To help you make the most of your retiree benefits, this guide describes the major features of your benefits and explains how you can use them effectively. You’ll also find information on tools and resources to help you make informed choices, as well as instructions on how to enroll through Corteva Connection.

For more information about your benefits, visit the Corteva Benefits website at www.cortevabenefits.com and click on Retirees/Former Employees in the upper right-hand corner.
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This benefits guide is intended for all non-Medicare-eligible retirees and dependents. If this applies to you as a retiree, or if you have non-Medicare-eligible dependents, you should review this guide for further information.
## Eligibility

### Who Is Eligible

<table>
<thead>
<tr>
<th>Dependents</th>
<th>Eligibility</th>
</tr>
</thead>
<tbody>
<tr>
<td>Spouse</td>
<td>Your dependent is eligible for coverage as a spouse if he or she is your legal spouse at the time of your retirement. <strong>You may not add a spouse to your plan if he or she became your spouse after retirement.</strong> If your spouse has previously declined or chooses to drop Corteva medical coverage, he or she may only re-enroll if he or she has lost eligibility for other group coverage. You will need to provide proof within 60 days of when your spouse loses eligibility.</td>
</tr>
<tr>
<td>Child</td>
<td>Your dependent qualifies as your child if he or she is your biological or adopted child, stepchild, foster child, or a child for whom you have court-appointed permanent legal guardianship, up through the end of the month in which your child turns age 26. You may continue to cover the child on your health care coverage beyond his or her 26th birthday provided the child is your federal tax dependent and has been certified as disabled by your medical carrier prior to reaching age 26.</td>
</tr>
</tbody>
</table>

**Note:** Special eligibility rules apply for survivor benefits. Please contact **Corteva Connection** at **1-800-775-5955** for further details.

### Dependent Verification

You should ensure that any covered dependents meet the eligibility requirements. Any dependents who do not meet the eligibility requirements should not be covered.

If you have not previously participated in a verification process, you may be asked to submit documentation of your covered dependent’s eligibility, such as a birth certificate. Additionally, you will be required to provide a Social Security number for your covered dependents.
Working Spouse Rule

The medical plan’s “working spouse” eligibility provision requires working spouses to purchase primary coverage through their own employer if (1) it is available, and (2) the premium cost for the lowest priced option (for individual coverage) is less than $100 per month. If the prior two conditions are met, you may still cover your “working spouse” under the Corteva Medical Plan; however, your spouse’s Corteva coverage will be secondary to the other employer’s coverage.

What You Need to Do

If you’re electing coverage for your spouse, you will be asked to confirm your spouse meets the medical plan’s eligibility requirements (as explained above). Throughout the year, working spouses who have access to other medical coverage must use Corteva as their secondary coverage for medical, prescription drug, and behavioral health care.

If your spouse’s employer (1) does not provide medical coverage, or (2) if the monthly premium for the lowest cost option available is $100 or more, the Corteva plan does not require you to purchase primary coverage (if offered) for your spouse. Your Corteva Medical Plan election can provide him or her with primary coverage. Please see below for more information.

As a reminder, the Corteva medical carriers have implemented additional processes to confirm if covered dependents (spouses and children) are covered by other insurance. Failure of your working spouse to obtain primary coverage (as described above) or your failure to respond to a medical carrier’s request for other coverage information could result in claims processing delays, benefit reductions, and, in some cases, claims denials.

Working Spouse Rule Eligibility: A Snapshot

Does your spouse work?  

YES  

NO

Does your spouse’s employer offer single medical coverage for less than $100 per month?  

YES  

NO

Has/will your spouse purchase(d) his or her employer’s medical plan?  

YES  

NO

Not eligible for Corteva retiree medical as primary coverage (claims may be reduced or denied)

Eligible for Corteva retiree medical as primary coverage

Your spouse must use his or her employer’s plan before submitting claims to Corteva.

Consider whether you really need your spouse covered both on his or her employer’s medical plan and the Corteva Retiree Medical Plan.

Are you paying premiums for coverage your spouse may not use?
Medical Plan Coverage

For 2020, you can choose to be covered by one of two medical plan options¹, both of which automatically come with prescription drug coverage. Your medical coverage is provided through Highmark Blue Cross Blue Shield. If you enroll in one of the medical plan coverage options, you may also be eligible to open or contribute to an existing Health Savings Account (HSA), either directly with Bank of America or another banking institution of your choice that offers HSAs.

Compare the Plans

The medical plan premiums, deductibles, and out-of-pocket maximums vary based upon the coverage level you choose. More information about your medical plan options will be provided on Corteva Connection.

<table>
<thead>
<tr>
<th>Preventive care (coverage follows the standard preventive care guidelines of the Patient Protection and Affordable Care Act; includes prescription drugs classified by the guidelines as preventive)</th>
<th>Retiree Core Option</th>
<th>Retiree Premium Saver Option</th>
</tr>
</thead>
<tbody>
<tr>
<td>In-network</td>
<td>Out-of-network</td>
<td>In-network</td>
</tr>
<tr>
<td>100% paid; no deductible</td>
<td>100% paid; reasonable and customary (R&amp;C) as applicable; no deductible</td>
<td>100% paid; no deductible</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Annual deductible (applies to medical, behavioral health/chemical dependency, and prescription drug expenses combined)</th>
<th>Retiree Core Option</th>
<th>Retiree Premium Saver Option</th>
</tr>
</thead>
<tbody>
<tr>
<td>$1,400 Retiree/ $2,800 Retiree + Dependent(s) levels</td>
<td>$2,500 Retiree/ $4,000 Retiree + Dependent(s) levels</td>
<td>$2,800 Retiree/ $5,600 Retiree + Dependent(s) levels</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Coinsurance for medical services</th>
</tr>
</thead>
<tbody>
<tr>
<td>Retiree Core Option</td>
</tr>
<tr>
<td>You pay 20% after deductible</td>
</tr>
</tbody>
</table>

| Prescription drugs (applies to retail [up to two fills] and mail order)² |
|---|---|
| Generic | No charge after meeting the deductible |
| Brand formulary (preferred) | You pay 25% coinsurance after deductible; $125 maximum³ |
| Brand non-formulary (non-preferred) | You pay 45% coinsurance after deductible; $250 maximum³ |

<table>
<thead>
<tr>
<th>Maintenance medications filled more than two times at a retail pharmacy other than CVS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Retiree Core Option</td>
</tr>
<tr>
<td>Not covered⁴</td>
</tr>
</tbody>
</table>

| Out-of-pocket maximum (applies to both medical and prescription drug expenses combined)⁵ |
|---|---|---|
| Retiree | Retiree + Dependent(s) (combined family out-of-pocket maximum) | No limit | No limit |
| $5,000 | $10,000 (limited to $5,000 for any one family member) | No limit | $12,000 (limited to $6,000 for any one family member) |

¹. Not applicable to retirees in Puerto Rico and Hawaii.
². If you purchase a brand-name drug for which a generic equivalent is available, you will be responsible for paying the difference in costs between the two drugs. Additionally, prescription drugs purchased out-of-network are subject to reasonable and customary (R&C) limits.
³. Applies before and after deductible is met when a generic equivalent is not available (e.g., contains the same active ingredients in the same strength). If a generic equivalent is available, you will pay the difference between the generic and brand cost; coinsurance will not apply.
⁴. Maintenance medications filled more than two times at a retail pharmacy other than CVS are NOT covered. You will pay 100% of the cost for your prescription. Your cost does not apply toward your deductible or out-of-pocket maximum.
⁵. The out-of-pocket maximum does not apply to infertility services. There is an infertility lifetime maximum benefit per family (including males and females) of $15,000 for medical and $10,000 for prescription drugs.
Enrolled in the Corteva Medical Plan? Use 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, and you should register for Teladoc as soon as your coverage takes effect so that you are all set when you are not feeling well. Simply set up an account with Teladoc at www.teladoc.com/corteva or call 1-800-TELADOC (1-800-835-2362) for assistance.

Then, when you need help, request a consultation. A doctor can help virtually diagnose and recommend a course of treatment for non-emergency medical problems, such as ear infections, sinus problems, or flu symptoms. In many locations, your Teladoc physician can even call in a prescription to your pharmacy if necessary.

A Teladoc doctor is significantly less expensive than urgent care and emergency room visits, and the charges are applied to your medical plan deductible. Once you meet your medical deductible, each appointment costs even less.

Note: Teladoc is available to covered participants in the Retiree Core and Premium Saver medical plan options. If you are a Medicare-eligible retiree (or a Medicare-eligible dependent of a non-Medicare-eligible retiree), you have access to Teladoc only if the medical plan you purchased through Via Benefits offers this service. Please check with your medical carrier for more details.

Use Network Providers

Medical coverage is offered through Highmark Blue Cross Blue Shield. Highmark BCBS offers a large, nationwide network with access to many high-quality health care providers.

You pay less for services when you use in-network providers. So use Highmark BCBS providers when you can. It’s one of the easiest ways to make the most of your health care dollars.

Medical Plan Monthly Premiums1

<table>
<thead>
<tr>
<th></th>
<th>Retiree Core Option</th>
<th>Retiree Premium Saver Option</th>
</tr>
</thead>
<tbody>
<tr>
<td>Monthly Premiums</td>
<td>(the amount you will owe each month)</td>
<td></td>
</tr>
<tr>
<td>Retiree only</td>
<td>$220</td>
<td>$175</td>
</tr>
<tr>
<td>Retiree + Spouse</td>
<td>$445</td>
<td>$345</td>
</tr>
<tr>
<td>Retiree + Child(ren)</td>
<td>$330</td>
<td>$255</td>
</tr>
<tr>
<td>Retiree + Family</td>
<td>$555</td>
<td>$435</td>
</tr>
<tr>
<td>Spouse only</td>
<td>$225</td>
<td>$170</td>
</tr>
<tr>
<td>Children only</td>
<td>$115</td>
<td>$90</td>
</tr>
<tr>
<td>Spouse + Child(ren)</td>
<td>$340</td>
<td>$280</td>
</tr>
</tbody>
</table>

How to Find Highmark BCBS Providers

- Go to www.highmarkbcbsde.com.
- From the tabs at the top of the homepage, click on “Find a Doctor or Pharmacy.”
- Then, click “Find a Doctor, Hospital or other Medical Provider.”
- Under “Pick a Plan,” type “C2B” in the “member ID” field and BCBS PPO will populate the “Plan Name” field.
- Then, do a search by provider name, specialty, or condition.
- Finally, enter your location.

1. These amounts differ for individuals who retired early (prior to earning the full Company subsidy).
How the Medical Plan Works

You receive comprehensive medical coverage benefits with either the Retiree Core or Premium Saver options:

- Annual adult preventive exams are covered at 100% every year — whether you see an in- or out-of-network doctor;
- For non-preventive care, you will pay full costs for your care until you reach your deductible (you can pay for these costs with any HSA contributions you might have, or your personal savings); and
- For in-network care, you pay based on the network-negotiated rate.

### Corteva Retiree Medical Plan

**Receiving in-network preventive care? You pay nothing.**

Any time you receive in-network preventive care, the plan pays 100%.

- Annual physicals
- Immunizations
- Preventive medications

**Haven’t met your deductible? You pay 100%.**

When you receive non-preventive care or prescriptions, you pay 100% until you reach the deductible. There are separate deductibles for in- and out-of-network services.

**Met your deductible? You and the plan share the cost.**

When you receive non-preventive care or prescriptions after you’ve met your deductible:

- The plan pays the majority of the cost: 80% in-network, 60% out-of-network, varying amounts for prescription drugs.
- You pay coinsurance: 20% in-network, 40% out-of-network, varying amounts for prescription drugs.

**Reached your out-of-pocket maximum? The plan pays 100% of in-network covered services for the rest of the year.**

The out-of-pocket maximum is there to protect you from the catastrophic costs of a serious health issue.

---

1. Out-of-network services/expenses are subject to reasonable and customary (R&C) limits.
2. Out-of-pocket limits apply to in-network services only and do not apply to out-of-network services. There is no out-of-pocket maximum for out-of-network claims. Additionally, infertility services are not subject to the out-of-pocket maximum.
3. Includes any contributions made by your spouse.
Prescription Drug Coverage¹

You will be automatically enrolled in prescription drug coverage, administered through CVS Caremark, when you elect retiree medical coverage. Your prescription drug costs will depend on if you choose to purchase drugs at retail or mail order, an in-network or out-of-network pharmacy, and the category of the drug on the CVS Caremark drug list (also called a formulary).

Information on how to view drug pricing, find an in-network pharmacy, and the 2020 formulary is available on the CVS Caremark website at www.caremark.com.

Where to Purchase Medications

You can purchase up to a 30-day supply of a drug at any retail pharmacy, although you may save money when you use an in-network pharmacy. In-network pharmacies include CVS, Walgreens, Giant, Kroger, Rite Aid, Walmart, Target (which are CVS pharmacies), and many others.

For long-term maintenance medications, fill up to a 90-day supply:

- By mail; or
- Order and fill it at a CVS retail pharmacy (including those in Target stores) for the same price as using mail order.

Pay Your Deductible First

You pay the full cost of your medications until you reach your combined medical and prescription drug deductible. Once you meet your deductible, the coinsurance and per prescription maximums in the chart on the next page will apply.

There Are Special Exceptions for Preventive Care Medications

These drugs are not subject to the deductible:

- Preventive care medications, such as generic contraceptives and smoking cessation medications, that are free as part of your Corteva Medical Plan benefits; and
- Certain additional medications identified by the IRS as preventive. Instead of paying toward the deductible, you’ll pay a coinsurance amount, as applicable, which counts toward your out-of-pocket maximum.

These additional medications are 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.

Medications classified as preventive can be confirmed on the CVS Caremark website at www.caremark.com.

¹ Not applicable to retirees in Puerto Rico and Hawai'i.

Bonus! Get 20% Off CVS Health-Brand Health-Related Items

As a CVS Caremark prescription drug program member, you can get a 20% discount off the regular price of most CVS-brand health-related products at retail CVS pharmacies when you use your CVS ExtraCare® Health Card.

When You’ll Pay More — and Less

• If a generic equivalent is available and you choose a brand formulary (preferred) or brand non-formulary (non-preferred) drug: You pay the difference between the cost of the generic and brand-name drug. Coinsurance does not apply.
• For the third and subsequent fills of a maintenance medication filled at a retail pharmacy other than CVS:

Prescriptions filled for a third time at a retail pharmacy other than CVS are not covered. You will pay 100% of the cost.
• If you purchase a prescription drug at an out-of-network pharmacy:

Reasonable and customary (R&C) limits apply.
What You Pay After the Deductible

After you meet your combined medical and prescription drug deductible, here’s what you’ll pay out of your pocket (excluding preventive medications1):

<table>
<thead>
<tr>
<th>Drug Type</th>
<th>Description</th>
<th>You Pay</th>
</tr>
</thead>
<tbody>
<tr>
<td>Generic</td>
<td>Drugs with the same active ingredients and strength as brand-name counterparts, according to the U.S. Food and Drug Administration</td>
<td>No charge after meeting the deductible</td>
</tr>
<tr>
<td>Brand formulary (preferred)</td>
<td>Brand-name drugs available at a lower cost than competing brand-name drugs</td>
<td>25% coinsurance after deductible; $125 maximum2</td>
</tr>
<tr>
<td>Brand non-formulary (non-preferred)</td>
<td>Brand-name drugs with lower-cost alternatives available</td>
<td>45% coinsurance after deductible; $250 maximum2</td>
</tr>
<tr>
<td>Maintenance medications filled more than two times at a retail pharmacy other than CVS</td>
<td>Prescription drugs for long-term health care needs</td>
<td>Not covered3</td>
</tr>
</tbody>
</table>

1. The deductible does not apply to preventive medications, as described above.
2. Applies before and after deductible is met when a generic equivalent is not available (e.g., contains same active ingredients in the same strength). See “When You’ll Pay More — and Less” on the previous page for additional details.
3. Maintenance medications filled more than two times at a retail pharmacy other than CVS are NOT covered. You will pay 100% of the cost for your prescription. Your cost does not apply toward your deductible or out-of-pocket maximum.

More About Mail Order

Purchasing your maintenance medications (up to a 90-day supply) through mail order or at a CVS retail pharmacy can help you avoid paying more coinsurance than necessary — saving you money.

If you fill a prescription for a maintenance medication more than twice at a retail pharmacy other than CVS, your prescription will not be covered and you will pay 100% of the cost. Your cost will not apply toward your deductible or out-of-pocket maximum.

If you take maintenance medication, ask your doctor to write the prescription for up to a 90-day supply, plus refills for up to one year. Fill the prescription at a CVS retail pharmacy, or register on the www.caremark.com website and place your order. When you order online, CVS Caremark will send up to a 90-day supply of your maintenance medications to your home with free delivery. There may be a day supply limitation on some prescriptions, such as controlled substances, subject to state and federal dispensing limitations.
Wondering How Your Prescription Might Be Covered?

Here are the top 10 most frequently prescribed generic medications for Corteva participants and how they’re covered under the prescription drug plan. Remember, you will pay more when choosing a brand-name medication if a generic equivalent is available.

<table>
<thead>
<tr>
<th>Generic Drug Name</th>
<th>Type of Generic</th>
<th>What You Pay</th>
<th>Associated Brand Name</th>
</tr>
</thead>
<tbody>
<tr>
<td>Amoxicillin</td>
<td>Regular</td>
<td>Free after you reach your deductible</td>
<td>Amoxil</td>
</tr>
<tr>
<td>Amoxicillin–Clavulanate Potassium</td>
<td>Regular</td>
<td>Free after you reach your deductible</td>
<td>Augmentin</td>
</tr>
<tr>
<td>Atorvastatin Calcium</td>
<td>Preventive</td>
<td>Deductible waived, $0 copay</td>
<td>Lipitor</td>
</tr>
<tr>
<td>Azithromycin</td>
<td>Regular</td>
<td>Free after you reach your deductible</td>
<td>Zithromax</td>
</tr>
<tr>
<td>Fluticasone Propionate</td>
<td>Regular</td>
<td>Free after you reach your deductible</td>
<td>Flonase</td>
</tr>
<tr>
<td>Hydrocodone–Acetaminophen</td>
<td>Regular</td>
<td>Free after you reach your deductible</td>
<td>Vicodin, Lortab, Loracet Plus, and many others</td>
</tr>
<tr>
<td>Lisinopril</td>
<td>Preventive</td>
<td>Deductible waived, $0 copay</td>
<td>Prinivil, Zestril</td>
</tr>
<tr>
<td>Omeprazole</td>
<td>Regular</td>
<td>Free after you reach your deductible</td>
<td>Prilosec</td>
</tr>
<tr>
<td>Prednisone</td>
<td>Regular</td>
<td>Free after you reach your deductible</td>
<td>Deltasone</td>
</tr>
<tr>
<td>Simvastatin</td>
<td>Preventive</td>
<td>Deductible waived, $0 copay</td>
<td>Zocor</td>
</tr>
</tbody>
</table>

Specialty Medications

CVS Caremark manages specialty medications through CVS Specialty. Specialty medications are drugs that are used to treat complex conditions, such as anemia, growth hormone deficiency, hemophilia, hepatitis C, high cholesterol, multiple sclerosis, and rheumatoid arthritis. Whether they’re administered by a health care professional, self-injected, or taken by mouth, specialty medications require special handling. These drugs are complex to use and expensive, and your therapy could require frequent adjustments to your doses and intensive clinical monitoring.

Clinical Programs

CVS Caremark manages the pharmacy benefit with clinical programs and dispensing rules. If you are affected by any of these programs based on the medicine you take, CVS Caremark will contact you. These clinical programs help control plan costs (including your premium costs) and provide you with clinically appropriate coverage.

An example of a clinical program is Step Therapy, which requires that participants try the most cost-effective drug therapy for certain diagnoses prior to moving to a more expensive therapy, based on a drug list created by CVS Caremark for your prescription drug plan. This list is updated as necessary. If you are a Step Therapy participant who does not respond satisfactorily to the first-line medicine, your plan will consider coverage for an alternative therapy.
Employee Assistance Program (EAP)

ComPsych GuidanceResources, the Employee Assistance Program (EAP) administrator, offers support, resources, and information for personal and work-life issues. It’s a Company-sponsored program, confidential, and provided at no cost to you and your dependents.

Log on to www.guidanceresources.com (use the access code “CORTEVAEAP”) for expert information on your relationships, work, school, children, wellness, legal, financial, free time, and more. You’ll find timely articles, HelpSheetsSM, tutorials, streaming videos, self-assessments, and even an “Ask the Expert” link for personal responses to questions you might have on a variety of topics.

You can also give GuidanceResources a call at 1-833-787-7771 for support with confidential counseling needs, financial information and resources, legal support, and work-life help, including qualified referrals and customized resources for child and elder care, moving and relocation, making major purchases, college planning, pet care, home repair, and more.

How to Search for Exclusive Discounts and Special Offers

All participants can contact ComPsych at 1-833-787-7771 or by visiting www.guidanceresources.com. The access code when you go online or call is: CORTEVAEAP.

Did you know that GuidanceResources offers free access to the Working Advantage members-only program? This unique program gives you access to exclusive discounts and special offers to theme parks, shopping, movie tickets, hotels, Broadway shows, and much more, with savings up to 60% off!

To access the Working Advantage program online, go to the GuidanceResources website and mouse over to “More.” Then select “Discounts.”

A user name and password will be required. If you’re not already registered, follow the steps to create them.
## Dental Plan Coverage

For non-Medicare-eligible retirees who are eligible for dental coverage, you have the choice between two dental plan options administered by MetLife®. When you use providers in the MetLife Preferred Dentist Program Plus (PDP Plus) network, you can limit your out-of-pocket costs. You can find PDP Plus dentists by visiting [www.metlife.com/mybenefits](http://www.metlife.com/mybenefits), or by calling MetLife at 1-888-883-0052. Using network dentists is recommended, but not required by the plan.

<table>
<thead>
<tr>
<th>Coverage</th>
<th>Standard Option</th>
<th>Limited Option</th>
</tr>
</thead>
<tbody>
<tr>
<td>Annual deductible</td>
<td>$50 per person, up to a maximum of $150 per family</td>
<td>None</td>
</tr>
<tr>
<td>Diagnostic and preventive care</td>
<td>Plan pays 100%&lt;sup&gt;1&lt;/sup&gt;</td>
<td>Plan pays 100%&lt;sup&gt;1&lt;/sup&gt;</td>
</tr>
<tr>
<td>- 2 regular cleanings per year or 4 periodontal cleanings with diagnosed condition (2 periodontal cleanings are in lieu of the 2 regular cleanings)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- 2 routine exams per year</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Dental X-rays:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Bitewing X-rays — One time per year</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Whole mouth X-rays — One time every 5 years</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Restorative care</td>
<td>After the deductible, you pay 50%&lt;sup&gt;2&lt;/sup&gt;</td>
<td>Not covered</td>
</tr>
<tr>
<td>Includes bridges, crowns, fillings, and other covered dental services</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Annual benefit limit</td>
<td>$1,500 per person</td>
<td>$500 per person</td>
</tr>
<tr>
<td>Lifetime orthodontic limit&lt;sup&gt;3&lt;/sup&gt;</td>
<td>$1,200 per covered child</td>
<td>Not covered</td>
</tr>
<tr>
<td>For children under age 19</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

1. For out-of-network claims, reasonable and customary (R&C) limits apply. R&C amounts are based on the 90th percentile, which means that 90% of providers in a geographic area charge no more than the R&C amount and 10% charge more.

2. The benefit for the Preferred Dental Provider Plus network dentist is determined on the network-negotiated amount. For out-of-network providers, R&C limits apply, where R&C amounts are based on the 90th percentile. Additional frequency limits may apply to certain covered dental services.

3. The lifetime orthodontic limit is a combined limit for all Corteva dental plan options (for both active employees and retirees).

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### Dental Works Differently

If you choose to enroll in the Limited Dental option, you cannot enroll in the Standard Dental option in the future. Enrolling in the Limited option is a permanent, irrevocable decision.

Dropping dental coverage is also a permanent, irrevocable decision. If you choose to drop dental coverage, you cannot re-enroll in dental coverage in the future unless you lose eligibility under another employer’s group dental plan and can provide proof of continuous coverage (during the period you were not covered by Corteva) under that plan.
When You Become Eligible for Medicare

Once you become eligible for Medicare (typically at age 65), you must use Via Benefits® services to purchase a Medicare Supplement plan for yourself and your eligible dependents. You will receive the Health Reimbursement Account (HRA) funding provided by Corteva to pay for some or all of the cost of the coverage you choose.

If you’re Medicare-eligible with non-Medicare-eligible dependents: Your dependents’ medical and dental coverage depends on your Via Benefits enrollment. If you do not enroll through Via Benefits for yourself, it will be assumed you declined coverage. As a result, you will lose coverage for yourself and your non-Medicare-eligible dependents. Those who are Medicare-eligible will lose their HRA contribution. Declining coverage is a permanent and irrevocable decision.

If your covered spouse is Medicare-eligible and you are not (or vice versa), you will have different retiree health care benefits available to you, and two different ways that you will need to enroll for 2020 coverage. The same applies to other covered dependents.

<table>
<thead>
<tr>
<th>Before You’re Medicare-Eligible</th>
<th>After You’re Medicare-Eligible</th>
</tr>
</thead>
<tbody>
<tr>
<td>Coverage Options</td>
<td></td>
</tr>
<tr>
<td>Receive non-Medicare-eligible coverage options under the Corteva Retiree Medical and Dental Plans (using the information in this guide and what is available through Corteva Connection).</td>
<td>Receive notification of premium changes directly from your individual Medicare plan carriers. (Note: Do not make plan changes through your carrier — see “Enrollment Process” below.)</td>
</tr>
<tr>
<td>Enrollment Process</td>
<td></td>
</tr>
</tbody>
</table>
| Enroll through Corteva Connection:  
  - http://digital.alight.com/corteva  
  - 1-800-775-5955 | You will receive information from Via Benefits including details about how to enroll. Enroll and make plan changes through Via Benefits during the Medicare Open Enrollment period (October 15 – December 7, 2019):  
  - http://my.viabenefits.com/corteva  
  - 1-855-535-7140 |

Becoming Medicare-Eligible Soon?

You and your dependents will automatically receive information directly from Via Benefits and Corteva Connection 90 days prior to becoming Medicare-eligible. This way you can easily make the transition to Medicare-eligible coverage. Be aware that in order to avoid a gap in coverage, you will need to enroll with Via Benefits before you become Medicare-eligible.

For retirees and dependents becoming Medicare-eligible, you will get a packet with materials from Via Benefits to help you enroll in Medicare-eligible retiree coverage directly. Take action as soon as you receive the materials.

About the Health Reimbursement Account (HRA)

When you enroll through Via Benefits, Corteva helps pay for the cost of your medical and dental coverage in the form of an HRA. To get the HRA, you must first be enrolled in Medicare Part A and Part B. Contact the Social Security Administration three months before you turn age 65 about your Medicare eligibility.

The HRA account is funded by Corteva at the beginning of every year for each HRA participant, including Medicare-covered dependents. The amount of your annual HRA allocation is based on your Corteva group health care coverage and considers your retiree health care reduction factor, which is based on your age and service at retirement.

Visit Corteva Connection to see the amount of your HRA allocation.
Retiree Life Insurance

If you are eligible to participate in Retiree Life Insurance, there is no action required on your part to continue your current coverage at 2020 rates. See your personalized enrollment worksheet, included with your enrollment kit, for detailed rate information.

If you need to reduce or cancel your Corteva Retiree Life Insurance, administered by Securian Financial, you can do so at any time during the year using Corteva Connection. You do not need to wait for a qualifying life event or until the next Annual Enrollment period.

About Your Coverage: Life Insurance Age-Related Reductions

The table below explains age-related reductions for retirees of Corteva. If you worked for Pioneer Hi-Bred International, Solae, Danisco, or Genecor, please refer to the Life Insurance Benefits Summary Plan Description, available at www.cortevabenefits.com, for details on your coverage and age-related reductions.

<table>
<thead>
<tr>
<th>When you turn age 65, if you are enrolled in:</th>
<th>What happens:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Retiree Life Insurance</td>
<td>At age 65, the total amount of coverage may not exceed the lesser of (1) the amount of coverage you had at retirement; (2) two times your pay; or (3) $250,000. Your benefit amount is determined, in part, by your retirement date. If you retired on or after January 1, 2015: Your Company-provided coverage amount is $10,000 regardless of age. If you retired prior to January 1, 2015: Your Company-provided coverage is reduced to 25% of your pre-retirement pay ($10,000 minimum) and any supplemental life insurance that you’re purchasing is set to zero. You will receive a personalized enrollment worksheet that shows your buy-back options at group rates. You will not need to provide Evidence of Insurability if you enroll within 31 days. If you take no action at that time, only the reduced Company-provided Retiree Life Insurance continues in force. You will receive notice of your rights to port/convert lost coverage to an individual policy.</td>
</tr>
<tr>
<td>Retiree Noncontributory Group Life Insurance (NCGLI)</td>
<td>Your benefit amount is determined, in part, by your retirement date. If you retired on or after January 1, 2015: Your Company-provided coverage amount is $10,000 regardless of age. If you retired prior to January 1, 2015: Your coverage amount begins reducing at age 65 and reduces annually until you reach age 75. Your coverage amount at age 75 will equal 25% of your pre-retirement pay ($2,500 minimum). Each year, you will receive notice of your rights to port/convert the amount of the reduction. For details on how your annual reductions are calculated, see the Life Insurance Benefits Summary Plan Description, available at <a href="http://www.cortevabenefits.com">www.cortevabenefits.com</a>.</td>
</tr>
<tr>
<td>Retiree Contributory Group Life Insurance (CGLI)</td>
<td>Your coverage amount begins reducing at age 65 and reduces annually until you reach age 75. Your coverage amount at age 75 will equal 50% of your pre-retirement pay ($1,500 minimum). Each year, you will receive notice of your rights to port/convert the amount of the reduction. For details on how your annual reductions are calculated, see the Life Insurance Benefits Summary Plan Description, available at <a href="http://www.cortevabenefits.com">www.cortevabenefits.com</a>.</td>
</tr>
</tbody>
</table>
Life insurance rates

<table>
<thead>
<tr>
<th>Age as of 12/31/20</th>
<th>Premium</th>
</tr>
</thead>
<tbody>
<tr>
<td>Under 55</td>
<td>$0.287</td>
</tr>
<tr>
<td>55-59</td>
<td>$0.341</td>
</tr>
<tr>
<td>60-64</td>
<td>$0.524</td>
</tr>
<tr>
<td>65-69</td>
<td>$1.007</td>
</tr>
<tr>
<td>70-74</td>
<td>$1.633</td>
</tr>
<tr>
<td>75-79</td>
<td>$2.649</td>
</tr>
<tr>
<td>80-84</td>
<td>$4.298</td>
</tr>
<tr>
<td>85-89</td>
<td>$6.969</td>
</tr>
<tr>
<td>90 and older</td>
<td>$12.220</td>
</tr>
</tbody>
</table>

Eligible for NCGLI or CGLI?

Go to Corteva Connection to confirm in which retiree life insurance plan you are enrolled and for your 2020 premium costs.

Premiums are not changing for retirees who have continuously participated in the historic Contributory Group Life Insurance (CGLI) plan (“Option Z”) since December 31, 1992.
Corteva Connection: Your Go-To Place for Personal Benefits Information

The Corteva Connection website at http://digital.alight.com/corteva is easy to use, is secure, and gives you control when it comes to learning about and acting on your benefits. You can access the website 24 hours a day, 7 days a week from any computer with Internet access. Use it to:

• Enroll in your non-Medicare-eligible retiree benefits;
• Access tools to help you compare, choose, and make the most of your retiree health and insurance benefits;
• Manage your personal and dependent/beneficiary information on file with Corteva;
• Review and update your life insurance beneficiaries, if applicable;
• Link and connect to other benefits resources, such as your medical plan carrier; and
• Make changes to your retiree medical benefit elections when you have a qualifying life event during the year and reduce or cancel Retiree Life Insurance at any time during the year.

When you access the site to enroll, estimate your total annual expenses under each medical plan option — including both the out-of-pocket costs you pay for care and your monthly rates.

Using Corteva Connection for the First Time

If you are using Corteva Connection for the first time, you will need to create a user ID and password. Here’s how:

• Go to Corteva Connection at http://digital.alight.com/corteva; and
• On the log-on page, simply click on the “Are you a new user?” link.

You will be asked to provide the last four digits of your Social Security number and your date of birth to establish your user ID and password.

If you haven’t set up your password online, enter your home ZIP code. You’ll also be prompted to create a password, which will expire every 90 days. You’ll use your password when you log on to or call Corteva Connection. (If you have trouble creating a password, you can still speak to a representative who will help you create it.)
Enrolling for Benefits

How to Enroll

You can review and enroll in your Corteva 2020 non-Medicare-eligible benefits coverage through Corteva Connection.

Online
http://digital.alight.com/corteva
Take action with your retiree health and insurance benefits using this personalized website. It gives you the benefits information you need and makes enrollment quick and easy. For enhanced security, you will be required to set up a new password for the site (your user ID will remain the same). Your password for the website will expire every 90 days.

Once you’re logged on, follow the instructions that pop up on your screen to enroll. If you experience any problems enrolling through the website, call Corteva Connection at 1-800-775-5955.

By Phone
1-800-775-5955
Call Corteva Connection and a representative will guide you through the enrollment process and take your elections by phone. Representatives are available Monday through Friday from 9:00 a.m. to 6:00 p.m., ET. Language assistance is available.

When you call, you’ll be asked to confirm your identity by entering your date of birth and, in some cases, your Social Security number. (You may also need to set up a separate, new PIN when you call. Follow the instructions when prompted on Corteva Connection.) You’ll then be connected to a representative.

If You End Your Corteva Retiree Coverage: A Reminder

If you choose to drop your Corteva retiree medical coverage — a permanent, irrevocable decision — coverage eligibility ends for your dependents too.

You may only re-enroll if you show proof that you have been continuously covered under another employer’s group plan during the period that you were not covered by Corteva, and lose eligibility for that other group coverage. You will need to provide this proof within 60 days of when you lose eligibility.

Dropping your dependents’ coverage will not cause your Corteva coverage to end, but it will be a permanent, irrevocable decision — unless they fall into the criteria above. You will not be able to enroll them again.
Changing Your Coverage During the Year: Qualifying Life Events

In general, you cannot change the coverage you elect until the next Annual Enrollment period. The only exception is if you have a “qualifying life event.” If you have a qualifying life event, you can enroll in or change your benefits during the year. The change must be consistent with the type of life event you are experiencing.

Examples of qualifying life events include:

- Divorce;
- Death of a spouse;
- Birth or adoption of a child, or a child placed with you for legal guardianship or foster care;
- Death of a child or child’s loss of eligibility for benefits; or
- A significant change in your eligible spouse’s medical coverage.

To make a benefit change due to a qualifying life event, you need to update your information on Corteva Connection within 31 days of the event.
Other Important Plan Information

Newborns’ and Mothers’ Health Protection Act of 1996 (Newborns’ Act)

Group health plans and health insurance issuers generally may not, under federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, federal law generally does not prohibit the mother’s or newborn’s attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under federal law, require that a provider obtain authorization from the plan or the insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

Women’s Health and Cancer Rights Act of 1998 (WHCRA)

If you have had or are going to have a mastectomy, you may be entitled to certain benefits under the Women’s Health and Cancer Rights Act of 1998 (WHCRA). For individuals receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending physician and the patient, for:

• All stages of reconstruction of the breast on which the mastectomy was performed;
• Surgery and reconstruction of the other breast to produce a symmetrical appearance;
• Prostheses; and
• Treatment of physical complications of the mastectomy, including lymphedema.

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this plan. Therefore, deductibles and coinsurance apply. If you would like more information on WHCRA benefits, call your medical carrier.

HIPAA Notice of Privacy Practices for Protected Health Information

To all Corteva Health Plan participants, this is a reminder that the Corteva HIPAA Notice of Privacy Practices and other related documents are located on the HR Direct website: https://agcompany.sharepoint.com/sites/hr/en/Pages/Corteva-Protected-Health-Information-Forms.aspx. This notice is also available upon request by calling Corteva Connection at 1-800-775-5955. The HIPAA Notice reflects a change to the HIPAA Privacy Official’s name and contact information.
In the event that the content in this guide or any oral or written representations made by any person regarding the plan conflict with or are inconsistent with the provisions of the Plan Document, the provisions of the Plan Document will always govern. In the event of a discrepancy between this guide, the Summary Plan Description, and the Plan Documents, the Plan Documents will govern.

Corteva Agriscience reserves the right to change, modify, suspend, or discontinue at its discretion any of its plans, policies, or programs, in whole or in part, at any time, including any level or form of coverage by appropriate company action. All employees may not participate in all plans described. Further, if you are in a collective bargaining unit, the benefits described are subject to the existing provisions of the collective bargaining agreements and subject to meeting any bargaining obligation.

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