22
How Coverage Works	23
The Coverage Network	23
Allowable Charge Amounts	23
Pre-existing Conditions	25
Deductible	25
Office and Facility Visits	26
Coinsurance	26
Out-of-Pocket Maximums	27
Annual and Lifetime Maximum Benefits	28
Medically Necessary and Appropriate	28
Precertification	29
What Is Covered	30
Preventive Care	30
Other Medical Care (Non-Preventive)	31

MEDICAL PLAN

<i>Hospice Care</i>	39
<i>Prescription Drugs</i>	40
<i>Behavioral Health and Substance Abuse (BH/SA)</i>	45
<i>What Is Not Covered</i>	46
<i>Alternative Coverage Highlights</i>	48
<i>Using a Health Savings Account (HSA)</i>	49

Highlights

The Company provides U.S. mainland employees with three medical options: the Core Option, the Premium Saver Option, and the Traditional Copay PPO Option. An outline of these options is shown below. Read the full summary for more details.

For employees enrolled in the Core Option, the Premium Saver Option, and the Traditional Copay PPO Option, A1A is your single point of contact to help you with medical, prescription drug, and behavioral health/substance abuse care questions. Once you connect with A1A, you and your covered family members will be assigned a dedicated Health Assistant for personalized, confidential support. Your dedicated Health Assistant will take the time to get to know you and understand your needs, while partnering with a team of doctors, nurses, and benefit specialists to support you in making the best healthcare decisions possible.

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

	Core Option	Premium Saver Option	Traditional Copay PPO Option
Medical Plan Benefits			
<i>HSA Company Contribution for qualifying employees</i>	\$600 for you only coverage, or \$1,200 for other coverage levels	\$600 for you only coverage, or \$1,200 for other coverage levels	Not Applicable
<i>Deductible (individual/other coverage levels)</i> (annual amount, combined for medical and prescription drug claims)	<ul style="list-style-type: none"> ▪ In network: \$1,800/\$3,600 ▪ Out-of-network: \$2,600/\$4,200 	<ul style="list-style-type: none"> ▪ In network: \$3,100/\$6,200 ▪ Out-of-network: \$3,900/\$6,800 	<ul style="list-style-type: none"> ▪ In network: \$1,000/\$2,000 ▪ Out-of-network: \$1,800/\$2,600
Preventive Care (see your medical carrier for a list of covered services)	<ul style="list-style-type: none"> ▪ In network: 100% paid, no deductible ▪ Out-of-network: 100% paid based on R&C, no deductible 	<ul style="list-style-type: none"> ▪ In network: 100% paid, no deductible ▪ Out-of-network: 100% paid based on R&C, no deductible 	<ul style="list-style-type: none"> ▪ In network: 100% paid, no deductible ▪ Out-of-network: 100% paid based on R&C, no deductible

MEDICAL PLAN

	Core Option	Premium Saver Option	Traditional Copay PPO Option
Medical Plan Benefits			
Office and Facility Visits <ul style="list-style-type: none"> ▪ Primary care provider (PCP) office visits [including outpatient behavioral health/substance abuse visits] ▪ Specialist office visits ▪ Urgent care office visits ▪ Retail clinic visits, and ▪ Emergency Room [ER] visits 	<ul style="list-style-type: none"> ▪ In network: You pay 20% after deductible ▪ Out-of-network: You pay 40% after deductible, except for ER visit, you pay 20% after deductible. 	<ul style="list-style-type: none"> ▪ In network: You pay 20% after deductible ▪ Out-of-network: You pay 40% after deductible, except for ER visit, you pay 20% after deductible. 	<ul style="list-style-type: none"> ▪ In network: Amounts not subject to the deductible. You pay: <ul style="list-style-type: none"> ▫ PCP office visit: \$30 copay ▫ Specialist office visit: \$45 copay ▫ Urgent care visit: \$45 copay ▫ Retail clinic visit: \$30 copay ▫ ER visit: \$250 copay, not waived if admitted ▪ Out-of-Network: You pay 40% after deductible, except for ER visit, you pay \$250 copay, not waived if admitted.
Teladoc® (Telemedicine) Non-emergency, general medicine services	<ul style="list-style-type: none"> ▪ Before you meet the deductible: You pay \$56 ▪ After you meet the deductible: You pay \$11.20 	<ul style="list-style-type: none"> ▪ Before you meet the deductible: You pay \$56 ▪ After you meet the deductible: You pay \$11.20 	<ul style="list-style-type: none"> ▪ You pay a \$30 primary care provider copay
Teladoc Dermatology services	<ul style="list-style-type: none"> ▪ Before you meet the deductible: You pay a \$85 consult fee ▪ After you meet the deductible: You pay 20% of the consult fee (\$17) 	<ul style="list-style-type: none"> ▪ Before you meet the deductible: You pay a \$85 consult fee ▪ After you meet the deductible: You pay 20% of the consult fee (\$17) 	<ul style="list-style-type: none"> ▪ You pay a \$45 specialist copay
Teladoc Behavioral health services	<ul style="list-style-type: none"> ▪ Before you meet the deductible, you pay: <ul style="list-style-type: none"> ▪ \$90 consult fee (therapist or psychologist) ▪ \$215 (psychiatrist evaluation) ▪ \$100 (ongoing sessions with a psychiatrist) ▪ After you meet the deductible: You pay 20% of the consult fee 	<ul style="list-style-type: none"> ▪ Before you meet the deductible, you pay: <ul style="list-style-type: none"> ▪ \$90 consult fee (therapist or psychologist) ▪ \$215 (psychiatrist evaluation) ▪ \$100 (ongoing sessions with a psychiatrist) ▪ After you meet the deductible: You pay 20% of the consult fee 	<ul style="list-style-type: none"> ▪ You pay a \$30 primary care provider copay

MEDICAL PLAN

	Core Option	Premium Saver Option	Traditional Copay PPO Option
Medical Plan Benefits			
CVS Virtual Care	<ul style="list-style-type: none"> ▪ Before you meet the deductible, you pay: <ul style="list-style-type: none"> ▫ Medical \$55 ▫ Behavioral Health for Individual Talk Therapy \$85 ▫ Psychiatric Diagnostic Evaluation (MD) \$215 ▫ Virtual Primary Care for Initial Annual Evaluation \$144 ▫ Follow Up Visits \$99 ▪ After you meet the deductible: You pay 20% of the consult fee 	<ul style="list-style-type: none"> ▪ Before you meet the deductible, you pay: <ul style="list-style-type: none"> ▫ Medical \$55 ▫ Behavioral Health for Individual Talk Therapy \$85 ▫ Psychiatric Diagnostic Evaluation (MD) \$215 ▫ Virtual Primary Care for Initial Annual Evaluation \$144 ▫ Follow Up Visits \$99 ▪ After you meet the deductible: You pay 20% of the consult fee 	<ul style="list-style-type: none"> ▪ Medical \$55 ▪ Behavioral Health for Individual Talk Therapy \$85 ▪ Psychiatric Diagnostic Evaluation (MD) \$215 ▪ Virtual Primary Care for Initial Annual Evaluation \$144 ▪ Follow Up Visits \$99
Hinge Health (musculoskeletal support)	<ul style="list-style-type: none"> ▪ 100% paid, no deductible 	<ul style="list-style-type: none"> ▪ 100% paid, no deductible 	<ul style="list-style-type: none"> ▪ 100% paid, no deductible
2nd.MD (second opinion service)	<ul style="list-style-type: none"> ▪ 100% paid, no deductible 	<ul style="list-style-type: none"> ▪ 100% paid, no deductible 	<ul style="list-style-type: none"> ▪ 100% paid, no deductible
Other Medically Necessary Care (Chiropractic care (\$1,000 annual limit), labs, X-rays, hospitalization, surgery, etc.)	<ul style="list-style-type: none"> ▪ In network: You pay 20% after deductible ▪ Out-of-network: You pay 40% after deductible 	<ul style="list-style-type: none"> ▪ In network: You pay 20% after deductible ▪ Out-of-network: You pay 40% after deductible 	<ul style="list-style-type: none"> ▪ In network: You pay 20% after deductible, except for Chiropractic care: \$45 copay ▪ Out-of-network: You pay 40% after deductible
Prescription Cost Sharing			
<ul style="list-style-type: none"> ▪ The deductible is waived for medications on the preventive medication list (see “Preventive Medications” on page 43) ▪ 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 drug coverage appears under “Prescription Drugs” on page 40 ▪ Prescription information below is for both in and out-of-network 			
<i>Generic</i>	\$10.00 after deductible at retail/\$30.00 after deductible through mail order	\$10.00 after deductible at retail/\$30.00 after deductible through mail order	\$10.00 after deductible at retail/\$30.00 after deductible through mail order
<i>Brand Formulary (Preferred)</i>	You pay 25% after deductible; \$125 maximum* per fill	You pay 25% after deductible; \$125 maximum* per fill	You pay 25% after deductible; \$125 maximum* per fill
<i>Brand Non-Formulary (Non-Preferred)</i>	You pay 45% after deductible; \$250 maximum per fill	You pay 45% after deductible; \$250 maximum* per fill	You pay 45% after deductible; \$250 maximum* per fill

MEDICAL PLAN

	Core Option	Premium Saver Option	Traditional Copay PPO Option
Medical Plan Benefits			
<i>Specialty Medications</i>	0% coinsurance (after deductible) if the drug is on the PrudentRx drug list and member enrolls in the program; 30% coinsurance (after deductible) if drug is on the PrudentRx drug list and member does NOT enroll in the program; 30% coinsurance (after deductible) if specialty drug is not on the PrudentRx drug list	0% coinsurance (after deductible) if the drug is on the PrudentRx drug list and member enrolls in the program; 30% coinsurance (after deductible) if drug is on the PrudentRx drug list and member does NOT enroll in the program; 30% coinsurance (after deductible) if specialty drug is not on the PrudentRx drug list	0% coinsurance if the drug is on the PrudentRx drug list and member enrolls in the program; 30% coinsurance if drug is on the PrudentRx drug list and member does NOT enroll in the program; 30% coinsurance if specialty drug is not on the PrudentRx drug list
<i>Maintenance medications after second fill at retail pharmacies</i>	You pay 45% after deductible; no maximum	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)			
<ul style="list-style-type: none"> ▪ Each Person 	<ul style="list-style-type: none"> ▪ In network: \$5,000 ▪ Out-of-network: No limit 	<ul style="list-style-type: none"> ▪ In network: \$6,000 ▪ Out-of-network: No limit 	<ul style="list-style-type: none"> ▪ In network: \$6,000 ▪ Out-of-network: No limit
<ul style="list-style-type: none"> ▪ All Covered Family Members Combined 	<ul style="list-style-type: none"> ▪ In network: 10,000 ▪ Out-of-network: No limit 	<ul style="list-style-type: none"> ▪ In network: \$12,000 ▪ Out-of-network: No limit 	<ul style="list-style-type: none"> ▪ In network: \$12,000 ▪ Out-of-network: 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/domestic partner or Medicare, may not be eligible. See "Who Is Eligible?" On page 49 for details.

Hinge Health

Hinge Health is a free service that is included in medical coverage for employees enrolled in the Core Option, the Premium Saver Option, and the Traditional Copay PPO Option. The Hinge Health program provides virtual musculoskeletal care. Targeting back, knee, hip, shoulder and neck pain, the Hinge Health program is designed to reduce pain and, in many cases, avoid surgery. The Hinge Health program is intended to be convenient and fit your schedule, since it can be done anywhere, at any time.

The Hinge Health program includes:

- Personalized exercise therapy to improve strength and mobility in 15-minute sessions
- Personal health coaching and physical therapists to provide care, motivation, and support virtually

MEDICAL PLAN

- Education to teach you how to manage your condition and treatment options
- Wearable sensors for live feedback in the app.

If you or an eligible dependent over the age of 18 has chronic musculoskeletal pain, contact A1A at 1-877-383-4756 to learn more about Hinge Health or call Hinge Health at 1-855-902-2777 or apply at www.hingehealth.com/dupont.

Some medical procedures require pre-certification prior to being covered under the DuPont medical plan; examples of these types of procedures include certain joint and spine surgeries. Pre-certification requirements may include completing physical therapy in-person with a provider. Members should consider any potential future medical procedures prior to selecting a provider for more conservative treatments like physical therapy.

2nd.MD

2nd.MD is a free service that is included in medical coverage for employees enrolled in the Core Option, the Premium Saver Option, and the Traditional Copay PPO Option. 2nd.MD can connect you and your covered dependents with top national specialists, via phone or video, to review a diagnosis and treatment plan, all within a matter of days. To use this service contact A1A at 1-877-383-4756 or call 2nd.MD at 1-866-410-8649 or visit www.2nd.md/dupont.

Your Medical Care Plan Options

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

- Core Option
- Premium Saver Option
- Traditional Copay PPO Option

You also have the option to waive coverage.

A1A is your single point of contact to help you with medical, prescription drug, and behavioral health/substance abuse care questions.

Claims administration and preferred provider networks:

- The medical and behavioral health/substance abuse Claims Administrator is Aetna.
- Prescription drug claims are administered through CVS Caremark.

ALTERNATIVE COVERAGE OPTION FOR EMPLOYEES ON INTERNATIONAL ASSIGNMENTS

If you are an employee on an international assignment, an Alternative Coverage option is available to you, such as the:

- International PPO, provided through Aetna International

The option available will be listed in your personalized enrollment materials. For an overview of the option, please see "Alternative Coverage Highlights" on page 48.

IF YOU WAIVE COVERAGE

If you waive medical coverage, you will still be eligible to receive twelve 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.

YOUR MONTHLY* PREMIUMS FOR 2026

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

Alternative Coverage Costs

If you are on international assignment, call DuPont Connection, 1-833-253-7719 for your costs.

Coverage Level	Core Option	Premium Saver Option	Traditional Copay PPO Option
<i>You Only</i>	\$145	\$96	\$145
<i>You + Spouse/Domestic Partner</i>	\$353	\$240	\$353
<i>You + Child(ren)</i>	\$257	\$176	\$257
<i>You + Family</i>	\$448	\$304	\$448

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

Healthy Incentive Credit—Save Up to \$40 a Month!

The Healthy Incentive credit program is designed to help you:

- Identify your health risks and
- Improve your health or stay healthy.

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

By completing the Healthy Incentive annual program, you can earn up to a \$40 monthly credit that reduces your premiums in the following calendar year, if you are enrolled in either the Core, Premium Saver, or Traditional Copay PPO options. The value of the credit, along with the steps required to earn it are subject to change each year.

For 2026, the program consists of earning 6,000 points in each of Quarters 1 through 3 to earn the full Healthy Incentive Credit for 2026, by completing the biometric screening, by completing an annual preventative care adult checkup or well woman exam by September 30, 2026 for the Fast Pass option. Points reset to zero at the end of each quarter. You can also earn Rewards Cash which can be redeemed for gift cards or merchandise through the Personify Health store.

If you are hired between January 1 and March 31, 2026, you will automatically receive the 1st quarter credit (\$160) for 2026 and can earn additional credits in the 2nd and 3rd quarter (\$160 in each quarter) for 2026, plus Rewards Cash. If you are hired between April 1 and June 30, 2026, you will automatically receive the 1st and 2nd quarter credits (\$320) for 2026 and can earn additional credit in the 3rd quarter (\$160), plus Rewards Cash. Employees hired on or after July 1 automatically receive the credit for the following calendar year and can earn Rewards Cash.

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 Option (International Assignment). The Healthy Incentive credit is already factored into the premium cost you pay for the Alternative Coverage Options. You are eligible to participate in the Healthy Incentive program and earn Rewards Cash.

Personify Health—Our Healthy Incentive Partner

The Company's Healthy Incentive credit and the tobacco cessation program are offered by our partner, Personify Health. For information, call Personify Health at 1-888-671-9395 or visit www.myhealth.dupont.com.

MEDICAL PLAN

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. You have 30 days following your termination from employment to redeem Rewards Cash.

Health Screening Is Confidential—By Law!

The information collected on the health risk assessment and through the health screening is confidential. Our screening partner, Personify Health, 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.

The tobacco surcharge applies to U.S. and expatriate employees enrolled in active medical coverage. If you are a tobacco user, you can avoid paying the surcharge for the next plan year by enrolling with our wellness partner, Personify Health, at www.myhealth.dupont.com and completing the Tobacco Cessation program. For 2026, the program consists of three Tobacco Cessation Coaching sessions by phone with a Personify Health coach between January 1 and October 31 and completion of one Tobacco Cessation Journey by October 31.

To encourage tobacco users to stop tobacco, if you are receiving the \$50 monthly surcharge in 2026 and you complete three Tobacco Cessation Coaching sessions and a Tobacco Cessation Journey by March 31, the \$50 surcharge will be removed effective May 1. If you complete three Tobacco Cessation Coaching sessions and a Tobacco Cessation Journey between April 1 and June 30, the \$50 monthly surcharge will be removed effective August 1.

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 the Core and Premium Saver Options Work

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.
<i>Core Option</i>	Higher	Lower	Lower
<i>Premium Saver Option</i>	Lower	Higher	Higher
<i>Traditional Copay PPO Option</i>	Same as the Core Option	Lowest	Same as the Premium Saver Option

See the "Highlights" chart on page 13 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. A1A can provide you with a list of in-network providers (or you can search Aetna and CVS's 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 43 for more information.

MEDICAL PLAN

- 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 27 for more information.
- See "What Is Covered" on page 30 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.

The Company will make one contribution per calendar year. If you receive a Company HSA contribution, terminate and are rehired in the same year, you will not be eligible for a Company HSA contribution upon rehire.

- 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.

Note: If you cover your domestic partner and his or her child(ren) who meet the eligibility requirements for medical coverage and you do not claim them as dependents on your tax return, distributions from your HSA related to claims incurred by your domestic partner and his or her child(ren) will not be qualified medical expenses. They will be taxable and may be subject to an additional 20% tax. Please consult your individual tax advisor for additional information.

What Is a Health Savings Account?

An 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.

How the Traditional Copay PPO Works

The Traditional Copay PPO covers the same services, provides the same prescription drug benefit, and has the same limitations and exclusions as the Core and Premium Saver options, but is **not** a high deductible health plan (HDHP) as defined by the Internal Revenue Service (IRS). This means that if you enroll in the Traditional Copay PPO, you cannot contribute to a Health Savings Account (HSA) or receive the Company's HSA contribution. If you have an HSA, you may use that to cover qualified medical expenses that you incur while enrolled in the Traditional Copay PPO.

Note that:

- There are separate benefits for in-network and out-of-network care. Your Claims Administrator/carrier manages the network. A1A and can provide you with a list of in-network providers (or you can search Aetna and CVS's provider directories online).
- Preventive care is covered at 100% and is not subject to the annual deductible. Certain preventive medications are available at no cost; others are not subject to the annual deductible but may be subject to coinsurance.
- You pay fixed amounts, called copays, for Teladoc and CVS Virtual Care as well as in-network visits to primary care and specialist providers, urgent care centers, retail clinics, and the emergency room. You do not need to meet your deductible before you pay copays for these types of visits. Copays count toward your out-of-pocket maximum, but not your deductible.
- For all other services, you pay the full cost of coverage until you reach your annual deductible amount. Medical and prescription drug costs both count toward the same annual deductible amount. 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 27 for more information.
- See "What Is Covered" on page 30 for further information about your benefits including information on emergency care, covered services and limitations and exclusions.

How Coverage Works

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. Employees enrolled in the Core Option, Premium Saver Option, or Traditional Copay PPO Option can contact A1A to confirm if a provider is in-network or search Aetna’s and/or Caremark’s online directories. Employees on international assignment can get a copy of the provider directory from your carrier (or search their online directories) for:

- the medical (including behavioral health or substance abuse) service network; and
- the prescription drug retail, mail, and specialty pharmacy network.

Refer to “Contacts” on page 137 for a list of carriers and their contact information. Or, contact A1A or your carrier (if you have Alternative Coverage) using the information printed on your medical and pharmacy ID cards.

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.

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 A1A or your medical carrier if you have Alternative Coverage.

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 a carrier’s network must meet strict standards and agree to follow guidelines set by the applicable carrier. 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.

RECOGNIZED AND CUSTOMARY CHARGES — (R&C) (OUT-OF-NETWORK)

The amount of an out-of-network provider’s charge that is eligible for coverage. You are responsible for all amounts above what is eligible for coverage.

If your ID card displays the National advantage Program (NAP) logo your cost may be lower when you get care from a NAP provider. Through NAP, the recognized charge is determined as follows:

- If your service was received from a NAP provider, a pre-negotiated charge will be paid. NAP providers are out-of-network providers that have contracts with Aetna, directly or through third-party vendors, that include a pre-negotiated charge for services. NAP providers are not network providers.
- If your service was not received from a NAP provider, a claim specific rate or discount may be negotiated by Aetna or a third-party vendor.

If your claim is not paid as outlined above, the recognized charge for specific services or supplies will be the out-of-network plan rate, calculated in accordance with the following:

Service or Supply	Out-of-Network Plan Rate
<i>Professional services</i>	An amount determined by Aetna, or its third-party vendors, based on data resources selected by Aetna, reflecting typical costs, competitive charges and/or payments for a service, adjusted for the geographic area in which the service was provided.

MEDICAL PLAN

Service or Supply	Out-of-Network Plan Rate
<i>Inpatient and outpatient charges of hospitals</i>	An amount determined by Aetna (such as FCR), or its third-party vendors, based on data resources selected by Aetna, reflecting typical costs, competitive charges and/or payments for a service, adjusted for the geographic area in which the service was provided.
<i>Inpatient and outpatient charges of facilities other than hospitals</i>	Facility Charge Review

Important Note: If the provided bills less than the amount calculated using the out-of-network plan rate described above, the recognized charge is what the provider bills.

In the event you receive a balance bill from a provider for your out-of-network service, Patient Advocacy Services may be available to assist you in certain circumstances.

If NAP does not apply to you, the recognized charge for specific services or supplies will be the out-of-network plan rate set forth in the above chart.

The out-of-network plan rate does not apply to involuntary services. Involuntary services are services or supplies that are one of the following:

- Performed at a network facility by certain out-of-network providers
- Not available from a network provider
- Emergency services

Aetna will calculate your cost share for involuntary services in the same way as they would if you received the services from a network provider. If you receive a surprise bill, your cost share will be calculated at the median contracted rate.

Important Note: In the case of a surprise bill from an out-of-network provider, where you had no control of their participation in your covered services, you will pay the same cost share you would have if the covered services were received from a network provider. The cost share will be based on the median contracted rate. Contact A1A if you receive such a bill.

Special terms used:

- Facility charge review (FCR) rate is an amount that Aetna determine is enough to cover the facility provider's estimated costs for the service and leave the facility provider with a reasonable profit. For hospitals and other facilities that report costs (or cost-to-charge ratios) to CMS, the FCR rate is based on what the facilities report to CMS. For facilities that do not report costs (or cost-to-charge ratios) to CMS, the FCR rate is based on statewide averages of the facilities that do report to CMS. Aetna may adjust the formula as needed to maintain the reasonableness of the recognized charge. For example, Aetna may make an adjustment if they determine that in a particular state the charges of ambulatory surgery centers (or another class of facility) are much higher than charges of facilities that report costs (or cost-to-charge ratios) to CMS.
- Geographic area is normally based on the first three digits of the U.S. Postal Service zip codes. If Aetna determines they need more data for a particular service or supply, they may base rates on a wider geographic area such as an entire state.

Aetna reserves the right to apply their reimbursement policies to all out-of-network services including involuntary services. Their 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

MEDICAL PLAN

- 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
- The educational level, licensure or length of training of the provider

Aetna's reimbursement policies may consider:

- The Centers for Medicare and Medicaid Services' (CMS) National Correct Coding Initiative (NCCI) and other external materials that say what billing and coding practices are and are not appropriate
- Generally accepted standards of medical and dental practice
- The views of physicians and dentists practicing in the relevant clinical area
- Aetna's own data and/or databases and methodologies maintained by third parties

Aetna uses commercial software to administer some of these policies. The policies may be different for professional services and facility services.

How Are Out-of-Network Benefits Determined?

- *If your doctor's charges for covered services are less than or equal to the recognized charge, benefits apply to the full billed charges.*
- *If your doctor charges more than what is the recognized charges, you pay your share of the covered recognized charge amount plus any excess fees.*

Call A1A or your medical carrier (Aetna International or Triple S) 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	Traditional Copay PPO Option
Medical Plan Benefits			
Deductible (individual/other coverage levels) <i>(combined for medical and prescription drug claims)</i>	<ul style="list-style-type: none"> ▪ In-network: \$1,800/\$3,600 ▪ Out-of-network: \$2,600/\$4,200 	<ul style="list-style-type: none"> ▪ In-network: \$3,100/\$6,200 ▪ Out-of-network: \$3,900/\$6,800 	<ul style="list-style-type: none"> ▪ In-network: \$1,000/\$2,000 ▪ Out-of-network: \$1,800/\$2,600

The annual deductible applies to most covered services, such as: X-rays, prescription medications, hospitalization, surgery, and behavioral health and substance abuse care (except outpatient office visits if you're enrolled in the Traditional Copay PPO option). If you are enrolled in the Core or Premium Saver options, office visits are also subject to the deductible. The deductible is waived for covered preventive care (as described under "Preventive Care" on page 30) 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.

MEDICAL PLAN

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.

Office and Facility Visits

The amount you pay for an office visits depends on the medical plan option and the type of visit.

	Core Option	Premium Saver Option	Traditional Copay PPO Option
Medical Plan Benefits			
Office and Facility Visits <ul style="list-style-type: none"> ▪ Primary care provider (PCP) office visits [including outpatient behavioral health/substance abuse visits] ▪ Specialist office visits ▪ Urgent care office visits ▪ Retail clinic visits, and ▪ Emergency Room [ER] visits 	<ul style="list-style-type: none"> ▪ In-network: You pay 20% after deductible ▪ Out-of-network: You pay 40% after deductible 	<ul style="list-style-type: none"> ▪ In-network: You pay 20% after deductible ▪ Out-of-network: You pay 40% after deductible 	<ul style="list-style-type: none"> ▪ In-network: Amounts not subject to the deductible. You pay: <ul style="list-style-type: none"> ▫ PCP office visit: \$30 copay ▫ Specialist office visit: \$45 copay ▫ Urgent care visit: \$45 copay ▫ Retail clinic visit: \$30 copay ▫ ER visit: \$250 copay, not waived if admitted ▪ Out-of-network: You pay 40% after deductible

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	Traditional Copay PPO Option
Medical Plan Benefits			
Coinsurance for medical services <ul style="list-style-type: none"> ▪ Chiropractic care (\$1,000 annual limit) ▪ Labs and X-rays ▪ Hospitalization ▪ Inpatient behavioral health/substance abuse care ▪ Surgery 	<ul style="list-style-type: none"> ▪ In-network: You pay 20% after deductible ▪ Out-of-network: You pay 40% after deductible 	<ul style="list-style-type: none"> ▪ In-network: You pay 20% after deductible ▪ Out-of-network: You pay 40% after deductible 	<ul style="list-style-type: none"> ▪ In-network: You pay 20% after deductible, except for Chiropractic Care: \$45 copay ▪ Out-of-network: 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, and the Traditional Copay PPO Option
<i>Generic</i>	\$10.00 after deductible at retail/\$30.00 after deductible through mail order
<i>Brand Formulary (Preferred)</i>	You pay 25% after deductible; \$125 maximum per fill

MEDICAL PLAN

Prescription Cost Sharing	Core Option, Premium Saver Option, and the Traditional Copay PPO Option
<i>Brand Non-Formulary (Non-Preferred)</i>	You pay 45% after deductible; \$250 maximum per fill
<i>Specialty Medications</i>	0% coinsurance (after deductible for Core and Premium Saver plans) if the drug is on the PrudentRx drug list and member enrolls in the program; 30% coinsurance (after deductible) if drug is on the PrudentRx drug list and member does NOT enroll in the program; 30% coinsurance (after deductible) if specialty drug is not on the PrudentRx drug list
<i>Maintenance medications after second fill at retail pharmacies</i>	You pay 45% after deductible; no maximum

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.

	Core Option	Premium Saver Option	Traditional Copay PPO Option
Medical Plan Benefits			
<i>Out of Pocket Maximum</i> (annual amount, combined for medical and prescription drug claims)			
<i>Each Person</i>	<ul style="list-style-type: none"> ▪ In-network: \$5,000 ▪ Out-of-network: No limit 	<ul style="list-style-type: none"> ▪ In-network: \$6,000 ▪ Out-of-network: No limit 	<ul style="list-style-type: none"> ▪ In-network: \$6,000 ▪ Out-of-network: No limit
<i>All Covered Family Members Combined</i>	<ul style="list-style-type: none"> ▪ In-Network: \$10,000 ▪ Out-of-Network: No limit 	<ul style="list-style-type: none"> ▪ In-network: \$12,000 ▪ Out-of-network: No limit 	<ul style="list-style-type: none"> ▪ In-network: \$12,000 ▪ Out-of-network: 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.

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 or Traditional Copay PPO Options), 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, in-network copays, and in-network coinsurance amounts for medical, prescription, and/or behavioral health/substance abuse 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.

No Max for Out-of-Network

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

MEDICAL PLAN

- Charges above recognized charges 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 A1A or your carrier (Aetna International or Triple S) using the number on your ID card 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, fertility, adoption, and surrogacy benefits shall not exceed a lifetime family maximum of \$30,000.

Expenses incurred under the lifetime fertility, adoption, and surrogacy 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, earlier charges under the prior option 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.

MEDICAL PLAN

Precertification

Precertification is required for the following services:

- certain joint and spine surgeries and
- Applied Behavioral Analysis (ABA).

Precertification is recommended for the following services:

- all behavioral health and substance abuse care;
- inpatient hospital admissions (including for behavioral health or substance abuse);
- 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, your treating physician should contact your medical carrier (using the phone number on the back of your medical ID card) at least 14 days before the service or admission is scheduled. If you are admitted to the hospital on an emergency basis, call the phone number on the back of your medical ID card 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 call the number on the back of your medical ID card at least 48 hours before the end of the initially approved period. You will be notified 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 46.

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 A1A or visit Aetna.com, and click on Health & Wellness, then under Wellness Tools click on the tile for Preventive Health Schedule. If you are an employee on international assignment, contact your medical carrier.

The Plan pays 100% benefits for covered preventive care services. No deductible or coinsurance applies. Recognized charge 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 if you are enrolled in the Core or Premium Saver options, and the office visit copay if you are enrolled in the Traditional Copay PPO option.

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 A1A or your medical carrier (if you have Alternative Coverage).

Note: Recognized 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 screenings, including initial screening mammograms, and if necessary, additional imaging (e.g., MRI, ultrasound, mammography) and pathology evaluation to complete the screening process
- 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.

MEDICAL PLAN

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 A1A (or your medical carrier if you have Alternative Coverage) 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 (in-person, telephonic or videoconference)
 - telephonic or videoconference 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 medical Opinions" on page 36 for more information.)
 - allergy testing and treatment
- chiropractic care by a licensed provider
 - Services limited to X-rays and manipulations of the spine, heat and ultrasound, therapeutic procedures and activities, traction and electrical stimulation. Services must be medically necessary and restorative in nature. Charges for services specifically to maintain a level of well-being are not covered. Benefits are limited to a maximum of \$1,000 per person per plan year.
- gynecological care

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/aetna. A Teladoc doctor is significantly less expensive than urgent care and emergency room visits.

See the medical "Highlights" chart on page 14 for the cost of Teladoc visits.

MEDICAL PLAN

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 A1A or 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/domestic partners; 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.

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.

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 30 days of birth to receive benefits retroactive to the date of birth.

When you call within 30 days of birth, your newborn's coverage will begin on the child's date of birth. If you call after 30 days, but no later than 90 days, your child's coverage will start on the date of your call.

MEDICAL PLAN

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 Recognized charge amount). Benefits for non-emergency services at the Emergency Room only are applied at the in-network or out-of-network level based on the network status of the provider (the physician and hospital). Non-emergency use of ambulance services (unless preauthorized) or urgent care is not covered.

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

When you experience an emergency medical condition, you should go to the nearest emergency room. You can also dial 911 or your local emergency response service for medical and ambulance help. 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 A1A (or 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

MEDICAL PLAN

- 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 A1A (or 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.

The surprise billing provisions of the No Surprises Act provides protections from surprise medical bills for:

- coverage of emergency services
- coverage of non-emergency services performed by an out-of-network provider at an in-network facility

Emergency services from an out-of-network provider

Your coverage for emergency services will continue until your condition is stabilized and:

- Your attending physician determines that you are medically able to travel or to be transported, by medical or non-emergency medical transportation, to another provider if you need more care;
- You are in a condition to be able to receive from the out-of-network provider delivering services the notice and consent criteria with respect to the services; and
- Your out-of-network provider delivering the services meets the notice and consent criteria with respect to the services

If your physician decides you need to stay in the hospital (emergency admission) or receive follow-up care, these are not emergency services. Different benefits and requirements apply. You can contact A1A or your network physician or primary care physician.

In the case of a surprise bill from an out-of-network provider, where you had no control of their participation in your covered services, you will pay the same cost share you would have if the covered services were received from a network provider. The cost share will be based on the median contracted rate. Contact A1A immediately if you receive such a bill.

The out-of-network plan rate does not apply to involuntary services. Involuntary services are services or supplies that are one of the following:

- Performed at a network facility by certain out-of-network providers
- Not available from a network provider
- Emergency services

Your cost share for involuntary services will be calculated in the same way as if you received the services from a network provider. If you received a surprise bill, your cost share will be calculated at the median contracted rate.

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/domestic partner'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,

MEDICAL PLAN

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

HEARING BENEFIT

The Core, Premium Saver, and Traditional Copay PPO options provide a hearing benefit, which includes:

- One hearing exam every 24 months, and
- Up to \$3,000 every 36 months to help cover hearing-related costs.

MEDICAL PLAN

A routine hearing screening done by a primary care physician is considered preventive care and is covered at 100%. A hearing screening done by an audiologist will be covered under the hearing benefit, along with hearing aid-related expenses, which are subject to the deductible and coinsurance if you are enrolled in the Core or Premium Saver options, and copays, if you are enrolled in the Traditional Copay PPO option.

To maximize your hearing benefit, members must contact Hearing Care Solutions (HCS) at 1-866-344-7756 prior to receiving care. HCS will assist with scheduling to ensure you receive the best price from a HCS provider. Aetna also uses Amplifon for hearing discounts and care. Amplifon can be reached at 1-888-HEARING (1-888-432-7464).

SECOND MEDICAL 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.

Alternatively, you can contact 2nd.MD at 1-877-410-8649 and request a free consultation with a top national specialist, via phone or video, to review a diagnosis and treatment plan, all within a matter of days.

SUPPLEMENTAL HEALTHCARE BENEFITS

To help complement your medical and/or disability coverage, we provide access to voluntary supplemental healthcare benefits that will complement your medical and/or disability coverage. The supplemental healthcare benefits can help safeguard your financial wellbeing through the following available products:

- Accident Insurance, see https://dupontbenefits.com/wp-content/uploads/2024/09/Accident-Insurance-Overview_091224.pdf
 - Provides cash payments for more than 150 covered accident events
- Critical Illness, see https://dupontbenefits.com/wp-content/uploads/2024/09/Critical-Illness-Overview_091224.pdf
 - Offers cash payments for newly diagnosed conditions like cancer and heart attack
- Hospital Indemnity, see https://dupontbenefits.com/wp-content/uploads/2024/09/Hospital-Indemnity-Overview_091224.pdf
 - Provides payments directly to you in the event of being hospitalized

Please review each plan booklet to review the covered services, cash reimbursement levels, and plan premiums. Upon enrolling, premiums will be deducted directly from your paycheck.

Submitting Claims

To submit a claim, register at www.mybenefits.metlife.com. Answer a few questions about the claim and upload the supporting medical documentation. Cash payments are made directly to you.

INFERTILITY/FAMILY PLANNING

We've partnered with Carrot Fertility to provide comprehensive, inclusive fertility healthcare and family-forming benefits, including gender-affirming care. Through Carrot, you have access to exclusive resources designed to make fertility care more accessible and affordable to everyone — regardless of age, sex, sexual orientation, gender identity, or location. Coverage and support includes:

- Preservation (e.g., egg, sperm, embryo)
- Assisted reproduction (e.g., in vitro fertilization)
- Adoption
- Gestational surrogacy

MEDICAL PLAN

- Donor assistance
- Menopause and low testosterone

When you use Carrot's services, DuPont will reimburse 100% of eligible expenses, up to a combined \$30,000 family lifetime maximum. These funds may be considered additional income and therefore a taxable benefit. For more information about Carrot's program offerings, please review the following Summary Documents for each service, all on DuPont Connection:

- Fertility Services
- Surrogacy Services
- Adoption Services

Submitting Claims for Reimbursement

The claims reimbursement process can be started through Carrot's website, at <https://app.get-carrot.com/signup>. All reimbursement claims and required documentation must be submitted no later than 90 days following the end of each plan year (namely, March 31).

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.

TRAVEL AND LODGING FOR MEDICAL BENEFITS

The Plan provides coverage for travel and lodging for certain medical benefits to the extent permitted by law. For detailed health care information, please contact A1A at 1-877-383-4756. The following coverage will be provided:

- Travel expenses for you and one companion, up to \$10,000 per covered service
- Travel includes covered expenses for you and one companion, to travel between an employee's home residence and the nearest qualified provider
- Coach class air fare, train or bus travel, and hotel fees are examples of covered expenses
- To qualify, there would need to be no provider available within 100 miles of the home residence
- Upon traveling, an Aetna in-network facility must be utilized to receive in-network benefit coverage

There is no prior approval needed but it is recommended covered travel be verified with Aetna prior to utilizing the service

AETNA INSTITUTES™ GENE BASED, CELLULAR AND OTHER INNOVATIVE THERAPY (GCIT™) DESIGNATED CENTERS

Gene Based, Cellular and Other Innovative Therapy (GCIT) services are gene-based, cellular and/or innovative therapies that have a basis in genetic/molecular medicine. GCIT products and services, as determined by Aetna, are FDA approved therapies that have the potential to cure previously untreatable, often fatal, conditions. All GCIT services will be authorized in accordance with Aetna's Drug Infusion Site of Care Policy and with the Aetna Member's specific benefit plan. Preauthorization is required for coverage to be effective for all GCIT services. Providers that offer GCIT services and have met our criteria are designated to participate in the Aetna Institutes™ GCIT designated network ("Designated GCIT Providers"). Designated GCIT Providers have demonstrated a commitment to providing value for our members.

MEDICAL PLAN

Gene-based, cellular and other innovative therapies (GCIT)

Covered services include GCIT provided by a physician, hospital or other provider.

GCIT are defined as any services that are:

- Gene-based
- Cellular and innovative therapeutics

The services have a basis in genetic/molecular medicine and are not covered under the Institutes of Excellence™ (IOE) programs. We call these "GCIT services."

GCIT covered services include:

- Cellular immunotherapies.
- Genetically modified oncolytic viral therapy.
- Other types of cells and tissues from and for use by the same person (autologous) and cells and tissues from one person for use by another person (allogenic) for certain therapeutic conditions. Human gene-based therapy that seeks to change the usual function of a gene or alter the biologic properties of living cells for therapeutic use. Examples include therapies using:
 - Luxturna® (Voretigene neparvovec)
 - Zolgensma® (Onasemnogene abeparvovec-xioi)
 - Spinraza® (Nusinersen)
- Products derived from gene editing technologies, including CRISPR-Cas9.
- Oligonucleotide-based therapies. Examples include:
 - Antisense. An example is Spinraza.
 - siRNA.
 - mRNA.
 - microRNA therapies.
 - Gene-based, cellular and other innovative therapies (GCIT)

Key Terms

Here are some key terms we use in this section. These will help you better understand GCIT.

Gene

A gene is a unit of heredity which is transferred from a parent to child and is thought to determine some feature of the child.

Molecular

Molecular means relating to or consisting of molecules. A molecule is a group of atoms bonded together, making the smallest vital unit of a chemical compound that can take part in a chemical reaction.

Therapeutic

Therapeutic means a treatment, therapy, or drug meant to have a good effect on the body or mind; adding to a sense of well-being.

Description	In-network (GCIT-designated facility/provider)	Out-of-network (Including providers who are otherwise part of Aetna's network but are not GCIT-designated facilities/providers)
<i>Services and supplies</i>	Covered based on type of service and where it is received	Not covered
<i>Gene therapy products, prescription drugs</i>	Subject to coinsurance after deductible	Not covered

Facilities/provider for gene-based, cellular and other innovative therapies

We designate facilities to provide GCIT services or procedures. GCIT physicians, hospitals and other providers are GCIT-designated facilities/providers for Aetna and CVS Health.

Important note:

You must get GCIT covered services from the GCIT-designated facility/provider. If there are no GCIT-designated facilities/providers assigned in your network, it's important that you contact AIA so we can help you determine if there are other facilities that may meet your needs. If you do not get your GCIT services at the facility/provider we designate, they will not be covered services.

GENDER AFFIRMATION 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 behavioral health and substance abuse 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.
- trachea shave/thyroid reduction chondroplasty
- facial bone reduction
- voice modification surgery

Your treating physician should call the phone number on the back of your ID card to precertify treatment in advance of you receiving care to review coverage. Extensive coverage limitations and exclusions apply. Related cosmetic procedures and surgeries and prosthetic devices are excluded from coverage. Examples of cosmetic procedures include laser hair removal or electrolysis, rhinoplasty, blepharoplasty, 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. Your provider should call the phone number on the back of your ID card to precertify hospice care. See "Precertification" on page 29 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.

MEDICAL PLAN

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.)

Prescription Drugs

The Medical Plan includes prescription drug coverage administered through two pharmacy Claims Administrators. 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 practitioner;
- 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.

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.

Non-Medical Dental Coverage

For information on the dental coverage available through the dental plan, see Dental Plan on page 54.

Pharmacy ID Cards

Employees enrolled in the Core, Premium Saver, or Traditional Copay PPO Option will receive prescription drug ID cards from CVS Caremark. If you present your ID card at a CVS Caremark 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.

HOW PRESCRIPTION COVERAGE WORKS

CVS Caremark and PrudentRx are the Claims Administrators for the Plan's prescription drug benefit for the Core Option, the Premium Saver Option, and the Traditional Copay PPO Option. The following section references CVS Caremark and their specialty medication subsidiary, CVS Specialty, and PrudentRx, the Specialty drug manager. If you participate in an Alternative Coverage Option (for International Assignments), contact your medical carrier for prescription coverage information.

CVS Caremark 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 CVS Caremark mail service. You must present your CVS Caremark 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 recognized charges limits will apply.

Most prescription drug expenses are subject to the Plan deductible. Contact CVS Caremark 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.

MEDICAL PLAN

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 or a CVS retail pharmacy. 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 non-CVS 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 CVS Caremark.
- Specialty medication will only be covered when purchased through the Plan's specialty medication provider. PrudentRx will manage specialty drugs. Except in rare cases, your specialty prescription(s) will continue to be filled via the CVS Specialty pharmacy. See "Specialty Medications" on page 43 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 a 90-day supply via home delivery or a CVS retail pharmacy. 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 by mail, or ordered and filled at a CVS retail pharmacy (including those in Target stores), 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 CVS Caremark Pharmacy order form and required coinsurance. You can receive mail order forms by calling 1-844-212-8696, or through www.caremark.com.
2. Ask if your doctor has electronic ordering capabilities with CVS Caremark Pharmacy. Your doctor may need your member ID number (which is on your DuPont prescription plan ID card)
3. Ask your doctor to call 1-800-378-5697 for instructions on how to fax the 90-day prescription to CVS Caremark. Your doctor must have your member ID number to fax your prescription.

MEDICAL PLAN

WHAT YOU PAY FOR PRESCRIPTION DRUGS

Type of Medication*	Amount You Pay <i>For up to a 30-day supply at retail or a 90-day supply at mail order</i>
Preventive Medications designated by the Affordable Care Act, including: <ul style="list-style-type: none">▪ 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	\$10.00 after meeting the deductible at retail pharmacies/\$30.00 after meeting the deductible through mail order
Brand Formulary (Preferred)	25% coinsurance after deductible; \$125 maximum
Brand Non-Formulary (Non-Preferred)	45% coinsurance after deductible, \$250 maximum
Specialty Medications	0% coinsurance if the drug is on the PrudentRx drug list and member enrolls in the program; 30% coinsurance if drug is on the PrudentRx drug list and member does NOT enroll in the program; 30% coinsurance if specialty drug is not on the PrudentRx drug list
Maintenance medications filled more than two times at a non-CVS retail pharmacies	45% coinsurance after deductible; no maximum

MEDICAL PLAN

GENERIC DRUGS

You will pay \$10.00 per generic medication after meeting your deductible when purchased through a CVS Caremark participating retail pharmacy, or \$30.00 after meeting your deductible when purchased through the CVS Caremark mail order service. You are responsible for the deductible, unless the medication is listed on the CVS Caremark 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.

PREVENTIVE MEDICATIONS

The Core, Premium Saver, and Traditional Copay PPO 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 CVS Caremark website at www.caremark.com. 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 cancer, growth hormone deficiency, hemophilia, hepatitis C, immune deficiency, multiple sclerosis, and rheumatoid arthritis. CVS Specialty (through the PrudentRx Solution) manages specialty medications.

Medications on the PrudentRx Program Drug List will be subject to a 30% co-insurance, after satisfaction of any applicable deductible.

However, if a member enrolls and participates in the PrudentRx Solution (which includes enrollment in an available manufacturer copay assistance program for their specialty medication) the member will have a \$0 out-of-pocket responsibility for their prescriptions covered under the PrudentRx Solution.

Special Note for HDHP Plans (Core and Premium Saver)

Drugs covered under the PrudentRx Program Drug List and listed on the plan's HDHP Preventive Drug List will be available at a \$0 copay (if the member enrolls and participates in the PrudentRx Solution). Drugs covered under the PrudentRx Program Drug List and not listed on the plan's HDHP Preventive Drug List will be available at a \$0 copay (if the member enrolls and participates in the PrudentRx Solution) after the plan's deductible has been satisfied.

How Financial Assistance Impacts Cost-Sharing

If you receive financial assistance (such as, for example, a manufacturer's coupon for prescription drugs or a direct reimbursement from the manufacturer, etc.), your net cost after the financial assistance will be applied towards your deductible and out-of-pocket maximum.

For example, if you use a \$125 coupon to purchase a \$150 medication, the cost of the drug is reduced to \$25 after the coupon. The \$125 coupon value does not apply to your deductible or your out-of-pocket maximum.

If you receive financial assistance such as a manufacturer's reimbursement or coupon, you are obligated to report the financial assistance amount to the Plan's prescription drug provider, including any supporting documentation as may be requested.

MEDICAL PLAN

Copay assistance is a process in which drug manufacturers provide financial support to patients by covering all or most of the patient cost share for select medications - in particular, specialty medications. The PrudentRx Solution will assist members in obtaining copay assistance from drug manufacturers to reduce a member's cost share for eligible medications thereby reducing out-of-pocket expenses.

All eligible members must call PrudentRx at 1-800-578-4403 to register for any manufacturer copay assistance program available for your specialty medication (as some manufacturers require you to sign up to take advantage of the copay assistance that they provide for their medications). Eligible members who fail to enroll in an available manufacturer copay assistance program or who choose not to enroll and participate in the PrudentRx Solution will be responsible for the full amount of the 30% co-insurance on specialty medications that are eligible for the PrudentRx Solution.

If you or a covered family member are not currently taking, but will start a new medication covered under the PrudentRx Solution, you can reach out to PrudentRx or they will proactively contact you so that you can take full advantage of the PrudentRx Solution. PrudentRx can be reached at 1-800-578-4403 to address any questions regarding the PrudentRx Solution.

The PrudentRx Program Drug List may be updated periodically.

Payments made on your behalf, including amounts paid by a manufacturer's copay assistance program, for medications covered under the PrudentRx Solution will not count toward your plan deductible or out-of-pocket maximum (if any), unless otherwise required by law.

Payments made by you for a medication that does not qualify as an "essential health benefit" under the Affordable Care Act (ACA), will not count toward your deductible or ACA out-of-pocket maximum (if any), unless otherwise required by law. A list of specialty medications that are not considered to be "essential health benefits" under the ACA is available. An exception process is available for determining whether a medication that is not an "essential health benefit" under the ACA is medically necessary for a particular individual.

PrudentRx can be reached at 1-800-578-4403 to address any questions regarding the PrudentRx Solution.

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.

MEDICAL PLAN

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. However, you should always tell your doctor about your current medications before beginning a new drug.

Behavioral Health and Substance Abuse (BH/SA)

Lyra is DuPont's preferred provider for all behavioral health/substance abuse care, and Aetna will remain as the Claims Administrator/carrier for Plan's BH/SA benefit for the Core, Premium Saver, and Traditional Copay PPO Options. If you participate in an Alternative Coverage Option (for International Assignments), contact your medical carrier for BH/SA coverage information.

If you are enrolled in the Core or Premium Saver options, all behavioral health/substance abuse care is 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.

If you are enrolled in the Traditional Copay PPO option, outpatient behavioral health/substance abuse care is subject to a primary care provider office visit copay, and not the deductible. Inpatient behavioral health/substance abuse care is 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.

Covered services include:

- inpatient (when medically necessary) care at a hospital or specialized treatment center
- office visits and outpatient behavioral health care and substance abuse care (in-person & virtual)
- Applied Behavioral Analysis (ABA) therapy for the treatment of autism spectrum disorder
- Medication management
- Mental health coaching

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

To use the Lyra network for services, you must register first by visiting the Lyra website at <http://dupont.lyrahealth.com/> and follow the steps to register.

All Lyra Health support sessions are billed directly through your health plan, meaning that any copays, coinsurance, or deductibles for in-network mental health services may apply.

Virtual Behavioral Health services are also available through Teladoc. Contact Teladoc at 1-855-TELADOC (1-855-835-2362) or log onto www.Teladoc.com/aetna to schedule a virtual visit.

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 twelve 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 1-844-856-8778. If additional or more intensive behavioral health or substance abuse care is required, the Plan benefits apply and Lyra will be the Claims Administrator, not ComPsych.

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 or contact lenses (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)

The Medical Plan will not pay "primary" to any automobile insurance policy's personal injury protection coverage. Therefore, employees should make sure that they have sufficient auto insurance personal injury protection to cover medical claims that may result from an auto accident.

MEDICAL PLAN

- 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 as described under "Transplant Services and Centers of Excellence" on page 37 and "Travel and Lodging for Medical Benefits" on page 37
- 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 recognized 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
- Medications not specifically covered under the Plan's prescription medication formulary.

Alternative Coverage Highlights

INTERNATIONAL PPO, PROVIDED THROUGH AETNA INTERNATIONAL

The following table summarizes the 2026 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.

Medical Care Benefits	U.S. Expatriate Option		Option for International Employees on Assignment in the U.S.	
	<i>Outside the U.S.</i>	<i>In-Network* in the U.S.</i>	<i>Outside the U.S.</i>	<i>In-Network* in the U.S.</i>
Deductible (annual amount, combined for medical and prescription drug claims)	\$800 for you only coverage \$1,600 for other coverage levels (A \$2,500 individual and \$4,000 family deductible for U.S. care received out-of-network applies)		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)	Routine child physical exam: No charge after deductible; Routine adult physical exam: No charge up to \$1,000 calendar year maximum. All other preventive care is 100% paid, no deductible	100% paid, no deductible	Routine adult physical exam: No charge up to \$1,000 calendar year maximum All other preventive care: 100% paid	
Coinsurance for medical services <ul style="list-style-type: none"> ▪ Office visits ▪ Behavioral health/substance abuse care ▪ Chiropractic care ▪ Labs and X-rays ▪ Hospitalization ▪ Surgery 	You pay 20%, after deductible	Office visits: You pay 20%, no deductible Outpatient behavioral health/substance abuse care: You pay 20%, no deductible All Other: You pay 20%, after deductible	100% paid (You pay 60% for U.S. care received out-of-network)	

MEDICAL PLAN

Medical Care Benefits	U.S. Expatriate Option		Option for International Employees on Assignment in the U.S.	
	Outside the U.S.	In-Network* in the U.S.	Outside the U.S.	In-Network* in the U.S.
Prescription Cost Sharing				
<i>Generic</i>	No charge	<ul style="list-style-type: none"> ▪ Formulary: No charge ▪ Non-Formulary: You pay 45% (no deductible), up to \$250 maximum 	Free (Non-generic prescriptions filled in the U.S. out-of-network are subject to coinsurance and deductible amounts.)	
<i>Brand Formulary (Preferred)</i>	You pay 20% after deductible	You pay 25% (\$125 max per fill)		
<i>Brand Non-Formulary (Non-Preferred)</i>	You pay 20% after deductible	You pay 45% (\$250 max per fill)		
<i>Specialty Drugs</i>	You pay 20% after deductible	You pay 45% (\$150 max per fill)		
Out of Pocket Maximum (annual amount, combined for medical and prescription drug claims)				
▪ Each Person	\$5,000		\$6,300	
▪ All Covered Family Members Combined	\$10,000		\$12,600	

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

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. 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.

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.

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.

MEDICAL PLAN

- You cannot be covered by a Traditional (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/domestic partner's FSA or HRA) that pays or reimburses medical expenses during the same time period. It's okay to be in the Company's Limited Purpose Health Care 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 2026, the HSA contribution limits will be as follows:

- single—\$4,400
- family—\$8,750
- 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 the Company. You can take the account with you if you retire or leave the Company.

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
- over-the-counter medical products without a prescription from a physician
- 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
- COVID-19 at home testing kits
- Personal protective equipment, such as masks, hand sanitizers, and sanitizing wipes, for the primary purpose of preventing the spread of COVID-19

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

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.*

MEDICAL PLAN

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 at myhealth.bankofamerica.com or the 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 at myhealth.bankofamerica.com either electronically (direct to your personal checking or savings account) or by receiving a check.

THE HSA AND A HEALTH CARE FSA ARE SEPARATE!

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

- You can't pay for medical expenses, including prescription drugs, with the Limited Purpose Health Care FSA. For those expenses, you have to use the HSA.
- You can pay for medical expenses, including prescription drugs, with a Traditional Health Care FSA.
- With the Limited Purpose or Traditional Health Care 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.

IF YOU HAVE A HEALTH SAVINGS ACCOUNT AND YOUR EMPLOYMENT ENDS

If you have a Health Savings Account (HSA) that is **not paired** with a Limited Purpose Health Care Flexible Spending Account (FSA):

- When Bank of America receives your separation date, you will be sent a letter indicating you will be responsible for the monthly account maintenance fees beginning on the first day of the following month.
- The monthly maintenance HSA fees will be debited directly from your account and will be listed on your statement. The HSA schedule of fees can be found in the disclosure statement on the Bank of America Member website at myhealth.bankofamerica.com under Forms & Documents within the Tools & Support tab.
- Your account number will not change, and you will continue to access your HSA account using the same login credentials on the Mobile App or the Member website at myhealth.bankofamerica.com.
- Your current debit card will remain active. Any investments will remain intact, and the auto invest feature will remain at your current setting for any outside direct contributions made to your account. Investment fund choices will remain the same.
- Current listed beneficiaries and dependents will remain on your account.
- You will no longer receive a Company-paid HSA contribution after your separation.
- You may be able to make additional contributions to your HSA by going directly through Bank of America, provided you meet the eligibility requirements.
- You may use your HSA funds to pay for qualifying health care expenses or you may withdraw your HSA funds at any time, subject to the tax implications that apply to such withdrawals.
- You may elect to move your account to a new HSA provider at any time by contacting Bank of America.

MEDICAL PLAN

If you have a Health Savings Account (HSA) that **is paired** with a Limited Purposes Health Care Flexible Spending Account (FSA):

- When Bank of America receives your separation date, you will be sent a letter indicating you will be responsible for the monthly HSA account maintenance fees beginning on the first day of the following month.
- The monthly maintenance fees will be debited directly from your account and will be listed on your statement. The HSA schedule of fees can be found in the disclosure statement on the Bank of America Member website at myhealth.bankofamerica.com under Forms & Documents within the Tools & Support tab.
- FSA transactions will no longer function on your current debit card and you will be mailed a new card for your HSA within five to seven business days. Claims for eligible FSA expenses for dates of service through date of termination can be processed on the Bank of America Member website at myhealth.bankofamerica.com.
- The FSA has a run out period to submit eligible claims through April 15th of the following year unless an additional extension period is provided under National Emergency Relief.
- Your HSA account number will not change, and you will continue to access your HSA and FSA accounts using the same login credentials on the Mobile App or the Member website at myhealth.bankofamerica.com.
- Any investments will remain intact, and the auto invest feature will remain at your current setting for any outside direct contributions made to your account. Investment fund choices will remain the same.
- Current listed beneficiaries and dependents will remain on your account.
- You will no longer receive a Company-paid HSA contribution after your separation.
- You may be able to make additional contributions to your HSA by going directly through Bank of America, provided you meet the eligibility requirements.
- You may use your HSA funds to pay for qualifying health care expenses or you may withdraw your HSA funds at any time, subject to the tax implications that apply to such withdrawals.
- You may elect to move your account to a new HSA provider at any time by contacting Bank of America.

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 CVS Caremark 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).*

Dental Plan

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

The Plan offers two options for coverage.

Questions?

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



SECTION CONTENTS

<i>Highlights</i>	55
<i>Your Dental Plan Options</i>	56
<i>The MetLife Preferred Dental Program (PDP) Plus Network</i>	56
<i>Cost of Coverage</i>	56
<i>How Coverage Works</i>	57
<i>Recognized and Customary (R&C) Amounts</i>	57
<i>Allowable Charge Amounts</i>	58
<i>Pre-existing Conditions</i>	58
<i>Deductibles</i>	58
<i>Coinsurance</i>	58
<i>Annual Benefit Maximum</i>	58
<i>Lifetime Orthodontia Maximum Benefits</i>	59
<i>Predetermination of Benefits</i>	59
<i>What Is Covered</i>	59
<i>Preventive and Diagnostic Care</i>	59
<i>Restorative and Other Care</i>	60
<i>Orthodontia</i>	61
<i>What Is Not Covered</i>	61
<i>When Coverage Ends</i>	62

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 <ul style="list-style-type: none"> ▪ 2 regular* or 4 periodontal cleanings per year (with diagnosed condition) ▪ 2 routine exams per year ▪ Dental X-rays: <ul style="list-style-type: none"> ▫ 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 <i>Includes bridges, crowns, fillings, and other covered dental services</i>	50%**	75%**
Annual Maximum Benefit	\$1,250 per person	\$2,000 per person
Lifetime Orthodontic Maximum Benefit	Orthodontic care is not covered by the Standard Option	100%, up to \$2,000 per person (adult or child)

* For pregnant women and employees with certain chronic conditions, additional preventive care treatments may be available.

** 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 recognized 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 Dental 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 Plan Options

The Dental Plan has two options:

- The Standard Option.
- The High Option.

You can also waive coverage.

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 the Company. 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

Here are the monthly employee premiums for 2026, which depend on how many dependents you cover:

Coverage Level	Standard Option	High Option
<i>You Only</i>	\$11	\$20
<i>You + Spouse/Domestic Partner</i>	\$22	\$36
<i>You + Child(ren)</i>	\$26	\$38
<i>You + Family</i>	\$39	\$60

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

Dental Coverage While You Are on International Assignment

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

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 recognized 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 \$1,250 per person per year.
- 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 \$2,000 per person.

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.

Recognized and Customary (R&C) Amounts

Recognized 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 recognized 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 recognized and customary charges, the full charge will be used to calculate your plan benefit. If your dentist charges more than what is recognized and customary, the recognized and customary charge will be used to calculate your plan benefit. In addition, you will be responsible for any amount that exceeds the recognized and customary charges.

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 Dental 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.

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.

DENTAL PLAN

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 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 Standard option provides no benefits for orthodontia, but under the High Option the Plan pays 100% up to the lifetime orthodontia maximum of \$2,000. Coinsurance does not apply for this High Option coverage, 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 Plan will pay for expenses you incur during the plan year. The annual benefit maximum is:

- \$1,250 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 recognized and customary amounts
- orthodontia benefits which are subject to a separate lifetime benefit maximum

See "What Is Covered" on page 59 and "What Is Not Covered" on page 61 for more information.

DENTAL PLAN

Lifetime Orthodontia Maximum Benefits

The Standard Option does not provide any coverage or benefit for orthodontia care. The maximum the Plan pays for orthodontia care under the High Option is a lifetime limit of \$2,000.

***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 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 Plan covers these services:

Preventive and Diagnostic Care

The Dental 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

DENTAL PLAN

- 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 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 seven 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
 - replacement of an existing crown, provided that it is at least seven years old and cannot be made serviceable
- 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 seven years old and cannot be made serviceable. The seven-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

DENTAL PLAN

- implantology (placing teeth or supports in a surgically prepared cavity) where medically necessary
 - replacement of an existing implant, provided that it is at least seven years old and cannot be made serviceable
- 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 High Option for the Dental Plan will cover orthodontic expenses incurred for corrective treatment of maloccluded 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 High Option for the Dental 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.
- Benefits are paid quarterly at the end of the quarter.

Consider the FSA or HSA to Cover Orthodontia Expenses

Consider using the Traditional Health Care FSA, Limited Purpose Health Care 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 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 Plan pays benefits for a wide range of dental services and procedures, there are certain exclusions. The Dental 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

DENTAL PLAN

- charges which, in the judgment of the Claims Administrator, exceed the recognized 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 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 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 more details in "When Coverage Ends" on page 122.

Vision 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 Vision 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

<i>Highlights</i>	64
<i>Cost of Coverage</i>	64
<i>How Coverage Works</i>	65
<i>The VBA Network</i>	65
<i>Out-of-Network Coverage</i>	65
<i>Out-of-Area Coverage</i>	66
<i>Scheduled Benefits/Plan Year</i>	66
<i>Plan Allowances</i>	66
<i>Copayments</i>	66
<i>VBA Discounts</i>	66
<i>What Is Covered</i>	67
<i>Eyeglass Lens Options</i>	67
<i>Contact Lenses</i>	67
<i>Medically Necessary Contact Lenses</i>	67
<i>LASIK Eye Surgery</i>	68
<i>Hearing Benefits</i>	68
<i>What Is Not Covered</i>	68

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 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)** <i>Note: Digital Progressives available at additional cost.</i>	Prescription Lenses: <ul style="list-style-type: none"> ▪ 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 (Recognized and Customary)	Up to \$300
LASIK Eye Surgery	N/A	Up to \$250 allowance toward the total cost on both eyes, once every eight years.

* 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.

** 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	2026 Monthly Premium
<i>You Only</i>	\$7.95
<i>You + Spouse/Domestic Partner</i>	\$13.81
<i>You + Child(ren)</i>	\$13.81
<i>You + Family</i>	\$20.47

How Coverage Works

The Vision 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 64.

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 Including: Single, Bifocal, Blended Bifocal, Progressive, Trifocal, Lenticular, Polycarbonate, one-year Scratch-Resistant Coatings, UV 400 and Optional Lens Tints	<ul style="list-style-type: none"> ▪ 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 (Recognized 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 64. 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 Traditional Health Care FSA, Limited Purpose Health Care 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;

VISION PLAN

- 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 Vision 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).

VISION PLAN

LASIK Eye Surgery

The Plan will pay up to a \$250 allowance toward the total cost of LASIK eye surgery on both eyes, once every eight years. LASIK eye surgery is available at a discount through TLC Laser Eye Centers® and QualSight® LASIK. Schedule a free LASIK eye surgery exam at a credentialed LASIK surgeon near you, and you can save up to 35% on the procedure. Call 1-877-437-6105 for more information.

Hearing Benefits

VBA also offers hearing benefits. Schedule a free hearing exam and save over 40% on premium aids with the latest technology through Your Hearing Network. For more information, call 1-888-819-5333.

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

Health Care Flexible Spending Accounts

The Company provides two health care spending accounts:

- The Traditional Health Care FSA provides a way for you to save money on your medical, prescription drug, over-the-counter medical products, dental, and vision expenses. It cannot be used with a high-deductible health plan; it can be used with a PPO.
- The Limited Purpose Health Care FSA provides a way for you to save money on your **dental and vision expenses only**. It’s called “limited” because the types of expenses that can be reimbursed are limited to qualified out-of-pocket dental and vision costs. A Limited Purpose Health Care FSA can be used along with a high-deductible health plan.



A Health Care FSA is a benefit plan that lowers your taxes, helping you save money. But be careful! A Health Care FSA has a “use it or lose it” rule. Unused money in your account at the end of the year is forfeited.

FSA stands for Flexible Spending Arrangement, a term used by the Internal Revenue Service (IRS) to describe plans like the Traditional Health Care FSA and the Limited Purpose Health Care 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 Traditional Health Care FSA or the Limited Purpose Health Care 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

<i>Highlights</i>	70
<i>How the Plans Work</i>	71
<i>Choosing How Much to Contribute</i>	72
<i>When Your Account Funds Are Accessible</i>	72
<i>Forfeiting Unused Contributions</i>	72
<i>Bank of America Visa® Debit Card</i>	72
<i>Effect on Social Security</i>	72
<i>Federal Tax Credit</i>	73
<i>Whose Expenses Are Eligible?</i>	73
<i>Eligible Expenses – Limited Purpose Health Care FSA</i>	74
<i>Ineligible Expenses – Limited Purpose Health Care FSA</i>	74

HEALTH CARE FLEXIBLE SPENDING ACCOUNTS

<i>Eligible Expenses – Traditional Health Care FSA.....</i>	<i>75</i>
<i>Ineligible Expenses – Traditional Health Care FSA.....</i>	<i>75</i>
<i>Filing Claims for Reimbursement</i>	<i>76</i>

Highlights

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

	Limited Purpose Health Care FSA	Traditional Health Care FSA
How the Account Works	You contribute before-tax dollars to pay for eligible dental and vision expenses throughout the year.	You contribute before-tax dollars to pay for eligible medical, dental and vision expenses throughout the year.
Eligible Employees	<ul style="list-style-type: none"> ▪ Employees enrolled in the Core or Premium Saver option ▪ Employees who opt out of medical coverage ▪ Employees on expatriate assignment outside of the U.S. 	<ul style="list-style-type: none"> ▪ Employees enrolled in the Traditional Copay PPO ▪ Employees who opt out of medical coverage ▪ Employees on expatriate assignment outside of the U.S.
Contributions	<ul style="list-style-type: none"> ▪ From \$120 to \$3,300 annually ▪ Contributions prorated over the number of pay periods in the year 	
Eligible Expenses	<p>Eligible expenses include, but are not limited to:</p> <ul style="list-style-type: none"> ▪ Dental and vision plan deductibles, coinsurance and copays; and ▪ Amounts not covered by a dental or vision benefit plan or insurance, including costs for: <ul style="list-style-type: none"> ▫ 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.). 	<p>Eligible expenses include, but are not limited to:</p> <ul style="list-style-type: none"> ▪ Medical, dental and vision plan deductibles; coinsurance and copays, and ▪ Amounts not covered by a medical, dental, or vision benefit plan or insurance, including cost for: <ul style="list-style-type: none"> ▫ All items listed as eligible under a Limited Purpose Health Care FSA ▫ Over-the counter medical products without a prescription from a physician ▫ Prescription drugs ▫ COVID-19 at home testing kits, purchased prior to January 15, 2022 and after the end of the public health emergency, as well as testing kits in excess of eight purchased in any 30 days during the public health emergency ▫ Personal protective equipment, such as masks, hand sanitizers, and sanitizing wipes, for the primary purposes of preventing the spread of COVID-19
Expenses Not Eligible	<ul style="list-style-type: none"> ▪ 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 	<ul style="list-style-type: none"> ▪ 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

HEALTH CARE FLEXIBLE SPENDING ACCOUNTS

	Limited Purpose Health Care FSA	Traditional Health Care FSA
Reimbursement	<ul style="list-style-type: none"> Pay with the Limited Purpose Health Care 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 Limited Purpose Health Care FSA in the table under “How to File a Claim” on page 107 under <i>Claiming Benefits and Other Information</i>. You may be reimbursed up to your full annual contribution amount at any time during the year. 	<ul style="list-style-type: none"> Pay with the Traditional Health Care 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 Traditional Health Care FSA in the table under “How to File a Claim” on page 107 under <i>Claiming Benefits and Other Information</i>. You may be reimbursed up to your full annual contribution amount at any time during the year.
Deadlines	<ul style="list-style-type: none"> 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. 	
<ul style="list-style-type: none"> December 31 April 15 		

How the Plans Work

You use the Traditional Health Care FSA to reimburse yourself for eligible medical, prescription drug, over-the-counter medical products, dental and vision expenses not covered by any benefit plan. You use the Limited Purpose Health Care 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 Traditional Health Care FSA allows you to pay for qualified medical, dental and vision expenses with before-tax dollars. The Limited Purpose Health Care 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 Traditional Health Care FSA or a Limited Purpose Health Care 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>.*

HEALTH CARE FLEXIBLE SPENDING ACCOUNTS

Choosing How Much to Contribute

You can contribute from a minimum of \$120 to a maximum of \$3,300 for the year.

If you and your spouse/domestic partner both work for the Company and are each enrolled in the Limited Purpose or Traditional Health Care FSA, your combined contribution maximum cannot exceed \$6,600.

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

If you're currently contributing, your contributions will be set to \$0 for the following year. You must make new contribution elections every year, or your participation will be cancelled.

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 medical, vision and dental expenses (for the Traditional Health Care FSA) or eligible vision and dental expenses only (for the Limited Purpose Health Care FSA) which are listed as eligible for reimbursement.

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 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 medical, dental and vision costs (for the Traditional Health Care FSA) or estimated dental and vision costs (for the Limited Purpose Health Care FSA) 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 FSA, you will receive a Bank of America Visa debit card. If you elect a Health Care FSA, the card will be loaded on 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 expenses will automatically be deducted from your Health Care 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 a Health Care 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 may be able to deduct the expenses on your tax return. A Health Care 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 a Health Care 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 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 a Health Care FSA and claim the same expenses on your federal income tax return.

Whose Expenses Are Eligible?

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

- you;
- your spouse/domestic partner*;
- your son, daughter, stepchild, foster child, brother, sister, stepbrother, stepsister, half-brother, half-sister or descendant of the same (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 26 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; and
 - 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 \$4,400 or more, or
 - you, or your spouse if filing jointly, could be claimed as a dependent on someone else's most recent tax return.

** Note: You cannot claim health care or dependent care expenses for a domestic partner or a domestic partner's child(ren) unless they are considered by the IRS to be your dependents.*

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

Not for Dependent Care

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

- *Money you set aside for your Traditional Health Care FSA or Limited Purpose Health Care 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 – Limited Purpose Health Care FSA

The IRS determines which expenses are eligible for reimbursement. You can use the Limited Purpose Health Care 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.).

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 Limited Purpose Health Care FSA.

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

Filing Claims

For more details on filing claims for the Limited Purpose Health Care FSA and using your debit card, see the row for the Limited Purpose Health Care FSA in the table under "How to File a Claim" on page 107 under Claiming Benefits and Other Information.

Ineligible Expenses – Limited Purpose Health Care FSA

You can't use the Limited Purpose Health Care 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, behavioral health, substance abuse or other expenses that are not primarily dental or vision in nature.

Eligible Expenses – Traditional Health Care FSA

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

- medical, prescription drug, dental and vision plan deductibles, coinsurance and copays;
- over-the-counter products (prescription no longer needed)
- 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; and devices (braces, retainers, etc.);
- COVID-19 at home testing kits:
 - purchased prior to January 15, 2022 or after the end of the public health emergency; or
 - in excess of eight (8) testing kits purchased per 30 days during the public health emergency; and
- Personal protective equipment, such as masks, hand sanitizers, and sanitizing wipes, for the primary purpose of preventing the spread of COVID-19.

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

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

Ineligible Expenses – Traditional Health Care FSA

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

- can't be deducted from your federal tax return (except if it can't be deducted because it is less 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 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

Filing Claims

For more details on filing claims for the Limited Purpose Health Care FSA and using your debit card, see the row for the Limited Purpose Health Care FSA in the table under "How to File a Claim" on page 107 under Claiming Benefits and Other Information.

Filing Claims for Reimbursement

You can access your Limited Purpose or Traditional Health Care 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.

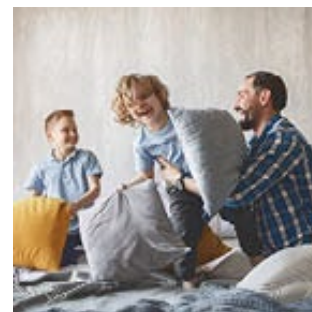
For more information, see the row for the Limited Purpose and Traditional Health Care FSA in the table under “How to File a Claim” on page 107 under *Claiming Benefits and Other Information*.

Dependent Daycare FSA

The Dependent Daycare FSA provides an easy way to save money on the cost of caring for your loved ones, so you and your spouse/domestic partner (if applicable) 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/domestic partner, 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 Daycare 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 Daycare FSA Is Not for Health Care Expenses!

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

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

The three 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	78
How the Account Works	79
Contribution Limits	79
Choosing How Much to Contribute	79
When Your Account Funds Are Accessible	80
Forfeiting Unused Contributions	80
Bank of America Visa® Debit Card	80
Effect on Social Security	80
Dependent Care Tax Credit	80
Whose Expenses Are Eligible?	81
Eligible Expenses	81
Expenses That Can't Be Reimbursed	82
Filing Claims for Reimbursement	82

Highlights

This table highlights key features of the Dependent Daycare 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	<ul style="list-style-type: none"> ▪ Contribution limits vary based upon whether you meet the IRS definition of a “highly compensated employee” (HCE): <ul style="list-style-type: none"> ▫ Non-HCE: May contribute between \$120 to \$5,000 annually ▫ HCE: May contribute between \$120 to \$2,000 annually ▪ If you’re married, your contribution limits depend on how you and your spouse file your taxes.
Whose Care Is Eligible	<p>Only care for children under age 13 and disabled dependents is eligible.</p> <p>Note: dependent care expenses for a domestic partner or a domestic partner’s child(ren) are eligible only if they are considered by the IRS to be your dependents.</p>
Eligible Expenses	<p>If you’re married or if you have a domestic partner who qualifies as a dependent for tax purposes, your spouse/domestic partner must work, attend school full time or be physically or mentally unable to provide self-care, for your expenses to be eligible.</p> <p>Eligible expenses include:</p> <ul style="list-style-type: none"> ▪ 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	<p>Ineligible expenses include but are not limited to:</p> <ul style="list-style-type: none"> ▪ Expenses for services received when you or your spouse/domestic partner 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	<ul style="list-style-type: none"> ▪ Pay with the Dependent Daycare 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 107 under <i>Claiming Benefits and Other Information</i>. ▪ You can only be reimbursed up to the amount of money that has been deposited into your account.
Deadlines	<ul style="list-style-type: none"> ▪ Receive Service by December 31, 2026 (for the 2026 plan year) ▪ File Claim by April 15, 2026 (for the 2026 plan year)

How the Account Works

- You use the Dependent Daycare FSA to reimburse yourself for eligible dependent care expenses you have so that you and your spouse/domestic partner (if applicable) can work or attend school full-time or if your spouse/domestic partner 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 Daycare 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 Daycare 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 Daycare FSA. Note: if your spouse's employer has a similar dependent care assistance program, the combined total of contributions to your Dependent Daycare 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 Daycare 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 are limited to \$2,000 per year (and could further be limited if needed to 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're currently contributing, your contributions will be set to \$0 for the following year. You must make new contribution elections every 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.

DEPENDENT DAYCARE FSA

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 9 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 Limited Purpose and Traditional Health Care FSAs, which can reimburse you for eligible expenses even if the funds haven't been deposited in your account yet, with the Dependent Daycare 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 grace period.

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

Bank of America Visa® Debit Card

When you first start contributing to a Dependent Daycare 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 Limited Purpose Health Care FSA or Traditional Health 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.

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 Daycare 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.”

Note: You cannot claim health care or dependent care expenses for a domestic partner or a domestic partner’s child(ren) unless they are considered by the IRS to be your dependents.

** 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 Daycare 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 Daycare FSA and the Limited Purpose Health Care and Traditional Health Care FSA are separate.

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

DEPENDENT DAYCARE FSA

Only expenses for care that enables you to work are eligible. And, if you're married, your spouse/domestic partner 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/domestic partner) to work or attend school full-time or because your spouse/domestic partner 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 107 under *Claiming Benefits and Other Information*.

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.

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

<i>Basic Coverage Paid for by the Company</i>	84
<i>Supplemental Coverage Available for Purchase</i>	85
<i>Coverage Options</i>	85
<i>Examples of Coverage Amounts</i>	86
<i>Cost of Coverage</i>	86
<i>Examples of Cost of Coverage</i>	87
<i>Naming a Beneficiary</i>	87
<i>If Your Beneficiary Predeceases You</i>	88
<i>If No Beneficiary Is Named</i>	88
<i>If You Assigned Your Benefits</i>	88
<i>When Benefits Are Paid</i>	88
<i>If You Are Terminally Ill</i>	89
<i>Occupational Accidental Death Coverage</i>	89
<i>Restrictions and Exclusions</i>	89

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: <ul style="list-style-type: none">▪ 1.5× your Pay, up to a maximum of \$1 million;<ul style="list-style-type: none">▫ Coverage that is not a multiple of \$1,000 will be rounded up to the next \$1,000; or▪ \$50,000.
Cost	The Company pays the premiums for this coverage.
Imputed Income	<ul style="list-style-type: none">▪ 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 \$50,000.
Occupational Accidental Death Coverage	<ul style="list-style-type: none">▪ 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. Coverage that is not a multiple of \$1,000 will be rounded up to the next \$1,000.▪ See "Occupational Accidental Death Coverage" on page 89.

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 Group Life Coverage to Individual Coverage" on page 127 and "Portability of Employee and Dependent Life Coverage" on page 127.

Supplemental Coverage Available for Purchase

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

Coverage	<ul style="list-style-type: none">▪ You can purchase coverage of an additional 1× to 7× your Pay, to a maximum of \$7 million of supplemental coverage.<ul style="list-style-type: none">▫ 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:<ul style="list-style-type: none">▫ Initial enrollments for supplemental life amounts over 2× Pay (total employee life insurance coverage of 3.5× Pay or greater); and▫ Any increase in coverage thereafter.
Cost	<p>The cost depends on:</p> <ul style="list-style-type: none">▪ 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 3.5× Pay (Basic plus Supplemental coverage combined) and any subsequent increase in insurance. See "Evidence of Insurability" on page 5 under *Eligibility and Enrollment* for more information.

**Maximum Life Benefit:
\$8 Million**

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

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.

Coverage Options

When you elect employee life insurance coverage, your options will show both the Basic and Supplemental options, along with the cost of each Supplemental option. You select the amount of Basic and Supplemental coverage that you want.

Basic coverage option amounts that are paid for by the Company include:

- \$50,000
- 1.5× Pay

Supplemental coverage option amounts that you pay for include:

- 1× Pay
- 2× Pay
- 3× Pay
- 4× Pay
- 5× Pay
- 6× Pay
- 7× Pay

You must elect a minimum of 1.5× Pay or \$50,000 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 9 under *Eligibility and Enrollment*.

EMPLOYEE LIFE INSURANCE

Examples of Coverage Amounts

Kari's annual Pay is \$80,300 and she elects Basic coverage of 1.5× Pay and Supplemental coverage of 1× Pay, for total coverage of 2.5× Pay. Her Basic coverage will be rounded up to \$121,000 and her Supplemental coverage will be \$81,000, for total coverage of \$242,000, as shown below.

1.5× Pay Basic Coverage (\$120,450 rounded up to \$121,000)	\$121,000
1× Pay Supplemental Coverage (1 × \$80,300 = \$80,300 rounded up to \$81,000)	\$81,000
Total Coverage	\$242,000

George's annual Pay is \$50,700 and he elects Basic coverage of 1.5× Pay and Supplemental coverage of 3× Pay*, for total coverage of 4× Pay. His Basic coverage will be rounded up to \$77,000, and his Supplemental coverage will be \$152,100 rounded up to \$153,000, for total coverage of \$230,000.

1.5× Pay Basic Coverage (\$76,050 rounded up to \$77,000)	\$77,000
3× Pay Supplemental Coverage (3 × \$50,700 = \$152,100 rounded up to \$153,000)	\$153,000
Total Coverage	\$230,000

* *EOI is required for an initial enrollment supplemental coverage and any subsequent increase in insurance. See "Evidence of Insurability on page 5 under Eligibility and Enrollment for more information.*

Cost of Coverage

The Company pays the premium costs of Basic coverage.

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
<i>Under 25</i>	\$0.013
<i>25 – 29</i>	\$0.014
<i>30 – 34</i>	\$0.022
<i>35 – 39</i>	\$0.033
<i>40 – 44</i>	\$0.045
<i>45 – 49</i>	\$0.079
<i>50 – 54</i>	\$0.138
<i>55 – 59</i>	\$0.228
<i>60 – 64</i>	\$0.356
<i>65 – 69</i>	\$0.638
<i>70 – 74</i>	\$1.109
<i>75 and older</i>	\$1.654

When Premium Costs Change

The premium costs shown are for the 2026 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.

EMPLOYEE LIFE INSURANCE

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 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 \$6.71.

Supplemental coverage amount ($2 \times \$74,600 = \$149,200$, rounded up to \$150,000)	\$150,000
Monthly cost per \$1,000 of coverage for a 43-year-old	\$0.045
Monthly cost of coverage ($\$0.045 \times \$150,000/\$1,000 = \6.75)	\$6.75

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 \$1.06.

Supplemental coverage amount ($1 \times \$47,700 = \$47,700$, rounded up to \$48,000)	\$48,000
Monthly cost per \$1,000 of coverage for a 32-year-old	\$0.022
Monthly cost of coverage ($\$0.022 \times \$48,000/\$1,000 = \1.06)	\$1.06

Naming a Beneficiary

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

- Your beneficiary must be on file with DuPont Connection. Archived designations made outside of DuPont Connection will no longer be honored.
- 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.
- Your domestic partner will not be your default beneficiary for your life insurance, but can be designated as a beneficiary, if you choose.

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 or divorce. Contact DuPont Connection at 1-833-253-7719 to change your beneficiaries at any time.

All Plan participants are encouraged to keep their life insurance beneficiary information up to date. Contact DuPont Connection at 1-833-253-7719 to change your beneficiaries at any time.

EMPLOYEE LIFE INSURANCE

If Your Beneficiary Predeceases You

- Any beneficiary that predeceases you is taken out of consideration.
- If you designate a primary beneficiary and a contingent beneficiary and the primary beneficiary predeceases you, the contingent beneficiary becomes the beneficiary. If the contingent beneficiary also predeceases you, see “If No Beneficiary Is Named” below.
- If you designate more than one primary beneficiary, and a primary beneficiary predeceases you, the deceased primary beneficiary’s percentage will be divided among the remaining living primary beneficiaries based on their designation percentage.

If No Beneficiary Is Named

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

- the beneficiary designated by you under the previous plan sponsored by E. I. du Pont de Nemours and Company (now known as Corteva Agriscience) as of May 31, 2019 that was replaced by this plan as of June 1, 2019, but only if the designation is on file with DuPont Connection;
- 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.

Your domestic partner will not be your default beneficiary for your employee life insurance, but can be designated as a beneficiary, if you choose.

If You Assigned Your Benefits

If you assigned your life insurance benefits under E. I. du Pont de Nemours and Company (now known as Corteva Agriscience) before January 1, 2014, that assignment is invalid with the Company as of June 1, 2019. Contact DuPont Connection at 1-833-253-7719 to make a new beneficiary designation.

No life insurance benefits can be assigned.

See “Assignment of Benefits” on page 111 under *Claiming Benefits and Other Information* 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.

The Plan has a minimum of the lesser of 1× Pay or \$50,000 death benefit for active employees. The maximum death benefit is \$8 million.

Claiming Your Benefits

See Claiming Benefits and Other Information on page 106 for details on how to file a claim for benefits.

EMPLOYEE LIFE INSURANCE

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 benefit of \$3 million.

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

Notwithstanding anything to the contrary in this Summary Plan Description, Temporary Employees are eligible for Occupational Accidental Death coverage. Temporary Employees are not eligible for any other Health, Insurance or Other benefits described in this Summary Plan Description.

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 Insurance and Accidental Death Insurance" on page 112 under "Assignment of Benefits" on page 111 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 127, and contact the insurer for further details.

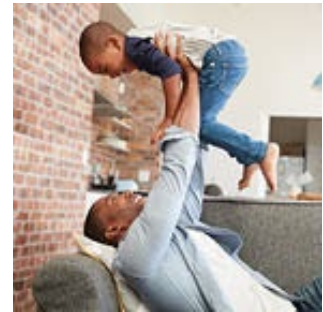
Also see the conversion of coverage option, under "Converting Group Life Coverage to Individual Coverage" on page 127.

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 Group Life Coverage to Individual Coverage" on page 127 and "Portability of Employee and Dependent Life Coverage" on page 127.



Life Insurance for Your Spouse/Domestic Partner and Children

SECTION CONTENTS

<i>Spouse/Domestic Partner Life Insurance</i>	<i>91</i>
<i>Child Life Insurance</i>	<i>91</i>
<i>Newborn coverage</i>	<i>92</i>
<i>Cost of Coverage</i>	<i>92</i>
<i>Spouse/Domestic Partner Life Insurance</i>	<i>92</i>
<i>Child Life Insurance</i>	<i>93</i>
<i>You Are the Beneficiary</i>	<i>93</i>
<i>When Benefits Are Paid</i>	<i>93</i>
<i>If Your Spouse/Domestic Partner Is Terminally Ill</i>	<i>93</i>
<i>Exclusions and Limitations</i>	<i>93</i>

Spouse/Domestic Partner Life Insurance

You can purchase dependent life insurance for your spouse/domestic partner. 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/Domestic Partner Life Insurance when you are a new hire or when your spouse/domestic partner first becomes eligible. EOI is always required if coverage is purchased later and for any increases in coverage. See "Evidence of Insurability" on page 5 under *Eligibility and Enrollment* for more information.

Coverage	Ten levels of spouse/domestic partner life insurance are available: <ul style="list-style-type: none">▪ \$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/domestic partner life insurance. The cost is based on: <ul style="list-style-type: none">▪ Your spouse/domestic partner'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: <ul style="list-style-type: none">▪ \$5,000▪ \$10,000▪ \$20,000
Cost	You pay the full cost of child life insurance.

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

DEPENDENT LIFE INSURANCE PLAN

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 (effective January 1st of the following calendar year) 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 9 under *Eligibility and Enrollment* 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 2026 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/Domestic Partner Life Insurance

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

Age as of 12/31 of the Current Year	Monthly Premiums per \$1,000 of Coverage
<i>Under 25</i>	\$0.016
<i>25 – 29</i>	\$0.020
<i>30 – 34</i>	\$0.029
<i>35 – 39</i>	\$0.044
<i>40 – 44</i>	\$0.059
<i>45 – 49</i>	\$0.104
<i>50 – 54</i>	\$0.182
<i>55 – 59</i>	\$0.303
<i>60 – 64</i>	\$0.473
<i>65 – 69</i>	\$0.850
<i>70 – 74</i>	\$1.477
<i>75 and older</i>	\$1.854

DEPENDENT LIFE INSURANCE PLAN

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/Domestic Partner and Child Life Insurance coverage, you are the beneficiary. In the event that your covered spouse/domestic partner 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/domestic partner or child(ren) dies for any reason. Payments are not reduced because of any other life insurance.

If Your Spouse/Domestic Partner Is Terminally Ill

If your spouse/domestic partner 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/domestic partner 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/domestic partner's death.

To receive this benefit, a licensed physician must certify that your spouse/domestic partner'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 Dependent Life Insurance coverage.

Claiming Your Benefits

See Claiming Benefits and Other Information on page 106 for details on how to file a claim for benefits.

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/domestic partner and/or children too, at group rates.



SECTION CONTENTS

<i>Accidental Death Insurance—Basic</i>	95
<i>Accidental Death Insurance—Voluntary</i>	95
<i>Plan Benefits</i>	95
<i>Accidental Death Insurance Defined Terms</i>	96
<i>Additional Benefits</i>	97
<i>Cost of Coverage</i>	99
<i>Monthly Cost of Voluntary Accidental Death Coverage</i>	99
<i>Naming a Beneficiary</i>	99
<i>If Your Beneficiary Predeceases You</i>	100
<i>If No Beneficiary Is Named</i>	100
<i>If You Assigned Your Benefits</i>	100
<i>When Benefits Are Paid</i>	100
<i>Examples</i>	101
<i>Exclusions and Limitations</i>	101

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

Additional Benefits

The Plan pays additional benefits under certain circumstances. See "Additional Benefits" on page 97 for more information.

Benefits Based on Pay

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

In addition, Pay is the same as "Normal Annual Earnings" which includes such pay as shift differential, regular scheduled overtime, and Sunday premium pay.

Accidental Death Insurance—Voluntary

You can purchase Voluntary Accidental Death coverage for yourself, your spouse/domestic partner, 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/Domestic Partner	<ul style="list-style-type: none"> ▪ You: \$500,000 ▪ Spouse/ Domestic Partner: \$300,000 	<ul style="list-style-type: none"> ▪ You: \$250,000 ▪ Spouse/ Domestic Partner: \$150,000 	<ul style="list-style-type: none"> ▪ You: \$100,000 ▪ Spouse/ Domestic Partner: \$50,000 	<ul style="list-style-type: none"> ▪ You: \$50,000 ▪ Spouse/ Domestic Partner: \$25,000
You and Your Children	<ul style="list-style-type: none"> ▪ You: \$500,000 ▪ Children: \$100,000 	<ul style="list-style-type: none"> ▪ You: \$250,000 ▪ Children: \$50,000 	<ul style="list-style-type: none"> ▪ You: \$100,000 ▪ Children: \$25,000 	<ul style="list-style-type: none"> ▪ You: \$50,000 ▪ Children: \$10,000
You, Your Spouse/Domestic Partner and Your Children	<ul style="list-style-type: none"> ▪ You: \$500,000 ▪ Spouse/ Domestic Partner: \$300,000 ▪ Children: \$100,000 	<ul style="list-style-type: none"> ▪ You: \$250,000 ▪ Spouse/ Domestic Partner: \$150,000 ▪ Children: \$50,000 	<ul style="list-style-type: none"> ▪ You: 100,000 ▪ Spouse/ Domestic Partner: \$50,000 ▪ Children: \$25,000 	<ul style="list-style-type: none"> ▪ You: \$50,000 ▪ Spouse/ Domestic Partner: \$25,000 ▪ Children: \$10,000

If both you and your spouse/domestic partner 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/domestic partner, or your covered children
Life	100%
<ul style="list-style-type: none"> ▪ 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%

ACCIDENTAL DEATH INSURANCE PLAN

Loss	The percentage of benefit paid for you, your covered spouse/domestic partner, or your covered children
<ul style="list-style-type: none">▪ Speech or hearing in both ears▪ One hand or one foot▪ All four fingers of one hand▪ Sight of one eye▪ Uniplegia	50%
<ul style="list-style-type: none">▪ 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 functional degree by aid or device.

QUADRIPLÉGIA

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).

HEMIPLÉGIA

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

<p>Seat Belt Benefit</p>	<ul style="list-style-type: none"> ▪ 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.
<p>Airbag Benefit</p>	<ul style="list-style-type: none"> ▪ 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

<p>Spouse/ Domestic Partner Tuition Reimbursement Benefit</p>	<ul style="list-style-type: none"> ▪ Reimburses tuition at an accredited educational institution or an institution of vocational training to prepare your spouse/domestic partner 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/domestic partner 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.
<p>Child Tuition Reimbursement Benefit</p>	<ul style="list-style-type: none"> ▪ Reimburses tuition at an accredited post-secondary educational institution for dependent child if you or your covered spouse/domestic partner 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.
<p>Child Care Expense Benefit</p>	<ul style="list-style-type: none"> ▪ Pays a benefit for child care expenses for a dependent child under age 13 if you or your covered spouse/domestic partner 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.

ACCIDENTAL DEATH INSURANCE PLAN

Additional Benefits Paid Only if Voluntary Accidental Death Insurance Purchased

Felonious Assault Benefit	<ul style="list-style-type: none"> ▪ 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).
Return of Remains Benefit	<ul style="list-style-type: none"> ▪ 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	<ul style="list-style-type: none"> ▪ 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	<ul style="list-style-type: none"> ▪ 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	<ul style="list-style-type: none"> ▪ Paid to the covered individual if you, your spouse/domestic partner, 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	<ul style="list-style-type: none"> ▪ 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	<ul style="list-style-type: none"> ▪ 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	<ul style="list-style-type: none"> ▪ 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	<ul style="list-style-type: none"> ▪ 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/domestic partner 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

2026 Costs

The cost information shown is for the 2026 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.

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

Naming a Beneficiary

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

- You are the beneficiary for your spouse/domestic partner 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.
 - Your domestic partner will not be your default beneficiary for your employee life insurance, but can be designated as a beneficiary, if you choose.
 - Beneficiary designations that were in place on May 31, 2019 with E. I. du Pont de Nemours and Company (now known as Corteva Agriscience) were carried over to the Company and will remain in place until you change your beneficiary designation.

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.

All Plan participants are encouraged to keep their accidental death insurance beneficiary information up to date. Contact DuPont Connection at 1-833-253-7719 to change your beneficiaries at any time. Your beneficiary for accidental death insurance must be on file with DuPont Connection. Archived designations made outside of DuPont Connection will no longer be honored.

ACCIDENTAL DEATH INSURANCE PLAN

If Your Beneficiary Predeceases You

- Any beneficiary that predeceases you is taken out of consideration.
- If you designate a primary beneficiary and a contingent beneficiary and the primary beneficiary predeceases you, the contingent beneficiary becomes the beneficiary. If the contingent beneficiary also predeceases you, see "If No Beneficiary Is Named" below.
- If you designate more than one primary beneficiary, and a primary beneficiary predeceases you, the deceased primary beneficiary's percentage will be divided among the remaining living primary beneficiaries based on their designation percentage.

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 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:

- the beneficiary designated by you under the previous plan sponsored by E. I. du Pont de Nemours and Company (now known as Corteva Agriscience) as of May 31, 2019 that was replaced by this plan as of June 1, 2019, but only if the designation is on file with DuPont Connection;
- 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.

Your domestic partner will not be your default beneficiary for your accidental death insurance, but can be designated as a beneficiary, if you choose.

If You Assigned Your Benefits

If you assigned your accidental death insurance benefit under E. I. du Pont de Nemours and Company (now known as Corteva Agriscience) before January 1, 2014, your assignment is invalid with the Company as of June 1, 2019. Contact DuPont Connection at 1-833-253-7719 to make a new beneficiary designation.

No accidental death insurance benefits can be assigned.

See "Assignment of Benefits" on page 111 under *Claiming Benefits and Other Information* for more information.

When Benefits Are Paid

When you or your covered spouse/domestic partner 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 Accidental Death Insurance benefit is \$1 million.

The Plan does not have a Basic Accidental Death Insurance minimum benefit.

Claiming Your Benefits

See Claiming Benefits and Other Information on page 106 for details on how to file a claim for benefits.

ACCIDENTAL DEATH INSURANCE PLAN

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

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.

Legal Plan

Quality legal assistance can be pricey. And it can be hard to know where to turn to find an attorney you trust. The Legal Plan gives you access to the expert guidance and tools you need to handle a broad range of personal legal needs you might face throughout your life.



SECTION CONTENTS

How It Works 102
What’s Covered 102
Cost of Coverage 103

How It Works

The Legal Plan service is tailored to your needs. With network attorneys available in person, by phone, or by email and online tools to do-it-yourself or plan your next move – MetLife makes it easy to get legal help. And you have the choice in which attorney to use. You can choose one from MetLife’s network of prequalified attorneys, or use an attorney outside of the network and be reimbursed some of the cost. If you use an out-of-network attorney, you will be responsible to pay the difference, if any, between the Legal Plan’s payment and the out-of-network attorney’s charge for services.

You have unlimited access to MetLife attorneys for all legal matters covered under the plan. For a monthly premium, paid through payroll deduction, an expert is on your side as long as you need them.

When using a network attorney for a covered matter, there are no waiting periods, no deductibles and no claims forms.

If you have a non-covered matter, the Legal Plan provides a combined maximum of four hours of network attorney time and services per year to the employee, spouse/domestic partner and qualified dependents.

To find an attorney go to members.legalplans.com, or call 1-800-821-6400, Monday through Friday, between 8:00 am and 8:00 pm (ET). Then call the attorney you select, provide your case number and schedule a time to talk or meet.

What’s Covered

Money Matters	<ul style="list-style-type: none"> ▪ Debt Collection Defense ▪ Identity Management Services¹ 	<ul style="list-style-type: none"> ▪ Identity Theft Defense ▪ Negotiations with Creditors ▪ Personal Bankruptcy 	<ul style="list-style-type: none"> ▪ Promissory Notes ▪ Tax Audit Representation ▪ Tax Collection Defense
Home & Real Estate	<ul style="list-style-type: none"> ▪ Boundary & Title Disputes ▪ Deeds ▪ Eviction Defense ▪ Foreclosure 	<ul style="list-style-type: none"> ▪ Home Equity Loans ▪ Mortgages ▪ Property Tax Assessments 	<ul style="list-style-type: none"> ▪ Refinancing of Home ▪ Sale or Purchase of Home ▪ Tenant Negotiations
Estate Planning	<ul style="list-style-type: none"> ▪ Codicils ▪ Complex Wills ▪ Healthcare Proxies ▪ Living Wills 	<ul style="list-style-type: none"> ▪ Power of Attorney (Healthcare, Financial, Childcare, Immigration) 	<ul style="list-style-type: none"> ▪ Revocable & Irrevocable Trusts ▪ Simple Wills

LEGAL PLAN

Family & Personal	<ul style="list-style-type: none"> ▪ Adoption ▪ Affidavits ▪ Conservatorship ▪ Demand Letters ▪ Garnishment Defense ▪ Guardianship ▪ Immigration Assistance 	<ul style="list-style-type: none"> ▪ Insurance Claims ▪ Juvenile Court Defense, Including Criminal Matters ▪ Name Change ▪ Parental Responsibility Matters 	<ul style="list-style-type: none"> ▪ Prenuptial Agreement ▪ Protection from Domestic Violence ▪ Review of ANY Personal Legal Document ▪ School Hearings ▪ Reproductive assistance
Civil Lawsuits	<ul style="list-style-type: none"> ▪ Administrative Hearings ▪ Civil Litigation Defense 	<ul style="list-style-type: none"> ▪ Disputes Over Consumer Goods & Services ▪ Incompetency Defense 	<ul style="list-style-type: none"> ▪ Pet Liabilities
Elder-Care Issues	<ul style="list-style-type: none"> ▪ Consultation & Document Review for your parents: ▪ Deeds ▪ Leases 	<ul style="list-style-type: none"> ▪ Medicaid ▪ Medicare ▪ Notes ▪ Nursing Home Agreements 	<ul style="list-style-type: none"> ▪ Powers of Attorney ▪ Prescription Plans ▪ Wills
Driving & Criminal	<ul style="list-style-type: none"> ▪ Defense of Traffic Tickets ▪ Driving Privileges Restoration ▪ Driving Under the Influence Defense 	<ul style="list-style-type: none"> ▪ Expungement ▪ Habeas Corpus ▪ License Suspension Due to DUI 	<ul style="list-style-type: none"> ▪ Misdemeanor Defense ▪ Repossession

¹ This benefit provides the Participant with access to Life Stages Identity Management Services provided by CyberScout, LLC. CyberScout is not a corporate affiliate of MetLife Life Plans.

Cost of Coverage

You pay the cost of Legal Plan coverage through payroll deduction. There are two levels of coverage to choose from.

Coverage Level	Monthly Premiums * for 2026
Employee Only	\$13.85
Family	\$19.85

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

Identity Protection Program

Identity theft can happen to anyone. The Allstate Identity Protection Program protects you from identity theft and gives you peace of mind.

Benefits include:

- Financial account and credit monitoring
- Social media monitoring
- 24/7 alerts and fraud recovery
- Up to \$1 million identity theft expense reimbursement



You can enroll in (or change) coverage on DuPont Connection during your new hire enrollment period, during future Annual Enrollment periods, or if you experience a qualifying life event during the year.

SECTION CONTENTS

Cost of Coverage 104

Cost of Coverage

You pay the cost of Identity Protection coverage through payroll deduction. There are two levels of coverage to choose from.

Coverage Level	Monthly Premiums for 2026
Employee Only	\$6.50
Family	\$12.50

If you enroll, you will receive an email with login instructions when your coverage begins. You will need to provide your Social Security Number (SSN) and date of birth to login and then you'll need to enter certain information to activate your account. Your identity protection won't begin until your account has been activated.

Commuter Benefits Program

DuPont offers a pre-tax commuter benefit program so you can set aside pre-tax dollars to pay for qualified transit and parking expenses associated with your commute to work.

SECTION CONTENTS

How It Works 105



How It Works

Eligible employees who travel to work using public transit (such as trains, buses, subways, ferries, or vanpools) and/or pay for parking at or near work can save on Federal, State, Social Security, and FICA taxes on these expenses (up to established limits). Milage, tolls, fuel, carpooling, and business travel are not eligible for this program.

For 2026, the pre-tax limits are \$340 a month for transit expenses and \$340 a month for parking expenses. If you pay transit and parking expenses, you can take advantage of both benefits. The federal government sets these limits and are subject to change annually. You can start and stop participating in the Commuter Benefits Program at any time.

Follow these steps to purchase your commuter products online:

- Log on to DuPont Connection (<http://digital.alight.com/dupont>)
- Select the Commuter Benefits tile under “Quick Links”
- Select Place an Order

Through the Commuter portal, you’ll be able to:

- Order a transit and/or parking pass
- Have a transit and/or parking pass automatically renewed (monthly)
- Track your order history
- Maintain personal account information

You must place your order by the 10th of the month to have a transit and/or parking pass available for the following month. For example, you must place your order(s) by December 10th to have a transit and/or parking pass available for the month of January.

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

<i>How to File a Claim</i>	<i>107</i>
<i>If You Have Other Coverage</i>	<i>110</i>
<i>Assignment of Benefits</i>	<i>111</i>
<i>For Medical, Dental, and Vision Care Coverage</i>	<i>111</i>
<i>For Life Insurance and Accidental Death Insurance.....</i>	<i>112</i>
<i>Claims Review Notification and Explanations of Benefits</i>	<i>112</i>
<i>Timing for Notification of Claims.....</i>	<i>112</i>
<i>Overpayments and Other Errors.....</i>	<i>114</i>
<i>Subrogation</i>	<i>115</i>
<i>Claims Appeals</i>	<i>116</i>
<i>Notice of Benefit Determination on Appeal.....</i>	<i>118</i>
<i>Review Procedures on Appeal</i>	<i>119</i>
<i>Legal Remedies</i>	<i>119</i>
<i>External Review Procedure.....</i>	<i>120</i>

If You Have Alternative Medical Coverage

If you have Alternative Medical Coverage because you 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, behavioral health, and substance abuse, 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 A1A (or your carrier if you have Alternative Coverage). See "Contacts" on page 137.

Type of Care/Claim	How to File
Medical Care, including behavioral health/substance abuse care (Core, Premium Saver, and Traditional Copay PPO Options) <i>From an in-network provider</i>	<ul style="list-style-type: none"> ▪ 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, including behavioral health/substance abuse care (Core, Premium Saver, and Traditional Copay PPO Options) <i>From an out-of-network provider</i>	<ul style="list-style-type: none"> ▪ 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 www.aetna.com. ▪ Alternatively, you can file a claim after you've received the care. In this case, you would 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. ▪ You, or your provider, have 12 months from the date of service to submit a claim for reimbursement. Claims submitted after the 12-month deadline will be denied for failure to meet the Plan's timely filing requirement.
Prescription Drugs	<ul style="list-style-type: none"> ▪ When you use a pharmacy in the CVS Caremark 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 CVS Caremark before it is covered. ▪ If you are not able to use your CVS Caremark card at a pharmacy, you may print a paper claim form or submit a claim online at the CVS Caremark website at www.caremark.com (detailed pharmacy receipt is required).
Supplemental Healthcare Benefit	<ul style="list-style-type: none"> ▪ Register at www.mybenefits.metlife.com. ▪ Complete the appropriate claim form(s) and upload the supporting medical documentation.
Infertility/Family Planning	<ul style="list-style-type: none"> ▪ Register at https://app.get-carrot.com/signup ▪ Complete the appropriate claim form(s) and upload the supporting medical documentation. ▪ Claims must be submitted within 90 days following the end of each plan year.

CLAIMING BENEFITS AND OTHER INFORMATION

Type of Care/Claim	How to File
Dental Care <i>From an in-network provider</i>	<ul style="list-style-type: none"> ▪ 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.
Dental Care <i>From an out-of-network provider</i>	<ul style="list-style-type: none"> ▪ 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 <i>From an in-network provider</i>	<ul style="list-style-type: none"> ▪ See "The VBA Network" on page 65 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 <i>From an out-of-network provider</i>	<ul style="list-style-type: none"> ▪ 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."
Limited Purpose and Traditional Health Care FSAs	<ul style="list-style-type: none"> ▪ The simplest way to access your account is to use the debit card that you will receive from Bank of America. <ul style="list-style-type: none"> ▫ 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. <ul style="list-style-type: none"> ▫ 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.

CLAIMING BENEFITS AND OTHER INFORMATION

Type of Care/Claim	How to File
Dependent Daycare FSA	<ul style="list-style-type: none">▪ You can file claims online, at www.bankofamerica.com/benefitslogin.▪ If you are filing for reimbursement on the Bank of America portal or app, you will need to select the account that the expense should be paid from. Selecting the 2025 DC FSA will allow funds to be paid from your remaining 2025 DC FSA balance first. If you did not elect a DC FSA in 2025, or have already been fully reimbursed, you should select 2026 DC FSA.▪ 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. If you are filing a claim using a Claim Reimbursement Form, under the Claim Information section you would indicate "2026 DC FSA" in the Plan Type column to have the claim reimbursed from your 2023 DC FSA balance first.▪ 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 plan year 2026 is April 15, 2027. Any funds not claimed will be forfeited.
Life Insurance or Dependent Life Insurance	<ul style="list-style-type: none">▪ Contact DuPont Connection at 1-833-253-7719 to begin the claim process. Your claim will be filed with Securian.▪ A death certificate and other information will need to be provided, as may be requested by the insurance company.
Accidental Death Insurance	<ul style="list-style-type: none">▪ If you or a covered dependent experience an injury that qualifies for accidental death or dismemberment benefits, contact DuPont Connection at 1-833-253-7719 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.

Except where inconsistent with applicable law, a claim for medical, dental or vision benefits must be filed no later than the date that is two years from the date the medical, dental or vision service for which the claim is being made was performed.

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) 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/domestic partner 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/domestic partner's employer's medical plan, your spouse's/domestic partner's plan is your secondary coverage.
- A plan that covers a participant as an active employee will be primary to a plan that covers the person as a retiree, terminated employee, 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/domestic partner'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.

CLAIMING BENEFITS AND OTHER INFORMATION

- 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/domestic partner 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 or your right to request plan documents under the Plan. However, you may provide written authorization to allow a provider to submit an appeal or request documents on your behalf.

CLAIMING BENEFITS AND OTHER INFORMATION

For Life Insurance and Accidental Death Insurance

The life insurance and accidental death insurance plans do not allow benefits to be assigned. If you assigned your life insurance and/or accidental death insurance benefits under E. I. du Pont de Nemours and Company (now known as Corteva Agriscience) before January 1, 2014, your assignment is invalid with the Company as of June 1, 2019. Contact DuPont Connection at 1-833-253-7719 to make a new beneficiary designation. Your beneficiary for life insurance and accidental death insurance must be on file with DuPont Connection. Archived designations made outside of DuPont Connection will no longer be honored.

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	Limited Purpose and Traditional Health 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.

CLAIMING BENEFITS AND OTHER INFORMATION

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	Limited Purpose and Traditional Health 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
Claims other than group health plan claims	Not Applicable	Not Applicable	Not Applicable

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 specific Plan provisions on which the determination is based;
- a description of what additional material or information is necessary to perfect the claim and why; and
- a description of the Plan's review procedures and the time limits applicable to such procedures, including a statement of your right to bring a civil action under section 502(a) of ERISA following an adverse benefit determination on review.

For group health plan benefits (medical, dental, vision, limited purpose and traditional health care flexible spending accounts), the notice will also include the following:

- if an internal rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination, either the specific rule, guideline, protocol, or other similar criterion; or a statement that such a rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination and that a copy of such rule, guideline, protocol, or other criterion will be provided free of charge to the claimant upon request;
- if the adverse benefit determination is based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the claimant's medical circumstances, or a statement that such explanation will be provided free of charge upon request; and
- in the case of a claim involving urgent care, a description of the expedited review process applicable to such claim.

To the extent that the benefit program is subject to the Patient Protection and Affordable Care Act as amended by the Health Care and Education Reconciliation Act, every notice of an adverse benefit determination will be provided in writing or electronically in a culturally and linguistically appropriate manner (to the extent required under applicable law) calculated to be

CLAIMING BENEFITS AND OTHER INFORMATION

understood by the claimant, and will include the items list above as well as all of the following that pertain to the determination:

- information sufficient to identify the claim involved, including the date of service, the health care provider, the claim amount (if applicable), and a statement describing the availability, upon request of the diagnosis code and its corresponding meaning and the treatment code and its corresponding meaning;
- a description of the Plan's internal review procedures and time limits applicable to such procedures, available external review procedures, if applicable, as well as the claimant's right to bring a civil action under Section 502(a) of ERISA following a final appeal; and
- the availability of and contact information for an applicable office of health insurance consumer assistance or ombudsman established under Section 2793 of the Public Health Service Act.

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

	Medical and Dental	Vision	Limited Purpose and Traditional Health Care Flexible Spending Accounts	Life Insurance, Dependent Life Insurance, Accidental Death Insurance, NCGLI/CGLI
Pre-service urgent care claims	As soon as possible, but not later than 72 hours; however, if additional information is needed, the decision must be made within 48 hours after the Plan's receipt of the requested information (or, if earlier, the end of the time period afforded to the claimant to provide the requested information)	Not Applicable	Not Applicable	Not Applicable
Pre-service non-urgent claims	Within 15 days (30 days if an extension is needed)	Within 15 days (30 days if an extension is needed)	Not Applicable	Not Applicable
Post service claims	Within 30 days (45 days if an extension is needed)	Within 30 days (45 days if an extension is needed)	Within 30 days (45 days if an extension is needed)	Not Applicable
Claims other than group health plan claims	Not Applicable	Not Applicable	Not Applicable	Within 90 days (180 days if an extension is needed)

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.

CLAIMING BENEFITS AND OTHER INFORMATION

Benefits under the Plan are coordinated not only with other group health benefit plans (as noted above) but also with other sources of payment. "Other sources of payment" include, but are not limited to, automobile insurance, awards, judgments, or settlements in connection with tort claims, malpractice claims, product liability claims or contract claims, regardless of whether any portion of the award, judgment or settlement is specifically allocated or attributed to health or medical care expenses. This Plan's coverage is secondary, to the fullest legally permissible extent, to such other sources of payment. If you or your covered dependent have a claim for benefits under an auto insurance policy or health insurance policy, you or the covered dependent should submit a claim under that policy before submitting a claim for benefits under this Plan.

If payment(s) from the other source(s) plus payment(s) by this Plan exceed 100% of the medical expense incurred, the excess is an overpayment and is subject to the provisions of this section. You or the covered dependent or the legal representatives, estate or heirs of you or the covered dependent, shall promptly reimburse to the Plan from any settlement, verdict or insurance proceeds received by you or the covered dependent (or by their legal representatives, estate or heirs), the amount of such overpayment.

In order to secure the rights of the Plan under this section, you or the covered dependent hereby: (1) grants to the Plan a first priority equity lien against the proceeds of any such settlement, verdict or other amounts received by you or the covered dependent; (2) assigns to the Plan any benefits you or the covered dependent may have under any automobile policy or other coverage, to the extent of the Plan's claim for reimbursement; and (3) holds any payment received from a third party arising from an illness, injury, or condition, whether recovered through a settlement, judgment, or otherwise, in a constructive trust for the benefit of the Plan, until the Plan releases its rights to the funds. You or the covered dependent (or his or her legal representatives, heirs or estate) will sign and deliver, at the request of the Plan or its agents, any documents needed to protect such lien or to make such assignment of benefits.

The Plan is entitled to full reimbursement of its overpayment on a first-dollar basis from any third party payments (before subtraction of attorneys' fees and other expenses), even if payment to the Plan results in a recovery to you or the covered dependent that is insufficient to make him whole (i.e., the "make whole" and "common fund" doctrines do not apply). In addition, the Plan is entitled to full recovery regardless of whether any liability for the payment is admitted by the third party and regardless of whether the settlement or judgment received by you or the covered dependent identifies the medical benefits the Plan provided or purports to allocate any portion of such settlement or judgment to payment of expenses other than medical expenses. The Plan is entitled to recover from any and all settlements or judgments, even those designated as pain and suffering, non-economic damages and/or general damages only.

Subrogation

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

Self-insured benefits, including 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 independent 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.

You or the covered dependent will cooperate with the Plan and its agents, and will sign and deliver any documents the Plan or its agents reasonably request to protect the Plan's right of reimbursement, provide any relevant information and take such actions as the Plan or its agents reasonably request to assist the Plan in making a full recovery of the amount of the overpayment described previously. You or the covered dependent will not take any action that prejudices the Plan's right of reimbursement. The Plan will be responsible for only those legal fees and expenses to which it agrees in writing. If the Plan must institute legal action against you or the covered dependent to recover the overpayment, you or the covered dependent will be liable for all costs of collection, including reasonable attorney's fees. 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 "Contacts for Appeals" on page 139 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 after you receive the original claim decision or after you receive a claim denial (or, for second level appeals, after you receive a Level 1 Appeal denial), as set forth below:

- a request for reconsideration under a group health plan such as the Medical Plan, Dental Plan, or Vision Plan should be made as soon as practicable following receipt of the denial and in no event later than 180 days after receiving the denial; and
- a request for reconsideration under any other type of plan such as the Employee Life Insurance Plan or Dependent Life Insurance Plan should be made as soon as practicable following receipt of the denial and in no event later than 60 days after receiving the 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.

For a second appeal of a medical claim denial that is not enrollment or eligibility related, the Plan Administrator shall refer the appeal to an external Independent Review Organization for review (see the External Review Procedure below for more detail). 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.

CLAIMING BENEFITS AND OTHER INFORMATION

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
<i>Eligibility and Enrollment</i>	<ul style="list-style-type: none"> ▪ Within 30 days
<i>Medical</i>	<ul style="list-style-type: none"> ▪ 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 30 days for pre-service claims; ▪ Within 60 days for post-service claims.
<i>Supplemental Healthcare</i>	<ul style="list-style-type: none"> ▪ Within 45 days
<i>Rx</i>	<ul style="list-style-type: none"> ▪ 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.
<i>Dental</i>	<ul style="list-style-type: none"> ▪ 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.
<i>Vision</i>	<ul style="list-style-type: none"> ▪ Within 30 days for pre-service claims; ▪ Within 60 days for post-service claims. ▪ The decision will be final and binding
<i>Limited Purpose and Traditional Health Care Flexible Spending Accounts</i>	Within 30 days
<i>Life and Accident Insurance</i>	Within 30 days (120 days if an extension is needed)
<i>Carrot</i>	Within 60 days

Special circumstances may cause the review to take longer. You will be notified if the review is extended and of the reason for the extension.

When you (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. For medical, 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.

CLAIMING BENEFITS AND OTHER INFORMATION

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
<i>Eligibility and Enrollment</i>	<ul style="list-style-type: none"> ▪ The Benefit Plan Appeals Committee will respond within 30 days with respect to Medical, Rx, Dental, Vision, Limited Purpose and Traditional Health Care Flexible Spending Accounts, and Dependent Care Flexible Spending Account eligibility and enrollment claims and within 60 days with respect to Life and Accidental Death Insurance
<i>Rx</i>	<ul style="list-style-type: none"> ▪ Within 72 hours for pre-service urgent-care claims; ▪ Within 15 days for pre-service claims; ▪ Within 30 days for post-service claims.
<i>Dental</i>	<ul style="list-style-type: none"> ▪ Within 72 hours for pre-service urgent-care claims; ▪ Within 15 days for pre-service claims; ▪ Within 30 days for post-service claims.
<i>Vision</i>	<ul style="list-style-type: none"> ▪ Not Applicable
<i>Limited Purpose and Traditional Health Care Flexible Spending Accounts</i>	<ul style="list-style-type: none"> ▪ Within 30 days
<i>Life and Accident Insurance</i>	<ul style="list-style-type: none"> ▪ Within 60 days (120 days if an extension is needed)

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.

Notice of Benefit Determination on Appeal

Every notice of a determination on appeal will be provided in writing or electronically and, if an adverse determination, will include:

- the specific reason or reasons for the adverse determination;
- reference to the specific Plan provisions on which the determination is based;
- a statement that the individual is entitled to receive, upon request and free of charge, reasonable access to and copies of all documents, records, and other Relevant Information (as defined below); and
- a statement describing any voluntary appeal procedures offered by the Plan and any claimant's right to bring an action under ERISA Section 502(a).

For group health plan benefits (medical, dental, vision, limited purpose and traditional health care flexible spending accounts), the notice will also include the following:

- if an internal rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination, either the specific rule, guideline, protocol, or other similar criterion; or a statement that such rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination and that a copy of the rule, guideline, protocol, or other similar criterion will be provided free of charge to the claimant upon request;
- if the adverse benefit determination is based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the claimant's medical circumstances, or a statement that such explanation will be provided free of charge upon request; and
- a statement that claimant may have other voluntary alternative dispute resolution options such as mediation and that one way to find out what may be available is to contact the local U.S. Department of Labor office and state insurance regulatory agency.

CLAIMING BENEFITS AND OTHER INFORMATION

To the extent that the benefit program is subject to the Patient Protection and Affordable Care Act as amended by the Health Care and Education Reconciliation Act, every notice of a determination on appeal will be provided in writing or electronically and, if an adverse determination, will include the information described above as well as the following:

- information sufficient to identify the claim involved, including the date of service, the health care provider, the claim amount (if applicable), and a statement describing the availability, upon request of the diagnosis code and its corresponding meaning and the treatment code and its corresponding meaning; and
- a statement describing any voluntary appeal procedures offered by the Plan.

Relevant Information is any document, record, or other information which (a) was relied upon in making the benefit determination; (b) was submitted, considered, or generated in the course of making the benefit determination, without regard to whether such document, record, or other information was relied upon in making the benefit determination; (c) demonstrates compliance with the administrative processes and safeguards required by federal law in making the benefit determination; or (d) in the case of a group health plan constitutes a statement of policy or guidance with respect to the Plan concerning the denied treatment option or benefit for the claimant's diagnosis, without regard to whether such advice or statement was relied upon in making the benefit determination.

Review Procedures on Appeal

In the conduct of any review of a group health plan claim, the following will apply:

- no deference will be afforded to the initial adverse determination;
- the review will be conducted by Aetna as the named fiduciary who is neither the individual who made the adverse benefit determination that is the subject of the appeal, nor the subordinate of such individual;
- in deciding an appeal that is based in whole or in part on a medical judgment, the fiduciary shall consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment;
- any medical or vocational experts whose advice was obtained on behalf of the Plan in connection with an adverse determination will be identified, without regard to whether the advice was relied upon in making the determination;
- any health care professional consulted in making a medical judgment shall be an individual who was neither consulted with in connection with the adverse determination that is the subject of the appeal, nor the subordinate of any such individual; and
- in the case of a claim involving urgent care, an expedited review process will be available pursuant to which a request for an expedited appeal may be submitted orally or in writing by the claimant, and all necessary information, including the Plan's determination on review, shall be submitted between the Plan and the claimant by telephone, facsimile or other available similarly expeditious method.
- to the extent that the benefit program is subject to the Patient Protection and Affordable Care Act, the claimant will be provided with any new or additional evidence considered, relied upon, or generated by the Plan in connection with the claim, as well as any new or additional rationale for denial. The claimant will have a reasonable opportunity to respond to such new evidence or rationale.

Legal Remedies

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.

Except where inconsistent with applicable law, a claim for medical, dental or vision benefits must be filed no later than the date that is two years from the date the medical, dental or vision service for which the claim is being made was performed.

If you are seeking judicial review of an adverse benefit determination under the Plan, whether in whole or in part, you must file any suit or legal action (including, without limitation, a civil action under Section 502(a) of ERISA) within 12 months (the "Limitations Period") following the date the final adverse benefit determination is issued, except as may be otherwise required by a collective bargaining agreement or applicable law. Notwithstanding the foregoing, if you fail to engage in or exhaust the

CLAIMING BENEFITS AND OTHER INFORMATION

claims and review procedures, you must file any suit or legal action within the Limitations Period following the date of the alleged facts or conduct giving rise to the claim (including, without limitation, the date the claimant alleges he or she became entitled to the Plan benefits requested in the suit or legal action), except as may be otherwise required by a collective bargaining agreement or applicable law. Nothing in this SPD should be construed to relieve you of the obligation to exhaust all claims and review procedures under the Plan before filing suit in state or federal court. If you fail to file such suit or legal action within the Limitations Period, you will lose any rights to bring any such suit or legal action thereafter.

Notwithstanding the foregoing, to the extent any insurance policy is used to fund benefits under the Plan, the statute of limitations provided in that policy shall control for a lawsuit related to benefits under that policy to the extent the statute of limitations provided in that policy is inconsistent with the statute of limitations described herein.

External Review Procedure

To the extent that the benefit program is subject to the Patient Protection and Affordable Care Act as amended by the Health Care and Education Reconciliation Act (i.e., the medical plan component of the Plan), you may be able to file a request for an external review as described in this section.

The external review program offers an independent review process to review the denial of a requested service or procedure or the denial of payment for a service or procedure. The process is available at no charge after exhaustion of the Plan's internal claims and appeals process described above (except that such exhaustion may not be required with respect to an external review request that qualifies for an expedited external review as described below). An adverse benefit determination related to the failure to meet the Plan's eligibility requirements is not eligible for external review.

All requests for an external review must be made in writing within 4 months of the date of receipt of the adverse benefit determination. The Plan will review a request for external review within five business days of its receipt of the request. The Plan will notify the claimant in writing within one business day of the completion of its review whether the adverse benefit determination is eligible for external review and if any additional information is required. If additional information is required, the claimant must supply the information by the later of (a) the last day of the 4-month filing period described above or (b) 48 hours after receipt of the notification.

If the claimant's adverse benefit determination is eligible for external review, the Plan will forward the request for external review to an Independent Review Organization (IRO) with which the Plan has contracted. The IRO will provide the claimant with a written notification that it has received and accepted the request for external review, and it will give the claimant the opportunity to submit additional information within 10 business days. The Plan will provide the IRO any information and documentation it considered in making its adverse benefit determination. If the claimant supplies additional information to the IRO, the IRO will forward that information to the Plan, at which point the Plan may reconsider its adverse benefit determination.

The IRO will review the claim without giving deference to the prior decisions and will take into account any additional information the claimant has supplied. In addition, in making its determination, the IRO may consider all documents and information provided, including, but not limited to, the claimant's medical records, the claimant's physician's recommendations, the terms of the Plan, appropriate practice guidelines, and the opinion of the IRO's clinical reviewer(s).

The IRO will render its decision within 45 days of its receipt of the request for review and will provide written notification to both the claimant and the Plan. This notification will include (1) a general description of the reason for the request for external review, including sufficient information to identify the claim, (2) the date the IRO received the request for external review and the date of its decision, (3) reference to the evidence or documentation considered in reaching its decision, (4) the reason(s) for its decision, including any evidence-based standards that were relied on, (5) a statement that the determination is binding except to the extent other remedies are available under state or federal law, (6) a statement that judicial review may be available, and (7) current contact information for any applicable office of health insurance consumer assistance or ombudsman.

If the decision of the IRO reverses the adverse benefit determination, the Plan will accept the decision and provide benefits for the service or procedure in accordance with the terms and conditions of the Plan. If the decision of the IRO confirms the Plan's adverse benefit determination, the Plan will not be obligated to provide benefits for the service or procedure.

CLAIMING BENEFITS AND OTHER INFORMATION

An adverse benefit determination may be eligible for an expedited external review if:

- the claimant has received an adverse benefit determination which involves a medical condition for which the timeframe for completion of an expedited internal appeal would seriously jeopardize the claimant's life or health, or the claimant's ability to regain maximum function, and the claimant has filed a request for an expedited internal appeal, or
- the claimant has received a final internal adverse benefit determination which involves a medical condition where the timeframe or completion of a standard external review would seriously jeopardize the claimant's life or health or would jeopardize the claimant's ability to regain maximum function, or if the final adverse benefit determination concerns an admission, availability of care, continued stay, or health care item or service for which the claimant received emergency services, but the claimant has not been discharged from a facility.

If the claimant makes a request for an expedited external review, the Plan will immediately review the request and provide the claimant with written notice of whether the adverse benefit determination is eligible for external review. If the adverse benefit determination is eligible for external review, the Plan will forward the request to an IRO (electronically, by telephone or fax, or by other similar manner) as described above, along with all documents and information considered in making the adverse benefit determination. The IRO will follow the review process described above and render a decision within 72 hours after it receives the request for review. The IRO will provide a written confirmation of its decision to both the claimant and the Plan with 48 hours thereafter.

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 10 under *Eligibility and Enrollment* for more details.

- If you or your dependent(s) lose health coverage (for the Medical, Dental, Vision, Limited Purpose and Traditional Health Care FSA plans), you may have the option to continue coverage, under COBRA, as described under “Continuing Coverage Under COBRA” on page 123.
- 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 126.
- For life insurance, you may have options to continue your coverage.

SECTION CONTENTS

<i>Continuing Coverage Under COBRA</i>	<i>123</i>
<i>What Is COBRA Continuation Coverage?</i>	<i>123</i>
<i>When Is COBRA Continuation Coverage Available?</i>	<i>123</i>
<i>How Is COBRA Coverage Provided?</i>	<i>124</i>
<i>If You Have Questions</i>	<i>125</i>
<i>Continuing Coverage While on Military Leave</i>	<i>126</i>
<i>Converting Group Life Coverage to Individual Coverage</i>	<i>127</i>
<i>Portability of Employee and Dependent Life Coverage and Accidental Death Insurance.....</i>	<i>127</i>

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, Limited Purpose and Traditional Health Care FSAs) 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.

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/domestic partner, 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/domestic partner of an employee, you will become a qualified beneficiary if you lose your coverage under the Plan because any of the following qualifying events happen:

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

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

- 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."

When Is COBRA Continuation 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.
- Death of the employee.
- The employee becoming entitled to Medicare benefits (under Part A, Part B, or both)

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 1-833-253-7719.

WHEN COVERAGE ENDS

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/domestic partner.
- A dependent child's losing eligibility for coverage as a dependent child.

To notify DuPont Connection of the qualifying event, call 1-833-253-7719.

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/domestic partners, and parents may elect COBRA continuation coverage on behalf of their children.

Reason Regular Coverage Ends	How Long COBRA Coverage Can Last
<ul style="list-style-type: none">▪ Your employment with the Company ends for any reason other than gross misconduct▪ Your regularly scheduled work hours are reduced, making you ineligible for coverage	<ul style="list-style-type: none">▪ 18 months
<ul style="list-style-type: none">▪ 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.	<ul style="list-style-type: none">▪ 29 months
<ul style="list-style-type: none">▪ You become entitled to Medicare▪ You die▪ You divorce, have your marriage annulled or legally separate▪ Your dependent stops being eligible for coverage	<ul style="list-style-type: none">▪ 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.

WHEN COVERAGE ENDS

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/domestic partner 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/domestic partner 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/domestic partner 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 1-833-253-7719.

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, Medicare, Medicaid, Children's Health Insurance Program (CHIP), or other group health plan coverage options (such as a spouse/domestic partner'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.

Can I enroll in Medicare instead of COBRA Continuation Coverage?

In general, if you don't enroll in Medicare Part A or B when you are first eligible because you are still employed, after the Medicare initial enrollment period, you have an 8-month special enrollment period¹ to sign up for Medicare Part A or B, beginning on the earlier of

- The month after your employment ends; or
- The month after group health plan coverage based on current employment ends.

If you don't enroll in Medicare and elect COBRA continuation coverage instead, you may have to pay a Part B late enrollment penalty and you may have a gap in coverage if you decide you want Part B later. If you elect COBRA continuation coverage and later enroll in Medicare Part A or B before the COBRA continuation coverage ends, the Plan may terminate your continuation coverage. However, if Medicare Part A or B is effective on or before the date of the COBRA election, COBRA coverage may not be discontinued on account of Medicare entitlement, even if you enroll in the other part of Medicare after the date of the election of COBRA coverage.

Medicare is considered "primary" insurance when coordinated with COBRA coverage. This means that when the COBRA plan processes a medical claim, it will consider any benefit payments Medicare paid (or would have paid, if elected) when determining its payment. The benefit payable under the COBRA plan will be reduced by the Medicare payment (or amount Medicare would have paid, if elected) and is therefore considered "secondary". COBRA participants (former employees or covered dependents) who are eligible for Medicare you should carefully consider enrolling as soon as they are eligible.

For more information visit <https://www.medicare.gov/medicare-and-you>.

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 the required premiums 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 1-833-253-7719. For more information about your rights under ERISA, including COBRA, the Patient Protection and Affordable Care Act (PPACA), 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

¹ <https://www.medicare.gov/sign-up-change-plans/how-do-i-get-parts-a-b/part-a-part-b-sign-up-periods>.

WHEN COVERAGE ENDS

(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.) For more information about the Marketplace, visit www.HealthCare.gov.

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 DuPont Connection 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, Limited Purpose or Traditional Health Care 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 Limited Purpose or Traditional Health Care 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 Disability and Leave Center (Sedgwick) at 1-855-267-4402 for more information about a military leave.

Converting 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 and Accidental Death Insurance

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

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/domestic partner 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/domestic partner.
- \$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 DuPont de Nemours, Inc.
- Where we refer to the "Company" in this summary, we mean the DuPont affiliated organization that has adopted or participates in the Health and Insurance Benefits Plans and employs you.

PAY

"Pay" means your regular rate of base pay computed on an annual basis and includes regular scheduled overtime and shift premium pay, without consideration of occasional or temporary variations from normal working hours.

What's Not Included as "Pay"

Pay does not include:

- casual overtime, or overtime for holidays, sometimes worked;
- allowances in connection with the transfer of employment or termination of employment and other special payments; and
- awards, variable pay, or payments under a gain sharing program, an incentive compensation plan, an equity compensation plan, or similar plans of the Company or any of its affiliated companies.

QUALIFYING LIFE EVENT

Qualifying Life Event that may impact your coverage and may allow 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/domestic partner starts a new job or becomes unemployed.
- Your spouse/domestic partner's employment changes in a way that affects their eligibility for benefits (such as changing from part-time to full-time).
- Your spouse/domestic partner takes an unpaid leave of absence.
- Your spouse/domestic partner'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/domestic partner or dependent child dies.
- For the Dependent Care FSA, you change caregivers, or your caregiver has a significant change in costs.

DEFINED TERMS

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 Employee 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;
- someone who is not a Company employee; or
- except as provided in the "Who Is Eligible?" on page 3, an individual whose home country is outside of the United States that is on temporary assignment in the United States.

The term employee does not include any individual who is not classified by the Company as a common law employee, even if such individual is later determined by any governmental agency or court to have been a common law employee of the Company.

Notwithstanding anything herein to the contrary, an employee in a bargaining unit represented by a union for collective bargaining will not be eligible to participate in this Plan unless and until the site manager has authorized the benefit, collective bargaining on the coverage has taken place (unless waived), and any requisite obligations thereunder have been fulfilled.

Administrative Information

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

SECTION CONTENTS

<i>ERISA Rights</i>	131
<i>HIPAA Privacy and Security</i>	132
<i>Governing Law</i>	132
<i>Agent for Service of Legal Process</i>	132
<i>Administrative Plan Details</i>	132
<i>The Medical Plan</i>	133
<i>The Dental Plan</i>	133
<i>The Vision Care Plan</i>	134
<i>The Flexible Spending Account (FSA) Plans</i>	134
<i>Life Insurance Plan, Dependent Life Insurance Plan, and Accidental Death Insurance Plan</i>	135
<i>Legal Plan</i>	135
<i>Hospital Indemnity, Critical Illness and Accident Plans</i>	136

ERISA Rights

As a participant in any of the plans described in this summary (except for the Flexible Benefits Plan, the Dependent Care Flexible Spending Account, and Health Savings 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 131.

Agent for Service of Legal Process

Legal process may be served on:

DuPont de Nemours, Inc.
Chestnut Run Plaza
974 Centre Road
P.O. Box 2915
Wilmington, DE 19805

Legal process may also be served on the Plan Administrator.

Administrative Plan Details

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

DuPont de Nemours, Inc.
974 Centre Road
Wilmington, DE 19805

The Plan Sponsor's EIN is 81-1224539.

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

The Benefit Plans Administrative Committee
974 Centre Road
Wilmington, DE 19805
1-833-253-7719

The Plan Administrator for purposes of certain appeals of claims only is:

Benefit Plan Appeals Committee
974 Centre Road
Wilmington, DE 19805
1-833-253-7719

The Plan Administrator has full discretion and authority to interpret Plan provisions, resolve any ambiguities, and evaluate claims. Decisions made by the Plan Administrator are final and binding.

ADMINISTRATIVE INFORMATION

The plan year for all the plans covered in this summary is January 1 to December 31.

You may examine or obtain a complete list of the employers that have adopted the Plans by making a written request to the Benefit Plans Administrative Committee.

The Medical Plan

Plan Name	DuPont Consolidated Health and Welfare Plan This SPD describes benefits under the Medical Plan portion of the DuPont Consolidated Health and Welfare Plan
Plan Number	501
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	For the Core, Premium Saver, and Traditional Copay PPO Options, the Claims Administrator is: Aetna, Inc. P. O. Box 14079 Lexington, KY 40512 1-866-603-9957 Aetna International P.O. Box 981543 El Paso, TX 79998-1543 1-800-231-7729 or 1-813-775-0190
Source of Benefits Funding	The plan is not funded by a trust; you, the employee, and the Company pay the cost.

The Dental Plan

Plan Name	DuPont Consolidated Health and Welfare Plan This SPD describes benefits under the Dental Plan portion of the DuPont Consolidated Health and Welfare Plan
Plan Number	501
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 1-855-638-3944
Source of Benefits Funding	You, the employee, and the Company pay the cost.

ADMINISTRATIVE INFORMATION

The Vision Care Plan

Plan Name	DuPont Consolidated Health and Welfare Plan This SPD describes benefits under the Vision Plan portion of the DuPont Consolidated Health and Welfare Plan
Plan Number	501
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 The Plan Insurer is responsible for day-to-day administration of benefits and processing and deciding claims. The Plan Insurer has full discretion and authority to interpret the terms of the insurance policy(ies), resolve any ambiguities, and evaluate claims and appeals for benefits. Decisions made by the Plan Insurer are final and binding.
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	DuPont Consolidated Health and Welfare Plan This SPD describes the following benefits: The Limited Purpose and Traditional Health Care FSAs (this Summary also describes the Dependent Daycare Flexible Spending Account, which is not covered by ERISA)
Plan Number	501
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.

ADMINISTRATIVE INFORMATION

Life Insurance Plan, Dependent Life Insurance Plan, and Accidental Death Insurance Plan

Plan Name	DuPont Consolidated Health and Welfare Plan This SPD describes benefits under the Life and Accidental Death Insurance portions of the DuPont Consolidated Health and Welfare Plan
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 Insurer	Securian Financial 400 Robert Street North St. Paul, MN 55101-2098 Phone: 1-866-293-6047 The Plan Insurer is responsible for day-to-day administration of benefits and processing and deciding claims. The Plan Insurer has full discretion and authority to interpret the terms of the insurance policy(ies), resolve any ambiguities, and evaluate claims and appeals for benefits. Decisions made by the Plan Insurer are final and binding.
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 pay the premium cost of Supplemental Coverage under the Life Insurance program.

Legal Plan

Plan Name	DuPont Consolidated Health and Welfare Plan This SPD describes benefits under the Legal Plan portion of the DuPont Consolidated Health and Welfare Plan
Plan Number	501
Type of Plan	The Plan is a welfare plan as defined by the Employee Retirement Income Security Act of 1974 (ERISA) that provides certain group legal benefits.
Claims Administrator	MetLife Legal Plans, Inc. 1111 Superior Avenue, Suite 800 Cleveland, OH 44114 Phone: 1-800-821-6400
Source of Benefits Funding	You, the employee, pay the entire cost.

ADMINISTRATIVE INFORMATION

Hospital Indemnity, Critical Illness and Accident Plans

Plan Name	DuPont Consolidated Health and Welfare Plan This SPD describes benefits under the Legal Plan portion of the DuPont Consolidated Health and Welfare Plan
Plan Number	501
Type of Plan	The Plan is a welfare plan as defined by the Employee Retirement Income Security Act of 1974 (ERISA) that provides certain group legal benefits.
Claims Administrator	MetLife Legal Plans, Inc. 1111 Superior Avenue, Suite 800 Cleveland, OH 44114 Phone: 1-800-821-6400
Source of Benefits Funding	You, the employee, pay the entire cost.

Contacts

Service/Resource	Contact Details
<i>DuPont Connection</i>	http://digital.alight.com/dupont 1-833-253-7719
<i>A1A (Medical, including Behavioral Health/Substance Abuse (U.S. Mainland))</i>	1-877-383-4756 Member.A1A.com
<i>Carrot</i>	get-carrot.com/start
<i>Lyra</i>	1-877-230-4544 Dupont.lyrahealth.com
<i>Healthy Incentive Program</i>	Personify Health 1-888-671-9395 www.myhealth.dupont.com
<i>Pharmacy Network and Non-Specialty Medication Manager</i>	CVS Caremark 1-844-212-8696 www.caremark.com
<i>Specialty Medications Fills and Refills</i>	CVS Specialty 1-800-237-2767
<i>Specialty Medication Manager</i>	CVS Speciality (through the PrudentRx program) 1-800-578-4403
<i>Musculoskeletal Support</i>	Hinge Health 1-855-902-2777 www.hingehealth.com/dupont
<i>Second Opinion Service</i>	2 nd .MD 1-866-410-8649 www.2nd.md/dupont
<i>Employee Assistance Program</i>	ComPsych 1-844-856-8778 www.guidanceresources.com
<i>Telephone medical consultation (for minor illness or injury, behavioral health, and dermatology)</i>	Teladoc 1-855-Teladoc (1-855-835-2362) www.teladoc.com/aetna
<i>Health Savings Account</i>	Bank of America P.O. Box 2203 Fargo, ND 58108 1-877-319-8115 www.bankofamerica.com/benefitslogin
<i>MetLife Supplemental Healthcare Benefits</i>	1-855-638-3944 www.metlife.com/mybenefits

CONTACTS

Service/Resource	Contact Details
<i>Medical (International)</i>	Aetna International P.O. Box 981543 El Paso, TX 79998-1543 1-800-231-7729 1-813-775-0190 www.aetnainternational.com
<i>Dental</i>	MetLife Dental P.O. Box 981282 El Paso, TX 79998-1282 1-855-638-3944 www.metlife.com/mybenefits
<i>Vision</i>	VBA 400 Lydia Street, Suite 300 Carnegie, PA 15106 1-800-432-4966 www.vbaplans.com
<i>Limited Purpose and Traditional Health Care FSAs and Dependent Care FSA</i>	Bank of America P.O. Box 2203 Fargo, ND 58108 1-877-319-8115 www.bankofamerica.com/benefitslogin
<i>COBRA Coverage</i>	DuPont Connection 1000 S. Perimeter Road P.O. Box 7101 Rantoul, IL 61866-7101 http://digital.alight.com/dupont 1-833-253-7719
<i>Life and Accidental Death Insurance</i>	Securian Financial 400 Robert Street North St. Paul, MN 55101-2098 1-866-293-6047 www.lifebenefits.com
<i>Legal Plan</i>	MetLife Legal Plans 1111 Superior Avenue, Suite 800 Cleveland, OH 44114 1-855-638-3944 member.legalplans.com

Contacts for Appeals

Type of Appeal	Contact Details
<i>Eligibility and Enrollment</i>	DuPont Connection: Benefit Determination Review Team P.O. Box 299107 Lewisville, TX 75029-9107
<i>Dependent Verification</i>	DuPont Connection: Dependent Verification Center P.O. Box 1415 Lincolnshire, IL 60069-1415
<i>Medical</i>	Aetna: Aetna Customer Resolution Team P.O. Box 14463 Lexington, KY 40512
<i>Rx – Non-Specialty</i>	<i>CVS Caremark</i> Appeals Department, MC109 P.O. Box 52084 Phoenix, AZ 85072-2084 Fax: 1-866-443-1172 Clinical Exceptions / Medical Necessity Requests Fax: 1-888-487-9257 Urgent Verbal Exception Phone: 1-877-203-1681 External Review Appeals Department MC109 P.O. Box 52084 Phoenix, AZ 85072-2084 Fax: 1-866-443-1172
<i>Rx – Specialty</i>	<i>CVS Speciality (through the PrudentRx program)</i> Prescriber Line: 1-800-578-4403
<i>Dental</i>	<i>MetLife Group Claims Review</i> P.O. Box 14589 Lexington, KY 40512
<i>Vision</i>	<i>VBA</i> Attn: Claims and Appeals 400 Lydia Street, Suite 300 Carnegie, PA 15106
<i>Limited Purpose and Traditional Health Care and/or Dependent Care Flexible Spending Accounts</i>	<i>Bank of America</i> 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
<i>Life and Accident Insurance Appeals</i>	<i>Securian Financial</i> Claims P.O. Box 64114 St Paul, MN 55164-0114

CONTACTS

Type of Appeal	Contact Details
<i>Legal Plan</i>	<i>MetLife Legal Plans, Inc.</i> Director of Administration 1111 Superior Avenue, Suite 800 Cleveland, OH 44114-2507

Premium Assistance Under Medicaid and the Children's Health Insurance Program (CHIP)

If you or your children are eligible for Medicaid or CHIP and you're eligible for health coverage from your employer, your state may have a premium assistance program that can help pay for coverage, using funds from their Medicaid or CHIP programs. If you or your children aren't eligible for Medicaid or CHIP, you won't be eligible for these premium assistance programs, but you may be able to buy individual insurance coverage through the Health Insurance Marketplace. For more information, visit www.healthcare.gov.

If you or your dependents are already enrolled in Medicaid or CHIP and you live in a state listed below, contact your state Medicaid or CHIP office to find out if premium assistance is available.

If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, contact your state Medicaid or CHIP office or dial 1-877-KIDS NOW or www.insurekidsnow.gov to find out how to apply. If you qualify, ask your state if it has a program that might help you pay the premiums for an employer-sponsored plan.

If you or your dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under your employer plan, your employer must allow you to enroll in your employer plan if you aren't already enrolled. This is called a "special enrollment" opportunity, and **you must request coverage within 60 days of being determined eligible for premium assistance**. If you have questions about enrolling in your employer plan, contact the Department of Labor at www.askebsa.dol.gov or call 1-866-444-EBSA (3272).

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of January 31, 2026. Contact your state for more information on eligibility.

ALABAMA – Medicaid

Website: <http://myalhipp.com/>
Phone: 1-855-692-5447

ALASKA – Medicaid

The AK Health Insurance Premium Payment Program
Website: <http://myakhipp.com/>
Phone: 1-866-251-4861
Email: CustomerService@MyAKHIPP.com
Medicaid Eligibility:
<https://health.alaska.gov/dpa/Pages/default.aspx>

ARKANSAS – Medicaid

Website: <http://myarhipp.com/>
Phone: 1-855-MyARHIPP (855-692-7447)

CALIFORNIA – Medicaid

Health Insurance Premium Payment (HIPP) Program
Website: <http://dhcs.ca.gov/hipp>
Phone: 916-445-8322
Fax: 916-440-5676
Email: hipp@dhcs.ca.gov

COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)

Health First Colorado Website:
<https://www.healthfirstcolorado.com/>
Health First Colorado Member Contact Center:
1-800-221-3943/ State Relay 711
CHP+: <https://hcpf.colorado.gov/child-health-plan-plus>
CHP+ Customer Service: 1-800-359-1991/ State Relay 711
Health Insurance Buy-In Program (HIBI):
<https://www.mycohibi.com/>
HIBI Customer Service: 1-855-692-6442

PREMIUM ASSISTANCE UNDER MEDICAID AND THE CHILDREN'S HEALTH INSURANCE PROGRAM (CHIP)

FLORIDA – Medicaid

Website:
<https://www.flmedicaidprecovery.com/flmedicaidprecovery.com/hipp/index.html>
Phone: 1-877-357-3268

GEORGIA – Medicaid

GA HIPP Website: <https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp>
Phone: 678-564-1162, Press 1
GA CHIPRA Website:
<https://medicaid.georgia.gov/programs/third-party-liability/childrens-health-insurance-program-reauthorization-act-2009-chipra>
Phone: 678 564-1162, Press 2

INDIANA – Medicaid

Health Insurance Premium Payment Program
All other Medicaid
Website: <https://www.in.gov/medicaid/>
<http://www.in.gov/fssa/dfr/>
Family and Social Services Administration
Phone: 1-800-403-0864
Member Services Phone: 1-800-457-4584

IOWA – Medicaid and CHIP (Hawki)

Medicaid Website:
<https://hhs.iowa.gov/programs/welcome-iowa-medicaid>
Medicaid Phone: 1-800-338-8366
Hawki Website: <https://hhs.iowa.gov/programs/welcome-iowa-medicaid/iowa-health-link/hawki>
Hawki Phone: 1-800-257-8563
HIPP Website: <https://hhs.iowa.gov/programs/welcome-iowa-medicaid/fee-service/hipp>
HIPP Phone: 1-888-346-9562

KANSAS – Medicaid

Website: <https://www.kancare.ks.gov/>
Phone: 1-800-792-4884
HIPP Phone: 1-800-967-4660

KENTUCKY – Medicaid

Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP) Website:
<https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx>
Phone: 1-855-459-6328
Email: KIHIPP.PROGRAM@ky.gov
KCHIP Website: <https://kynect.ky.gov>
Phone: 1-877-524-4718
Kentucky Medicaid Website:
<https://chfs.ky.gov/agencies/dms>

LOUISIANA – Medicaid

<https://www.ldh.la.gov/healthy-louisiana>
Medicaid Customer Service Line: 1-888-342-6207
Louisiana Medicaid email: healthy@la.gov
Louisiana Health Insurance Premium Program (LaHIPP)
Website: <https://www.ldh.la.gov/lahipp>
LaHIPP phone: 1-877-697-6703
LaHIPP email: La.HIPP@la.gov
LaHIPP fax: 1-888-716-9787
LaHIPP mailing address: 100 Crescent Centre Parkway, Suite 1000 Tucker, GA 30084)

MAINE – Medicaid

Enrollment Website:
https://www.mymaineconnection.gov/benefits/s/?language=en_US
Phone: 1-800-442-6003
TTY: Maine relay 711
Private Health Insurance Premium Webpage:
<https://www.maine.gov/dhhs/ofi/applications-forms>
Phone: 1-800-977-6740
TTY: Maine relay 711

MASSACHUSETTS – Medicaid and CHIP

Website: <https://www.mass.gov/masshealth/pa>
Phone: 1-800-862-4840
TTY: 711
Email: masspremassistance@accenture.com

MINNESOTA – Medicaid

Website: <https://mn.gov/dhs/health-care-coverage/>
Phone: 1-800-657-3739

MISSOURI – Medicaid

Website: <http://www.dss.mo.gov/mhd/participants/pages/hipp.htm>
Phone: 573-751-2005

PREMIUM ASSISTANCE UNDER MEDICAID AND THE CHILDREN'S HEALTH INSURANCE PROGRAM (CHIP)

MONTANA – Medicaid

Website: <http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP>
Phone: 1-800-694-3084
Email: HSHIPPProgram@mt.gov

NEBRASKA – Medicaid

Website: <http://www.ACCESSNebraska.ne.gov>
Phone: 1-855-632-7633
Lincoln: 402-473-7000
Omaha: 402-595-1178

NEVADA – Medicaid

Medicaid Website: <http://dhcnp.nv.gov>
Medicaid Phone: 1-800-992-0900

NEW HAMPSHIRE – Medicaid

Website: <https://www.dhhs.nh.gov/programs-services/medicaid/health-insurance-premium-program>
Phone: 603-271-5218
Toll free number for the HIPP program:
1-800-852-3345, ext 5218
Email: DHHS.ThirdPartyLiabi@dhhs.nh.gov

NEW JERSEY – Medicaid and CHIP

Medicaid Website:
<http://www.state.nj.us/humanservices/dmahs/clients/medicaid/>
Phone: 1-800-356-1561
CHIP Premium Assistance Phone: 609-631-2392
CHIP Website: <http://www.njfamilycare.org/index.html>
CHIP Phone: 1-800-701-0710 (TTY:711)

NEW YORK – Medicaid

Website:
https://www.health.ny.gov/health_care/medicaid/
Phone: 1-800-541-2831

NORTH CAROLINA – Medicaid

Website: <https://medicaid.ncdhhs.gov/>
Phone: 919-855-4100

NORTH DAKOTA – Medicaid

Website: <https://www.hhs.nd.gov/healthcare/>
Phone: 1-844-854-4825 or (866) 614-6005

OKLAHOMA – Medicaid and CHIP

Website: <http://www.insureoklahoma.org>
Phone: 1-888-365-3742

OREGON – Medicaid and CHIP

Website: <http://healthcare.oregon.gov/Pages/index.aspx>
Phone: 1-800-699-9075

PENNSYLVANIA – Medicaid and CHIP

Website: <https://www.pa.gov/en/services/dhs/apply-for-medicaid-health-insurance-premium-payment-program-hipp.html>
Phone: 1-800-692-7462
CHIP Website:
<https://www.dhs.pa.gov/CHIP/Pages/CHIP.aspx>
CHIP Phone: 1-800-986-KIDS (5437)

RHODE ISLAND – Medicaid and CHIP

Website: <http://www.eohhs.ri.gov/>
Phone: 1-855-697-4347, or
401-462-0311 (Direct Rite Share Line)

SOUTH CAROLINA – Medicaid

Website: <https://www.scdhhs.gov>
Phone: 1-888-549-0820

SOUTH DAKOTA – Medicaid

Website: <http://dss.sd.gov>
Phone: 1-888-828-0059

TEXAS – Medicaid

Website:
<https://www.hhs.texas.gov/services/financial/health-insurance-premium-payment-hipp-program>
Phone: 1-800-440-0493

UTAH – Medicaid and CHIP

Utah's Premium Partnership for Health Insurance (UPP)
Website: <https://medicaid.utah.gov/upp/>
Email: upp@utah.gov
Phone: 1-888-222-2542
Adult Expansion Website:
<https://medicaid.utah.gov/expansion/>
Utah Medicaid Buyout Program Website:
<https://medicaid.utah.gov/buyout-program/>
CHIP Website: <https://chip.utah.gov/>

VERMONT – Medicaid

Website:
<https://dvha.vermont.gov/members/medicaid/hipp-program>
Phone: 1-800-250-8427

PREMIUM ASSISTANCE UNDER MEDICAID AND THE CHILDREN'S HEALTH INSURANCE PROGRAM (CHIP)

VIRGINIA – Medicaid and CHIP

Website:
<https://coverva.dmas.virginia.gov/learn/premium-assistance/famis-select>
<https://coverva.dmas.virginia.gov/learn/premium-assistance/health-insurance-premium-payment-hipp-programs>
Medicaid/CHIP Phone: 1-800-432-5924 or 1-855-242-8282

WASHINGTON – Medicaid

Website: <https://www.hca.wa.gov/>
Phone: 1-800-562-3022

WEST VIRGINIA – Medicaid and CHIP

Website: <https://bms.wv.gov/>
<https://dhhr.wv.gov/bms/>
<http://mywvhipp.com/>
Medicaid Phone: 304-558-1700
CHIP Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)

WISCONSIN – Medicaid and CHIP

Website: <https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm>
Phone: 1-800-362-3002

WYOMING – Medicaid

Website: <https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/>
Phone: 1-800-251-1269

To see if any other states have added a premium assistance program since January 31, 2026, or for more information on special enrollment rights, contact either:

U.S. Department of Labor
Employee Benefits Security Administration
www.dol.gov/agencies/ebsa
1-866-444-EBSA (3272)

U.S. Department of Health and Human Services
Centers for Medicare & Medicaid Services
www.cms.hhs.gov
1-877-267-2323, Menu Option 4, Ext. 61565

Paperwork Reduction Act Statement

According to the Paperwork Reduction Act of 1995 (Pub. L. 104-13) (PRA), no persons are required to respond to a collection of information unless such collection displays a valid Office of Management and Budget (OMB) control number. The Department notes that a Federal agency cannot conduct or sponsor a collection of information unless it is approved by OMB under the PRA, and displays a currently valid OMB control number, and the public is not required to respond to a collection of information unless it displays a currently valid OMB control number. See 44 U.S.C. 3507. Also, notwithstanding any other provisions of law, no person shall be subject to penalty for failing to comply with a collection of information if the collection of information does not display a currently valid OMB control number. See 44 U.S.C. 3512.

The public reporting burden for this collection of information is estimated to average approximately seven minutes per respondent. Interested parties are encouraged to send comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the U.S. Department of Labor, Employee Benefits Security Administration, Office of Policy and Research, Attention: PRA Clearance Officer, 200 Constitution Avenue, N.W., Room N-5718, Washington, DC 20210 or email ebsa.opr@dol.gov and reference the OMB Control Number 1210-0137.

OMB Control Number 1210-0137 (expires 1/31/2026)

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