

Your Benefit
Summary



DuPont Long-Term Care Insurance Plan



Effective January 1, 2026

About this Summary

This Summary Plan Description (SPD) provides a concise description of the DuPont Long-Term Care Insurance Plan (the "Plan"). This summary is intended to help you understand your benefits, how the Plan operates, how to file claims, and your rights and responsibilities as a participant.

This summary does not describe every feature in the Plan 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 documents, the applicable official plan documents and the Certificate of insurance will govern and the Plan Administrator has the full discretion to interpret those documents.

While the Company intends to continue the Plan described in this summary, the Company reserves the right to change, modify, or discontinue the Plan at its discretion at any time.

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

YOUR BENEFIT SUMMARY

DuPont Long-Term Care Insurance Plan

JANUARY 2026

Although most people associate Long-Term Care with their later years, it’s important to know that the need for Long-Term care can happen at any time and at any age due to an unexpected illness or accident.

The DuPont Long-Term Care Insurance Plan (the “Plan”) is designed to provide asset protection in the event you or a covered family member can no longer perform simple everyday activities you take for granted, such as getting out of bed, eating, or bathing.

The Plan was closed to new entrants after December 31, 2012. For individuals who purchased coverage, the Plan offers:

- Coverage at Group Rates—This insured-pay-all plan is available at group rates.
- Flexibility—You can select the level of daily coverage you receive and the duration of the plan benefit, as well as choosing between Comprehensive or Facilities-Only coverage.
- Freedom of Choice—When you’re eligible for benefits, you make the decisions about where to receive care and which providers to use.



This insurance is provided by MetLife. You can reach MetLife by calling 1-888-526-8495.

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Eligibility

Eligible Employees

You are eligible for Plan coverage if you were a participating Company employee, former employee or an eligible family member and purchased coverage on or before December 31, 2012.

Benefits under this Plan were not available to any employee, or eligible family members of such employee, in a bargaining unit represented by a union for collective bargaining unless the site manager authorized the benefit, collective bargaining on the subject took place, and any requisite obligations thereunder were fulfilled.

Eligible Family Members

Eligible family members could enroll in the Plan even if the employee or former employee did not enroll. Eligible family members included:

- your lawful spouse;
- your registered same-sex domestic partner;
- your parents, stepparents and parents-in-law; and
- your grandparents and grandparents-in-law.

Enrollment Information

Enrolling in the Plan

Effective January 1, 2013, individuals may no longer enroll in this Plan.

Evidence of Insurability

Changes to coverage are subject to the approval of MetLife and may require the submission of evidence of insurability.

When Participation Begins

For Employees who enrolled within 60 days from the date of their original eligibility, Long-Term Care coverage became effective the first of the month following enrollment if you were actively at work on your scheduled effective date. If you were not at work on your scheduled effective date, coverage became effective the date that you return to work.

For all other eligible individuals, Long-Term Care coverage became effective the first of the month following the date MetLife accepted your request for enrollment.

Change	Statement of Health	When Effective
<i>Increase Daily Benefit (e.g., \$100 to \$150)</i>	Required	The first day of the month on or after the date MetLife approves the request
<i>Increase Total Lifetime Benefit (e.g., 3-year to 5-year)</i>	Required	Same as above
<i>Increase Coverage Level (e.g., Facilities-Only to Comprehensive)</i>	Required	Same as above
<i>Decrease Daily Benefit (e.g., \$150 to \$100)</i>	Not required	Same as above

PREMIUMS

Change	Statement of Health	When Effective
<i>Decrease Total Lifetime Benefit (e.g., 5-year to 3-year)</i>	Not required	Same as above
<i>Decrease Coverage Level (e.g., Comprehensive to Facilities-Only)</i>	Not required	Same as above

Any change in the cost of coverage will become effective on the first day of the month on or after the date MetLife approves the request. If the daily benefit is increased, the cost for the incremental increase will be based on the participant's age on the date the change is effective. For all other coverage increases, the new coverage will be based on the participant's age on the date the change is effective.

If coverage is decreased, the new cost is based on the age used to determine the participant's previous coverage.

When a participant increases the daily benefit, the total amount of coverage also increases.

Premiums

Long-Term Care premiums are based on your coverage selections and your age as of your effective date of coverage. The younger you were when you enrolled, the lower your premium.

If you enrolled during the 2001 Initial Enrollment Period when the Plan was first effective, your premium was based on your age as of the later of April 1, 2001 or the date your coverage became effective. If you became eligible after the 2001 Initial Enrollment Period (such as a new hire) and enrolled within 60 days from the date of your original eligibility, your premium was based on your age as of the date your coverage became effective.

Costs are also based on the Plan option, daily benefit amount, and lifetime benefit selected. Please contact MetLife at 1-866-526-8495 for further information regarding your premium. It is important that you be aware that, as explained in the Guaranteed Renewability statement in your certificate, and subject to any applicable regulatory approval, MetLife reserves the right to increase rates in the future.

Premium Payment

Employees and their spouses/partners, former employees, and other eligible family members will be billed directly by MetLife. Available payment options include:

- monthly checking account deduction;
- quarterly direct bill;
- semi-annual direct bill; and
- annual direct bill.

Premium Waiver

Once you have been authorized for benefits and have fulfilled the 90-day waiting period (see "Qualifying for Benefits" on page 8), MetLife will waive your premium as of the first of the following month. Premium payments will resume on the first day of the month after you are no longer eligible for Long-Term Care benefits and have not exhausted your total lifetime benefit.

Reinstatement

If coverage is canceled for non-payment of premium, you may request reinstatement within 12 months of the cancellation date. You must provide MetLife with evidence of insurability and, if accepted by MetLife, pay all past-due premiums.

If non-payment of premium was the result of a cognitive impairment or loss of functional capacity, you may request reinstatement within five months of the cancellation date without having to provide evidence of insurability. You must provide MetLife with proof of the cognitive impairment or loss of functional capacity and pay all past due premiums.

Coverage Options

When enrolling, participants selected either Facilities-Only Coverage or Comprehensive Coverage.

The Facilities-Only Coverage Option provides coverage for care in a nursing home, an assisted living facility, and an inpatient hospice facility. This Option also includes an Initial Care Advisory Visit and Transition Expense Benefit. This Option is not available to residents of Vermont.

The Comprehensive Coverage Option provides coverage for care in a nursing home, an assisted living facility, an in-patient hospice care facility, and for home care, adult day care, respite care, and at-home hospice care.

Comprehensive Coverage also includes an Initial Care Advisory Visit, Ongoing Care Advisory Services, Transition Expense Benefit, and Alternate Plan of Service.

Daily Benefit Levels

The Daily Benefit is the maximum amount of daily coverage available for nursing home, in-patient hospice care, assisted living facility, and respite services received in the United States. See "International Coverage" on page 7 for information on international coverage. The Daily Benefit options are:

- \$100;
- \$150; and
- \$200.

Under Comprehensive Coverage, Home Care, Ongoing Care Advisory Services, at-home hospice care and adult day care are covered at 50% of the daily benefit level.

Total Lifetime Benefit Options

The Total Lifetime Benefit is the maximum amount of benefits the Plan will pay. The options are:

- 3-year duration (1,095 times the Daily Benefit selected); and
- 5-year duration (1,825 times the Daily Benefit selected).

Benefits can last longer than the duration selected based on the cost of your care, how frequently services are needed, and what types of services are used. For example, if you have selected the \$150 Daily Benefit and you enter a nursing home that only costs \$125 per day, the difference of \$25 remains in your total lifetime maximum and extends the duration of the Plan. Or, if you receive care in your home and are reimbursed at 50% of the daily benefit, the other 50% of the daily benefit remains in your total lifetime maximum.

Covered Services

The Plan covers a wide range of services to give you more choices. You can choose the care that is best for you.

The following services are available under both Comprehensive and Facilities-Only Coverages:

- Initial care advisory visit
Once you are eligible for benefits, a professional care advisor can visit your home and help you assess your Long-Term Care needs and preferences, as well as explore resources and providers in your community. The Initial Care Advisory Visit does not reduce your Total Lifetime Benefit.
- Nursing home services
Coverage includes all levels of care, skilled to custodial, received in a licensed nursing home or Alzheimer's facility.
- Assisted living facility
Coverage includes licensed facilities providing 24-hour care and other services required by individuals who are unable to perform the Activities of Daily Living or who demonstrate Severe Cognitive Impairment.
- In-patient hospice care
Coverage includes health care and support services provided in a licensed hospice facility for those who are terminally ill.
- Transition expense benefit
This is a benefit equal to five (5) times the daily benefit. It can be useful for items such as durable medical equipment or an emergency response system. It is payable after completion of the waiting period and it does not reduce the Total Lifetime Benefit. The Transition Expense Benefit is not available if you are in non-forfeiture status.

The following services are only available under Comprehensive Coverage:

- Home care
Coverage includes care received at home from a nurse, home health aide, homemaker and/or a physical, occupational, respiratory, or speech therapist from a licensed home care agency. Care can also be received from a nurse (R.N., L.P.N., or L.V.N.) or therapist who is not from a licensed agency.
- At-home hospice care
Coverage includes health care and support services provided at home for those who are terminally ill.
- Adult day care
Coverage includes any licensed facility offering care, health support, and rehabilitative services for adults during the day.
- Respite services
Provides relief for the primary caregiver. Coverage includes care from licensed providers for 14 days per calendar year.
- Ongoing care advisory services
Coverage includes coordination of care and monitoring of the care you are receiving and assistance with altering your care plan as your needs change.
- Alternate plan of service
A MetLife care manager can authorize benefits for services that are not specifically defined as covered under the Plan. The service must meet the needs of the insured and may be a cost-effective alternative to services otherwise covered under the Plan.

Plan Exclusions

This Plan does not provide benefits for the following:

- Care specifically provided for detoxification of or rehabilitation for alcohol or drug abuse (chemical dependency), except drug abuse sustained at the hands of or while being treated by a Physician for an injury or sickness.
- Illness, treatment or medical condition arising out of:
 - war or act of war (whether declared or undeclared);
 - participation in a felony, riot or insurrection;
 - service in the armed forces or auxiliary units; or
 - attempted suicide (while sane or insane) or intentionally self-inflicted injury.
- Any care provided while in a hospital, except for confinement in a distinct part of a hospital, which is licensed as a nursing home or hospice.
- Any service provided by your immediate family.
- Any service or supply to the extent that such expenses are reimbursable under Medicare, or would be so reimbursable but for the application of a deductible or coinsurance or co-payment amount. This exclusion will not apply in those instances where Medicare is determined to be secondary payer under applicable law.
- Services for which no charge is normally made in the absence of Insurance.

Additional Plan Features

The Plan includes these special features, regardless of the Plan options you choose:

Inflation Protection

At least once every three years, participants will be given the option to increase coverage without providing proof of good health. The amount of the increase to the daily benefit will be 5% compounded annually. Any increase in your daily benefit will also increase your total lifetime maximum. The cost for the increased coverage amount will be based on the participant's age on the effective date of the change in coverage.

Return of Premium on Death

If a participant dies prior to age 65, all premiums paid, minus any benefits received, will be returned to the participant's estate. The amount of the refund will reduce by 10% per year from age 65 up to 75. At age 75, the Return of Premium on Death feature expires and no premiums will be returned. This feature is not available to residents of the state of Washington.

Nonforfeiture

This feature allows you to stop paying premiums and still keep a portion of your coverage. Participants who have paid premiums for at least 3 years and elect to stop making payments will be entitled to receive a reduced level of coverage. The feature provides your full Daily Benefit with a total lifetime benefit based on the amount of premium paid. The total lifetime benefit will be at least 30 times the daily benefit.

ADDITIONAL PLAN FEATURES

Restoration of Benefits

If you have not been eligible to receive benefits from the Plan for the prior two years, the Restoration of Benefits feature will restore your total lifetime benefit if all of the following conditions are met:

- the total lifetime benefit has not been exhausted;
- premium payments have been made for a continuous period of two years from the date you were no longer chronically ill; and
- satisfactory proof has been provided to a licensed health care practitioner (employed or retained by MetLife), stating that you have not been chronically ill at any time during a specified time period.

International Coverage

If you are eligible for benefits and are outside of the United States, the Plan will pay a per-diem benefit upon completion of the waiting period. For Comprehensive coverage, the per-diem benefit will be equal to 50% of the home care daily benefit. For Facilities-Only coverage, the per-diem benefit will be equal to 25% of the nursing home daily benefit amount. The per-diem benefit will be paid in U.S. dollars. MetLife will pay for benefits up to a maximum of 10 years while outside the U.S.

Bed Reservation Benefit

If a participant requires hospitalization, the Plan will continue to pay the daily benefit for up to 21 days per calendar year to hold the bed in the nursing home, hospice facility, or assisted living facility, if required.

Portability

Participating employees can continue coverage even when they retire or leave employment with the Company.

Guaranteed Renewable

As long as participants continue to pay premiums, MetLife cannot cancel their coverage.

Provider Discounts

Discounts with nursing homes, home health care agencies, and medical equipment providers are available throughout the country. All Plan participants are entitled to these discounts, which can allow your lifetime maximum benefit to last longer.

Qualifying for Benefits

To qualify for Long-Term Care benefits, MetLife must authorize benefits, and a waiting period must be satisfied about your participation.

Benefit Eligibility

Participants will be considered eligible for benefits when a licensed health care practitioner certifies them as being chronically ill. Chronically ill means:

- being unable to perform, without substantial assistance from another individual, at least two out of six of the following Activities of Daily Living for at least 90 days due to a loss of functional capacity:
 - bathing
 - eating
 - continence
 - toileting
 - dressing
 - transferring

OR

- requiring substantial supervision to protect you from threats to health and safety due to a severe cognitive impairment.

Benefits will be paid for services included in a Plan of Care prescribed by a licensed health care practitioner.

Participants with disabilities resulting from organic brain diseases including Alzheimer's disease or similar disorders are eligible for benefits. The Plan also pays benefits in cases where a participant's dependency results from mental or nervous disorders.

The participant, the participant's doctor, or representative must contact MetLife and request a determination of benefit eligibility based on the inability of the participant to perform these activities on their own. MetLife must approve the request for benefit eligibility, and in so doing, may also require access to the participant's medical records.

Waiting Period

The waiting period is 90 calendar days. Covered services do not need to be received during the waiting period. No benefits can be paid until this waiting period is satisfied.

Denial of Eligibility for Benefits

If a participant is not certified as chronically ill, (s)he will not be eligible for benefits. MetLife will send written notice of its decision no later than 10 working days after the company has received all necessary information.

Written requests should be sent to MetLife if a participant requires further explanation of the denial. Participants may appeal MetLife's denial of eligibility for benefits.

Concurrent Review

When a participant is receiving covered services, MetLife will review the case from time to time to see that the standards for benefit eligibility are still being met. MetLife may review records and/or contact the participant, the participant's doctor, or someone else familiar with the participant's condition. If it is determined that the participant is no longer eligible for benefits, (s)he will be notified by MetLife.

Claims Process

MetLife will notify participant of benefit eligibility and will provide forms to be used to submit claims for benefits.

How to Submit a Claim

MetLife will pay benefits only upon receipt of adequate written proof that expenses for covered services were incurred.

Written proof of claim must be submitted no later than 90 days after the end of the calendar year in which the expenses were incurred. Failure to submit proof of claim within the time limit may result in a claim denial unless it is shown that it was not reasonably possible to provide the proof of claim within the time period or that the proof of claim was submitted as soon as reasonably possible.

Approval of Claims

If MetLife approves a claim for benefits, they will send written notice of the decision no later than 10 working days after all necessary information is received.

How Benefits Are Paid

After MetLife has approved the claim, reimbursement for covered services will be paid directly to the participant. Payments for most services can be made directly to the provider at the request of the participant and the provider. Payments for Alternate Plan of Service and/or Transition Benefits cannot be made to anyone other than the participant.

Amount of the Benefit

The Daily Benefit selected by the insured determines the maximum amount that can be received each day. The amount payable will not exceed the total amount of expenses incurred for all services received in a day and will never be more than the Daily Benefit Amount selected.

Denial of Claims

If MetLife denies a claim for benefits, in whole or in part, it will send written notice of its decision no later than 10 working days after all necessary information is received. MetLife will provide a written explanation of the reasons for the denial and make available all information directly relating to such denial. Participants may appeal MetLife's denial of a claim.

See "Using ERISA's Claims Procedures" on page 12 for additional information on the procedures for benefit claim decisions.

Appeal of Claims

MetLife will reconsider its decision to deny a participant's eligibility for benefits or his or her claim for benefits. The participant must make a written request to MetLife for a review of the decision and this request must be sent within 60 days (180 days for disability claims) after the participant receives the denial.

Within 60 days (45 days for disability claims) of receiving the appeal, MetLife will provide a written response. However, if the review cannot be completed within the time frame, the participant will be notified in writing. That notification will outline the reasons behind the delay, the date by which MetLife expects to render the appeal determination, and the information needed to decide the participant's appeal. Extensions will not exceed another 60 days (45 days for disability claims). MetLife's final decision will be in writing, and if a denial, will include the specific reasons for the denial.

See "Using ERISA's Claims Procedures" on page 12 for additional information on the procedures for benefit claim decisions.

When Coverage Ends

Terminating Coverage

Participants can cancel their Long-Term Care coverage at any time. This cancellation will be effective at the end of the month in which cancellation is requested.

The following chart shows the circumstances under which Long-Term Care coverage will end and when the termination is effective:

Circumstance Causing Coverage to End	Coverage Ends:
<i>Participant requests cancellation of coverage</i>	At the end of the month in which you notify MetLife that you wish to terminate your coverage
<i>This coverage is replaced by another substantially similar plan, and the insured participant becomes eligible for that coverage</i>	On that date
<i>A participant does not pay the costs for coverage</i>	On the day following the last day of the coverage period for which MetLife received payment
<i>Death of a participant</i>	Date of death
<i>Participant reaches Maximum Lifetime Benefit</i>	Date that maximum benefit amount is paid out

Continuation of Coverage

If the Plan ends, participants will be able to continue their coverage directly with MetLife if:

- the Plan is not being replaced with a substantially similar plan;
- the Plan is being replaced with a substantially similar plan, but the participant is not eligible under the new plan, or
- the participant is no longer an eligible employee, eligible former employee, or eligible family member under the Plan.

To continue coverage, participants must pay the required premiums directly to MetLife.

Administrative Information

Plan Name and Identification Numbers

The complete name of the program is the DuPont Long-Term Care Insurance Plan. In any formal correspondence about the DuPont Long-Term Care Insurance Plan, refer to the Employer Identification Number assigned by the Internal Revenue Service to DuPont de Nemours, Inc. DuPont's number is EIN 81-1224539. The official Plan number is 502.

Type of Plan and Plan Year

The DuPont Long-Term Care Insurance Plan is a welfare plan subject to the Employee Retirement Income Security Act of 1974 (ERISA). Records for the Plan are maintained on a calendar-year basis.

Plan Administration and Funding

Legal process may be served on:

Benefit Plans Administrative Committee
974 Centre Road
Wilmington, DE 19808

1-833-253-7719 as Plan Administrator.

The Plan is paid for by participant contributions.

Insurance Company and Plan Underwriter

The insurance coverage under this Plan is provided by:

Metropolitan Life Insurance Company ("MetLife")
P.O. Box 990028
Hartford, CT 06199-0028

1-888-526-8495

Plan Documents

This Summary Plan Description is intended to provide you with a reasonably thorough explanation of the DuPont Long-Term Insurance Care Plan. Wherever possible, non-technical language has been used to explain Plan provisions. The official Plan language and the Certificate of Insurance are the governing documents in the event that questions arise.

ERISA Rights

As a participant in the DuPont Long-Term Care Insurance Plan, 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 Plan. These documents may include insurance contracts, collective bargaining agreements if applicable, and the latest annual report (Form 5500) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.
- Obtain, after sending a written request to the Plan Administrator, copies of documents governing the operation of the Plan, including insurance contracts and collective bargaining agreements if applicable, and copies of the latest annual report (Form 5500 Series) and updated Summary Plan Description. You may be asked to pay a 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 your Plan, called "fiduciaries," have a duty to do so prudently and in the best interest of you and other Plan participants and beneficiaries. No one, including your employer, your union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a benefit or exercising your rights under ERISA.

If your claim for a benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

Under ERISA, there are several steps you can take to enforce your rights. For instance, if you request a copy of plan documents or the latest annual report from the Plan and do not receive it within 30 days, you can file suit in a 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.

ADMINISTRATIVE INFORMATION

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. 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 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 may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

Using ERISA's Claims Procedures

ERISA requires that the plans it covers include certain procedures for filing claims and for reviewing claims that are denied. The intent is to make sure that all benefit claims are considered fully, clearly and promptly.

Although DuPont's procedures have been providing full and fair consideration of benefit claims for many years, ERISA requires certain formal approaches.

Keep in mind that nothing required by ERISA changes the way DuPont benefits are normally administered. ERISA's claims procedures are available if you feel you aren't getting the benefits to which you are entitled through normal channels.

You should file your claim in writing with:

MetLife LTC Claims
P.O. Box 14407
Lexington, KY 40512-4633

If your claim does not include the right information, you will be notified, in writing, what you need to do to get your claim processed.

If Your Claim Is Denied

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

- the specific reasons for denial;
- references to the provisions of the benefit plan or practice involved;
- a description of what additional information is necessary and why;
- for disability claims, a discussion of the decision, including an explanation of the basis for disagreeing with or not following:
 - the views you present to the Plan of health care professionals treating you and vocational professionals who evaluated you;
 - the views of medical or vocational experts whose advice was obtained on behalf of the Plan in connection with the denial, without regard to whether the advice was relied upon in making the determination; and
 - a disability determination regarding you made by the Social Security Administration that you presented to the Plan;
- for disability claims, either the specific internal rules, guidelines, protocols, standards or other similar criteria of the Plan relied upon in making the denial or, alternatively, a statement that such rules, guidelines, protocols, standards or other similar criteria of the Plan do not exist;

ADMINISTRATIVE INFORMATION

- for disability claims, 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 your medical circumstances, or a statement that such explanation will be provided free of charge upon request; and
- for disability claims, a statement that you are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to your claim for benefits.

Maximum timeframes for the Plan to notify you of a denied claim:

- 30 days for pre-service claims.
- 45 days for disability claims.
- 60 days for other claims.

If the reply cannot be made within the timeframe set forth above, you will be given a written notice of extension. Any notice of extension shall specifically explain the standards on which entitlement to a benefit is based, the unresolved issues that prevent a decision on the claim, and the additional information needed to resolve those issues.

APPEALING A DENIED CLAIM

You may appeal MetLife's denial of a claim, in whole or part, by submitting a written request to MetLife for a review of the decision within 180 days.

If the decision to deny or reduce the amount of the claim is not explained to your satisfaction or you have additional information that may change the decision, you should follow these steps to try to bring the claim denial to resolution:

- Step 1: Contact MetLife for a clearer explanation of the denial.
- Step 2: Provide additional written information to MetLife to reconsider your claim.

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

The request for appeal should include:

- specific reasons why you think the claim should be reconsidered and approved;
- any additional documentation that supports the approval of the claim;
- explanation of benefits statement for the denied claim; and
- a copy of the denial letter(s) received from the carrier.

You must make this request in a timely manner, within 180 days after you receive the original claim decision or after you receive a claim denial.

Your final appeal is to MetLife. Address your appeal in writing to:

MetLife LTC Claims
P.O. Box 14407
Lexington, KY 40512-4633

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MetLife will respond within 60 days (30 days for pre-service and 45 days for disability claims) of the date your request is submitted. However, if the review cannot be completed within 60 days (30 days for pre-service and 45 days for disability claims), you will be notified in writing. That notification will outline the reasons behind the delay, the date by which the Plan expects to render the appeal determination, and the information needed to decide your appeal. Extensions will not exceed another 60 days (45 days for disability claims). However, if the extension is needed due to your failure to submit necessary information, the time period for deciding your appeal will be tolled from the date you are sent the notice of extension until the date you respond to the request for additional information. If your appeal is denied, the notice of denial shall be provided in a culturally and linguistically appropriate manner to the extent required under applicable law and will include:

- specific reasons for the denial;
- references to the specific Plan provisions on which the denial is based;
- a statement that you are entitled to receive, upon request and free of charge, reasonable access to and copies of all documents, records, and other information relevant your claim;
- a statement describing any voluntary appeal procedures offered by the Plan and your right to obtain information about those procedures;
- a statement of your right to bring a civil action under ERISA 502(a);
- for a disability claim, a description of any applicable contractual limitations period that applies to your right to bring an action under Section 502(a) of ERISA, including the calendar date on which the contractual limitations period expires for the claim;
- for a disability claim, a discussion of the decision, including an explanation of the basis for disagreeing with or not following;
- for a disability claim, the views presented by you to the Plan of health care professionals treating you and vocational professionals who evaluated you;
- for a disability claim, the views of medical or vocational experts whose advice was obtained on behalf of the Plan in connection with the denial, without regard to whether the advice was relied upon in making the determination; and
- for a disability claim, a disability determination regarding you made by the Social Security Administration that you presented to the Plan;
- for a disability claim, if the denial 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 your medical circumstances, or a statement that such explanation will be provided free of charge upon request; and
- for a disability claim, either the specific internal rules, guidelines, protocols, standards or other similar criteria of the Plan relied upon in making the denial or, alternatively, a statement that such rules, guidelines, protocols, standards or other similar criteria of the Plan do not exist.

MetLife has full discretion and authority to interpret Plan provisions, resolve any ambiguities, and evaluate claims. The decision made by MetLife is final and binding.

The exhaustion of the claim and appeal procedure is mandatory for resolving any claim arising under this Plan. Applicable law requires you to pursue all claim and appeal rights on a timely basis before seeking any other legal recourse regarding claims for benefits. Failure to follow the claims and appeals procedures in a timely manner will cause you to lose your right to sue regarding your claim.

ADMINISTRATIVE INFORMATION

HOW THE PLAN WILL HANDLE YOUR APPEAL

In reviewing your appeal, all information that you submit, regardless of whether that information was considered at the time you submitted your initial claim, will be considered and a new review will be completed. The party reviewing your appeal will not have participated in the original claim determination and will not be a subordinate of the party who made the original claim determination by MetLife. In deciding an appeal of any adverse benefit determination that is based in whole or in part on a medical judgment, MetLife shall consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment.

Future of the Plan

While the Company intends to continue the benefits and policies described in this booklet, the Company reserves the right to suspend, modify, or terminate the Plan at its discretion at any time. Individual coverage is guaranteed renewable so long as an insured pays premiums and there are insureds remaining in the Group Plan.

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